Training Manual for the Minimum Data Set Assessment Tools for Residential Care Facilities (MDS-RCA) and Adult Family Care Homes (MDS-ALS)

Revised by

The Maine Department of Health and Human Services
Office of MaineCare Services

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This document builds on the work of John N. Morris and Katharine Murphy of the Hebrew Rehabilitation Center for the Aged (HRCA) in Boston and Sue Nonemaker, of the Health Care Finance Administration in developing a training manual for the Nursing Home Resident Assessment Instrument and with Catherine Hawes, Charles Phillips, Brant Fries, and Vince Mor on the development of the original RAI training manual.

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1. THE RESIDENTIAL CARE and ADULT FAMILY CARE HOME ENVIRONMENT

1.1. Background and Overview

In light of the growing demand for long-term care and the significance of the assisted housing sector, there is a need for greater understanding of the types of clients being served, the quality of care they receive and the ability to adequately reimburse providers for the care and services required to meet these needs. In Maine, the Minimum Data Set has been developed to assist providers in the care and service planning process. The MDS consists of a core set of screening and assessment elements, including common definitions and coding categories that form a basis for a comprehensive assessment. The MDS does not provide all information a facility will need for a *comprehensive* assessment. Facilities will want to augment and add items to this core set as appropriate to complete their comprehensive assessment process. Additional items relevant to the client's status should be documented in their record.

Information from the MDS assessment also is used to reimburse providers for care and services provided to MaineCare members residing in these settings. As of July 2004, providers of Adult Family Care Home services, also referred to as Level III or Level IV Residential Care Facilities, based on the number of beds in the facility, are required to collect and submit MDS information on all clients for use in quality monitoring and reimbursement.

Maine has a long history of development and use of assessment tools known as the Resident Assessment Instrument (RAI) Minimum Data Set (MDS). Since the early 1990s Maine has used the RAI in nursing facilities for assessment, care planning, quality of care and reimbursement. Maine developed a tool, referred to as the Medical Eligibility Determination (MED) assessment form, to determine eligibility for long term care services. This tool was based on the MDS. In 1995, Maine implemented the MDS for Residential Care facilities (MDS). The MDS is currently used in Level IV Private Non-Medical Institution (PNMI) facilities. The MDS-ALS is similar to the MDS; however, it does not include the Resident Entry Tracking form nor the Correction Forms.

The intent of this manual is to offer guidance, instruction and example for the effective use and completion of the MDS assessment tool. The manual should be readily available for staff use and consultation as they complete the assessment process. Assessing staff should be trained in the use of the MDS prior to its use. The Maine Department of Health and Human Services routinely offers training sessions on how to complete the MDS assessment. Contact the MDS Helpdesk for more information at 207-624-4095 or via email at MDS3.0.dhhs@maine.gov.

1.2. Assessor Responsibilities

As assessors, selected by the owner/operator of the home, it is your responsibility to complete the MDS for each resident in your facility. The assessor will need to conduct interviews with residents and direct-care staff for these residents. The goal is to identify resident's strengths, needs, and preferences to develop a service plan.

Your general responsibilities as an assessor include:

- reading the training materials;

- attending a case mix sponsored training session; This is recommended for residential care facilities (MDS-RCA) and required for adult family care homes (MDS- ALS) in accordance with the MaineCare Benefits Manual.

- completing the assigned number of resident assessments in a thorough, efficient and timely manner;

- maintaining confidentiality;

- editing all completed MDSs for typographical errors and incorrect responses to assure accurate data entry of information into provider software;

- submitting all MDS materials, including assessments, tracking forms, discharges, and corrections as instructed and in a timely manner; NOTE: adult family care homes do not utilize or submit tracking forms or corrections.

It is the responsibility of the facility staff assessor to complete the MDS in a thorough and accurate manner. One MDS must be completed and submitted for each resident.

1.25 Facility Responsibilities

New Facilities

Facilities must be licensed before they can admit residents. Facilities must operate in compliance with state licensure. The MDS assessments are a condition of participation for MaineCare payment and should be performed according to specifications in the MaineCare Benefits Manual and this training manual. The MDS assessment schedule is determined by the date a resident is admitted to a facility.

NOTE: Even in situations where the facility's license is delayed due to the need for a resurvey, the facility must continue performing MDS assessments according to the original schedule based on the resident's admission.

Transfer of Residents

Any time a resident is transferred to a new facility (regardless of whether or not it is a transfer within the same chain), a new assessment must be done within 30 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS-ALS assessments, to support the continuity of resident care. However, when the second facility admits the resident, the MDS-ALS schedule starts from the beginning with an Admission assessment. The admitting facility should of course look at the previous facility's assessment (in the same way they would review other incoming documentation about the resident) for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new admission assessment for the purpose of planning care.

When there has been a transfer of residents' secondary to disasters (flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact DLRS for guidance. When the originating facility determines that the resident will not return to the evacuating facility, the provider will discharge the resident. The receiving facility will then admit the resident and the

MDS-ALS cycle will begin as of the admission date. For questions related to this type of situation, providers should contact DLRS.

Facility Closing

When a facility closes and the facility will no longer be licensed, all residents must be discharged. Residents transferred to another facility are treated as transferring residents and procedures outlined above are followed.

Facility Change in Level of Care

When a facility applies and receives a license for a new level of care new regulatory and payment requirements apply. Facilities are required to know and adhere to these requirements. When a facility that is required to use an MDS assessment changes level of care to another level that also requires an MDS assessment, even when the same buildings are to be used – facilities are required to discharge all residents and admit them to the new level of care. New MDS-ALS admission assessments are completed, and a new assessment schedule is observed. Residents not moving into the new level of care should be discharged and transferred appropriately. Administrative systems including MDS-ALS software should be updated to reflect the requirements of the new level of care.

Facility Situation	Facilities Responsibilities and Procedures
Facility name changes NPI and address remain the same Ownership remains the same	• Facility name change in MDS software header; facility must contact software vendor • Residents remain on the same assessment schedule • Contact Catherine Gunn at Muskie School
Facility ownership changes New NPI number is assigned New owner "assumes assignment" from previous owner	• Change NPI number in MDS software, facility must contact the software vendor • Residents remain on the same assessment schedule • Contact Catherine Gunn at Muskie School
Facility moves to a different building with a new address Ownership remains the same NPI remains the same	• Change address in MDS software – contact Vendor • Residents remain on same assessment schedule • Contact Catherine Gunn at Muskie School
Facility ownership changes Facility may or may not have a new name New NPI number is issued New owner does NOT "assume assignment" from previous owners	• Discharge all residents from old facility • Facility's MDS software reflects new owner's information; facility must contact software vendor • All residents must have new admission assessments completed within 30 days • Contact Catherine Gunn at Muskie School
Facility closes Residents are distributed to new facilities	• Old facility discharges all residents • New facility(s) completes new admission assessments within 30 days • Contact Catherine Gunn at Muskie School
These changes would be required for the following facility types: Adult Family Care home to PNMI, Level IV, Appendix C PNMI Level IV Appendix C to Adult Family Care Home	• Current facility type discharges all residents • New Facility Type completes new admission assessments within 30 days or in accordance with policy • Contact Catherine Gunn at Muskie School

"Assume assignment" means the new owner is accepting the facility's assets and liabilities including history of sanctions, deficiencies, resident assessments, Quality Indicators, debts, etc.

Contact Catherine Gunn at Muskie School at 780-5576 for any of the above situations.

1.3. Contacts with Caregiver Staff

When selecting a staff person to interview - that is, to provide information about a resident—remember that he/she must provide direct personal care or assistance to the residents. It is inappropriate to interview the housekeeper or the cook if they do not provide any direct care or assistance to residents.

Some staff respondents may be eager to talk in more detail than is necessary about the home, the residents, or other topics. When a staff person strays from the topic at hand, gently guide him or her back to the questions. For example, you might say, "That's interesting, now I need to know," or "Let's get back to…," and continue immediately to the next item. You should keep in mind that some staff persons might be reluctant to answer certain questions. Read the staff consent form to them and reassure them that all information we collect will be kept strictly confidential.

1.4. Contacts with Residents

When interviewing residents, keep in mind that they may have scheduled activities they want to attend, or they may get tired. Offer to come back at a later time during your visit. Some residents may be eager to talk in more detail or wander from the subject. Gently guide him or her back to the questions, using the techniques mentioned earlier. If residents are reluctant to answer questions reassure them that all information we collect will be kept confidential.

2. CONFIDENTIALITY REQUIREMENTS AND RESIDENTS' RIGHTS

2.1. The Importance of Maintaining Confidentiality

It is crucial that all information gathered from any source be treated as confidential. No information can be divulged that in any way would serve to identify any individual resident, operator, staff or home. Each assessor is bound by the strictures of confidentiality.

As often as possible, attempt to conduct individual interviews in private. This will decrease the likelihood that others will overhear responses. For example, you can ask the resident to go with you to a room or area that is private, or where you will find a quiet space.

You, as the interviewer, need to be aware of relevant laws, regulations, and project rules about confidentiality. This will better prepare you to reassure respondents about the confidentiality of the information that is collected. In addition, you have a responsibility to keep any information you collect totally confidential and not to discuss any home, resident, or staff person by name with anyone other than staff at the Muskie School of Public Service that is the States' designated MDS data-collector or the Department of Health and Human Services. For example, someone may question you about other homes that are participating or about residents' responses. If you respond, "I'm sorry, but that is confidential information, and I am not permitted to discuss it," you will not only be in compliance with the rules and laws but will also provide additional evidence of the sincerity of the facility's confidentiality assurances.

Keep all completed forms with you; do not leave them where someone else can read them. It is important that you exhibit behaviors that express your commitment to confidentiality. This will encourage accurate responses.

All information that is sent to the Muskie School is filed and maintained in accordance with the Institute's policies for assuring that information is confidential. Data confidentiality and security is governed by a Business Associates Agreement (BAA) between the Maine Department of Health Human Services, Office of MaineCare Services and the Muskie School.

3. GENERAL PROCEDURES FOR COMPLETING THE INSTRUMENTS

This section includes detailed instructions for your preparation and use of the questionnaires. A detailed set of item-by-item instructions for each questionnaire is included in the next chapter.

3.1. Completing the Assessments

Resident Records

The resident's record may include a medical eligibility determination (MED) assessment referral form and physician notes, admission document, a case manager's service plan, flow sheets, focused charting, as well as other information. This record will serve as one source of information. Efficient use of this record will allow you to identify quickly what you need from the record and move on. Note: MED assessments are not required to determine eligibility for residents in an Adult Family Care Home, but there are eligibility requirements described in the MaineCare Benefits Manual, Chapter II, Section 2.

As much information as possible should be obtained from the record for the Basic Assessment Tracking Form, Sections AA and AB of the Face Sheet, and Section A, Identification and Background Information. However, assessment of resident functioning, review of documentation, and interviews with residents and staff will provide most of the information for completion of the MDS form.

Resident, Family and Staff Interviews

When interviewing the residents, family and/or staff, help them feel at ease and comfortable with the interview. During the initial contact and throughout the interviewing process you should:

- maintain a positive attitude;
- assume a nonjudgmental, noncommittal, neutral approach to the subject matter so that the questions will be answered truthfully;
- reassure respondents that any information you obtain will be kept confidential;
- maintain control of the interview.

3.2. Probing

You will sometimes need to probe residents to obtain a more complete, accurate, or specific answer. Knowing the objective of a question will allow you to better define the objectives of each question and will help you make this decision.

To elicit complete, satisfactory answers, it will often be necessary to use an appropriate neutral probe. In probing **do not suggest answers or lead the respondent.** General rules for probing are:

- Use neutral questions or statements to encourage a respondent to elaborate on an incomplete response. Examples of neutral probes are “What do you mean?” “How do you mean?” “Tell me what you have in mind” and “Tell me more about….”.

- Pause or hesitate (a silent probe) to indicate that you need more or better information. This is a good probe to use after you have determined the respondent's response pattern.

- Use clarification probes when the response is unclear, ambiguous, or contradictory. Be careful not to appear to challenge the respondent when clarifying a statement and always use a neutral probe. An example of an appropriate probe is: “Please be more specific.

- Repeat the question or item if it appears to have been misunderstood or misinterpreted.

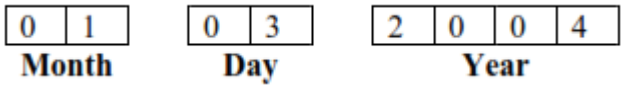
3.3. Recording Responses to Items

Most sections of this assessment form require you to check one response, check all that apply, or enter a response in columns. These sections are lettered from AA to T. Each section contains one or more items labeled sequentially. For instance, the third item in Section B would be referred to as “B3,” the fifth item in Section O would be “O5”. ***Understanding these labeling conventions is very important because of another standard questionnaire convention called “skip patterns.”*** Whenever you attempt to respond to the items, remember to follow their sequence as closely as possible with the separate sections (e.g., Section B).

Each section of the MDS also has columns containing blocks, which correspond to each item. Each item has a description of the information to be obtained. The basic answer formats used to record the information are:

- Items for which a line is provided requesting non-standard information: for these items, fill in the most complete, yet accurate response possible using BLOCK-LETTERED PRINTING.

All lines requiring a numeric entry for weight or height are to be recorded using standard (non-metric) measurements with numbers rounded to the nearest whole number. Ninety-eight pounds, 5 ounces would be recorded as “98 lbs.” Similarly, a height of just over 64 and one-half inches may be recorded as “65 inches”. Where month, day, and year are to be recorded, enter two digits for the month and the day and four digits for the year. For example, the third day of January of this 2004 would be recorded as:



The appropriate response for white boxes is a check mark. The check mark signifies a “Yes,” and the item applies to the resident. A blank (no check mark) signifies a response of “No,” and the item does not apply to the resident. The appropriate response for a line is to record the numeric code for the correct response only. Darkly shaded (black) boxes are to create space between items and should be left blank. It is important that you record the proper type of information for each item.

3.4. Instrument and Recording Conventions

The recording practices below must be followed at all times. This will ensure that the responses are recorded in a uniform manner, that they accurately reflect the respondent's answers, and that the assessment data can be converted to computer files.

- Use black or blue ink,
- Print legibly,
- Listen to what is said by the residents and staff and record the answer if the response satisfies the objective of the item, as stated in the item-by-item specifications. If the answer does not satisfy the objective, probe or obtain the information from another source.
- Fill in the box with the correct number/response or place a check mark in the box corresponding to the correct response.
- Record a "dash" (-) if an item cannot be answered because there is no information available in the resident's record.
- Note that "None of the Above" is a response option in several items. USE THIS TO INDICATE THAT NONE OF THE OTHER RESPONSES APPLY, NOT TO SIGNIFY A LACK OF INFORMATION ABOUT THE ITEM (e.g., no information available).

Mandatory Response Selection

You have several types of responses for each MDS item. These include a check mark, a numerical entry, or a pre-assigned code. In cases where information is unavailable and, despite your continued probing, will remain unavailable, you are to enter a circled dash or enter (-).

Items may be left blank as a result of skip pattern directions. Parts of items may also be left blank when you are instructed to "check all that apply." Any items that are left blank will be edited to determine if you were directed to leave the item blank. When relevant items are discovered to be missing, it will be necessary to recover the missing items. A dash - will always be interpreted to mean that you tried various sources to obtain an answer for this item and there is no way that you, or any other assessor, could determine the correct response.

It is inconvenient and costly to contact you and request that you retrieve the missing information; therefore, it is essential that you make every attempt to be thorough in your efforts when you edit your work.

3.5. Sources of Information for the Assessment

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

The Resident's Record

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

Direct Care Staff

Staff that provides direct care to residents is a vital source of information about the resident's cognitive performance, health, and physical and social functioning. Other staff may provide useful insights, but the staff member who provides care on most days to the resident is the single best source of staff information.

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

The Resident

The resident is a critical source of information. Most residents, including many with mild to moderate cognitive impairment, will be valuable sources of information about their routines, preferences, mood, and psychosocial well-being as well as their cognitive status and physical functioning in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Discussions with the resident are an essential part of the assessment. When residents cannot communicate or are so impaired cognitively that they cannot verbally impart useful information, observation of the resident may provide a method to gain information.

The Resident's Family

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

3.6. Order to Follow in Completing the MDS

There is no required order of completion. You should let the availability of residents and staff, as well as, the timing of access to resident's records, helps determine the order in which you seek information for specific items and complete items and sections. However, you should look over the MDS carefully and consider:

- which items require information from the resident's record (or another source such as the billing office) so that you can complete all these items during one review of the record;
- which items for which a discussion with the resident is essential (e.g., customary routine, mood, psychosocial well-being, activity preferences and patterns, cognitive status), so that you can group them in your discussion with the resident; and

- which items require specific discussions (or probes) with staff.

When you find conflicting reports about a resident's functioning in a particular area, seek additional information to clarify the issue and, when possible, resolve the apparent conflict. When a conflict remains, use your best judgment in reaching a decision. There must be documentation in the clinical record of the decision-making process when there is a conflict between various sources of documentation.

3.7. The MDS Is Not a Questionnaire

The items on the MDS are not questions, and you should not proceed through the assessment as if they were (e.g., "are you feeling suicidal today?") Instead, the items are part of a structured inquiry using multiple sources of information to discover the **resident's strengths, preferences and needs.**

You will also find that having a discussion with the resident, which may start with the topic of his or her life and routines before entering the facility, spontaneously provides the information you need to assess other items (e.g., mood, relationships with others, long-term memory).

- Complete the review of the resident's record, as specified under the assessment procedures. As you review the record, note MDS items, which can be scored solely by using information from the resident's record.

3.8. Overview to the Item-by Item Guide to MDS

This chapter provides information to facilitate an accurate resident assessment. Item-by-item instructions focus on:

- the intent of items included on the MDS

- supplemental definitions and instructions for completing MDS items,

- reminders of which MDS items refer to a time frame for observing the resident other than the standard 7-day observation period, and

- sources of information to be consulted for specific MDS items.

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

Intent: Reason(s) for including the item (or set of items) in the MDS discussions of how the information will be used by staff to identify resident problems and develop the service plan.

Definition: Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an item. Sources include:

- Discussion with facility, staff, both licensed and non- licensed staff members
- Resident interview and observation.
- Records - physician orders, laboratory results, medication records, treatment sheets, service plans, and any similar documents in the facility record system.
- Discussion with the resident's family

Coding: Documentation is required to support the time periods and information coded on the MDS as this ensures an accurate resident assessment

4. BASIC ASSESSMENT TRACKING FORM

Section AA. Identification Information

This section provides the background information for each resident. This identification information is necessary to track the resident in the automated system. The Basic Assessment Tracking Form includes all items in Section AA. Identification Information (AA1.- AA8.). The Basic Assessment Tracking Form is completed with all assessments and discharges. This section is also included in the "face sheet" in adult family care homes. The Face Sheet includes Sections AA - AD and is completed at the time of the client's initial admission to the facility.

AA1. <u>Resident Name</u>

Definition: Legal name in record

Coding: Enter, in the following order - a.) First name, b.) Middle initial, c.) Last name, d.) Jr. /Sr. If the resident goes by his or her middle name, enter the full middle name. If the resident has no middle initial, leave item (b) blank.

AA2. <u>Gender</u>

Coding: Check "1" for Male or "2" for Female.

AA3. <u>Birth Date</u>

Coding: Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0".

For example: January 2, 1918 should be entered as:

0	1		0	2		1	9	1	8
Month			**Day**			**Year**			

AA4. Race/Ethnicity

Process: Check the race or ethnic category the resident uses to identify himself or herself. Consult the resident, as necessary.

Coding: Choose only one answer.

AA5. Social Security and Medicare Numbers

Intent: To record resident identifier numbers.

Process: Review the resident's record; if these numbers are missing, consult with your facility's business office.

Coding: Enter one number per box starting with the left-most box; recheck the number to be sure you have written the digits correctly.

a. Social Security Number – Enter the social security number of the resident, one number per box

b. Medicare number (or comparable railroad insurance number) - Approximately 98% of persons age 65 or older have a Medicare number. Enter the resident's Medicare number. This number occasionally changes with marital status. If a question arises, check with your facility's business office, social worker, or a family member. In rare instances, the resident will have neither a Medicare number nor a Social Security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, place a "C" in the left most Medicare Number box and continue entering the number itself one digit per box, beginning with the second box. This field may be left blank if there are not enough spaces to accommodate the new numbering system.

AA6. Facility Name and Provider Numbers

Intent: To record the facility's name and provider number.

Definition: The name and provider number assigned to the Residential Care Facility or Adult Family Care Home.

Process: You can obtain the facility's name from the facility's business office or owner. The provider number is assigned by the Muskie School of Public Service. Once you have these items, they apply to all residents of that facility

Coding: Write the facility name on the line provided. To record the facility number, begin writing in the left-hand box. Enter one digit per box. Recheck the number to be sure you have entered the digits correctly.

AA7. MaineCare (formerly Medicaid) Number (if applicable)

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

AA8a. Signature(s) of Person(s) Completing Tracking Form (RCF only)

Coding: Staff who completed parts of the Tracking Form of the MDS must enter their signatures, their title, the sections they completed or edited, and the date they completed the sections. The date should reflect the date the tracking form information is completed.

AA8c. Date Tracking Form Completed (RCF only)

Intent: This item should reflect the date that the Tracking Form information is completed or amended.

Coding: Enter the date the Tracking Form Information is completed. Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 3, 2004 should be entered as:

0	1
Month	

0	3
Day	

2	0	0	4
Year			

5. BACKGROUND INFORMATION- Demographic Information

This section provides the background information for each resident. It is also known as the "Face Sheet" in residential care facilities. The Face Sheet includes items AB - AD and is completed at the time of the resident's initial admission to the facility and should be maintained in the resident's record. Most software programs, if used, contain this section. When subsequent assessments are completed, do not sign or date this section again. If changes must be made to the original responses, make these changes by hand on the original paper copy using the standards of practice for documentation, including date and signature of change(s).

Section AB. Demographic Information

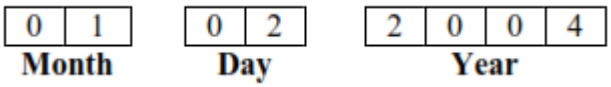
AB1. Date of Entry

Intent: Normally the MDS Face Sheet (Sections AB through AD) is completed only once, when an individual first enters your facility. However, the face sheet is also required if the person is entering your facility after a discharge.

Definition: Date the stay began - The date the resident was most recently admitted to your facility.

