MDS Compliance

The Key Areas with Potential for Significant Impact

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Identify key sections of the MDS that impact survey
Identify key sections of the MDS that impact reimbursement
Examine strategies for enhanced resident care based on MDS coding
Discuss the proposed MDS focus survey

Glossary of Terms/Abbreviations

- CMS – Centers for Medicare and Medicaid Services
- OBRA – Omnibus Budget Reconciliation Act
- RAI – Resident Assessment Instrument
- MDS – Minimum Data Set
- RUG – Resource Utilization Group
- PPS – Perspective Payment System
- BIMS – Brief Interview of Mental Status
- CAM – Confusion Assessment Method
- PHQ – Personal Health Questionnaire
- CAA – Care Area Assessment

Resident Assessment Instrument (RAI) Manual

- The current RAI Manual is dated October 2014 and should be version 1.12.
- Pages associated with the October 2014 errata document will have October 2014 (R)
Assessment Changes as of October

COT Changes/Clarifications

COT OMRAs may only be completed when a resident is currently classified into a RUG-IV therapy group (regardless of whether or not the resident is classified into this group for payment (index maximizing rule) based on the resident’s most recent assessment used for payment.

COT Changes/Clarifications

COT OMRAs may be completed when a resident in not currently classified into a RUG-IV therapy group, only if both of the following conditions are met:
1. Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident’s current Medicare Part A stay and
2. No discontinuation of therapy (planned or unplanned) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into the current on-therapy RUG-IV category and the ARD of the COT OMRA that reclassifies the resident into a RUG-IV therapy group.

NOTE: under these circumstances, COT completion may be considered optional.
Clarification For Combining Scheduled PPS and COT Assessments

To combine a scheduled PPS assessment and COT assessment, “the ARD must be set within the window of the scheduled assessment and on day 7 of the COT observation period. If both ARD requirements are not met, the assessments may not be combined.”

If you combine the assessments improperly – it will result in early or late assessments and default payment.

MDS Coding Changes

October 2014 Updates to the RAI

- Deleted Readmission/Return Assessment option in A0310B
- Clarified A0410 – when to submit an assessment
- Clarified A1600 – entry/re-entry date – date the resident admitted or reentered the facility
- New A1900 – Admission date – date the episode of care began
October Updates continued
- Added ADL definitions of each task for clarity of coding
- Influenza coding – provided more detail to support vaccine administration
- Chapter 5 updates related to timeline for correcting errors – 3 years (2 years if MDS being terminated.) Still have only 14 days to once an error is identified

Key Areas of the MDS With Impact on Survey or Reimbursement

Areas with Survey Risk
- Section B – determination of resident interviews
- Section C – Cognition (BIMS)
- Section D – Mood (PHQ)
- Section F – Resident Preferences
- Section J – Falls
- Section K – Weight
- Section M – Skin Issues
- Section N – Medication coding
- Section P - Restraints
The Key to Doing Interviews
B0700 – Makes Self Understood

Remember: verbal AND non-verbal. Includes writing, conversation, sign

<table>
<thead>
<tr>
<th>DEFINITIONS</th>
<th>MAKES SELF UNDERSTOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to express class and wants, consider both verbal and non-verbal expression.</td>
<td></td>
</tr>
<tr>
<td>D. Underscored: Difficulty communicating own needs or finding thoughts that are able to be processed in previous.</td>
<td></td>
</tr>
<tr>
<td>E. Sometimes understood: Ability to develop and make some sort of sense.</td>
<td></td>
</tr>
<tr>
<td>F. Rarely understood:</td>
<td></td>
</tr>
</tbody>
</table>

Deficits in the ability to make one's self understood (depressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty or finding the right word, making sentences, writing, and/or gesturing.

May 2011

The Interviews

Resident Centered Assessment

<table>
<thead>
<tr>
<th>Section</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Cognitive Patterns</td>
</tr>
<tr>
<td>D</td>
<td>Mood</td>
</tr>
<tr>
<td>F</td>
<td>Preferences for Customary Routines and Activities</td>
</tr>
<tr>
<td>J</td>
<td>Health Conditions (Pain)</td>
</tr>
<tr>
<td>Q</td>
<td>Participation in Assessment and Goal Setting</td>
</tr>
</tbody>
</table>

The Interviews

- All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives
- Self-report is the single most reliable indicator of topics such as mood, preferences, pain
- Setting
  - Privacy, quiet with no distractions, lighting, ability to hear, comfort, positioning, interpreter needed, explanation of why, rapport and respect essential
- Before each interview section, assessor determines if interview should be conducted

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Interview Complete or Not?

- Each interview has instructions as to when the interview is complete or can be stopped.
- Surveyors are looking for completion of interviews.

Brief Interview for Mental Status (BIMS)

- Attempt with all residents except those who are "rarely or never understood" (B0700).
  - Consists of three components:
    - Repetition of 3 words (sock, blue, and bed).
    - Temporal orientation (year, month, day).
    - Recall – with or without cues.
  - Results are compiled into a Summary Score.
  - Summary Score used also to determine RUG group in Behavioral Symptoms and Cognitive Performance.

BIMS Summary Score

- For healthcare professional use only.
- A zero score does not mean the interview was incomplete.
- 90% of residents can complete the BIMS.