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

Coding: Use all boxes. For a one-digit month or day, place a zero in the first box. For example: January 2, 2004 should be entered as:



AB2. <u>Admitted From (At Entry)</u>

Intent: To facilitate care planning by documenting the place from which the resident was admitted to the facility or home on the date given in item AB1. For example, if the admission was from an acute care hospital, an immediate review of current medications might be warranted since the resident could be at higher risk for delirium associated with acute illness, medications or anesthesia. Or, if admission was from home the resident could be grieving due to losses associated with giving up one's home and independence.

Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification.

Definition: The location of the resident immediately before he/she entered your facility (e.g., the day before).

1. **Private home or apartment** - Any house, condominium or apartment in the community whether owned by the resident or another person. Retirement communities and independent housing for the elderly are included in this category if they are not licensed as a domiciliary care or assisted living facility.

2. **Other board and care/assisted living group home** - A community residential setting that provides room, meals, and protective oversight and provides or arranges other services such as personal care, medication supervision, transportation, and home health care.

3. **Nursing home** - A licensed facility devoted to providing medical nursing or custodial care over an extended period of time.

4. **Acute care hospital** - A facility devoted primarily to treatment of serious illnesses, usually for a short period of time.

5. **Psychiatric hospital** - A hospital for the treatment of persons needing mental care around the clock.

6. **ID/DD facility** – Facilities for People with Intellectual Disabilities (ID) or Developmental Disabilities (DD). Examples include ID/DD

institutions, intermediary care facilities for people with intellectual disabilities and group homes.

7. Rehabilitation hospital - A hospital facility or unit providing inpatient rehabilitative services.

8. Other - Includes hospice.

Process: Review admission records. Consult the resident and the resident's family.

Coding: Check only one answer. Specify the location if you check "other".

AB3. <u>Lived Alone (Prior to Entry)</u>

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

Definition: In other facility - Any institutional/supportive setting, setting such as nursing home, group home, sheltered care, board and care home.

Process: Review admission records. Consult the resident and the resident's family.

Coding: If living in another facility (i.e. nursing facility, group home, assisted living) prior to admission to the nursing home, check "2".
If the resident was not living in another facility prior to admission to the nursing home, check "0" or "1" as appropriate.

<u>Examples</u>

Mrs. H lived alone, and her daughters took turns sleeping in her home so she would never be alone at night. Check "0" for No (did not live alone). However, if her daughters stayed with her only 3-4 nights per week, check "1" for Yes (lived alone).

Mr. J lived in his own second-floor apartment of a two-family home and received constant attention from his family, who lived on the first floor. Check "0" for No (did not live alone).

Mrs. X was the primary caregiver for her two young grandchildren, who lived with her after their parent's divorce. Check "0" for No (did not live alone).

Mrs. K was admitted directly from an acute care hospital. She had been living alone in her own apartment prior to hospital stay. Check "1" for Yes (lived alone).

Mr. M, who has been blind since birth, was admitted with his seeing eye dog, Rex. Mr. M. and Rex lived together for the past 10 years in housing for the elderly. Check "1" for Yes (lived alone).

Mr. G lived in a board and care home. Check "2" (In other facility).

AB4. Zip Code of Prior Primary Residence

Definition: Prior primary residence. The community address where the resident last resided prior to admission. A primary residence includes a primary home or apartment board and care home, group home. If the resident was admitted to your facility from a nursing home or institutional setting, the prior primary residence is the address of the resident's home prior to entering the nursing home, State mental institution, 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 town, state and zip code. For zip code, enter one digit per box beginning with the left box. For example, Beverly Hills, CA 90210 should be entered as Beverly Hills, CA:

9	0	2	1	0

Examples

Mr. T was admitted to the facility from the local hospital. Prior to hospital admission he lived with his wife in a trailer park in Jensen Beach, Florida. Enter the zip code for Jensen Beach.

Mrs. F was admitted to the facility after spending 3 years living with her daughter's family in Chapel Hill, NC. Prior to moving in with her daughter, Mrs. F lived in Vine Swamp, NC, for 50 years with her husband until he died. Enter the Chapel Hill zip code. Rationale: Her daughter's home was Mrs. F's primary residence prior to moving to the facility.

Ms. Q was admitted from a state psychiatric hospital in Butner where she had spent the previous 16 years of her life. Prior to that, Ms. Q lived with her parents in Wilmington, NC. Enter the Wilmington zip code.

AB5. Residential History 5 Years Prior to Entry

Intent: To document the resident's previous experience living in institutional or group settings.

Definitions:

a. Prior stay at this home - Resident's prior stay was terminated by Discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

b. Nursing home - Prior stay in one or more nursing homes. If the resident had a prior stay at an attached nursing home (i.e., a multi-level facility with nursing home/ assisted living combination but was in the nursing home part of the facility), check nursing home.

c. Other residential facility – Board and care home, assisted living, and group home.

d. MH/psychiatric setting – Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

e. ID/DD Facility – Examples include facilities for residents with intellectual disabilities (ID) or developmental disabilities (DD), intermediate care facilities for the intellectual disability (ICF/IDs), and ID/DD group homes.

f. None of the above

Process: Review the admission record. Consult the resident or family. Consult the resident's physician.

Coding: Check ALL institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1.) Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to (i.e., the place the resident called "home" at that time). If the resident has not lived in any of these settings in the past five years, check ***NONE OF ABOVE.***

AB6. Lifetime Occupation

Intent: To identify the resident's role or past role in life and to establish familiarity in how staff should address the resident. For example, a resident may appreciate being referred to as "Doctor" if they trained and worked as a doctor. Knowing a person's lifetime occupation is also helpful for care planning purposes. For example, a carpenter might enjoy pursuing hobby shop activities.

Coding: Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left box. The lifetime occupation of a person whose primary work was in the home should be recorded as "Homemaker." When two occupations are identified, place a slash (/) between each occupation. A person who had two careers (e.g., carpenter and night watchman) should be recorded as "Carpenter/Night Watchman".

AB7. Education (Highest Level Completed)

Intent: To record the highest level of education the resident attained. Knowing this information is useful for assessment (e.g., interpreting cognitive patterns or language skills) and planning for resident education in self-care skills.

Definition: Code the highest level of education attained.

1. No schooling – Resident did not attend school.

2. 8th grade or less – Resident completed elementary school but did not attend high school.

3. 9 – 11 grades – Resident attended high school but did not graduate**.**

4. High school – Resident completed and received a high school diploma or equivalent (e.g. GED).

5. Technical or Trade School: Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g., carpentry, plumbing, acupuncture, baking, secretarial, computer programming, etc.).

6. Some College: Includes completion of some college courses, junior (community) college, or associate degree.

7. Bachelor's Degree: Includes any undergraduate bachelor's level college degree.

8. Graduate Degree: Master's degree or higher (MS, Ph.D., M.D., JD, etc.).

Process: Ask the resident and significant other(s). Review the resident's record.

Coding: Check the best response.

AB8. Primary Language

Definition: Primary language - The language the resident primarily speaks or understands.

Process: Interview the resident and family. Observe and listen. Review the clinical record.

Coding: Check "0" for English,"1" for Spanish, or "2" for French. If the resident's primary language is not listed, check "3" for Other and print the resident's primary language on the line below.

AB9. Mental Health History

Intent: To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

Definition: Resident has one of the following:

A. Intellectual Disability;

B. Mental illness, i.e. schizophrenic, mood or paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder, other psychotic disorder or other mental health disorder that may lead to chronic disability;

C. Developmental disability;

BUT

Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder

AND

The disorder results in functional limitations, and the treatment history indicates that the individual has experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required.

Process: Review the resident's clinical record only. For a "Yes" response to be entered, there must be written documentation (i.e., verbal reports from the resident or resident's family are not sufficient).

Coding: Check "0" for No or "1" for Yes.

AB10. <u>Conditions Related to ID/DD Status (Intellectual Disability/ Developmental Disabilities)</u>

Intent: To document conditions associated with intellectual disability or developmental disabilities.

Definition: For item 10f, "Other organic condition related to ID/DD" -Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrocephaly, meningomyelocele, congenital hydrocephalus, etc.

Process: Review the resident's clinical record. For any item (10b through 10g) to be checked, the condition must be documented in the clinical record.

Coding: Check all conditions related to ID/DD status that were present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

If an ID/DD condition is not present, check item 10a ("Not Applicable - No ID/DD") and skip to Section AB11, Alzheimer/Dementia History.

If an ID/DD condition is present, check "Yes" for each condition that applies.

If an ID/DD condition is present but the resident does not have any of the specific conditions listed, check items 10g ("ID/DD with No Organic Condition").

AB11. Alzheimer's or other Dementia History

Intent: To document a primary or secondary diagnosis of Alzheimer's disease or dementia other than Alzheimer's disease.

Definition Resident has one of the following:

- Alzheimer's disease;
- Dementia other than Alzheimer's disease;

AND

The diagnosis results in functional limitations, and the treatment history indicates that the individual has experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required.

Process: Review the resident's clinical record only. For a "Yes" response to be entered there must be written documentation (i.e., verbal reports from the resident or resident's family are not sufficient). Check "1" for Yes.

Section AC. Customary Routine

AC1. Customary Routine

(In the year prior to DATE OF ENTRY to this facility, or year last in community if now being admitted from a nursing home or psychiatric hospital)

Intent: These items provide information on the resident's usual community lifestyle and daily routine in the year prior to DATE OF ENTRY (AB1) to your facility, or in the year the resident was last in the community, if they are now being admitted from a nursing home or psychiatric hospital. If the resident is being admitted from another home, nursing home, or hospital, review the resident's routine during the last year the resident lived in the community. The items should initiate a flow of information about any other topics addressed in the MDS, such as cognitive patterns, activity preferences, ADL scheduling and performance, psychosocial well-being, mood, continence issues, etc. The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the MDS that focus on particular-functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized service plan.

Process: Engage the resident in conversation. A comprehensive review can be facilitated by a questioning process such as described in Guidelines for Interviewing Resident that follows. If the resident cannot respond (i.e., is severely demented or aphasic), ask a family member or other

representative of the resident (i.e.,) legal guardian). For some residents you may be unable to obtain this information) i.e., a demented resident who first entered the facility many years ago and has no family to provide accurate information).

Definition:

Cycle of Daily Events

a. Stayed up late at night (e.g., after 9 pm)

b. Napped regularly during day – at least 1 hour

c. Went out 1 or more days per week – Went outside for any reason (i.e., socialization, fresh air, or clinic visit).

d. Stayed busy with hobbies, reading or fixed daily routine

e. Spent most of time alone or watching TV

f. Moved independently indoors – with appliances, if used

g. Use of tobacco products at least daily - Smoked any type of tobacco (i.e., cigarettes, cigars, and pipe) at least once daily. This item also includes sniffing or chewing tobacco.

h. None of above

Eating Patterns

i. Distinct food preferences - This item is checked to indicate the presence of food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; hates hot dogs; allergic to wheat and avoids bread. *Do not check this item for simple likes and dislike.*

j. Eats between meals all or most days

k. Use of alcoholic beverages(s) at least weekly – Drank at least one alcoholic drink per week.

l. None of Above

ADL Patterns

m. In bedclothes much of day

n. Wakened to toilet all or most nights – Awoke to use the toilet at least once during the night all or most of the time.

o. Had irregular bowel movement pattern – Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether the resident prefers a different pattern.

p. Showers for bathing

q. Sponge bath

r. Bathing in PM – Took shower or bath in the evening.

s. None of Above

Involvement Patterns

t. Daily contact with relatives/close friends – Includes visits and telephone calls. Does not include exchange of letters only.

u. Usually attended church, temple, or synagogue (etc.) – Refers to interaction regardless of type (i.e., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

v. Found strength in faith

w. Daily animal companion/presence – Refers to involvement with animals (i.e., house pet, seeing-eye dog, fed birds daily in yard or park).

x. Involved in group activities

y. None of Above

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

Process: Engage the client in conversation. A comprehensive review can be facilitated by a questioning process such as described in Guidelines for Interviewing Client that follows.

If the client cannot respond (i.e., is severely demented or aphasic), ask a family member or other representative of the client (i.e., legal guardian). For some clients you may be unable to obtain this information (i.e., a demented client who first entered the facility many years ago and has no family to provide accurate information).

Coding: Coding is limited to selected routines in the year prior to the resident's first admission to a residential care facility. Code the resident's actual routine rather than his or her goals or preferences (i.e., if the resident would have

liked daily contact with relatives but did not have it, do not check "Daily contact with relatives/close and friends").

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

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

If information is unavailable for all the items in the Customary Routine section, check the final box "UNKNOWN". If UNKNOWN is checked, no other boxes in the Customary Routine section should be checked.

Guidelines for Interviewing Client

Staff should regard this step in the assessment process as a good time to get to know the client as an individual and an opportunity to set a positive tone for the future relationship. It is also a useful starting point for building trust prior to asking difficult questions about urinary incontinence, advanced directives, etc.

The interview should be done in a quiet, private area where you are not likely to be interrupted. Use a conversational style to put the client at ease. Explain at the outset why you are asking these questions ("Staff want to know more about you so you can have a comfortable stay with us," "These are things that many older people find important," "How you usually spend your day.")

The interview should be done in a quiet, private area where you are not likely to be interrupted. Use a conversational style to put the client at ease. Explain at the outset why you are asking these questions ("Staff want to know more about you so you can have a comfortable stay with us," "These are things that many older people find important," "How you usually spend your day.")

Begin with a general question – i.e., "Tell me, how do you spend a typical day before coming here (or before going to the first facility)?" or "What were some of the things you liked to do?" Listen for specific information about sleep patterns, eating patterns, preferences for timing of baths or showers, and social and leisure activities involvement. As the client becomes engaged in the discussion, probe for information on each item of the Customary Routine section (i.e., cycle of daily events, eating patterns, ADL patterns, involvement's patterns). Realize, however, that a client who has been in an institutional setting for many years prior to coming to your facility may no longer be able to give an accurate description of pre-institutional routines.

Some clients will persist in describing their experience in the long-term care setting and will need to be reminded by the interviewer to focus on their usual routines prior to admission. Ask the client "Is this what you did before you came to live here?"

If the client has difficulty responding to prompts regarding particular items, backtrack by re-explaining that you are asking these questions to help you understand how the client's usual day was spent and how certain things were done. It may be necessary to ask a number of open-ended questions in order to obtain the necessary information. Prompts should be highly individualized.

Mentally "walk" the client through a typical day. Focus on usual habits, involvement with others, and activities. Phrase questions in the past tense. Periodically reiterate to the client that you are interested in the client's routine before assisted housing facility admission, and that you want to know what he or she actually did, not what he or she might like to do.

For Example:

After you retired from your job, did you get up at a regular time in the morning?
When did you usually get up in the morning?
What was the first thing you did after you arose?
What time did you have breakfast?
What happened after breakfast? (probe for naps or regular post-breakfast activity such as reading the paper, taking a walk, doing chores, washing dishes.)
When did you have lunch? Was it usually a big meal or just a snack?
What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
Did you ever have a drink before dinner? Every day? Weekly?
What time did you usually bathe? Did you usually take a shower tub bath? How often did you bathe? Did you prefer AM or PM? Did you snack in the evening?
What time did you usually go to bed? Did you usually wake up during the night?

Section AD. Face Sheet Signatures

AD1. Signature(s) of Person(s) Completing Face Sheet

Coding: Staff who completed parts of the Background sections of the MDS must enter their signatures, their title, the sections they completed, and the date they completed the sections.

AD2. Date Completed

Intent: This item should reflect the date that the Background Face Sheet Information is completed or amended.

Coding: Enter the date the Background Face Sheet Information is originally completed. If a knowledgeable family member is not available during the 30-day assessment period, it is difficult to fill in all the background information

requested on this form. However, the information is often obtained at a later date. As new or clarifying information becomes available, the facilities may record any additional information on the form itself and then enter the date of this revision in the margin next to the item. Initial the correction and show the date. Signature should be only of staff member who completed this section.

Example

Mr. B was admitted to your facility on 12/01/03 and was unable to communicate. By reviewing transmittal records that accompanied him from the acute care hospital, you find that you are only able to partially complete Section AC (Customary Routine). You decide to complete what you can by the 30th day of Mr. B's residency (the date the MDS is to be completed). On 12/30/03, Mr. B's only relative, a daughter, visits and you are able to obtain additional information from her. Enter the

new information (i.e., demographic or customary routines) on the form and then enter the date 12/30/03 for item AD 2.

6. FUNCTIONAL ASSESSMENT

Section A. Identification and Background Information

A1. Resident Name

Definition: Legal name in resident's record

Coding: Print the resident's names in the following order – a.) first name, b.) middle initial, c.) last name, d.) Jr. /Sr. If the resident goes by his or her middle name, enter the full middle name. If the resident has no middle initial, leave item (b) blank.

A2. Social Security and Medicare Numbers

Intent: To record resident identifier numbers.

Process: Review the resident's record; if these numbers are missing, consult with your facility's business office.

Coding: Begin writing one number per box starting with the left-most box; recheck the number to be sure you have written the digits correctly.

a. Social Security Number – Enter the Social Security number of the resident, one number per box.

b. Medicare number (or comparable railroad insurance number) – Approximately 98% of persons age 65 or older have a Medicare number. Enter the resident's Medicare number. This number occasionally changes with marital status. If a question arises, check with your facility's business office, social worker, or a family member. In rare instances, the resident will have neither a Medicare number nor a Social Security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, place a "c" in the left most Medicare Number box and continue entering the number itself one digit per box, beginning with the second box. This field may be left blank if there are not enough spaces to accommodate the new numbering system.

A3. Facility Name and Provider Numbers

Intent: To record the facility's name and RCA provider number.

Definition: The name and provider number assigned to the facility.

Process: You can obtain the facility's name from the facility's business office or owner. Contact the Muskie School of Public Service for the Provider number. Once you have these items, they apply to all residents of that facility.

Coding: Write the facility name on the line provided. To record the facility number, begin writing in the left-hand box. Enter one digit per box. Recheck the number to be sure you have entered the digits correctly.

A4. MaineCare (formerly Medicaid) Number

Coding: Record this number if the resident is a MaineCare recipient. Begin writing one number per box in the left-hand box. Enter a "+" in the left most box if the number is pending. If not applicable, enter "N".

A5. Assessment Date

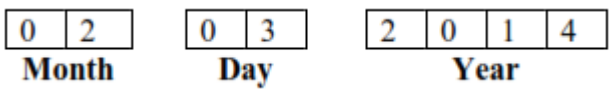
Intent: To establish a common reference point for all staff participating in the resident's assessment. Although staff members may begin their individual evaluation tasks on different dates, they should refer the assessment to a fixed end date, thereby ensuring the commonality of the assessment period.

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

Coding: The first coding task is to enter the observation reference date (e.g., the end date of the observation period). For an admission assessment, this date can be any day up to the 30th day following admission (the last possible date for completing the admission assessment), but as a practical matter, a somewhat earlier date is probably better. For a follow up assessment, select a common reference date within the period the assessment must be completed. This date is the endpoint to which all MDS items must refer.

For an admission assessment, staff will begin to gather some information on the day of admission. An observation end date will be set, often prior to day 30 of residency.

Use all boxes. For a one-digit month or day, place a zero in the first box. For example: February 3, 2014 should be entered as:



A6. Reason for Assessment

Intent: To document the reason for completing the assessment. Most of the types of assessments listed below will require completion of the MDS and development or revision of a comprehensive service plan.

Definition:

1. Admission assessment – A comprehensive assessment is required by day 30. Admission day is counted as day one. The admission assessment includes all items on the Face Sheet: Background Information (Sections AA-AD) and full Assessment.

2. Annual assessment – A comprehensive reassessment is required for all residents within 12 months of the most recent MDS comprehensive assessment.

3. Significant change in status assessment – A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts two or more areas of the resident's clinical status, and requires revision of the service plan. The assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. "Self-limiting" means the condition will normally resolve itself without further intervention or by staff implementing standard interventions within 14 days.

A Significant Change assessment is warranted if there is a consistent pattern of change with two or more areas of **decline or improvement** of the resident's clinical status. Documentation of the identification of an event or situation that may lead to completion of a significant change assessment must be in the resident's clinical record. This note will serve as the beginning of the observation period to determine if there are changes in the resident's condition that meet the definition of "significant change" (i.e. a major change that is not self-limiting, impacts two or more areas of the resident's clinical status, and requires revision of the service plan) to ensure the change in the resident's needs is being addressed. A single note in the clinical record on or around the assessment date (item A5) indicating the resident had a significant change without documentation of the qualifying characteristics does not meet the requirements for a significant change.

The MDS assessment must be completed at item S2b with revision of the service plan no later than 14 days after the identification of the event or situation that lead to completion of the significant change assessment. The next assessment would be due 180 days from the S2b date of the significant change assessment.

4. Semi-annual assessment – A comprehensive assessment required within 180 days of the last comprehensive assessment. The assessment is sequenced from the date in Section S2b of the previous assessment.

5. Other – This is an assessment that is done at the request of a nurse consultant reviewer after an error has been found. It will reset the "clock" for all subsequent assessments.

A7. Marital Status

Coding: Choose the answer that describes the current marital status for the resident.

A8. Current Payment Source(s) for Stay

Intent: To determine payment source(s) that will cover the daily per diem services for the resident's days of stay in the facility over the last 30 days or since admission, if less than 30 days.

Definition:

a. MaineCare (formerly Medicaid) – A Federal/State program that pays for acute, primary care for people who are members of a category of eligible persons (e.g., aged, blind, disabled, etc.).

b. SSI – Federal Supplemental Security Income for the poor who are aged, blind, or disabled.

c. VA – Payment from the Department of Veteran's Affairs Community residential care.

d. Social Security – Federal Social Security income – a government program providing economic assistance to older adults.

e. Private pay – The resident is responsible for the full payment or for the co-payment.

f. Private Insurance (including co-payment) – The resident's private insurance company is covering daily charges.

g. SSDI – Social Security Disability Insurance

h. Other – Examples include Commission for the Blind, Alzheimer's Association, or CHAMPUS.

Process: Check with the billing office or person who handles the facility finances to review current payment sources. Do not rely exclusively on information recorded in the resident's record, as the resident's condition may trigger different sources of payment over time. Usually the business office tracks such information.

Coding: Check all payment sources that are correct at the time of the assessment.

Example of Current Payment Sources

Mr. F. was recently admitted to your facility from an acute care hospital. SSI covered his per diem, and Maine Care covered ancillary services. Check "b", SSI, and "a" Maine Care.

A9. Responsibility/Legal Guardian

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

Definition:

a. Legal guardian – someone who has been appointed after a court hearing and is legally authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.

b. Other legal oversight – Use this category for any other program in your state whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.

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

d. Durable power of attorney/financial – Documentation that someone other than the resident is legally responsible for financial decisions *if the resident is or becomes unable to make decisions*.

e. Family Member responsible – Includes immediate family or significant other(s) as designated by resident. Responsibility for decision making may be shared by both resident and family.

f. Self – Resident retains responsibility for decisions in the absence of guardianship or legal documents indicating that decision making has been delegated to others, always assume that the resident is the responsible party.

g. Legal Conservator – Documentation that someone other than the resident is responsible for the welfare and the property of a person ruled incompetent.

h. Representative Payee – Someone other than the resident who has financial responsibility for the payment of bills.

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

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

A10. Advanced Directives

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

Definition: Resident or proxy specifies one of the following treatment options:

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

b. Do not resuscitate (DNR) – In the event of respiratory or cardiac failure, the resident or family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to restore the resident's respiratory or circulatory function.

c. Do not hospitalize – A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

d. Organ Donation – Instructions indicating that resident wishes to make organs available for transplantation, research, or medical education upon death.

e. 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 incubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

Process: You will need to familiarize yourself with the legal status of each type of directive in your state. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the clinical record for directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made with the resident's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

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

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

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

- If your facility has a standard protocol for withholding 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 “1” for Yes, if any of the above stated treatment options are documented in medical records. If none of the directives are verified by

documentation in the medical records, check "0" for No. Please specify if you check "Other" advanced directive.

Section B. Cognitive Patterns

Intent: To determine the resident's ability to remember, think coherently, and organize daily self-care activities. These items are crucial factors in many care-planning decisions.

Questions about cognitive function and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the resident knows he or she cannot answer the question coherently.

Be sure to interview the resident in a private, quiet area without distractions – i.e., not in the presence of other residents or family, unless the resident is too agitated to be left alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust with the resident. After eliciting the resident's responses to the questions, turn to the direct staff caregiver(s) or the resident (or the resident's family or others) to clarify or validate information regarding the resident's cognitive function over the last seven days.

- Engage the resident in general conversation to help establish rapport.

- Actively listen and observe for clues to help you structure your assessment. Remember – repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide valuable information about cognitive function.

- Be open, supportive, and reassuring during your conversation with the resident (e.g., "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you").

If the resident becomes agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example, "Let's talk about something else now," or "We don't need to talk about that now. We can do it later." Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

B1. Memory

Intent: To determine the resident's functional capacity to remember both recent and long-past events (i.e., short-term and long-term memory).

Process:

a. Short-Term Memory: Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test.

b. Long-Term Memory: Engage in conversation that is meaningful to the resident. Ask questions for which you already know the answers (from your review of the resident's record, general knowledge, or the resident's family).

Coding: Check the numbered boxes that correspond to the observed responses. Check "0" if memory appears OK. Check "1" if there appears to be a memory problem. The following examples may be used to help assess short and long-term memory.

Examples

Ask the resident to describe the breakfast meal or an activity just completed.

Ask the resident to remember three items (e.g., book, watch, and table). After you have stated all three items, wait a few minutes and ask the resident to repeat the name of each item. If the resident is unable to recall all three items, check "1"

Ask the resident, "Where did you live just before you came here? If "at home" is the reply, ask, "What was your address?" If "a nursing home" is the reply, ask, "What was the name of the place?" then ask: "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?" "In what year were you born?"

B2. Memory/Recall Ability

Intent: To determine the resident's memory/recall performance within the environmental setting. A resident may have intact social graces and respond to staff and others with a look of recognition yet have no idea who they are. This item will enable staff to probe beyond first, perhaps mistaken, impressions.

Definition:

a. Current season – Able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).

b. Location of own room – Able to locate and recognized own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.

c. Staff names/faces – Able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.

d. That he/she is currently living in a facility/home -To check this item, it is not necessary that the resident be able to state the name of the facility, but

he/she should be able to refer to the facility by a term such as a "home for older people", "rest home", "a place where older people live", etc.

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

Coding: For each item that the resident can recall, check the corresponding answer box. If the resident can recall none, check ***NONE OF ABOVE***.

B3. Cognitive Skills for Daily Decision-Making

Intent: To record the resident's actual performance in making everyday decisions about the tasks or activities of daily living.

Process: Review the clinical record. Consult family and caregiver staff. Observe the resident. *The inquiry should focus on whether the resident is actively making these decisions, and not whether staff believes the resident might be capable of doing so. A resident who makes a poor decision is still making a decision.* Remember the intent of this item is to record what the resident is doing (performance). When a staff member has taken decision-making responsibility away from the resident regarding tasks of everyday living, or the resident is unable to participate in decision-making, the resident should be considered to have impaired performance in decision-making. This item is especially important for further assessment and care planning in that can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence. When coding, identify the most representative level of function, not necessarily the highest**.** Staff must use clinical judgment to decide if a single observation provides sufficient information on the resident's *typical* level of function. There must be documentation to support all coding on the MDS. The look back period for this item is seven days. (6/1/18)

The clinical record must include documentation of the resident's *actual* performance in making everyday decisions about tasks or activities of daily living within the look back period. The documentation must include specific examples of resident behaviors and ability to make decisions to support the coding selected.

Coding: Check the numbered box that is the *most representative* level of function, not necessarily the highest**.** Staff must use clinical judgment to decide if a single observation provides sufficient information on the resident's typical level of function. (6/1/18)

0. Independent – The resident's decisions were consistent and reasonable

(reflecting lifestyle, culture, values); the resident organized daily routine and make decisions in a consistent, reasonable, and organized fashion.

1. Modified Independence – The resident organized daily routine and made safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations. If there have been no new tasks or situations within the look back, this choice cannot be coded. (6/1/18)

2. Moderately Impaired – The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and conducting daily routines.

3. Severely Impaired – The resident's decision-making was severely impaired; the resident never made independent decisions. If the resident does not respond to reminders, cues, or supervision, the resident is dependent on others for everyday decision-making. (6/1/18)

Examples

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker and using it faithfully.

B4. Cognitive Status

Intent: To record resident's status or abilities now as compared to 180 days ago. If the resident is a new admission or has not been in the facility for 180 days, review the record and make an assessment based on that information.

Coding:

0. No change
1. Improved
2. Declined

Section C. Communication/Hearing Patterns

Intent: To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others.

There are many potential causes for the communication problems experienced by elderly residents. Usually a communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The resident's physical, emotional, and social situation may also complicate communication problems. Additionally, a

noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in the resident's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

C1. Hearing

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

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

Be alert to what you must do to communicate with the resident. For example, if you must speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the resident needs to see your face to know what you are saying, or if you have to take the resident to a quieter area to conduct the interview – all of these are cues that there is a hearing problem and should be so indicated by the corresponding numbered box that is checked.

Also, observe the resident interacting with others and in group activities. Ask the activities personnel how the resident hears during group leisure activities.

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

0. Hears adequately – the resident hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.

1. Minimal difficulty – The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditional or when not in one-on-one situations.

2. Hears in special situations only – Although hearing-deficient the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speakers face is clearing visible.

3. Highly impaired/absence of useful hearing – the resident hears only

some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

C2. Communication Devices/Techniques

a. Hearing aid, present and used – A hearing aid or another assistive listening device is available to the resident and is used regularly.

b. Hearing aid, present and not used regularly – A hearing aid or another assistive device is available to the resident and is not regularly used (e.g., resident has a hearing aid that is broken or is used only occasionally).

c. Other receptive communication techniques used – A mechanism or process is used by the resident to enhance interaction with others (e.g., reading lips, touching to compensate for hearing deficit, writing by staff member, use of communication board).

Process: Consult with the resident and direct care staff. Observe the resident closely during your interaction.

Coding: Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check ***NONE OF ABOVE***.

C3. Making Self Understood

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

Process: Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g. one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the primary caregivers (over all shifts), the resident's family, if available, and speech-language pathologist.

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

0. Understood – The resident expresses ideas clearly.

1. Usually Understood – The resident has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the resident requires some prompting to make self-understood.

2. Sometimes Understood – The resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet, and pain).

3. Rarely or Never Understood – At best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language/gestures (e.g., indicated presence of pain or need to toilet).

C4. Ability to Understand Others

Intent: To describe the resident's ability to comprehend information whether communicated to the resident orally, by writing, in sign language, or Braille. This item measures the resident's ability to process and understand language.

Process: Interact with the resident. Consult with primary caregiver staff over all shifts, and, if possible, the resident's family, and speech-language pathologist.

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

0. Understands – The resident clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.

1. Usually Understands – the resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.

2. Sometimes Understands – The resident demonstrates frequent difficulties integrating information and responds adequately only to simple and direct questions or directions. When staff rephrases or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.

3. Rarely/Never Understands – The resident demonstrates very limited ability to understand communication. Or, staff has difficulty determining whether the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

C5. Communication

Intent: To record resident's status or abilities now as compared to 180 days ago. If resident is a new admission or has not been in the facility for 180 days, review the record and make an assessment based on that information. To evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g. glasses, magnifying glass).

Coding:
0. No Change
1. Improved
2. Declined

Section D. Vision Patterns

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

Definition: **"**Adequate" lighting is the amount of lighting that is sufficient or comfortable for an individual with normal vision.

Process:

- Ask direct care staff over all shifts if possible, if the resident has manifested any change in usual vision patterns over the past seven days – e.g., if the resident could previously, is the resident still able to read newsprint, menus, greeting cards, etc.?

- Then ask the resident about his or her visual abilities.

- Test accuracy of your findings by asking the resident to look at regular size print in a book or newspaper with whatever visual appliances he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the regular book or newspaper print.

- Be sensitive to the fact that some residents are not literate or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.

- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the resident has any visual ability.

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

0. Adequate – The resident sees fine detail, including regular print in newspapers/books.

1. Impaired – The resident sees large print, but not regular print in newspapers/books.

2. Moderately Impaired – The resident has limited vision, is not able to see newspaper headlines but can identify objects in his or her environment.

3. Highly Impaired – The resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).

Note: Many residents with severe cognitive impairments are unable to

participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use check "3", Highly Impaired. With our current limited technology, this is the best assessment you can do under the circumstances.

4. Severely Impaired – The resident has no vision; sees only light colors or shapes; or eyes do not appear to be following objects (especially people walking by).

D2. Visual Appliances

Intent: To determine if the resident uses visual appliances regularly.

Definition: This section includes glasses, contact lenses, magnifying glass, or any type of corrective device used by the resident. The second section (part B.) asks if the resident has any artificial eye.

Coding: Enter "1" if the resident used any visual appliances or has an artificial eye. Enter "0" if none apply.

Section E. Mood and Behavior Patterns

Mood distress is a serious condition and is associated with declines in health and functional status. Associated factors include poor adjustment to the nursing home, functional impairment, resistance to daily care, inability to participate in or withdrawal from activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly residents because they are very treatable. In addition, case management and other services are available for persons with persistent mental illness including depression.

In most facilities, staff has not received specific training in how to evaluate residents who have distressed mood or behavioral symptoms. Therefore, many problems are under diagnosed and under treated. The goal of the following items is to assist staff in recognizing signs and symptoms so that, if needed, residents can be referred for further evaluation and services.

E1. Indicators of Depression, Anxiety, Sad Mood

Intent: To record the frequency of indicators observed and reported *in the last 28 days (or since admission if less than 28 days),* irrespective of the assumed cause of the sign or symptom (behavior). (6/1/17)

Definition: Feelings of emotional or psychological distress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the residential care population. Rather, distress is more commonly expressed in the following ways:

Verbal Expressions of Distress

a. Resident made negative statements – e.g., Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die.

b. Repetitive questions – e.g., "Where do I go; What do I do?"

c. Repetitive verbalizations – e.g., Calling out for help, ("God help me").

d. Persistent anger with self or others – e.g., easily annoyed, anger at placement in domiciliary care home; persistent anger at care received.

e. Self-deprecation – e.g., "I was nothing; I am of no use to anyone."

f. Expression of what appears s to be unrealistic fears – e.g., fear of being abandoned, left alone, being with others.

g. Recurrent statements that something terrible is about to happen – e.g., believes he or she is about to die, have a heart attack.

h. Repetitive health complaints – e.g., persistently seeks medical attention, obsessive concern with body functions.

i. Repetitive anxious complaints/ concerns (non-health related) – persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

Distress may also be expressed non-verbally and identified through observation of the resident in the following areas during usual daily routines:

Sleep Cycle Issues

Distress can also be manifested through disturbed sleep patterns.

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep patterns – e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep.

Sad, Apathetic, Anxious Appearance

l. Sad, pained, worried facial expressions – e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements – e.g., pacing, hand wringing, restlessness, fidgeting, picking.

Loss of Interest

The next two items refer to a **change in resident's usual pattern of behavior,** i.e. withdrawal or reduced social interaction as a change rather than a resident's usual behavior**.** It may not be appropriate for these items to be coded continually without breaks as this suggests it may be the resident's baseline personality and individual choice.

o. Withdrawal from activities of interest – e.g., no interest in long standing activities or being with family/friends.

p. Reduced social interaction – e.g., less talkative, more Isolated.

Indicators of Mania

q. Inflated self-worth - exaggerated self-opinion; inflated belief about one's own ability, etc.

r. Excited behavior - motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity).

Process: Review daily staff documentation, consult with or interview staff across all shifts for the time frame of the observation. Daily staff documentation for all shifts is the preferred method to support the coding of these indicators. When daily documentation is not utilized, the results of the consultations and/or interviews must be documented in the resident's record to support the entire time frame. *If the loss of interest items (E1o. and E1p) have occurred during the look back period but is not a change in the usual pattern for the resident, this information could be referenced in the monthly summary or other areas of documentation in the resident's clinical record.* Evaluation of staff documentation will allow the facility to be aware of changes in the resident's behavior. (1/1/20)

Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about their distress or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with or interview direct-care staff across all shifts and, if possible, family who have direct knowledge of the resident's behavior. Relevant information may also be found in the record.

Be aware that staff may fail to note these signs and symptoms or think they are "normal" for the elderly. Asking a resident about sad or anxious mood, feeling depressed or even feeling suicidal will not "create" those feelings although it may allow the resident to voice those feelings for the first time.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 28 days. Remember; code regardless of what you believe the cause to be. (3/1/18). For E1o and E1p, there must be documentation in the clinical record of the coder's rationale for coding a change. (9/1/20)

CODING: (3/1/18)

0. Indicator exhibited less than one day each week in last 28 days

1. Indicator exhibited one to five *days* per week during the past 28 days. Behavior must have occurred at least one day every week.

2. Indicator exhibited daily or almost daily (6 to 7 *days* each week) during the past 28 days **or** the average of the four weeks is 6.0 or greater.

NOTE: Average is defined as the total of the values for each week in the look back period divided by number of weeks in the look back period.

	A5 date		E1 items, enter number of ***days*** behavior occurred each week			
	weeks (7-day periods)		E1a	E1b	E1c	E1
week 1	1/19/18	1/25/18	7	1	3	
week 2	1/26/18	2/1/18	5	2	1	
week 3	2/2/18	2/8/18	6	0	2	
week 4	2/9/18	2/15/18	6	4	2	
			6.0	1.8	2.0	average

Code 0: if less than 1 or did not occur at least one day *every* week

Code 1: if the behavior occurred at least *one day every* week.

Code 2: if the *average* is greater than or equal to 6

Example:

In the example above, E1a occurred an average of 6.0 times per week and would be coded on the MDS as a "2." E1b occurred an average of 1.8 times per week but did not occur every week and would be coded as "0" on the MDS. E1c occurred at least one time *every* week and would be coded as "1" on the MDS.

E2. Mood Persistence

Intent: To identify if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over the last seven days.

Process: Observe the resident and discuss the situation with direct caregivers over all shifts and, if possible, family members or friends who visit frequently or have frequent telephone contact with the resident.

Coding: Check "0" if the resident did not exhibit any mood indicators over last 7 days, "1" if indicators were present and easily altered by staff interactions with the resident or "2" if any indicator was present but not easily altered (e.g., mood persisted despite staff efforts to console or "cheer up" the resident).

E3. Mood

Intent: To record resident's status or abilities now **as compared to** 180 days ago. If the resident is a new admission or has not been in the facility for 180 days, review the record and make an assessment based on that information.

Coding:

0. **No change**
1. **Improved**
2. **Decline**

E4. Behavioral Symptoms

Intent: To identify the frequency (column A) and alterability (column B) of behavioral symptoms in the last seven days that cause distress to the resident or disruptive to facility resident or staff members. Column C is to identify those behaviors that have been present in the last 6 months. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g., "Mrs. R's calling out isn't much different than others in the home. There are many noisy residents;" or "Mrs. L doesn't mean to hit me. She does it because she's confused.")

Acknowledging and documenting the resident's behavioral symptom patterns on the MDS provides basis for further evaluation, delivery of consistent, appropriate care that will allow appropriate management of the behavioral symptoms and identify residents who may need mental health services. Once the frequency of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

Definition:

a. Wandering – Locomotion with no discernible, rational purpose. A Wandering resident may be oblivious to his or her physical safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be walking or by wheelchair. Do not include pacing as wandering behavior. Pacing back and forth in a set pattern is not considered wandering, and if it occurs, it should be documented in item E1n, "Repetitive physical movements".

b. Verbally Abusive Behavioral Symptoms – Other residents or staff were threatened, screamed at, or cursed at.

c. Physically Abusive Behavioral Symptoms – Other residents or staff were hit, shoved, scratched, sexually abused, or experienced a gross physical assault.

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

e. Resists Care – Resists taking medications/injections, ADL assistance or help with eating. *This category does not include instances where resident has made an informed choice not to follow a course of care* (e.g., resident has exercised his or her right to refuse treatment and reacts negatively as staff try to reinstitute treatment).

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

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

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

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

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

j. Fire Setting - This act would be intentional not accidental in nature.

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

Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts). A symptomatic behavior can be present, and the Assessment Coordinator might not see it because it occurs during care on another shift. Therefore, *it is especially important that input from all caregivers having contact with the resident be solicited*.

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

Column A: Frequency

Coding: Record the frequency of behavioral symptoms manifested by the resident over a 24-hour period, throughout the day and evening.

0. If the described behavioral symptom was not exhibited in last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program).

1. If the described behavioral symptom occurred 1-3 days per week.

2. If the described behavioral symptom occurred 4-6 days per week but not daily.

3. If the described behavioral symptom occurred daily.

Column B: Alterability

Intent: To describe whether any behavior symptom exhibited by the resident was easily altered or represented a more serious challenge in terms of management.

Definition: Easily altered – means that the resident was easily distracted from persisting in a behavior or his/her behavior symptom was easily channeled into other activities. For example, a resident who wanders into a noisy room and becomes very agitated and verbally abusive has easily altered behavior if he/she immediately stops the verbal abuse when a staff member gently guides him/her to a quieter room.

Coding: Code for the least easily altered behavior exhibited by the resident during the last 7 days.

0. The described behavioral symptom is not present, or it is easily alterable.

1. The described behavioral symptom is not easily alterable.

Column C: History

Coding: **0.** If there is no history of this behavioral symptom in the last 6 months.

1. If there is a history of this behavioral symptom in the last 6 months.

Examples for Wandering

Mrs. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit. Despite the repetitive, daily nature of her wandering, this behavior is easily channeled into other activities when staff redirects Mrs. T. by inviting her to activities. Mrs. T is easily engaged and is content to stay and participate in whatever is going on.

Frequency = 3 Alterability = 0

Mr. W. has dementia and is severely impaired in making daily decisions. He wanders all around the residential unit throughout each day. He is extremely hard of hearing and refused to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs. Numerous attempts to redirect his wandering have been successful. Over time staff has found him to be most content while he is wandering within a structured setting.

Frequency = 3 Alterability = 1

E5. Suicidal Ideation or Suicide Attempts

Intent: To record any suicidal thoughts, plans, or attempts by the resident in the last 30 days.

Process: Observe the resident for indications of suicidal ideation or attempt either verbal or physical.

Coding: Check appropriate box, “yes” or “no”.

E6. Sleep Problems

Intent: To record any 2 days in the last 7 that the resident exhibited sleep problems.

Process: Observe the resident for signs of interrupted sleep, restlessness, inability to fall asleep, or inability to awaken when desired.

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

E7. Insight into Mental Health

Intent: To assess the extent the resident understands his/her condition and the ability to assimilate information regarding that condition.

Coding: Check **one** appropriate box.

E8. Behaviors

Intent: To record resident's status or abilities now *as compared to* 180 days ago. If the resident is a new admission or has not been in the facility for 180 days, review the record and make an assessment based on that information.

Coding:
0. No change
1. Improved
2. Declined

Section F. Psychosocial Well-Being

Intent: To determine the resident's emotional adjustment to the facility, including his or her general attitude, adaptation to surroundings, and change in relationship patterns.

F1. Sense of Initiative/Involvement

Intent: To assess the degree to which the resident is involved in the life of the facility and takes initiative in participating in various social and recreational programs, including solitary pursuits.

Definition:

a. At ease interacting with others – Consider how the resident behaves during the time you are together, as well as reports of how the resident behaves with other residents, staff, and visitors. A resident who tries to shield him or herself from being with others, spend most time alone, or becomes agitated when visited, is not "at ease interacting with others."

b. At ease doing planned or structured activities – Consider how the resident responds to organized social or recreational activities. A resident who feels comfortable with the structure or not restricted by it is "at ease doing

planned or structured activities." A resident who is unable to sit still in organized group activities and either acts disruptive or makes attempts to leave, or refuses to attend any such activities, is not "at ease doing planned or structured activities."

c. At ease doing self-initiated activities – These include leisure activities (e.g., reading, watching TV, talking with friends), and work activities (e.g., folding personal laundry, organizing belongings). A resident who spends most of his or her time alone and unoccupied, or who is always looking for someone to find something for him or her to do is not "at ease doing self-initiated activities."

d. Establishes own goals – Consider statements the resident makes, such as "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again, following a hip replacement or wanting to live to say goodbye to a loved one. However, some goals may not be verbalized by the resident, but the goals may be manifested in that the resident is observed to have an individual way of living at the facility (e.g., organizing own activities or setting own pace)

e. Pursues involvement in life of facility – In general, consider whether the resident partakes of facility events, socializes with peers, and discusses activities as if he or she is part of things. A resident who conveys a sense of belonging to the community represented by the domiciliary care home or assisted living facility or his/her particular unit of the facility is "involved in the life of the facility."

f. Accepts invitations into most group activities – A resident who is willing to try group activities even if later deciding the activity is not suitable, or who does not regularly refuse to attend group programs, "accepts invitations into most group activities."

Process: Selected responses should be confirmed by objective observation of the resident's behavior (either verbal or nonverbal) in a variety of settings (e.g., in own room, in dining room, in activities room) and situations (e.g., alone, in one-on-one situations, in groups) over the past seven days. The primary source of information is the resident. Talk with the resident and ask about his or her perception (how he or she feels), how he or she likes to do things, and how he or she responds to specific situations. Then talk with staff members who have regular contact with the resident (e.g., nurse assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Remember that it is possible for discrepancies to exist between how the resident sees himself or herself and how he or she actually behaves. Use your best judgment as a basis for deciding on the item response.

Coding: Check all that apply. None of the choices are to be construed as negative or positive. Each is simply a statement to be checked if it applies and not checked if it does not apply. If you do not check any items in Section F1, check ***NONE OF ABOVE***. For individualized care planning purposes,

remember that information conveyed by unchecked items is no less important than information conveyed by checked items.

F2. Unsettled Relationships

Intent: To indicate the quality and nature of the resident's interpersonal contacts (i.e., how the resident interacts with staff members, family, and other residents).

Definition:

a. Covert/open conflict with or repeated criticism of staff – The resident chronically complains about some staff members to other staff members, verbally criticizes staff members, or constantly disagrees with routines of daily life on the unit. Checking this item does not require any assumption about why the problem exists or how it might be remedied.

b. Unhappy with roommate – This category also includes "bathroom mate" for residents who share a private bathroom. Unhappiness may be manifested "bathroom mate" spending too long in the bathroom, or complaints about roommate rummaging in one's belongings, or complaints about physical, mental, or behavioral status of roommate. Other examples of roommate incompatibility might be seen in expressions of unhappiness or dissatisfaction with such issues as early bedtime vs. staying up and watching TV, neat vs. sloppy maintenance of personal area, roommate spending too much time on the telephone, or snoring, or odors from incontinence or poor hygiene. This definition refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e., repetitive, ongoing complaints beyond a reasonable level).

c. Unhappy with residents other than roommate – May be manifested by chronic complaints about the behaviors of others, poor quality of interaction with other residents, or lack of peers for socialization. This definition refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e., repetitive, ongoing complaints beyond a reasonable level).

d. Openly expresses conflict/anger with family/friends – Includes expressions of feelings of abandonment, ungratefulness on part of family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

e. Absence of personal contact with family/friends – Absence of visitors or telephone calls from significant others in the last seven days.

f. Recent loss of close family member/friend – Includes relocation of family member/friend to a more distant location, even temporarily (e.g., for the winter months), incapacitation or death of a significant other, or a significant relationship that recently ceased (e.g., a favorite staff member

transferred to another unit or leaving the home).

g. Does not adjust easily to change in routines – Signs of anger, prolonged confusion, or agitation when changes in usual routines occur (e.g., staff turnover or reassignment; new treatment or medication routines; changes in activity or meal programs; new roommate).

Process: Ask the resident for his or her point of view. Is he or she generally content in relationships with staff and family, or are there feelings of unhappiness? If the resident is unhappy, what specifically is he or she unhappy about? It is also important to talk with family members who visit or have frequent telephone contact with the resident. How have relationships with the resident been in the last 7 days? During routine care activities, observe how the resident interacts with staff members and other residents. Do you see signs of conflict? Talk with direct- care staff (e.g., nurse assistants, dietary aides who assist in the dining room, or activities staff) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that some staff members describing these relationships may be biased. As the evaluator, you are seeking to gain an overall picture, a consensus view.

Coding: Check all that apply over the last 7 days. If none apply, check ***NONE OF ABOVE.***

F3. Life Events History

Intent: To record any event in the last **2 years** that is important in assessing the psychosocial well-being of the resident.

Process: This will require interview of the resident, resident's family, significant others, or professionals that have had contact with the resident. Record review may also contain pertinent information regarding previous history.

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

Section G. Physical Functioning

Many residents are at risk of physical decline. Many elderly residents have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency, particularly for residents with chronic mental illness or others who may be taking psychotropic medications.

Due to these many, possibly adverse influences, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident himself or herself. Thus, all residents

are candidates for rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized service plans can be successfully developed only when the resident's self-

performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated.

G1. (A) Activities of Daily Living (ADL) Self-Performance

Intent: To record the resident's self-care performance in activities of daily living (i.e., what the resident actually did for himself or herself and/or how much help was provided by staff members) during the **last seven days**.

Definition: **ADL SELF-PERFORMANCE** Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

a. Bed Mobility – How the resident moves to and from a lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.

b. Transfer – How the resident moves between surfaces – i.e., to/from bed, chair, wheelchairs, standing position. **Exclude** from this definition transfers/movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

c. Locomotion – How the resident moves to and returns from other locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, how resident moves to and from distant areas on the floor. If in a wheelchair, self-sufficiency once in chair.

d. Dressing – How the resident puts on, fastens, and takes off all items of *street clothing*, including donning/removing a prosthesis or anti-embolism stockings. Hearing aides are not considered a prosthesis.

e. Eating – How the resident eats and drinks, regardless of skill (e.g., using fingers rather than fork). Does NOT include eating/drinking during a medication pass. Includes intake of nutrition by other means such as tube feeding or total parenteral nutrition.

f. Toilet Use – How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag. (1/1/20)

g. Personal Hygiene – How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands and perineum. A partial bath or partial sponge bath is included in personal hygiene. This item does not include a shower or full bath of any type. (6/1/17)

h. Stairs – How the resident climbs stairs, either inside or outside the home.

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

A resident's ADL self-performance may vary from day to day and within the day (e.g., from morning to night). There are many possible reasons for these variations, including mood, stamina, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the Assessor, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day – not only how you see the resident at one point in time for one day.

In order to accomplish this, it is necessary to gather information from multiple sources – i.e., interviews/discussion with the resident and direct care staff on all shifts, including weekends. Ask questions pertaining to all aspects of ADL activity definitions. For example, when discussing toileting with a caregiver, be sure to inquire specifically how the resident moves onto and off the toilet, how the resident cleans him/herself, and how the resident arranges his/her clothing after using the toilet. A resident can be independent in one aspect of toileting yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real world situations in assisted living homes, where slight variations are common. Where variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance and Extensive Assistance) permit one or two exceptions for the provision of heavier care. This is useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

To evaluate a resident's ADL Self-Performance, begin by reviewing any relevant information in the resident's record. Talk with staff from each shift to ascertain what the resident does for him or herself in each ADL activity. As previously noted, be alert to differences in resident performance from shift to shift and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as “2” (Limited Assistance) in Toilet Use.

Documentation to support coding for all areas of ADL and all shifts must be present in the clinical record.

Guidelines for Assessing ADL Self-Performance and ADL Support

- The responses in the ADL items are used to record the client's actual level of involvement in self-care and the type and amount of support actually received during the last seven days.
- Do not record your assessment of the client's capacity for involvement in self-care – i.e., what you believe the client "might" be able to do for himself or herself based on demonstrated skills or physical attributes. Assessment of potential capability is covered item G6 ("ADL and IADL Functional Rehabilitation Potential").
- Engage staff who have cared for the client from all shifts over the last 7 days in discussions regarding the client's ADL function ability. Remind staff that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (eating, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Here is a typical conversation between the Assessor and a caregiver regarding a resident's self-performance in eating:

Assessor "Describe to me how Mrs. L eats. By that I mean, once she is in the dining room and her tray is set up, how does she eat?"

Caregiver "She can feed herself finger food, but I help her with everything else."

Assessor "Does she pick up finger food, put it in her mouth, chew and swallow without any verbal instructions or physical help?"

Caregiver "No, I have to remind her to chew and swallow every time. But once I tell her to do that, she does it herself."

Assessor "How do you help her with other foods?"

Caregiver "I cut up her meat, butter her bread, and open milk cartons."

Assessor "Anything else?"

Caregiver "I put the food on her fork or spoon and help her guide it to her mouth."

Assessor "Does she grasp the fork or spoon?"

Caregiver "Yes."

Assessor "Do you lift her hand and guide it to her mouth?"

Caregiver "No, she lifts her hand and arm, and I just help guide it to her mouth."

Assessor "How many days during the last week did you give this type of help?"

Caregiver "Every day."

If ADL function in eating was similar throughout the day, Mrs. L would receive an ADL Self-Performance Code of "2" (Limited Assistance).

Now review the first two exchanges in the conversation between the Assessor and caregiver. If the Assessor did not probe further, he or she would not have received enough information to make an accurate assessment of either the resident's performance or the caregiver's actual workload.

Coding: For each ADL category, code the appropriate response for the resident's ***actual performance*** during the past seven days. Enter the code in the box following the ADL and its definition, under column A Self-Performance. Consider the resident's performance during a 24-hour period, as functionality may vary.

Exclude "Set-up" Help: In your "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the aide). In evaluating the resident's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. *For example:* If a resident grooms himself independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

0. Independent – No help from staff oversight –OR- staff help/oversight provided only one or two times during the last seven days.

1. Supervision – Oversight, encouragement, or cueing provided three or more times during last seven days –OR- supervision one or two times plus physical assistance provided only one or two times during last seven days.

Supervision of eating involves direct supervision of the resident. Oversight of all residents in the dining room cannot be coded as supervision for the individual resident. The service plan must describe the need for supervision, i.e. related to risk of choking, the resident needs direct cueing in order to eat, etc.

2. Limited Assistance – Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance on three or more occasions –OR- limited assistance one or two times plus weight-bearing support provided only one or two times during last seven days.

3. Extensive Assistance – While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

- Weight-bearing support provided three or more times.

- Full staff performance of activity (three or more times) during part (but not all) of last seven days.

4. Total Dependence – Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

For example: For a resident to be coded as totally dependent in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self a tube feeding or assisting with procedure) at any meal.

8. Activity did not occur during the entire 7-day period – Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

For example: The definition of Dressing specifies the wearing of street clothes. During the seven-day period, if the resident did not wear street clothing, a code of "8" would apply (i.e., the activity did not occur during the entire seven-day period). Likewise, a resident who was restricted to bed for the entire seven-day period and was never transferred from bed would receive a code of "8" for Transfer.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4 – Total Dependence) with the activity itself not occurring. *For example:* Even a resident who receives tube feedings but no food or fluids by mouth is engaged in "eating" (receiving nourishment) and should not be coded as an "8". Similarly, a resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another category demands an increase or decrease in the type of help the resident receives *OR* the number of times that help is provided. Thus, to move from Independent to Supervision, a resident must receive supervision, cueing or verbal encouragement more than one or two times (e.g., three or more times during the last seven days)

There will be times when no single type or level of assistance is provided to the resident three or more times during a seven-day period. If the activity occurred three or more times, but at different levels, the higher levels can be converted to the next lower level. If the next lower level, including the converted values, occurred three or more times, code the lower level on the MDS. (1/1/20)

Example:
A resident required supervision 18 times, limited assistance two times, and extensive assistance one time during the seven-day look-back period. Convert the extensive level to limited assistance (next lower level). Now the lower level of limited assistance has occurred three times and can be coded on the MDS. (1/1/20)

G1. (B) ADL Support Provided

Intent: To record the type and highest level of support the resident received in each ADL activity over the last 7 days.

Definition: **ADL SUPPORT PROVIDED** – measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. *This is a different scale and is entirely separate from the ADL Self-Performance assessment.*

SET-UP HELP – The type of help characterized by providing the resident with articles, devices, or preparation necessary for greater resident self-performance in this activity. This can include giving or holding out an item that the resident takes from the caregiver.

Process: For each ADL category, code the maximum level of support the resident received over the last seven days, regardless of frequency, and enter in the "SUPPORT" column, even if that level of support occurred one time only. Be sure your evaluation considers all shifts, 24 hours per day, including weekends.

Coding: Note: The highest code of physical assistance in this category (other than the "8" code) is a code of "3", not "4" as in Self-Performance.

0. No setup or physical help from staff.
1. Setup help only – The resident is provided with materials or devices necessary to perform the activity of daily living independently.
2. One-person physical assist.
3. Two+ person physical assist.
8. ADL activity itself did not occur during the entire 7 days when an "8" code is entered for an ADL Self-Performance category, enter an "8" code for ADL Support Provided in the same category.

****Note: Weight bearing does not refer to the resident's ability to bear weight but whether staff is bearing the resident's weight in support of ADL activity performance.***

Examples: ADL Self-Performance

Bed Mobility

Resident was physically able to reposition self in bed but tended to favor and remain on his left side. He needs frequent reminders and monitoring to reposition self while in bed

Code = 1

Resident received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.

Code = 1

Resident usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees; he occasionally slides down towards the foot of the bed. On 3 occasions the night staff helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.

Code = 3

Resident independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1-2 persons to turn to his right side or sit up in bed.

Code = 3

Because of severe, painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable.

Code = 4

Transfer

Despite bilateral above the knee amputations, resident almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind resident to retrieve the transfer board. On one other occasion, the resident was lifted by a staff member from the wheelchair back into bed.

Code = 0

Once someone correctly positioned the wheelchair in place and locked the wheels, the resident transferred independently to and from the bed.

Code = 0

Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.

Code = 2

Transferring ability varied throughout each day. Resident received no assistance at some of the time and heavy weight bearing assistance of one person at other times.

Code = 3

Locomotion

Resident ambulated slowly pushing a wheelchair for support, stopping to rest every 15-20 feet.

Code = 0

A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for full ambulation. Three nights last week, the resident was found in his bathroom after getting out of bed and walking independently.

Code = 2

Resident ambulates independently, socializing with others and attending activities during the day. She loves dancing and yoga. Because she can become afraid at night, she receives contact guard of one person to walk her to the bathroom at least twice every night.

Code = 2

During the last week resident was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.

Code = 3

Resident independently walked with a cane to all meals in the Main Dining Room and social and recreational activities in the nearby hobby shop. Resident received no set-up or physical help during the assessment period.

Code = 0

Resident is independent in walking. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility.

Code = 1

Resident did not leave her room during the 7-day assessment period.

Code = 8

Dressing

Resident usually dressed self. After a seizure, she received total help from two staff members once during the week.

Code = 0

Caregiver staff provided physical weight-bearing help with dressing every morning. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every evening.

Code = 3

A resident dressed herself if staff set out her clothes and gave her encouragement and cueing about how to dress (e.g., first put on your slip; now put on the dress). However, twice the resident was tired in the evening, and while she participated in undressing by pulling her arms out of the sleeves of her dress and lifting her feet out of her shoes, a staff member helped her undress by telling her what to do, unbuttoning her sweater and dress and helping the resident lift the dress up over her head.

Code = 2

Eating

Resident arose daily after 9:00am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.

Code = 0

Resident with a history of choking ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).

Code = 1

Resident is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat.

Code = 1

Cognitively impaired resident ate independently when given one food item at a time and monitored to assure adequate intake of each item.

Code = 1

Resident with difficulty initiating activity always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.

Code = 2

Resident with fine motor tremors fed self finger-foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils.

Code = 3

Resident fed self with staff monitoring a breakfast and lunch but tired later in day. She was fed totally by staff at supper (the evening meal).

Code = 3

Toileting Use

Resident used bathroom independently once up in a wheelchair but received weight-bearing assistance to get into his wheelchair. Used bedpan independently at night after it was set up on bedside table.

Code = 0

In the toilet room resident is independent. As a safety measure, the caregiver stays just outside the door, checking with her periodically.

Code = 1

When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.

Code = 3

Resident received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g., being handed toilet tissue or incontinence pads).

Code =3

Obese, severely physically and cognitively impaired resident receives a Hoyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete personal hygiene is provided at least every 2 hours by two persons.

Code = 4

Personal Hygiene

New resident, in the adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2-3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.

Code = 0

Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene.

Code = 0

Resident was able to carry out personal hygiene but was not motivated. She received daily cueing and positive feedback from staff to keep herself clean and neat. Once started, she could be left alone to complete tasks successfully.

Code = 1

Resident performed all tasks of personal hygiene except shaving. The facility barber visited him on the unit three times a week to trim his beard and shave the rest of his face.

Code = 3

Resident required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene.

Code = 3

G2. Bathing

Bathing is the only ADL activity for which the ADL Self-Performance codes in item G1 do not apply. A unique set of Self-Performance codes, to be used only in the bathing assessment, are described below. The Self-Performance codes for the other ADL items would not be applicable for bathing given the normal frequency with which the bathing activity is carried out during a 1-week period in many facilities. Assuming that the average frequency of bathing during a 7-day period would be one or two baths, the coding for the other ADL Self-Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all residents as “Independent” for bathing regardless of how much assistance the resident received each time he/she bathed.

Intent: To record the resident's Self-Performance and Support provided in bathing, including how the resident transfers into and out of the tub or shower.

Definition: Bathing – How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair. This does not include a partial bath or sponge bath. Cleansing of parts of the body, rather than a full-body cleansing, would be included in personal hygiene (G1.g) (6/1/17)

Coding: Bathing Self-Performance Codes – Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the resident received during the last 7 days.

0. Independent – No help provided
1. Supervision – Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity did not occur during entire 7 days

Examples: Bathing Self-Performance

Bathing
Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.

Code = 1

On Monday, one staff member helped transfer resident to tub. On Thursday, resident had physical help of one person to get into tub but washed himself completely.

Code = 2

The resident is afraid of Hoyer lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity.

Code = 3

For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. **Rationale:** The coding directions for bathing state "code for most dependent in self-performance and support."

Code = 4

G3A. Modes of Locomotion

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

Definition:

a. Cane/Walker/Crutch – Also check this item in those instances where the resident walks by pushing a wheelchair and using its handlebars for support. **DO NOT** count this type of use of the wheel chair as "wheeled self" for

support.

b. Wheeled self – Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility even for part of the time.

c. Another person wheeled – Another person pushed the resident in a wheelchair all or part of the time.

Coding: Check all that apply during the last 7 days. If none were used, check ***NONE OF ABOVE***.

G3B. Main Mode of Locomotion

Intent: To record if a wheelchair was the resident's primary mode of locomotion.

Definition: Wheelchair primary mode of locomotion – Even if resident walks some of the time (e.g., a few feet from bed to chair or bed to bathroom), he or she is primarily dependent on wheelchair to get around.

The wheelchair may be motorized, self-propelled, or pushed by another person. Do not count if it is used as a "walker," using it for support.

Coding: Check the answer box that indicates if a wheelchair was the resident's primary mode of locomotion within the last 7 days.

G3C. Bedfast/Chairfast

Intent: To determine if the resident has a physical health or mental condition that restricts the resident's functioning. For care planning purposes this information is useful for identifying residents who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behavior impairment related to social isolation.

Definition: Bedfast/chairfast all or most of the time – Resident is in bed or in a recliner in own room for 22 hours or more per day. This definition also includes residents who are primarily bedfast but get up only to use the bathroom.

Coding: Check the corresponding answer box. If none of these items apply, check ***NONE OF ABOVE***.

G4. Self Performance in ADLs

Intent: To record resident's status or abilities now as compared to 180 days ago. If the resident is a new admission or has not been in the facility for 180 days, review the record and make an assessment based on that information.

Coding:

0. No change in status or abilities in last 180 days.
1. Improved in status or abilities in last 180 days.

2. Declined in status or abilities in last 180 days.

G5A. IADL Self-Performance

Intent: **To record the resident's self-care performance in IADL** – instrumental activities of daily living (i.e., what the resident **actually did** for himself or herself and/or how much help was required by staff members) each time the activity occurred during the last 30 days.

Definition:

IADL Self-Performance – Measures what the resident **actually did** (not what he or she might be capable of doing) each time the activity occurred within each IADL category over the last 30 days according to a performance-based scale. (9/1/20)

a. Arranging Shopping – How the resident arranges for shopping. This includes, but is not limited to, making lists of needed items and preferences, notifying others of the need for shopping assistance; does not include actual purchase of desired items.

c. Shopping – How the resident actually purchases groceries, clothes, other incidentals. This includes selecting items at stores; does not include arranging for others to obtain items or transportation for shopping.

c. Arranging Transportation – How the resident actually plans or makes arrangements to get to appointments or to accomplish shopping and other errands.

d. Managing Finances – How the resident handles finances. The way the resident performs bank transactions (cashing or depositing checks), writes checks and manages checkbook, pays bills; does not include handling cash.

e. Managing Cash – How the resident handles cash, including personal needs allowance. Lack of money (e.g., except for a personal needs allowance) does not mean dependence. The way the resident manages cash should be assessed (e.g., recognizes change or bills as money, can calculate the amount to pay when given a bill). If a resident has no money you may code as "activity did not occur."

f. Light Meal / Snack Preparation – How the resident prepares light meals or snacks. This includes obtaining food and utensils within the home, opening packages, and other necessary preparation such as pouring, mixing or warming; does not include grocery shopping or main meal preparation.

g. Telephone – How the resident uses the phone. This includes locating phone numbers, dialing the correct number, and communicating by phone.

h Light Housework – How the resident does their own household tasks. This includes washing/drying dishes, dusting, making their bed, or taking care of their belongings, in the home.

i. Laundry – How resident does their own laundry. Includes sorting, washing, or folding laundry either in or outside the home; does not include transportation.

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

A resident's IADL self-performance may vary from day to day, shift to shift, or within shifts. [There are many possible reasons for these variations, including mood, medical condition, relationship issues and medications.] The responsibility of the Assessor, therefore, is to capture the total picture of the resident's IADL self-performance over the 30-day period, 7 days a week – e.g., not only how the evaluating staff person sees the resident, but how the resident performs at other times as well.

In order to accomplish this, it is necessary to gather information from multiple sources – e.g., interviews/discussion with the resident and direct care staff [on all three shifts, including weekends] and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the IADL activity definitions. For example, when discussing arranging shopping with a caregiver, be sure to inquire specifically how the resident remembers what items are needed, specifies their brand, size, or color preferences, and notifies others of the need for shopping assistance. The wording used in each coding option is intended to reflect real-world situations in residential care facilities, where slight variations are common.

To evaluate a resident's IADL self-Performance, begin by reviewing the documentation in the resident's or facility's records (e.g., the resident's service or care plan, staff and physician notes or instructions). Talk with staff from each shift to ascertain what the resident does for himself or herself in each IADL activity. As previously noted, be alert to differences in resident performance from shift to shift and apply the IADL codes that capture these differences. For example, a resident may be independent in arranging Transportation for routine daily activities but may require assistance for arranging transportation for evening outings (such as assistance with reading evening bus schedules). In this case, on Arranging Transportation, the resident self-performance would be coded “1” (Done with Help). Staff documentation should capture whether the activity occurred each shift, the resident’s level of self-performance and the level of staff supported provided. (9/1/20)

Coding: For each IADL category, check the answer box that best represents the resident's functioning during the past 30 days.

Self-Performance Codes:

0. **Independent** – No help or staff oversight provided during past 30 days.

1. **Done with Help** – Support is necessary for resident to adequately perform the function at least some of the time.

2. **Done by Others** – Resident is not involved in performing the activity; however, function is performed by others on behalf of resident.

3. **Activity Did Not Occur** – Over the last 30 days, the IADL activity was not performed. In other words, the activity did not occur at all.

This is the documentation on the MDS by the MDS coordinator that reflects the Resident's self-performance over the 30-day look back period. Staff documentation would capture whether the activity occurred each shift, the resident's level of self-performance and the level of staff support provided. (9/1/20)

G5B. Transportation

Intent: To record the resident's self-performance in traveling outside the home and how much help was required by staff members or others during the past 30 days.

Definition: Transportation Self-Performance – Measures what the residents actually did (not what he/she might be capable of doing) relative to transportation over the last 30 days according to self-performance categories. How the resident travels from the home to other locations, such as a doctor's office or shopping, by whatever means (e.g., taxi, bus, automobile); includes timely arrival at designated locations as necessary to meet transportation schedules, movement between vehicles and buildings, and identifying and gaining access to desired locations/destinations (e.g., office buildings, doctors' offices, or stores).

Process: A resident's self-performance for transportation may vary from day to day, or engagement to engagement, or by distance traveled. There are many possible reasons for these variations, including mood, medical condition, relationship issues and medications. The responsibility of the Assessor, therefore, is to capture the total picture of the resident's self-performance over the 30-day period, and consider various types of transportation needed—i.e., not only how the evaluating staff person sees the resident, but how the resident performs at other times as well.

To evaluate a resident's Transportation Self-Performance, begin by reviewing the documentation in the resident's or facility's records (e.g., the resident's service or care plan, staff and physician notes or instructions). Talk with staff from day and evening shifts to ascertain what the resident does for himself or herself relative to transportation. As previously noted, be alert to differences

in resident performance from day to day or shift to shift and CHECK ALL ITEMS that capture these differences.

Residents who have difficulty getting between buildings and vehicles, or who have difficulty locating their destination are distinguished based on their need for assistance beyond simply driving a vehicle. For example, a resident may be able to drive to local shopping areas for routine activities but may require someone else to drive them to appointments that are out of town and escort them into unfamiliar buildings to locate a new doctor's office. In this case, the resident's situation would be recorded by checks for both items "a". Resident drove car independently… and "c", Resident rode to destination with others and was accompanied…"

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

a. Resident drove car or used public transportation independently – Resident was not accompanied by a driver, staff, family or other individual expected to assist the resident in their travel to appointments or other engagements.

b. Resident rode to destination with staff, family, others (in car van, public transportation) but was not accompanied – Resident was accompanied by a driver or other individual expected to assist the resident while in the vehicle; individual accompanying the resident did not leave the vehicle or provide physical assistance into or out of buildings. Individual accompanying resident may have supervised resident by observing that resident managed to safely gain access to the destination building.

c. Resident rode to destination with staff, family, others (in car van public transportation) and **was accompanied** – Resident was accompanied by an individual (which may have been the driver of a second individual) who escorted the resident into and out of buildings, within buildings, and accompanied the resident to appointments or while they conducted business or participated in other activities.

d. Activity did not occur – Over the last 30 days, the resident did not use any transportation at all.

G6. ADL and IADL Functional Rehabilitation or Improvement Potential

Intent: To describe beliefs and characteristics related to the resident's functional status that may indicate he or she has the capacity for greater independence and involvement in self-care in at least some ADL or IADL areas. Even if highly independent in an activity, the resident may believe he or she can do better (e.g., walk longer distances, shower independently, manage all medications).

Process: Ask if the resident thinks he or she could be more self-sufficient given more time assistive devices, or training/therapy. Listen to and record what the

resident believes, even if it appears unrealistic. Also, as a clue to whether the resident might do better all the time, ask if his or her ability to perform ADLs

or IADLs varies from time to time, or if ADL or IADL functioning has declined or improved in the last 3 months.

Ask direct care staff (e.g., on all shifts) who routinely care for the resident if they think he or she is capable of greater independence, or if the resident's performance in ADLs or IADLs varies from time to time. Ask if ADL or IADL functioning has declined or improved in the last three months.

You may need to prompt staff to consider such factors as:

- Has self-performance in any ADL or IADL varied over the last week (e.g., the resident usually requires two-person assistance but on one day transferred out of bed with assistance of one person)?

- Was the resident slow in performing some activities that staff members intervened and performed the task or activity? Is the resident capable of increased self-performance when given more time?

- Is the resident capable of increased self-performance when tasks are broken into manageable steps (e.g., tasks are segmented)?

- Can the resident follow instructions to perform an activity if the instructions are provided one step at a time? Can the resident follow directions with no more than two steps?

- Does the resident tire noticeably during most days?

- Does the resident avoid an ADL or IADL activity even though physically or cognitively capable (e.g., refuses to walk alone for fear of falling, demands that others attend to personal care or managing incontinence pads because they do it better)?

- Has the resident's performance in any ADL or IADL improved?

- Does staff or the resident believe the resident could be more independent in any ADL or IADL if he/she had special equipment/assistive devices (such as a cane or walker) or received some skills training or therapy (e.g., OT)?

Coding: Check all that apply. If none of these items apply check ***NONE OF ABOVE.***

G7. New Devices Needed

Intent: To determine whether the resident needs new or additional assistive devices and what if any, is needed.

Definition:

a. Eyeglasses – includes contact lenses, or a new prescription for eyeglasses.

b. Hearing Aid – includes a new device or replacement of existing device; includes batteries if needed.

c. Cane or Walker – includes a new cane or replacement of an existing cane with a different cane (e.g., replacement with a new tripod cane).

d. Wheelchair – includes replacing a non-motorized chair the resident currently uses with an electric wheelchair.

e. Assistive Feeding Devices -- Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating (e.g., plate guard, stabilized built-up utensil).

f. Assistive Dressing Devices – Devices that help the resident dress (e.g., a buttonhook or Velcro closings).

g. Dentures - A removable appliance used to replace teeth. A complete denture replaces all of the teeth; a partial denture replaces some teeth.

h. Other – Includes prostheses. Please specify.

Process: Ask resident, staff, family.

Coding: Check all that apply. If the resident expresses or gives evidence of needing an assistive device that is not listed, check box lettered "g" for "Other" and specify the device. If none of these items apply check ***NONE OF ABOVE.***

G8. Self-Performance in IADLs

Intent: To record resident's status or abilities now as compared to 180 days ago. If the resident is a new admission or has not been in the facility for 180 days, review the record and make an assessment based on that information.

Coding:

0. No change in status or abilities in last 180 days.

1. Improved in status or abilities in last 180 days.

2. Declined in status or abilities in last 180 days.

Section H. Continence in Last 14 Days

H1. Continence Self-Control Categories

Note: This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel and bladder continence are evaluated over 14 days.

***Intent*:** To determine and record the resident's pattern of bladder and bowel continence control over the last 14 days.

Definition: Bladder and Bowel Continence – Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to resident's ability to toilet self – e.g., a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The resident's self-performance in toilet use is recorded in G1Af.

Process: Review the resident's record and any urinary or bowel elimination flow sheets (if available). Validate the accuracy of written records with the resident. Make sure that your discussions are held in private as control of bladder and bowel functions are sensitive subjects, particularly for residents who are struggling to maintain control. Many people with poor control will hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they mistakenly believe that incontinence is a natural part of aging and nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive and straightforward manner.

Validate continence patterns with people who know the resident well (e.g., primary family caregiver of newly admitted resident; direct care staff).

Remember to consider continence patterns over the last 14-day period, 24 hours a day, including weekends. If staff assignments change frequently, consider initiating and maintaining a bladder and bowel elimination flow sheet in order to gather more accurate information.

Coding: Choose one response to code the level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code the resident's actual bladder and bowel continence pattern – i.e., code the frequency with which the resident is wet and dry during the 14-day look-back period. Do not record the level of control that the resident might have achieved under optimal conditions.

A five-point coding scale is used to describe the continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bowel and bladder. The reason for these differences is that there are more episodes of urination per day and week, compared to bowel movements, which typically occur less often.

0. Continent – Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, indwelling catheters, or ostomy devices).
1. Usually Continent – Bladder, incontinent episodes occur once a week or less. Bowel incontinent episodes occur less than once a week.
2. Occasionally Incontinent – Bladder incontinent episode occur two or more times a week but not daily. Bowel incontinent episodes occur once a week.
3. Frequently Incontinent – Bladder, tended to be incontinent daily, but some control present (e.g., on day shift) Bowel, 2-3 times a week.
4. Incontinent – Bladder incontinent episodes occur multiple times daily. Bowel incontinence is all (or almost all) of the time.

Examples of Bladder Continence Coding

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. Code "0" for Continent" – Bladder.

Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet and is considered continent. Code "0" for "Continent" – Bladder.

Although she is generally continent of urine, every once in a while, (about once in two weeks) Mrs. T doesn't make it to the bathroom in time after receiving her daily diuretic pill Code "1" for "Usually Continent" – Bladder.

Late in the day when she is tired, Mrs. A sometimes (but not all days) has more episodes of urinary incontinence. Code "2" "Occasionally Incontinent" – Bladder, depending on her usual urinary incontinence frequency.

H2. Bowel Elimination Pattern

Intent: To record the effectiveness of resident's bowel function.

Definition:

a. Bowel elimination pattern regular – Resident has at least one bowel movement every three days.

b. Constipation – Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having bowel movement.

c. Diarrhea – Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

d. Fecal Impaction – The presence of hard stool upon digital rectal exam or by abdominal x-ray. Fecal impaction may also be present if stool is seen on abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the daily clinical record of daily bowel movement. NOTE: A digital exam is only performed by a licensed professional nurse or the physician.

e. Resident is Independent – No incontinence observed by staff.

Process: Ask the resident. Examine, if necessary. Review the record, particularly any documentation flow sheets of bowel elimination patterns. Ask direct care staff from all shifts.

Coding: Check all that apply in the last 14 days. If no items apply check ***NONE OF ABOVE.***

H3. Appliances and Programs

Definition:

a. Any scheduled toileting plan – A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal or remind the resident to go to the toilet. Includes habit training and/or prompting for bladder or bowels.

b. Bladder retraining program - A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

c. External (condom) catheter - A urinary collection appliance worn over the penis.

d. Indwelling catheter - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine catheters inserted through the urethra or by supra-pubic incision.

e. Intermittent catheter - A catheter that is used for draining urine from the bladder. This type of catheter is usually removed after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder emptying program (e.g., every shift in a resident with an under-active or a contractile bladder muscle).

f. Did not use toilet room/commode/urinal – Resident did not use any of these items, or a bedpan, during the last 14 days.

g. Pads/brief used – Any type of absorbent, disposable or reusable

undergarment or item, whether worn by the resident (e.g., diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

h. Enemas/irrigation – Any type of enema or bowel irrigation, including ostomy irrigations.

i. Ostomy present – Any type of ostomy of the gastrointestinal or genitourinary tract.

Process: Check the clinical record. Consult with direct care staff and the resident. Be sure to ask about items that are usually hidden from view because they are worn under street clothing (e.g., pads, briefs).

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

H4. Use of Incontinence Supplies

Intent: To determine and record the *resident's ability to manage* incontinence supplies, including pads, briefs, an ostomy, or a catheter, in the last 14 days. To "manage supplies" means to change the pad or brief, empty catheter and/or ostomy bag; it does not refer to ordering supplies or putting them away when supplies arrive. (9/1/20)

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

Coding:

0. Continent
1. Resident incontinent and able to manage supplies independently.
2. Resident incontinent and receives assistance with managing supplies.
3. Resident incontinent and does not use incontinence supplies.

H5. Change in Urinary Continence.

Intent: To document changes in the resident's urinary continence status as compared to 180 days ago (or since admission if less than 180 days), including any changes in self-control categories, appliances, or programs. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the resident's record and bladder continence patterns as recorded in the last assessment (if available). Validate findings with the direct care staff on all shifts. For new residents, consult with family if possible.

Coding: Code "0" No change, "1" Improved, or "2" Deteriorated. A resident who was incontinent 180 days ago who is now continent by virtue of a catheter should be coded as "1" Improved."

Section I. Diagnoses

I1. Diagnoses

Intent: To document diagnoses that currently have a relationship to the resident's ADL status, cognitive status, mood or behavior status, medical treatments, monitoring, or risk of death. In general, these are conditions that drive the current service plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan. In some facilities, staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's service plan. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status. **All diseases, conditions (not limited to those below) must have physician documented diagnosis in the clinical record.**

Definition:

a. Diabetes Mellitus – Includes insulin-dependent diabetes mellitus (IDDM) and diet (non-insulin) controlled diabetes mellitus (NIDDM).

b. Hypothyroidism

c. Hyperthyroidism

d. Arteriosclerotic Heart Disease (ASHD)

e. Cardiac dysrhythmia

f. Congestive Heart Failure – Inability of the heart to pump sufficient blood, resulting in an accumulation of fluids in the lungs, abdomen, and legs.

g. Deep vein thrombosis

h. Hypertension

i. Hypotension

j. Peripheral vascular disease

k. Other cardiovascular disease

l. Arthritis – Includes degenerative joint disease (DJD), Osteoarthritis (OA), and rheumatoid arthritis (RA).

m. Hip fracture – Includes any hip fracture that occurred at any time that ***continues*** to have a relationship to current functional status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, sub-capital fractures.

n. Missing limb (e.g., amputation) – Includes loss of any part of any upper or lower extremity.

o. Osteoporosis – A disease of the bone, where normal bone density is lost. It may cause pain, especially in the lower back, frequent broken bones, and loss of body height.

p. Pathological bone fracture

q. Alzheimer's Disease – A form of brain disease that can lead to confusion, memory loss, restlessness, perception problems, speech trouble, lack of orientation to time and place. ***Check only if the explicit diagnosis is present.***

r. Aphasia – A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.

s. Cerebral palsy – a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement, muscle coordination, and balance. CP affects the part of the brain that controls muscle movements. Many children with cerebral palsy are born with it, although it may not be detected until months or years later.

t. Cerebrovascular Accident (CVA/Stroke) – A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, emboli.

u. Dementia Other Than Alzheimer's – Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infract dementia, and dementia related to neurologic diseases other than Alzheimer's (e.g., Picks, Creutzfeldt-Jakob, Huntington's disease, etc.).

v. Hemiplegia/Hemiparesis – Paralysis/partial paralysis (temporary or permanent impairment of function and/or movement) of one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor.

w. Multiple Sclerosis – A disease of the nervous system characterized by loss of the protective myelin covering the nerve fibers of the brain and spinal cord. Symptoms may include muscle weakness, dizziness, and sight disturbances.

x. Paraplegia – Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.

y. Parkinson's disease – A slowly growing disorder caused by damage to the brain cells. Symptoms include tremors that occur while at rest and muscular rigidity.

z. Quadriplegia - Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury. Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition. (9/1/20)

aa. Seizure Disorder –A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain.

bb. Transient Ischemia Attack – A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

cc. Traumatic Brain Injury – Damage to the brain as a result of physical, trauma-related injury to the head.

dd. Anxiety Disorder – A category of psychiatric diagnosis that includes panic disorder, obsessive compulsive disorder, generalized anxiety disorder, and other.

ee. Depression – An emotional state in which there are extreme feelings of sadness, lack of worth or emptiness.

ff. Manic Depression (bipolar disease) – A mental disorder in which the resident has recurrent episodes of depression and mania. Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic depressive illness.

gg. Schizophrenia – A mental disorder in which the resident loses touch with reality.

hh. Asthma

ii. Emphysema/COPD – Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), chronic restrictive lung diseases such as asbestosis, and chronic bronchitis.

jj. Cataracts – A disease of the eye in which the lens loses its clearness. A gray-white film can often be seen in the lens behind the pupil. Do not include this diagnosis if after the removal the resident is no longer affected by the cataract.

kk. Diabetic retinopathy

ll. Glaucoma

mm. Macular degeneration

nn. Allergies

oo. Anemia

pp. Cancer – any type that is currently being treated, monitor, and/or causing complications.

qq. Renal Failure

rr. Tuberculosis – Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., Isoniazid (INH), ethambutol, rifampin, (cycloserine) for tuberculosis.

ss. HIV – Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test for the Human Immunodeficiency Virus or a diagnosis of AIDS.

tt. Intellectual and Developmental Disorders – Intellectual disability is a disability characterized by significant limitations both in **intellectual functioning** (reasoning, learning, problem solving) and in **adaptive behavior**, which covers a range of everyday social and practical skills. This disability originates before the age of 18. Developmental disabilities are severe chronic disabilities that can be cognitive or physical or both. The disabilities appear before the age of 22 and are likely to be lifelong

uu. Substance abuse disorders – Includes drugs and alcohol.

vv. Other Psychiatric Diagnosis – Any psychiatric condition not covered above (e.g., paranoia, personality disorder) Please note that you may record the diagnosis in I.2. if you cannot categorize the disorder.

ww. Explicit Terminal Prognosis – Primary Physician has documented in the record that the resident is terminally ill and, in his/her clinical experience, not expected to have more than 6 months to live. This judgment must be substantiated with a well-documented disease, diagnosis and deteriorating clinical course.

xx. None of the above

Process: Consult transfer documentation and medical record (including current physician treatment orders and service plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnosis and corresponding ICD codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form.

Consult with physician for confirmation and initiate necessary physician documentation. Physician involvement in this part of the assessment is crucial.

The physician must be asked to review the items in Section I at the time of the visit closest to the scheduled MDS assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are documented, and "inactive" diagnoses are designated as resolved. Inaccurate or missed diagnoses can be a

serious impediment to service planning. Thus, the facility must share this section of the MDS with the physician and ask for his or her input.

Full physician review of the most recent MDS Assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry or help to confirm existing observations or suggest the need for additional follow-up.

Check the diagnosis only if it has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Coding: Do not record any conditions that have been resolved and no longer affect the resident's functional status or service plan. Check all that apply. If none of the conditions apply, check ***NONE OF ABOVE***.

If you have more detailed information available in the record for a more definitive diagnosis than is provided in the list in Section I.1 check the more general diagnosis in I.1 and then enter the more detailed diagnosis under I.2.

For example: If the record reveals that the resident has "osteoarthritis", you check item I1.l Arthritis and record "Osteoarthritis" in Section I.2.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record.

I2. Other Current Diagnoses

Intent: To identify conditions not listed in item I.1 that affect the resident's current ADL status, mood and behavioral status, medical treatments, monitoring, or risk of death. Also, to record more specific designations for general diagnosis categories listed under I.1.

Coding: Enter the description of the diagnoses on the lines provided. It is not necessary to enter an ICD code as it not used to calculate quality measures or RUG groups.

Section J. Health Conditions

J1. Problem Conditions

To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

Definition:

a. Inability to lie flat due to shortness of breath – Resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air. This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check item J.1.b "Shortness of breath". If the resident does not have shortness of breath when upright (e.g., O.K. when using two pillows or sitting up) do not check item J.1.b.

b. Shortness of breath – Difficulty (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check item J.1.a (Inability to lie flat due to shortness of breath).

c. Edema – Excessive accumulation of fluid in tissues, either localized or systematic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

d. Dizziness/vertigo – The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

e. Delusions – Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., that he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned). Documentation must include a description of the delusions and evidence that the resident's delusion was false. A resident's repetitive delusions should be referenced on the service plan.

f. Hallucinations – False perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes). Documentation must include a description of the hallucinations.

g. Hostility – Having or expressing antagonism, extreme unfriendliness, enmity/hateful feelings.

h. Suspiciousness – Imagines or believes something is wrong in the absence of proof or evidence; distrustful.

i. Headache – any pain or discomfort in the area of the head.

j. Numbness/tingling – generally this applies to the extremities (hands, feet) but may be present in other parts of the body.

k. Blurred vision – inability to focus, images are not clear.

l. Dry mouth – mucous membranes of the mouth are not moist. May exhibit difficulty chewing or swallowing.

m. Excessive salivation or drooling – increased secretion production (often due to medications).

n. Change in normal appetite – may be an increase or decrease.

o. Other – specify in designated space

Process: Ask the resident if he or she has experienced any of the listed symptoms in the last 7 days. Review the records (including physician notes or records) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not voluntarily complain or mention these symptoms to staff members or others, attributing such symptoms to "old age". Therefore, it is important to ask and observe the resident directly if possible, since the health problems being experienced by the resident can often be remedied.

Coding: Check all conditions that occurred within the past 7 days unless otherwise indicated. If no conditions apply, check ***NONE OF ABOVE***.

J2. Extrapyramidal Signs and Symptoms

Intent: To record in the last 3 days any observable signs and symptoms of untoward medication reactions associated with the use of certain anti-psychotic drugs (e.g., Thorazine, Haldol, Risperdal, Prolixin, Mellaril, etc.).

Process: Observe the resident, especially before and after administration of any medications, for any changes in baseline. Be alert at times of medication changes or if a resident has been on a medication for a long period of time. These **signs are dangerous and should be immediately reported to supervisory staff** if they are a new development and not already being treated.

Coding: Check **all** boxes that apply.

Increase in Motor Activity

a. Akathisia – Resident reports subjective feeling of restlessness or need for movement; inability to sit down or still without anxiety.

b. Dyskinesia (tardive) – chewing, puckering, movements of the mouth; irregular movements of the lips; or rocking or writhing of the trunk.

c. Tremor – Regular, rhythmic quivering of a part or parts of the body (e.g., fingers, limbs).

Decrease in Motor Activity

d. Rigidity – Resistance to flexion and extension of muscles, e.g., continuous or cog wheeling rigidity (manually manipulated body parts take on the feel of a cogwheel).

e. Slow Shuffling Gait – reduction in speed and stride usually with a decrease in pendular arm movements.

f. Bradykinesis – decrease in spontaneous movements, e.g., reduced body movement or reduced facial expression, gestures or speech.

Muscle Contractions

g. Dystonia – muscle hypertonicity, e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes.

J3. Pain Symptoms

Intent: To record the intensity of signs and symptoms of pain. For service planning purposes, this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

Definition: **Pain -** For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Whether the resident shows evidence of pain depends on the observation of others (i.e., cues), either because the resident does not verbally complain, the resident may have a high pain tolerance level or is unable to verbalize.

Process: Ask the resident if he or she experienced any pain in the last 7 days. Ask him/her to describe the pain using a scale from "1" to "10" with "1" being the least and "10" being the most severe. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking

out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, you must use your judgment as to the intensity of symptoms for coding purposes.

Coding: Code for the level of pain stated by the resident in the last 7 days. If the resident has no pain, code "0", (No pain) and then Skip to item J7. If the resident is unable to communicate the level of pain, you must use your best judgment referring to the nonverbal indicators previously referenced. If you have difficulty, code for the higher level of pain.

Rationale: Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement.

Examples of Pain Intensity

Mrs. G, a resident with poor short-and long-term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, in the morning when you ask her about pain, Mrs. G tells you that she is fine and never has pain.

Rationale for Coding: It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain.

Code = 1

Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting but feels tired upon arising.

Rationale for Coding: Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.

Code = 3

J4. Pain Site

Intent: To record the location of physical pain as described by the resident or discerned from objective physical and laboratory tests. Sometimes is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive service plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definition:

a. Back Pain – Localized or generalized pain in any part of the neck or back.

b. Bone Pain – Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

c. Chest pain while doing usual activities – The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

d. Headache – The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

e. Hip Pain – Pain localized to the hip area. May occur at rest or with physical movement.

f. Incisional Pain – The resident complains or shows evidence of pain at the site of a recent surgical incision.

g. Joint Pain – (other than hip) – The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

h. Soft Tissue Pain – Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, wound pain.

i. Stomach Pain – The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

j. Other – Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

Process: Ask the resident and observe for signs of pain. Consult staff members. Use your best judgment.

Coding: Check all that apply during the last 7 days.

If the resident has mouth pain, check item K1d in Section K, "Oral/Nutritional Status".

J5. Pain Interferes

Intent: To record the amount of time in the last 7 days that pain interfered with the resident's normal activity, such as visiting with friends, going out, etc.

Process: Observe the resident for decrease from his or her normal activity level; if you suspect the presence of pain ask the resident if he or she is in discomfort.

Coding: Check **one** appropriate box

J6. Pain Management

Intent: To record the effectiveness if applicable of any pain control that has been implemented for the resident.

Process: Observe the resident for pain relief. Is he or she able to perform tasks, activities of daily living in an improved manner? Interview the resident and ask if treatment has resulted in relief from pain or lowered the pain level.

Coding: Check **one a**ppropriate box.

J7. Accidents

Intent: To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly residents. Residents who have sustained at least one fall are at risk of future falls. About one-third of all residents fall each year, with serious injury resulting from 6 to 10 percent of falls. Hip fractures account for approximately one-half of all serious injuries.

Definition:

a. Fell in the past 30 days.

b. Fell in the past 31-180 days

c. Hip fracture – in last 180 days.

d. Other fracture in last 180 days – Any fracture other than a hip fracture within the last 180 days.

Process: **New admissions** – Consult with the resident and the resident's family. Review any records the resident may have.

Current residents – Review the resident's records (including incident reports, current nursing care plan, and monthly summaries). Consult with the resident. Sometimes, a resident will fall, and believing that he or she "just tripped," will get up and not report the event to anyone. Therefore, do not rely solely on the records but also the resident directly if he or she has fallen during the indicated time frame. Asking the resident if she/he has fallen and hit the ground/floor or an object (e.g., table, chair) may stimulate his/her memory. If the resident cannot report and there are no facility records, ask staff. Probe if there are bruises or other indicators of falls.

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

J8. Danger of Fall

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g., strength training exercises; safety awareness).

Intent: To identify residents who are at risk for falls.

Definition: **Unsteady Gait** – Unsteady gait takes many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

Process: **Balance problem when standing** – The inability to stand (not walk) without the assistance of a person or assistive-device.

Coding: Check all responses that apply. If no danger of falls is observed, check D ***NONE OF ABOVE.***

Section K. Oral/Nutritional Status

K1. Oral Problems

Intent: To record any oral problems present in the last 7 days.

Definition:

a. Mouth is "dry" when eating a meal – resident complains of dryness, reports needing something to drink while chewing food.

b. Chewing Problem – Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., resident uses ill-fitting dentures, or has a neurologically impaired chewing problem or a painful tooth).

c. Swallowing Problem – Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time or excessive drooling.

d. Mouth pain – Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold), complaining of sores.

Process: Ask the resident about difficulties in these areas. Observe the resident during meals. Inspect the mouth for abnormalities that could contribute to mouth pain.

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

K2. Height and Weight

Intent: To record a current height and weight in order to monitor nutrition and hydration status over time; and, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can have an intended and expected weight loss as a result of taking a diuretic. Weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

a. Height

Process: **New admissions** – Measure height in inches.

Current resident – Check the resident's records. If the last height recorded was more than one year ago, measure the resident's height again.

Coding: Round height upward to nearest whole inch. Measure height consistently over time in accordance with standard facility practice (shoes off, etc.).

b. Weight

Process: Check the resident's records. If the last recorded weight was taken more than one month ago or weight is not available, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding: Round weight upward to the nearest whole pound. Measure weight consistently over time in accordance with standard facility practice (after voiding, before meal, etc.).

K3. Weight Change

Intent: To record variations in the resident's weight over time.

a. Unintended weight loss

Definition: Unintended weight loss in percentages (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

Process: **New admission** – Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current resident – Review the records and compare current weight with weights of 30 to 180 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: Check the box numbered "0" for No or "1" for Yes. If there is no weight to compare to, enter "NA."

b. Unintended weight gain

Definition: Unintended weight gain in percentages (i.e., 5% or more in last 30 days, or 10% or more in the last 180 days).

Process: **New admission** – Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current resident – Review the records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain during the specified time periods.

Coding: Check the box numbered "0" for No or "1" for Yes. If there is no weight to compare to, enter "NA."

K4. Nutritional Problems or Approaches

Intent: To identify specific problems, conditions, and risk factors for functional decline present in the last 7 days that affect or could affect the resident's health or functional status.

Definition:

a. Complains about the taste of much food – The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based – e.g., someone used to eating spicy foods may find meals at the facility bland.

b. Regular or repetitive complaints of hunger – On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

c. Leaves 25% or more of food uneaten at most meals – Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day.

d. Therapeutic diet – A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals.

e. Mechanically altered diet – A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, thickened liquids and ground meat.

f. Noncompliance with diet – Resident does not comply with specific diet orders.

g. Eating Disorders - e.g., anorexia nervosa (excessive fasting); bulimia (binge eating followed by purging); pica (craving to ingest any material not fit for food), etc.

h. Allergies – Specify any known food allergies that the resident has.

i. Restrictions – Specify any dietary restrictions, such as caffeine, chocolate, or meat that the resident may have

Process: Consult resident's records, dietary/fluid intake flow sheets, or dietary progress notes/assessments if they exist. Consult with direct-care staff and food service. Ask the resident if he or she experienced any of these symptoms or approaches in the last 7 days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask, "Why are you not eating?" Note if resident winces or makes faces while eating.

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

Section L. Oral/Dental Status

L1. Oral Status and Disease Prevention

Intent: To document the resident's oral and dental status and document any problematic conditions.

Definition: Broken, loose or carious – Carious pertains to tooth decay and disintegration (cavities).

Process: Ask the resident and examine the resident's mouth. Ask direct care staff if they have noticed any problems.

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

Section M. Skin Condition

To determine the condition of the resident's skin, document problematic skin conditions, and identify the presence of ulcers and foot problems.

M1. Skin Problems

Intent: To document the presence of skin problems other than ulcers.

Definitions:

a. Abrasions – Includes skin that has been scraped or rubbed away.

b. Burns (second or third degree) – Includes burns from any cause (e.g., heat, and/or chemicals) in any state of healing and treatments received within the 7-day look back period. This category does not include first degree burns (changes in skin color only). *The degree of the burn must be documented in the record by a physician or a registered nurse.*

c. Bruises – Includes ecchymosis, localized areas of swelling, tenderness and discoloration.

d. Rashes, itchiness, or body lice – Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritation substances such as urine or detergents, allergies, etc.) including rashes (dermatitis) within skin folds (intertrigo).

e. Open sores or lesions – An open wound, or destructive change in body tissue. A lesion is a generic term for any area of injury or disease to the living tissue on your body.

Process: Ask the resident if he or she has any problem areas. Examine the resident. Ask caregiving staff.

Coding: Check all that apply. If there is no evidence of such problems in the last 7 days, check ***NONE OF ABOVE*.**

M2. <u>Ulcers</u>

Intent: To record the presence of ulcers of any stage, on any part of the body, and treatments received in the last 7 days.

Definition: **Ulcer** – Any lesion *caused by pressure or decreased blood flow* resulting in damage to underlying tissues.

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

NOTE: If eschar and necrotic tissue are covering and preventing adequate staging of a pressure ulcer, the assessor will document and code the pressure ulcer as a Stage IV until the eschar has been debrided (surgically or mechanically) to allow staging. These instructions must be followed for MDS coding purposes until they are revised. Although the AHCPR and NPUAP system for staging pressure ulcers indicates that the presence of eschar precludes accurate staging of the ulcer, the facility must use these directions in order to code the MDS, but not necessarily to render treatment. Documentation must accurately reflect findings from assessments that were conducted.

For the MDS assessment, staging of ulcers should be coded in terms of what is seen during the look back period. For example, a healing stage 3 that has the appearance of a stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment.

Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.

This section requires a full body exam.

Process: Review the resident's record and consult with the staff about the presence of an ulcer. Without a full body check, an ulcer may be missed. Ulcers must be staged by a registered nurse or physician, as they appear at the time of the assessment, and must be documented in the clinical record during the observation period. For venous stasis ulcers, the clinical record must contain documentation by a registered nurse or physician of a detailed description of the ulcer that would match the stage, as defined in the MDS Training Manual, being coded.

To recognize Stage 1 ulcers in ebony complexions, look for: any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel look", (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: Record the number of ulcers at each stage - whether caused by pressure or impaired circulation. If there are none present at a stage, record "0" (zero). Code **all** that apply in the last **7** days. If there are **9 or more** ulcers present, code a "9"**.**

M3. <u>Foot Problems and Care</u>

Intent: To document if the resident's feet are inspected on a regular basis and record the presence of any foot problem in the last 7 days.

M3a. Resident or someone else inspects resident's feet on a regular basis:

Process: Ask the resident and direct care staff. Review the resident's records for indications or regular treatment by a podiatrist. Regular inspection is

especially important for residents with diabetes, impaired circulation or impaired sensation.

Coding: Check "0" for No if resident's feet are not inspected on a regular basis and "1" for Yes if they are (either by resident or someone else.

M3b. One or more foot problems in the last seven (7) days

Process: Ask the resident and direct care staff. Review the resident's clinical records for indications of foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrenous toes, foot fungus or enlarged toes.

Coding: Check "0" for No if the resident had no foot problems or infections and "1" for Yes if any of these conditions was present.

Section N. Activity Pursuit Patterns

Intent: To record the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility. This section will also document how often the resident has personal and telephone contact with family and friends.

Definition: refers to any activity other than ADLs (or therapies) that a resident pursues in order to enhance a sense of well-being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

N1. Time Awake

Intent: To identify those periods of a typical day (over the last 7 days) when the resident was awake all or most of the time (i.e., no more than one-hour nap during any such period). For care planning purposes this information can be used in at least two ways:

- The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group).

- The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.

Process: Consult with direct care staff, the resident, and the resident's family.

Coding: Check all periods when resident was awake all or most of the time over last 7 days. Morning is from 7 am (or when resident wakes up, if earlier or later than 7 am) until noon. Afternoon is from noon to 5 p.m. Evening is from 5 p.m. to 10 p.m. (or bedtime, if earlier). Night is from 10 p.m. to 7 am (or from resident's bedtime until when resident wakes up).

N2. Average Time Involved in Activities

Intent: To determine the proportion of available time that the resident was actually involved in activity pursuits as an indication of his or her overall activity-involvement pattern.

Process: Consult with direct care staff, activities staff members, the resident, and the resident's family. Ask about time involved in different activity pursuits.

Coding: Check the most appropriate measure for the last 7 days. In coding this item, exclude time spent in receiving treatments (e.g., medications, heat treatments, bandage changes, rehabilitation therapies, or ADL assistance). Include time spent in pursuing independent activities (e.g., watering plants, reading, letter writing); social contacts (e.g., visits, phone calls) with family, other residents, staff, and volunteers; recreational pursuits in a group, one-on-one, or an individual basis. The answer represents percent of available time that the resident is involved in activities. Also count any time the resident spent away from the home that involved an activity (e.g., visiting with friends/family; going to a movie or going shopping). Do NOT count sheltered workshop.

N3. Preferred Activity Settings

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

Process: Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behavior can be helpful but only provides part of the answer. Do not limit the preference list to only those areas or settings to which the resident now has access. Try to discover the range of possibilities for the resident's preferred setting(s).

Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?" Ask staff members to identify settings that resident frequents or where he or she appears to be most at ease or very ill at ease.

Coding: Check all responses that apply. If the resident does not wish to be in any of these settings, check ***NONE OF ABOVE.***

N4. General Activity Preferences (Adapted to resident's current abilities)

Intent: Determine which activities of those listed the resident would prefer to participate in (independently or with others). Choice should not be limited by whether or not the activity is currently available to the resident or whether the resident currently engages in the activity.

Definition:

c. Exercise/sports – Includes any type of physical activity such as weight training, yoga, walking, sports (e.g., bowling, croquet, golf, or watching sports).

e. Music – Includes listening to music or being involved in making music (singing, playing piano, etc.).

f. writing – Reading can be independent or done in a group setting where a leader reads aloud to the group or the group listens to "talking books." Writing can be solitary (e.g., letter-writing or poetry writing) or done as part of a group program (e.g., recording oral histories). Or a volunteer can record the thoughts of a blind or partially paralyzed resident in a letter or journal.

g. Spiritual/religious activities – Includes participating in religious services as well as watching them on television or listening to them on the radio.

k. Gardening or plants – includes tending one's own or other plants, participating in gardening club activities, regularly watching a television program or video about gardening.

l. Talking or conversing – Includes talking and listening to social conversations and discussions with family, friends, other residents, or staff. May occur individually, in groups, or on the telephone; may occur informally or in structured situations.

m. Helping others – Includes helping other residents or staff, being a good listener, assisting with unit routines, etc.

n. Doing chores around the house/facility – Includes cooking, light housework, laundry, and ironing. Be sure this represents a preference than an assigned task.

Process: Consult with the resident, the resident's family, activities staff members, and direct care staff. Explain to the resident that you are interested in hearing about what he or she likes to do or would be interested in trying. Remind the resident that a discussion of his or her likes and dislikes should not be limited by perception of current abilities or disabilities or what the facility makes available. Explain that many activity pursuits are adaptable to the resident's capabilities. For example, if a resident says that he used to love to read and misses it now that he is unable to see small print, explain about the availability of taped books or large print editions.

For residents with dementia or aphasia, ask family members about resident's former interests. A former love of music can be incorporated into the service plan (e.g., bedside audiotapes, sing-a-longs). Also observe the resident in current activities. If the resident appears content during an activity (e.g., smiling, clapping during a music program) check the item on the form.

Coding: Check each activity preferred. If none are preferred, check ***NONE OF ABOVE.***

N5. Preferred Activity Size

Intent: To determine what activity group size the resident is most comfortable.

Process: Consult with activities staff if available. Discuss options with the resident. Observe those activity groups that the resident gravitates towards.

Coding: Check **all** boxes that apply.

N6. Preferences in Daily Routine

Intent: To determine if the resident has an interest in pursuing activities not offered at the facility or not made available to the resident. This includes situations in which the resident would like a change in the type of activities offered. This also includes situations in which an activity is provided but the resident would like it to take place in a different location or at a different time. Residents who resist attendance/involvement in activities offered at the facility are also included in this category in order to determine possible reasons for their lack of involvement.

Review how the resident spends the day. Ask the resident if there are things he or she would enjoy doing (or used to enjoy doing) that are not currently available or, if available, are not "right" for him or her as the activity is done or organized at the facility. If the resident is unable to answer, ask the same question of a close family member, friend, activity professional, or nurse assistant. Would the resident prefer a change in his or her daily routine, or is everything OK?

Coding: Code for the resident's preferences for changes in daily routines by checking the answer boxes that best represent the type of changes he or she would prefer. Check "e", Resident prefers stability in daily routine" if the resident does not prefer change or if the resident benefits from consistency, structure in their daily routine. Check ***NONE OF ABOVE*** if no preference for change exists.

N7. Interaction with Family and Friends

Intent: To determine (to the best of your knowledge) the amount of contact the resident has with family and friends who are outside the facility.

Definition: Includes relatives by blood, marriage or adoption and friends who live outside the facility.

Coding: Check the appropriate box. Include all times the resident visited with/saw (N7a) or spoke on the telephone with (N7b) friends or family. In situations where more than one relative (or friend) visited or phoned at different times,

check the box that corresponds to the total number of visits or phone calls the resident received.

N8. Voting

Intent: To determine if resident is registered to vote or needs assistance in registering or voting.

Coding: Check "0" for No and "1" for Yes.

N9. Social Activities

Intent: To record resident's status or abilities now as compared to 180 days ago. If the resident is a new admission or has not been in the facility for `180 days, review the record and make an assessment based on that information.

Coding:

0. No change
1. Improved
2. Decline

Section O. Medications

O1. Number of Medications

Intent: To determine the number of *different* medications (over-the-counter and prescription drugs) the resident has received in the past 7 days.

Process: Count the number of *different* medications (not the number of doses or different dosages) administered by *any* route (e.g., oral, IV, injections, patch). "Medications" can also include topical preparations, ointments, creams used in wound care (e.g., Elase), eye drops, vitamins, and suppositories. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication.

Do not count as a medication:

- Herbal and alternative medicine products are considered dietary supplements;
- Ensure or any nutritional supplement; and
- Heparin included in saline solution used to irrigate a "heparin lock".

Coding: Write the appropriate number in the answer box. *Count **only** those medications actually administered and received by the resident over the last 7 days.* Do not count medications ordered but not given.

Example

Resident was given Digoxin 0.25 mg by mouth on Tuesday and Thursday and Digoxin 0.125 mg by mouth on Monday, Wednesday, and Friday. Although the dosage is different days of the week, the medication (Digoxin) is the same. Code "1" (one medication received).

O2. New Medications

Intent: To record if the resident is receiving medications that were initiated in the last 90 days (i.e., new medication).

Coding: Check the box numbered "0" if the resident did not receive any new medications in the past 90 days. Check the box numbered "1" if the resident is *currently* receiving new medications ordered in the last 90 days.

O3. Injections

Intent: To determine the number of days during the past 30 days that the resident received any type of medication, antigen, vaccine, or contrast material by injection. Although antigens and contrast materials are considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions.

Due to potential systemic and/or local complications from injections, it is important that staff ask the resident about the following situations:

- Actual administration is being done
- Any difficulties with the administration procedure
- Any distressing signs or symptoms that could be attributed to the medication
- Any signs or symptoms of problems at the injection site

There must be documentation to support that communication between resident and staff occurred, even if there were no complications.

Coding: Record the **NUMBER OF DAYS** in the answer box.

O4. Days Received the Following Medication

Intent: To record the number of days the client received any of the following types of medications in the last 7 days: Antipsychotic, antianxiety, antidepressant, or hypnotic, diuretic, Aricept (or any dementia treatment drug), and Insulin.

4a. Days Received the Following Medications

Definition: Medications include prescriptions for antipsychotics (such as Haldol), antianxiety (such as Ativan), hypnotics (such as Restoril), and antidepressants (such as Elavil), diuretics (such as Lasix), dementia treatment (Aricept or any dementia treatment drug), and injectable Insulins.

Process: Review the client's record for documentation that a medication was received by the resident during the past seven days.

Coding: Enter the number of days each of the listed types of medications was received by the client during the past seven days. In the case of a new admission, if it is clearly documented in their record that the client received any of the listed medications, record the number of days. If the records are not clear or do not reference the client receiving one of these medications record "0" (not used) in the corresponding box. If the resident uses long-lasting drugs that are taken less than weekly (e.g., Prolixin (Fluphenazine Deconate) or Haldol (Haloperidol Deconate) given every few weeks or monthly) enter "1"

4b. **PRN Medications**

Definition: PRN means the prescription ordered by the physician specifies the medication should be given on an "as needed" basis, by qualified staff, to the resident (or the resident may take it as needed). Unlicensed staff (i.e. CRMA) requires detailed description of behaviors from the physician in order to administer PRN (as needed) psychotropic medications.

Process: Review the client's medication sheet or prescription bottles.

Coding: Check the appropriate response.

O5. <u>Self-administered medications</u>

Intent: To record whether the resident self-administered any of the following medications in the last 7 days: insulin, oxygen, nebulizers, Nitro patch, glucoscan or over-the counter meds. Please specify if there were any other self-administered medications.

Process: Self-administration requires an assessment of the resident's safety to self-administer and a physician's order that would allow for resident's to have medications at the bedside and to self-administer. Document if the client did or did not *self-administer* any over-the-counter meds in the provider notes, monthly summaries, or the assessment tool. This would mean that the facility provided no assistance, over-sight, or cuing to the client.

Coding: Check all responses that apply. If the resident does not self-administer any medications, check ***NONE OF ABOVE***.

O6. <u>Medication preparation and administration</u>

Intent: To record whether the resident prepared **and** administered any of his/her own medications in the last 7 days.

Process: Documentation is required in the clinical record, monthly summary, or the medication administration record to support the coding.

Coding: **0.** Resident takes no medications
1. No Medications are prepared **and** administered by the resident.
2. Some medications are prepared **and** administered by the resident.
3. All medications are prepared **and** administered by the resident.

O7. Medication Compliance

Intent: To determine if there are specific or potential problems with the residents' medications or the way the resident takes medications.

Process: Review the resident's medication sheet, check with direct care staff.

Coding: Check the box that represents the resident's level of compliance during the last 30 days.

O8. Misuse of Medication

Intent: To determine the extent of misuse of drugs both over the counter and prescriptions in the last 6 months.

Process: ***Misuse of medication can involve substances other than narcotics or opioids.*** Does the resident take more or less than the medication prescribed? Do they run out of medication earlier than is expected? Do they take medications for purposes other than what the medication is intended, e.g., cough medicine to relax or to get high? Do they use inhaler correctly, incorrect administration can lead to too much or too little medication being delivered? Does a resident who uses a nicotine patch also smoke cigarettes or use another form of tobacco?

Coding: Check the appropriate box.

Section P. Special Treatment and Procedures

P1. Special Treatments, Procedures, and Programs

a. Special Care

Intent: To identify any special treatments, therapies, or programs that the resident received in the last 14 days (or since admission to the home if admission was less than 14 days ago).

Definition: **TREATMENTS –** The following treatments may be received by a resident either at the facility or on an outpatient or in-patient basis. Check the appropriate MDS item regardless of where the resident received the treatment. For new admissions, include treatments that started prior to admission only if they have also been received since the resident's admission to the facility.

a. Chemotherapy or radiation – includes any type of chemotherapy (anticancer drug) given by any route; radiation therapy; or radiation implant. NOTE: Chemotherapy can only be coded if it is administered for chemotherapy treatment (i.e., cancer).

b. Oxygen therapy –Includes continuous or intermittent 02 via mask, cannula, etc.

c. Dialysis – Includes peritoneal or renal dialysis.

PROGRAMS – The following programs refer to those received by the resident within the last 14 days (or since admission if within the last 14 days).

d. Alcohol/drug treatment program – A comprehensive interdisciplinary program either inpatient (e.g., within an entire or contiguous unit, wing, or floor) or outpatient (or a combination) where interventions are designed specifically for the treatment of alcohol or drug addictions.

e. Alzheimer's/dementia special care unit - Any identifiable part of this facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitive impaired residents (who may or may not have a specific diagnosis of Alzheimer's disease). Resident must be assigned to and living on this unit for the item to be checked.

f. Hospice care – The resident is identified as being in a program for terminally ill persons where services are necessary for the palliation management of terminal illness and related conditions.

g. Home health – Resident received licensed nursing care or monitoring (RN, LPN) or formal therapies (e.g., OT, PT, speech) from an "external" provider, such as a home health agency or nurse "pool."

h. Home care – Resident received personal care/ADL assistance from non-licensed staff (e.g., aides) who works for an external provider or agency.

i. Training in skills required to return to the community – Resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living).

j. Case management – Assessment and development of a service plan for the resident that is provided by an external agency, such as an area agency on aging or community mental health center.

k. Day treatment program – Includes adult day care programs (social or medical day care) or day treatment programs for persons with mental

illness or developmental disabilities; provided by an external agency.

l. Sheltered workshop/employment training program – Usually provided by an external agency to persons with developmental disabilities; sometimes to persons with a diagnosis of persistent mental illness; typically provided by an external agency outside the home but some facilities and nursing homes operate sheltered workshops within the facility.

m. Job training – Usually provided by an external agency to persons with developmental disabilities; sometimes to persons with a diagnosis of persistent mental illness; typically, a special vocational rehabilitation program provided by an external agency.

n. Transportation – Include only transportation provided by an outside agency that picks up the resident at the facility and returns the resident to the facility following the transportation need. May also include transportation provided to residents by Area Agency on Aging or special transportation by the city (recreation departments, transportation department) for persons with disabilities.

o. Psychological rehabilitation – Therapy given by any licensed mental health professional, such as psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

p. Formal Education - Any classes that the resident might attend including: adult education, college courses, GED, vocational training, etc.

Process: Review the resident's service plan; interview staff, resident, operator.

Coding: Check all treatments and procedures that were received during the last 14 days. If no items apply in the last 14 days, check **NONE OF ABOVE**. Many of these treatments, procedures, and programs require a written physician's order, in accordance with State and/or Federal regulations, prior to implementation. When coding these items, supporting documentation would include physician's orders and evidence the treatment was actually received by the resident during the look back period.

b. Therapies

Therapies the resident received *after* admission to the facility, were *ordered by a physician*, and *were performed by a qualified therapist* (i.e., one who meets state credentialing requirements or in some instances, under such a person's direct supervision). The therapy treatment may occur either inside or outside the facility and may have been started elsewhere (e.g., in the hospital but continue after admission) includes only therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.

Intent: To record any therapies the resident *received in the last 7 days*.

Definition:

a. Speech therapy - Therapy services that are provided or directly supervised by a qualified speech therapist. A qualified speech therapy assistant may provide therapy but not supervised others (e.g., aides or volunteers) giving therapy. Include services provided by a qualified speech therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified speech therapist.

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

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

d. Respiratory therapy – Included are coughing, deep breathing, nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional, such as a registered nurse or respiratory therapist. Does not include hand-held medication dispensers (e.g., inhalers). Count only the time that the qualified professional spends with the resident.

e. Psychological therapy by Licensed Mental Health Specialist – Evaluation or clinical services by a licensed mental health specialist – An assessment of a mood, behavior disorder, or other mental health problem or treatment/services (e.g., individual psychotherapy; group therapy, regimen of medications) by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on State practice acts. Do not check this item for routine visits by facility social worker or case manager. Evaluation and treatment (clinical services) may take place at the home, private office, clinic, community mental health center, etc.

Process: Review the resident's record and service plan; consult resident and therapist.

Coding: Check all the therapies the resident *received* during the last *7 days*. Record the number of days for each therapy. Also check off whether the therapy was received in the facility, out of the facility or both.

P2. Intervention Program for Mood, Behavior, Cognitive Loss

Intent: To record all interventions and strategies used in the last 7 days (unless a different time frame is specified). The service plan should clearly identify the following information for all interventions coded:

1. the problem, situation, or challenge being addressed,
2. the goal of the program, and
3. Approaches to be used.

Definition:

a. Special behavior symptom evaluation program – A program of ongoing, comprehensive, interdisciplinary *evaluation of behavioral symptoms*. The purpose of such a program is to evaluate the need to implement ways to understand the "meaning" behind the resident's health and functional status, in a social and physical environment. The ultimate goal of the evaluation is to develop and implement a service plan that serves to reduce distressing symptoms.

The clinical record must contain showing documentation of delivery of services, periodic evaluation of outcomes of treatment and need for continued services.

b. Special behavior management program – A program of ongoing, interdisciplinary *management of behavioral symptoms*, such as items coded in E4a through E4j. The goal of such a program is to help the resident to manage symptoms through direction, consistent interaction and environmental changes.

The clinical record must contain show documentation of delivery of services, periodic evaluation of outcomes of treatment and need for continued services.

c. Evaluation and/or treatment by a Licensed Mental Health Specialist within the last 90 days - An assessment of a mood, behavior disorder, or other mental health problem by a qualified professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on your State practice acts. **Do not check this item for routine visits by the facility social worker.** Evaluation may take place at the facility, private office, clinic, community mental health center, etc.

d. Group therapy – Resident regularly attends therapy sessions aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. This may include any group with goals and objectives but does not include recreational or leisure activity groups. Group therapy as an intervention must be referenced on the service plan. The sessions may take place in the facility (e.g., support group run by the facility's social worker) or outside the facility (e.g., group program at community mental health center, Alcoholics Anonymous meeting at a local church, Parkinson's Disease support group at local hospital). This item does not include group recreational or leisure activities. If there is a group that the facility feels may

meet the requirements for "group therapy, " document the groups purpose, goals and objectives.

e. Changes in environment – Adaptation of the environment focused on the resident's individual mood/behavior/cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings of other residents' rooms along the way.

f. Reorientation – Individual or group sessions that aim to reduce disorientation in confused residents. Includes environmental cueing in which all staff involved with the resident provide orienting information and reminders.

g. Validation/redirection – Approach to communication that validates what the resident is feeling. This is used as an intervention with cognitively impaired clients. The technique provides the resident with an acceptance of where they are. Redirection may follow validation as it attempts to guide the resident into alternative activities or behavior patterns.

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

h. Crisis Intervention in Facility – Resident's behavior escalated to a point where staff needed to implement an *internal crisis plan* utilizing facility staff to diffuse the behavior.

i. Crisis stabilization unit – Resident went out of the facility to a crisis stabilization unit.

Coding: Check all programs that have been used in the last seven days. Check ***NONE OF ABOVE*** if the resident has not participated in any of these interventions. Specify the program if j. "Other" is checked.

P3. <u>Need for Ongoing Monitoring</u>

Intent: **P3a**. **Acute Physical or Psychiatric Condition:** To record specific monitoring required by the resident, as determined by the physician or a registered nurse, for an acute condition.

Definition: The need for on-going monitoring of an acute condition (unstable, fluctuating, medically complex) or new treatment/medication must be determined by the

physician or Registered Nurse. This could include monitoring an acute condition (rapid onset, severe symptoms, and a short course) or a chronic condition that has **exacerbated into an acute episode**, i.e., diabetes with unstable glucose levels, or angina requiring increased medication as a result of recurring episodes. Other examples of acute conditions are: Gall Bladder Attack (Cholecystitis), Bronchial Pneumonias, as well as decompensating psychiatric conditions, e.g., Schizophrenia or Bipolar Disorder.

Intent: **P3b. New Treatment:** To record specific monitoring required by the resident for possible serious, untoward side effects related to a new medication or for effectiveness of a newly prescribed treatment.

Serious or untoward side effects:

- May result in death
- May be life threatening
- May lead to hospital admission or evaluation
- May require intervention to prevent disability or permanent damage
- May be an allergic or other systemic reaction

If the resident has been placed on a *new* medication, administered by any route, that requires special monitoring for serious side effects or drug interactions, it may be coded in this area. An increase or decrease in the dosage of a medication is **not** a new medication.

If the resident has a *newly prescribed* treatment that must be assessed for effectiveness, it could be coded in this area.

Coding: Check any condition that applies by placing the numeric code for the person responsible for the monitoring Code as follows:
0. No monitoring required,
1. RCF Nurse;
2. RCF Other Staff; or
3. Home Health Nurse.

If more than one person is responsible code for the highest level. If both a licensed staff nurse and other facility staff are monitoring, code licensed staff nurse. If both a home health nurse and other staff are monitoring, code home health nurse.

Process: The need for on-going monitoring of an acute condition (unstable, fluctuating, medically complex) or new treatment/medication must be documented by the physician or a Registered Nurse, including a description of what monitoring is required. ***Review the resident's clinical record. Clinical records must contain documentation by the person coded as being responsible for the monitoring to show that monitoring has occurred during the look back period.***

P4. Rehabilitation/restorative care

Definition: Included are interventions that assist or promote the resident's ability to attain his or her maximum functional potential. Skill practice in these activities can improve or maintain function in physical abilities, ADLs and IADLs. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P.1.b. Therapies.

Intent: To record the number of days, in the last 7 days for each technique that was provided for more than or equal to 15 minutes in a 24-hour period as a rehabilitative or restorative practice for the resident.

Coding: Record the number of days, 0-7 for items a-l. When these techniques or training were provided.

P5. Skill Training

Intent: **IADLs Skills training** – record the number of days in the last 30 days, that the appropriate tasks were performed by the resident with assistance from the staff as a skill training activity which is identified in the resident's service plan with an approach and goal for each.

Coding: Record the number of days, 0-30 for items a-l when this training took place. If the appropriate training is not available from those listed check “other”. This may include assistance with legal or financial issues.

P6. Adherence With Treatments/Therapies/Programs

Intent: To record in the last **6 months** the resident's compliance with treatments or programs.

Coding: Check **one** appropriate box.

P7. General Hospital Stays

Intent: To record how many times the resident was admitted to an acute care/general hospital with an overnight stay in the last 6 months or since the last assessment if less than 6 months.

Definition: **Hospital Stay** – The resident was formally admitted by a physician as an in-patient with the expectation that he or she will stay overnight. It does not include day surgery, outpatient services, ER, etc.

Process: Review the resident's record. If the resident is a new admission, ask the resident and resident's family. Sometimes transmittal records from recent hospital admissions are not readily available during a facility admission from the community.

Coding: Enter the number of hospital admissions in the box. Enter "0" if no hospital admissions. Numbers should be right justified and zero-filled as in the following examples.

0	0

0	2

Examples

Mrs. D, an insulin-dependent diabetic, was admitted to the facility yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the 6 months prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. **Code "02" for two hospital admissions.**

Mr. W has been a resident of the facility for two years. He received transfusions at the local emergency room twice monthly. In the last month Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. **Code "01" for one hospital admission in the last 6 months.**

P8. Emergency Room (ER) Visit(s)

Intent: To record if during the last 6 months the resident visited a hospital emergency room (e.g., for treatment or evaluation) but was not admitted to the hospital for an overnight stay at that time.

Definition: **Emergency room visit** – A visit to an emergency room is not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evaluation, transfusions, chemotherapy, etc. or other planned, scheduled outpatient procedures.

Process: Review the resident's record. For new admissions, ask the resident and the resident's family and review the transmittal record, or any information the resident brings with him or her.

Coding: Enter the number of ER visits in the last 6 months (or since last assessment if less than 6 months). **Enter"0" if no ER visits.** Numbers should be right justified and zero filled as in the following example:

0	0

0	1

Examples

One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was give IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the facility the next afternoon. **Code "0" for No ER visits.**

The rationale for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item. This hospital visit would be recorded under item P7.

During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the [facility] within several hours. **Code "01" for ER visit.**

P9. Physician Visits

Intent: To record the **number of days** during the last 6-month period the physician has examined the resident (or since admission if less than 6 months ago). Examination can occur in the facility or in the physician's office. It does not include daily visits by a physician when the resident is hospitalized.

Definition: **Physician** – Includes MD, DO (osteopath) or podiatrist, who is either the primary physician or consultant. Also includes authorized physician assistant, or nurse practitioner working in collaboration with the physician.

Physical exam – May be a partial or full exam. This does **NOT** include exams conducted in an emergency room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in Item 06, "Emergency Room" (Visits).

Coding: Enter the number of visits. If none, enter "00".

P10. Physician Orders

Intent: To record the number of days**, in the last 14 days**, that the physician has changed the resident's orders.

Definition: **Physician** – Includes MD, DO (Osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician.

Physician Orders - Includes written, telephone, fax or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. *Do not count visits or orders prior to the date of admission or reentry.*

A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order *change* simply because a different dose is administered based on the sliding scale guidelines. A PRN (as needed) order that has been in the clinical record and has been activated is not considered a new order.

The following do not count as new orders:

- admission / re-admission orders.
- renewal orders without changes.

- Clarifying orders without changes
- orders written by a pharmacist.

The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.

If a resident has multiple physicians; e.g., surgeon, cardiologist, internal medicine, etc. and they all visit and write orders on the same day, the MDS-RCA must be coded as 1 day during which a physician visited and 1 day in which orders were changed.

Coding: Enter the number of *days* on which physician orders were changed. If none, enter "00". Do not include order renewals without change, clarifications and admission orders.

P11. Abnormal Lab Values

Intent: To document whether the resident had any *abnormal* laboratory values during the last 90 days.

Definition: Abnormal is being defined as out of normal range according the reporting laboratory.

Process: Check medical records, especially laboratory reports.

Coding: Enter "0" if no abnormal value was noted in the record, and "1" if the Resident has had at least one abnormal laboratory value.

P12. Psychiatric Hospital Stay(s)

Intent: To record the number of times the resident was admitted to a psychiatric unit or hospital with an overnight stay in the last 6 months (or since the last assessment if less than 6 months).

Coding: Enter the number of acute psychiatric hospital admissions in the last 6 months in the box. Enter "0" if no psychiatric hospital admissions.

P13. Outpatient Surgery

Intent: To record the number of times the resident had outpatient surgery in the last 6 months.

Coding: Enter the number of times the resident had outpatient surgery in the last 6 months.

Section Q. Service Planning

Q1. Resident Goals

Intent: To record all goals that are **self-identified** by the resident.

Coding: Check all areas that apply.

Q2. <u>Conflict</u>

Intent: To identify any areas of conflict or disagreement concerning the service plan goals.

Coding: Check the **one** appropriate box.

Section R. Discharge Potential

R1. <u>Discharge Potential</u>

Intent: To identify residents who are potential candidates for discharge by monitoring their attitude and support person's attitude toward returning to the community and their overall progress at the facility over time. Some residents will meet the" "potential discharge" profile at admission; others will move into this status as they continue to improve during residency.

Definition: **Discharge** – Can be to home, another community setting, another care facility, or a residential setting.

Support person – Can be a spouse, family member, or significant other.

Self-sufficiency – Includes ADL and IADL self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

Process: For new and recent admissions, ask the resident directly. The longer the resident lives at the facility, the tougher it is to ask about preferences to return to the community. After one year of residency, many persons feel settled into the new lifestyle at the facility. Creating unrealistic expectations for a resident can be cruel. Use careful judgment. Listen to what the resident brings up (e.g., Calls out, "I want to go home". Ask indirect questions that will give you a better feel for the resident's preferences. For example, say, "It's been about 1 year that we've known each other. How are things going for you here at (Facility)?"

Review resident's record, transmittal records, previous assessments, and service or care plan. Discuss with direct staff caregivers, family, resident.

Coding: For "self-sufficiency," use your best judgment about the direction of any change, which may involve some areas in which status has improved and other areas in which there has been no change or a decline.

a. Resident expresses/indicates preference to return to the community.
b. Resident has a support person who is positive toward discharge.
c. Has resident's self-sufficiency changed compared to 6 months ago or since admission if less than 6 months?

Section S. Assessment Information

S1. Participation in Assessment

Intent: To record the participation of the resident, family and/or non-staff other in the assessment

Definition: **a. Resident** – an individual who is considered part of the facility census and occupies a facility bed.

b. Family - A spouse, kin (e.g., sibling, child, parent, niece) or in-law relationship**.**

c. Other Non-staff – May include close friend, partner, housemate, legal guardian, attorney or another person familiar with the resident who is not a staff member.

Coding: **Code "0" No** participation **or "1" Yes** for those who participated in the assessment.

S2. Signatures

Intent: The MDS coordinator and each person completing any portion of the MDS must sign the assessment.

Coding: The assessment coordinator should sign on the line at S2a. The assessment coordinator must also indicate completion date of the MDS at 2b. Others who complete any sections and are responsible for those sections should sign the assessment in this section on lines S2c-e. To the right of the name, enter title, letters of the sections of responsibility and date completed.

The S2b date must be signed as being complete within 7 days of the Assessment date (item A5). When calculating the due date for subsequent assessments, the S2b date is day 1.

Clarification notes written after the S2b (completion) date will not be accepted as supporting documentation for a case mix review.

S3. Case Mix Group

Intent: The Case Mix Group refers to the MaineCare reimbursement system established by the Department of Health and Human Services. The group is calculated from certain items in the MDS that reflects the amount of resources required to care for the resident. Residents are grouped according to their resource use.

Coding: After the state or designated agent processes the MDS, the facility will

receive a validation report identifying the Case Mix Group for that assessment. The Case Mix Group will be calculated automatically if using an approved vendor software and will also be on the final validation report. If you are an adult family care home and not using an approved vendor software product, the case mix index or Resource Utilization Group (RUG) will be on the final validation report.

Section T. Preventive Health Behaviors

T1. Preventive Health

Intent: To determine if resident has taken advantage of preventive health measures that could improve health or reduce the risk of future health problems.

Definition:

a. Blood pressure monitoring

b. Hearing assessment is an examination/evaluation by an ear, nose and throat physician or audiologist

c. Vision test is an examination/evaluation by an optometrist or ophthalmologist

d. Dental visit is an examination or treatment by a dentist or dental hygienist.

e. Influenza vaccine is an injection to prevent flu.

f. Pneumococcal vaccine is an injection to prevent pneumonia.

g. Breast exam – manual exam done by a health care professional (physician, nurse practitioner, PA) or a mammogram (breast x-ray).

h. Papanicolaou test (PAP smear) - vaginal exam to screen for cervical cancer.

i. PSA (Prostate Specific Antigen) – A blood test to screen for risk of prostate cancer.

Process: Review the resident's record; ask the resident or the resident's family, or the professional examining the resident or performing the procedure.

Coding: Check all the procedures that the resident has received during the last 12 months.

Section U. Medications List

U1. Medications

Intent: To record all medications given to the resident in the last 7 days.

Coding: Enter the medication name and dosage in column 1.
Enter the route of administration (RA) in column 2.
Enter the frequency that the medication is given, using the codes listed.
If the frequency is PR (for PRN) record the number of times during the last 7 days that each PRN medication was given.
Enter the National Drug Code (NDC).

7. DISCHARGE TRACKING FORM

Intent: To track the resident in the automated system.

Coding: Complete and submit this form when a resident is:

Discharged with no anticipation of return to your facility, coding the appropriate status of either "discharged" or "discharged prior to completing the assessment" if the assessment was unable to be finished.

Discharge tracking forms must be submitted within 30 days of completion.

D1. Identification Information

1. Resident Name

Definition: Legal name in record

Coding: Enter, in the following order - a.) First name, b.) Middle initial, c.) Last name, d.) Jr. /Sr. If the resident goes by his or her middle name, enter the full middle name. If the resident has no middle initial, leave item (b) blank.

2. Gender

Coding: Enter "1" for Male or "2" for Female.

3. Birth Date

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

0	1
Month	

0	2
Day	

1	9	1	8
Year			

4. Race/Ethnicity

Process: Check the race or ethnic category the resident uses to identify him or herself. Consult the resident, as necessary.

Coding: Choose only one answer.

5. Social Security and Medicare Numbers

Intent: To record resident identifier numbers.

Process: Review the resident's record; if these numbers are missing, consult with your facility's business office.

Coding: Begin writing one number per box starting with the left-most box; recheck the number to be sure you have written the digits correctly.

a. Social Security Number –Enter in the Social Security number of the resident – one number per box

b. Medicare number (or comparable railroad insurance number) Approximately 98% of persons age 65 or older have a Medicare number. Enter the resident's Medicare number. This number occasionally changes with marital status. If a question arises, check with your facility's business office, social worker, or a family member. In rare instances, the resident will have neither a Medicare number nor a Social Security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, place a "c" in the left most Medicare Number box and continue entering the number itself one digit per box, beginning with the second box. This field may be left blank if there are not enough spaces to accommodate the new numbering system.

6. Facility Name and Provider Numbers

Intent: To record the facility's name and provider number.

Definition: The name and provider number assigned to the facility.

Process: You can obtain the facility's name from the facility's business office or owner. The RCA provider number is assigned by the Muskie School of Public Service. Once you have these items, they apply to all residents of that facility.

Coding: Write the facility name on the line provided. To record the facility number, begin writing in the left-hand box. Enter one digit per box. Recheck the number to be sure you have entered the digits correctly.

7. MaineCare (formerly Medicaid) Number (if applicable)

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

8. Reason for Assessment

Intent: To record the reason for completing the discharge form.

Coding: Code a "6" if the resident has been in the facility, had at least one completed assessment, and is now being discharged. Code a "7" if the resident is being discharged from the facility prior to completing the admission assessment (i.e. discharged less than 30 days since admission, and the admission assessment was not completed.) NOTE: Admission assessment is required to be completed by day 30.

For AFCH only, if an assessment has not been completed prior to discharge, the facility will need to bill the default rate for all days the resident was in the facility. Without an assessment, a resource utilization group (RUG) score cannot be calculated.

D2. Demographic Information

1. Date of Entry

Intent: To track the entry information from Section AB (Demographic Information) that was recorded at the time of admission to the facility.

Definition: Date the stay began - The date the resident was most recently admitted to your facility.

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

Coding: Use all boxes. For a one-digit month or day, place a zero in the first box. For example: February 3, 2004 should be entered as:

0	2		0	3		2	0	0	4
Month			**Day**			**Year**			

2. Admitted From (At Entry)

Definition: The location of the resident immediately before he/she entered your facility (e.g., the day before). Enter information exactly as it was coded on the assessment that needs correction.

1. Private home or apartment - Any house, condominium or apartment in the community whether owned by the resident or another person. Retirement

communities and independent housing for the elderly are included in this category if they are not licensed as a domiciliary care or assisted living facility.

2. Other board and care/assisted living group home - A community residential setting that provides room, meals, and protective oversight and provides or arranges other services such as personal care, medication supervision, transportation, and home health care.

3. Nursing home - A licensed facility devoted to providing medical nursing or custodial care over an extended period of time.

4. Acute care hospital - A facility devoted primarily to treatment of serious illnesses, usually for a short period of time.

5. Psychiatric hospital - A hospital for the treatment of persons needing mental care around the clock.

6. ID/DD facility – Facilities for People with Intellectual Disabilities (ID) or Developmental Disabilities (DD). Examples include ID/DD institutions, intermediary care facilities for people with intellectual disabilities (ICF/ID) and group homes.

7. Rehabilitation hospital - A hospital facility or unit providing inpatient rehabilitative services.

8. Other - Includes hospice.

Process: Review admission records. Consult the resident and the resident's family.

Coding: Check only one answer. Specify the location if you check "other".

D3. Assessment/Discharge Information

1. <u>Discharge Status</u>

Definition: The location of the resident after he/she leave your facility (e.g., discharge location).

1. Private home or apartment with no home health services - Any house, condominium or apartment in the community whether owned by the resident or another person. Retirement communities and independent housing for the elderly are included in this category if they are not licensed as a domiciliary care or assisted living facility. Code one "1" when no home health services will be delivered to the resident at home.

2. Private home or apartment with home health services - Any house, condominium or apartment in the community whether owned by the resident or another person. Retirement communities and independent housing for the elderly are included in this category if they are not

licensed as a domiciliary care or assisted living facility. Code one "2" when home health services will be delivered to the resident at home.

3. Another residential care facility - A community residential setting that provides room, meals, and protective oversight and provides or arranges other services such as personal care, medication supervision, transportation, and home health care.

4. Nursing home - A licensed facility devoted to providing medical nursing or custodial care over an extended period of time.

5. Acute care hospital - A facility devoted primarily to treatment of serious illnesses, usually for a short period of time.

6. Psychiatric hospital, ID/DD facility – Psychiatric hospital is a hospital for the treatment of persons needing mental care around the clock. ID/DD facilities are facilities for people with Intellectual Disabilities (ID) or Developmental Disabilities (DD). Examples include ID/DD institutions, intermediate care facilities for people with intellectual disabilities (ICF/IDs) and group homes.

7. Rehabilitation hospital - A hospital facility or unit providing inpatient rehabilitative services.

8. Deceased

9. Other (specify) – other locations not included above.

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

Coding: Enter the corresponding number for the resident disposition upon discharge (i.e., the reason for discharge). If "specify" is requested (coded responses of 3, 4 or 9) enter discharge destination in space provided.

2. <u>Discharge Date</u>

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

Coding: Enter the date the resident was discharged. Use all boxes. For a one-digit month or day, place a zero in the first box. For example: February 3, 2004 should be entered as:

0	2		0	3		2	0	0	4
Month			**Day**			**Year**			

3. Signature(s) of Person(s) Completing the Assessment

Coding: Staff who completed the MDS Discharge Form must enter their signatures, their title, and the date they completed the sections. The date should reflect the date the assessment or correction is completed.

8. EDITING COMPLETED INSTRUMENTS

8.1. Initial Field Edits

Immediately after completion of the MDS, you will perform an initial edit. This edit should be performed while the respondent is present.

- Review all completed forms to make sure you have accurately followed all skip patterns.
- Check to see that all responses are legible.
- Check to see that you do not have any missing data.
- Resolve any inconsistencies or omissions with the appropriate respondent. This resolution time should be included in interviewing time, not editing time.

The importance of your initial edit cannot be overemphasized. All completed assessments should be error free. Therefore, it is essential that all errors be detected by the Assessor and corrected immediately.

8.2. Final Field Edits

As soon as possible after you complete all work on an MDS, you will perform a thorough edit of each MDS section. This final edit must be performed as soon as possible while details are still fresh in your mind and while you have a chance to make needed additions or corrections. Careful attention to detail during the editing process will guarantee an accurate assessment.

If you are completing the MDS electronically, it is the responsibility of the Assessor to verify that the data submitted matches the data on the printed form. Any discrepancies must be rectified before submitting the MDS to the state or designated agent.

9. SEMI ANNUAL ASSESSMENT

A new assessment is required within 180 days of the S2b date of the previous assessment, on an ongoing basis for as long as the resident resides in the facility, according to guidelines and time frames provided by the Department of Health and Human Services. If, at any time, a Significant Change in status assessment is submitted the “clock” will be reset for all subsequent assessments. If you are requested to perform another assessment by a nurse reviewer, the “time clock” will also be reset for all subsequent assessments.

10. CORRECTION OF THE MDS –<u>this section applies to Residential Care Facilities only</u>

10.1. Background

The Correction Request Form was implemented as part of a Correction Policy, effective July 1, 2004, to allow *residential care facilities* to correct erroneous MDS data previously submitted and accepted into the MDS database. The form is completed and submitted by the facility to request modification or inactivation of an erroneous MDS record (assessment or discharge). The use of the correction form is intended to remedy concerns about the accuracy of the data in the State databases when errors are accepted into the system without an option or mechanism to correct.

The MDS Correction Form contains two Sections: the **Prior Record** section and the **Correction** section. This form is to be completed when an inaccuracy is detected in an MDS record that resides in the MDS database at the state, that is, the record passed the standard edits and has been accepted by the state MDS system.

10.2. Timing and Types of MDS Corrections

Facilities may not "change" a previously completed MDS form as the resident's status changes during the course of the stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is part of the facility's responsibility to provide necessary care and services. Completion of a new MDS to reflect changes in the resident's status is not required unless the resident has had a significant change in status.

After the MDS is completed, the facility has up to 30 days to encode and edit the form. Amendments may be made to any items during this 30-day encoding period, ***provided the amended response refers to the same observation period***. To make revisions to a paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. Document the date and error which has been identified in the resident's record.

When the data is encoded into the facility's MDS system, the facility is responsible for verifying that all responses in the computer file match the responses on the paper form including any corrections. Any discrepancies must be corrected in the computer file during this 30-day encoding period.

In addition, the facility is responsible for running encoded MDS data against Maine's edits; software vendors are responsible for building edits into MDS computer software systems. For each MDS item, the response must be within the required range and be consistent with other item responses. During this 30-day period after the form is completed, the facility may "correct" item responses in order to meet the edits. An assessment is considered complete only if 100% of the required edits are passed. For "corrected" items, the facility must use the same "observation period" as was used for the original item completion (i.e., the same Assessment Date – A5). Any corrections must be accurately reflected in both the electronic and paper copies of the MDS (i.e., the paper version must be corrected.)

After an assessment has been completed, data entered, submitted to the state and verification of receipt has been received, no further changes may be made to the assessment record. Corrections are allowed, however if an assessment, data entry or software error has been made. Corrections must be completed within 14 days of detecting the error or errors, and then submitted within 30 days of completion of the correction forms.

10.3. MDS Records in Error Not Submitted to the State

This includes records that have been submitted and rejected or records that have not been submitted at all. Since none of these records have been accepted into the state database, appropriate corrections can be made, and these records can simply be transmitted without any special correction procedures. The paper copy should be corrected according to standard procedures.

10.4. MDS Records in Error Accepted into the State Database

If there is an error in the MDS that has been accepted into the state database, the facility must identify the type of correction that is necessary. It is very important that the information in the State database be correct. Generally, errors should be corrected through a Modification or Inactivation request submitted with a correction record. Minor errors such as the misspelling of an occupation in AB6 do not need to be corrected; they should be noted and corrected with the next assessment.

Two processes are available to correct MDS records that have been accepted and reside in the State database: 1) Modification and 2) Inactivation. The MDS Correction Request Form (Prior Record Section and Section AT) contains the minimum amount of information necessary to enable correction of the erroneous MDS data previously submitted and accepted into the State MDS database. A hard copy of the Correction Request Form is kept with the corrected paper MDS in order to track the changes made with the Modification. A hard copy of the Correction Request Form also is kept with an Inactivated Record. (A copy of the Correction Request Form can be found at the end of this chapter.)

A Modification request moves the inaccurate record into the History file in the State database and replaces it with the corrected record in the active database. An Inactivation moves the inaccurate record into the History file in the database.

10.5. Modification

A Modification should be requested when a valid MDS record (assessment or tracking form) is in the State MDS database, but the information in the record contains errors. A record is considered to be valid if it meets all of the following conditions:

1. The record corresponds to an actual event.
2. The record identifies the correct resident.
3. The record identifies the correct reasons for assessment.
4. The record is required to be submitted.

Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors.

Any item on the MDS including the identification information in section AA may be modified except the Reasons for Assessment (A6). A record submitted with the wrong Reasons for Assessment must be inactivated and **resubmitted** with the correct reasons.

If the identified error results in a "major" change (i.e. the assessed view of the resident's overall clinical status is inaccurate) the facility may perform a new assessment or a modification. If a new assessment is completed, the original erroneous assessment in the database must still be corrected.

10.6. Inactivation

Records may be inactivated when an incorrect reason for assessment has been submitted in item Reason for Assessment (A6). The record would then be resubmitted with the correct reason for assessment.

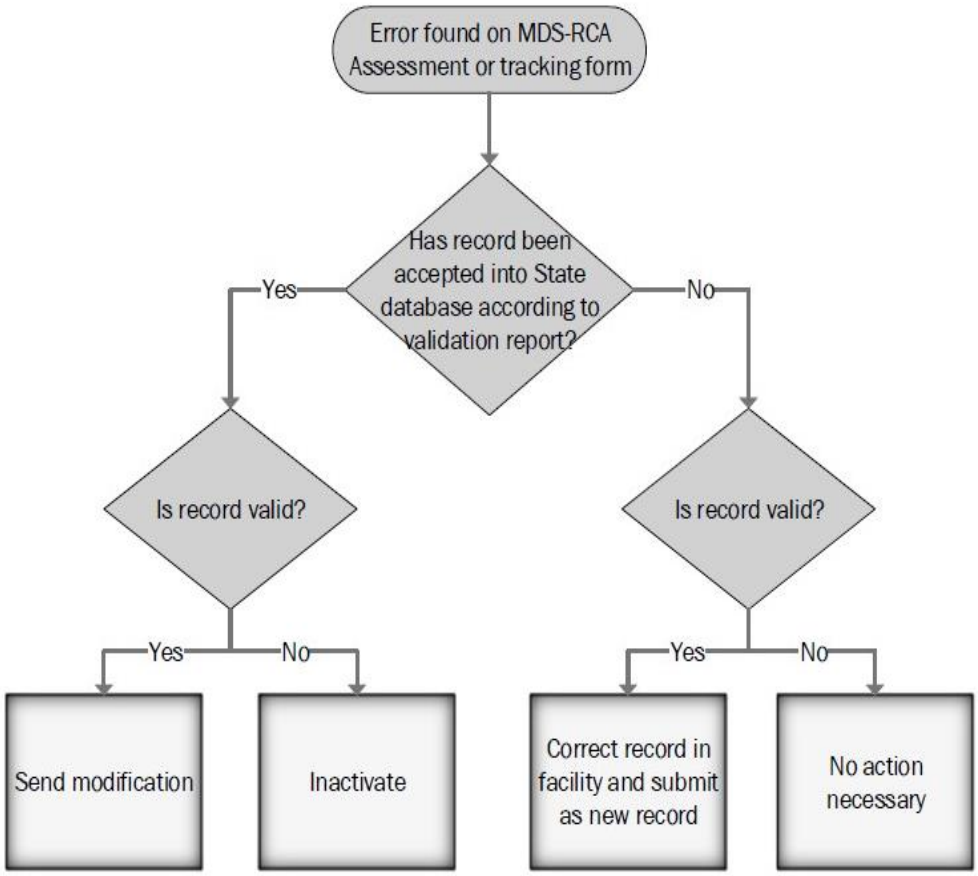
An Inactivation would also be used when an invalid record has been accepted into the State MDS database. A record is considered to be *invalid* in any of the following cases:

1. The event did not occur; e.g. the record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident but there was no actual discharge. There was no event.
2. The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.
3. The record submitted identifies the wrong reasons for assessment. For example, a semi- annual assessment was submitted instead of an admission assessment.
4. Inadvertent submission of a non-required record

When inactivating a record, the facility is required to submit an electronic inactivation record. The paper copy must also be maintained in the resident's record.

Modification and Inactivation assure that the MDS data in the State database is accurate. The following flow chart indicates the decision process.

Correction Policy Flowchart



10.7 Item-by-Item Guide to the MDS Correction Request Form

Prior Record Section

Intent: This Section is used to locate the erroneous assessment or tracking form record in the state database.

Process: Obtain the information for this section from the previously submitted, erroneous assessment or discharge tracking form.

Coding: Record the information **exactly as submitted and accepted into the State database**, even if the information is incorrect or requires correction.

Example: The MDS assessment was submitted and accepted for Joan L. Smith. When the assessment was data entered, the encoder typed "JOHN" by mistake. The facility submits the erroneous record to the State and it is accepted into the system. To correct this error, the facility should complete a Correction Request Form and a corrected assessment. When completing the Resident's Name Item in **Prior** Record Section of the Correction Request Form, "John" should be entered. This will permit the State system to locate the previously submitted assessment that is being corrected. If the correct name "Joan" is entered in this **Prior** Record Section, the State system **would not** be able to locate the prior assessment.

The Correction to modify the name "John" to "Joan" will be recorded in the corrected assessment that will accompany the Correction Request Form. The corrected assessment must include **all** assessment items appropriate for that assessment – **not just the corrected name**. Both the Correction Request Form and the corrected assessment information will then be encoded into a single submission record. This submission record will then be transmitted to the State to cause the desired correction to be made.

Prior_AA1. Resident Name

Definition: The name **exactly as submitted** in the MDS item AA1 **on the prior, erroneous record.**

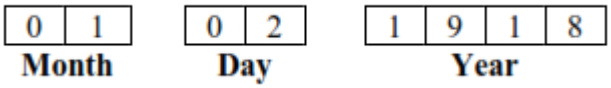
Coding: Enter, in the following order - a.) First name, b.) Middle initial, c.) Last name, d.) Jr. /Sr. exactly as indicated on the erroneous record.

Prior_AA2. Gender

Coding: Check "1" for Male or "2" for Female **exactly as submitted** in MDS item AA2 **on the prior, erroneous record.**

Prior_AA3. Birth Date

Coding: Fill in the boxes with the appropriate number **exactly as submitted** in MDS-RCA item AA2 **on the prior, erroneous record**. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 1918 should be entered as:



Prior_AA5a. Social Security Numbers

Definition: The social security number (SSN) **exactly as submitted** in the MDS item AA5 **on the prior, erroneous record.**

Coding: Enter one number per box starting with the left-most box with the SSN (a) exactly as submitted on the prior, erroneous MDS. Recheck the number to be sure you have written the digits correctly.

Prior_A6 or Prior_D1.8. Prior Reason for Assessment

Definition: Depending on the prior type of assessment, the reason for assessment (A6) or discharge (D1.8) **exactly as submitted** in the MDS item **on the prior, erroneous record.**

Coding: Enter the one-digit code corresponding to the reason for assessment or discharge exactly as submitted on the prior, erroneous MDS assessment or discharge tracking form.

Prior Date (Complete only one)

Intent: To document the reference period or discharge date of the prior record. If the prior, erroneous record is an assessment, complete Prior_A5 Prior Assessment Date only. If the prior, erroneous record is a discharge tracking form, complete Prior_D3.2 Prior Discharge Date only.

Coding: Fill in the boxes with the appropriate number **exactly as submitted** in MDS-RCA item **on the prior, erroneous record**. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 2004 should be entered as:

0	1		0	2		2	0	0	4
Month			**Day**			**Year**			

Prior_A5. Prior Assessment Date

Definition: For Correction of a prior assessment, the Assessment Date (A5) **exactly as submitted** in the MDS item **on the prior, erroneous record.**

Prior_D3.2. Prior Discharge Date

Definition: For Correction of a prior discharge tracking form, the Discharge Date (D3.2) **exactly as submitted** in the MDS item **on the prior, erroneous record.**

<u>Correction Section</u>

Intent: These items collect information describing the reason for the correction request and whether the request is to modify or to inactivate an MDS -RCA assessment or discharge tracking form that has been previously submitted and accepted by the State database.

AT1. Correction Sequence Number

Intent: To identify the total number of correction requests following the original assessment or tracking record, including the present request. Note that item AT1 is used to track successive correction requests.

Coding: For the first correction request for an MDS record, code a value of "01" (zero, one); regardless of the *number of items* being corrected in the assessment. For the second correction request for the same MDS record, code a value of "02"; etc. With each succeeding request, AT1 is incremented by one. For values from one though nine, a leading zero "0" should be coded in the first box.

AT2. Action Requested

Intent: To identify whether the correction request is being submitted to modify or to inactivate a prior, erroneous assessment or tracking form.

Process: If the request is to **MODIFY** an assessment or tracking form, the facility should take the following actions:

1. Make the necessary correction to the MDS in error using appropriate MDS records correction procedures – recording the corrected value, drawing a line through the previous response without obliterating it, and initialing and dating the corrected entry.

2. Complete both the Prior Record and Correction sections of the Correction Request Form. Be sure to exactly transcribe the necessary information from the prior assessment or discharge tracking form into the Prior Record Section of the Correction Request Form. (Note: your software may provide this information for you.)

3. Attach the Correction Request Form to the corrected prior assessment or discharge tracking form.

4. As instructed by your software vendor, encode all of the information from both the Correction Request Form and the corrected assessment or discharge tracking form into a single submission record. Submit this record as part of your standard submission process. For a modification, the submission record includes all items on the corrected prior assessment or tracking form, not just the corrected values for the items in error.

5. Retain in the resident's clinical record:
    a. the signed Correction Request Form,
    b. the attached corrected assessment or discharge form,
    c. documentation indicating the date the errors were detected,
    d. documentation substantiating the accuracy of the correction, relative to the resident's status as of the Assessment Reference

Date (MDS Item A5) of the original assessment, or the Discharge date (MDS Item D3.2).

If the request is to **INACTIVATE** an assessment or tracking form, the facility should take the following actions:

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1. Complete both the Prior Record and Correction sections of the Correction Request Form. Be sure to exactly transcribe the necessary information from the prior assessment or discharge tracking form into the Prior Record Section of the Correction Request Form. (Note: your software may provide this information for you.)

2. Attach the Correction Request Form to the prior assessment or discharge tracking form to be inactivated

3. As instructed by your software vendor, encode all of the information from both the Correction Request Form into a submission record. Submit this record as part of your standard submission process. For an inactivation, the submission record only includes items on the Correction Request Form. Items from the associated assessment or discharge tracking form are blank.

4. Retain the signed Correction Request Form and the attached assessment or discharge form in the clinical record with substantiating documentation. This documentation should indicate that errors were detected.

Coding: Enter a "1" in the action requested is to MODIFY and assessment or discharge form. Enter a "2" if the request is to INACTIVATE an assessment or discharge form.

AT3. Reason for Modification

Intent: To identify the reason(s) for the error(s) that require modification or the prior, erroneous assessment or discharge record that has previously been accepted into the State database.

Proper Error Correction Procedure -When an error is made in a medical record entry, proper error correction procedures must be followed. Draw line through entry (thin pen line). Make sure that the inaccurate information is still legible. Initial and date the entry. State the reason for the error (i.e. in the margin or above the note if room). Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry. Do not obliterate or otherwise alter the original entry by blocking out with marker, using white out or writing over an entry.

Definition:

a. Transcription error – Includes any error made while recording MDS-RCA assessment or discharge information from other sources. An example is transposing the digits from the patient's weight (e.g., recording "191" rather than the correct weight of "119").

b. Data entry error -- Includes any error made while recording MDS assessment or discharge tracking form information into the facility's computer system. An example is a "key punching" error where the response to physician visits (P9) is incorrectly coded "90" rather than the correct number of "09" visits on the MDS form.

c. Software Product error -- Includes any error created by the encoding software, such as "storing" an item with the wrong format (e.g., misplacing the decimal point in an ICD-9 code in item I3) or "storing" an item in the wrong position in an electronic MDS record.

d. Item coding error – Includes any error made coding an MDS item, such as choosing an incorrect code for an ADL self-performance item in G1 (e.g., choosing a code of "4" in G1aA for a resident who requires limited assistance and should be coded as "2"). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.

e. Other error – Includes any other reason for error that causes prior assessment or tracking form record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided on the form.

Coding: If the action request is a modification (AT2= "1"), check all that apply. Leave all blank if the action requested is an inactivation (AT2= "2").

AT4. Reason for Inactivation

Intent: To identify the reason(s) for the requiring inactivation of an invalid assessment or discharge form record that has previously been accepted into the State database.

Definition:

a. Test record submitted as a production record – An example is a fictitious assessment or discharge form record which was fabricated to test a software product and then inadvertently submitted to the state as a production record.

b. Event did not occur – Includes submission of an assessment or discharge form record describing an event that did not occur. The event did not occur if any of the following apply:

1. The record submitted does not correspond to an actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was **no event**.

2. The record submitted identifies the wrong resident. For example, a discharge form was completed and submitted for the wrong person.

3. The record submitted identifies the **wrong reason for assessment.** For example, an admission assessment was submitted when the annual was due.

c. Inadvertent submission of inappropriate record -- An example would be submission of a non-required assessment performed for an "in-house" training program being conducted by the facility.

d. Other reason requiring inactivation – Includes any other reason for error that causes a prior assessment or discharge form record to require inactivation under the Correction Policy. Facility staff should describe the "other error" in the space provided on the form.

Coding: If the action requested (AT2) is an inactivation (= "2"), check all that apply. Leave all blank if the action requested (AT2) is a modification (= "1").

AT5. MDS Coordinator

Intent: To identify the facility staff completing the Correction Request form and assuring the accuracy of the information.

Coding: Staff who completed the MDS Correction Request form must enter their name, signature, and their title. Enter the name beginning with the first name, followed by the last name and then their title. *The entire form should be signed and completed within 14 days of detecting an error in an MDS record that resides in the State database.* A hardcopy of this form, including signature of the responsible staff, must be attached to the modified or inactivated MDS record and retained in the resident's record.

AT6. Correction Date

Intent: To identify the date the facility staff certified the completion and accuracy of the corrected information.

Coding: Do not leave any boxes blank. Enter the date the facility staff certified the completion and accuracy. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 2004 should be entered as:

0	1		0	2		2	0	0	4
Month			**Day**			**Year**			