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Possible Cognitive Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 – 15</td>
<td>Cognitively intact</td>
</tr>
<tr>
<td>08 - 12</td>
<td>Moderate impairment</td>
</tr>
<tr>
<td>00 - 07</td>
<td>Severe impairment</td>
</tr>
</tbody>
</table>
Staff Assessment for Mental Status
- Conduct ONLY if BIMS was NOT completed
- Consists of 4 familiar items from MDS 2.0
  - Short-term memory OK
  - Long-term memory OK
  - Memory/Recall Ability
  - Cognitive Skills for Daily Decision Making
- Relies on multiple information sources – observation of resident across all shifts; interview direct care staff across all shifts, family members and/or significant others; review medical record

The Interviews Continue
- Section D – Mood
  - Mood distress is a serious condition that is underdiagnosed and undertreated in the NH
  - Associated with significant morbidity
  - Signs and symptoms of mood distress are treatable – treatments are very effective
  - Coding the presence of indicators does not automatically mean a diagnosis of depression or other mood disorder

The Mood Interview
- D0100 Mood – attempt with all residents except those who are “rarely or never understood” (B0700)
  - Most residents are able to attempt the interview
  - Attempt to conduct the interview with all residents if at all possible
  - The interview (PHQ-9©) has been translated into over 80 languages – check online for availability as needed
The Hard Question on the PHQ-9©

Refer to D02001: Thoughts that you would be better off dead, or of hurting yourself in some way

Experience with this question indicates:
- Residents appreciate the opportunity to express this
- Does NOT give residents any ideas toward self harm
- Ask the question openly and without hesitation

D0500 Staff Assessment of Mood PHQ-9-OV

- If the resident has been in the facility less than 14 days:
  - Talk to family or significant other
  - Review transfer records
- Look-back period is 14 days
- Ask staff to select how often a symptom occurred during the look-back period
- Code the higher frequency if staff has difficulty selecting between 2 options
- Same items as in PHQ-9© with the addition of the item about the resident being short-tempered, easily annoyed
Safety Notification

D2000. Safety Notification

1. Thought that you would be better off dead, or of hurting yourself or someone else?

D2001. Safety Notification (Complete only if D2000 = 1 indicating possibility of resident self-harm)

☐ Yes
☐ No

Acts as a reminder to take appropriate action

Untreated depression can cause significant distress and increased mortality beyond the effects of other risk factors

Although rates of suicide have historically been lower in NHs, indirect self-harm and life threatening behaviors are common

Total Severity Score

D1500. Total Severity Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.

Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

Able to look over time – getting better or worse?
Do not score during the interview
Total only the frequency items (Column 2)
Score will be between 00 and 27
Score for PHQ-OV will be between 00 and 30
Severity score critical for care planning and reimbursement (result will impact 26 RUG groups – severity score is greater than or equal to 10, but not 99)

PHQ-9 SCORING FOR SEVERITY DETERMINATION

for healthcare professional use only

Total Score Depression Severity

• 0-4 Minimal depression
• 5-9 Mild depression
• 10-14 Moderate depression
• 15-19 Moderately severe depression
• 20-30 Severe depression

One additional question on the staff questionnaire:

— Resident short tempered or easily annoyed?
Section F - Preferences for Customary Routines and Activities

Lack of attention to preferences and activities can result in:
- Boredom
- Depressed mood
- Behavior disturbances

Resident responses can provide clues:
- Understanding pain
- Perceived functional limitations
- Perceived environmental barriers

Serves as a guide for individualized daily care and activity planning – a portion of the assessment – not meant to be all-inclusive

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Section F – Preferences for Customary Routines and Activities

Interview for Daily Preferences

While you are in this facility... How important is it to you to...
- Choose clothes to wear
- Take care of personal belongings
- Choose between a bath, shower, bed or sponge bath
- Have snacks available between meals
- Choose your own bedtime
- Have family or close friend involved in discussions about your care
- Be able to use the phone in private
- Have a place to lock your things to keep them safe

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Activity Preferences

Interview for Activity Preferences

While you are in this facility... How important is it to you to....
- Have books, newspapers and magazines to read
- Listen to music you like
- Be around animals such as pets
- Keep up with the news
- Do things with groups of people
- Do your favorite activities
- Go outside to get fresh air when weather is good
- Participate in religious services or practices
**Activity and/or Daily Preferences**

Responses based on importance to resident:
1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can’t do or no choice**
9. No response or non-responsive

**Section J – Pain Assessment**

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

**Pain Presence**

- Pain Presence
  - Ask the question as written: Have you had pain or hurting at any time in the last 5 days?
  - Code for the presence or absence of pain regardless of pain management efforts
  - Rates of self-reported pain are higher than observed rates
**Pain Frequency**

- **Ask the question as written:** How much of the time have you experienced pain or hurting over the last 5 days?
- Do not offer definitions of the response options, but may offer response options on cue card.
- A resident’s response should be based on the resident’s interpretation of the frequency options.
- If the resident has difficulty choosing between two options,
  - Use echoing to help resident clarify the response.
  - Code the more frequent of the 2 responses.

**Pain Effect on Function**

- **Ask the question as written:** Over the past 5 days, has pain made it hard for you to sleep at night? Over the last 5 days have you limited your day-to-day activities because of pain?
- Do not offer definitions of the response options.
- A resident’s response should be based on the resident’s interpretation of the frequency options.
- If the resident has difficulty choosing between two options,
  - Use echoing to help resident clarify the response.
  - Code the more frequent of the 2 responses.

**Pain Assessment Interview**

- Ask the questions as written: Over the past 5 days, has pain made it hard for you to sleep at night? Over the last 5 days have you limited your day-to-day activities because of pain?
- Do not offer definitions of the response options.
- A resident’s response should be based on the resident’s interpretation of the frequency options.
- If the resident has difficulty choosing between two options,
  - Use echoing to help resident clarify the response.
  - Code the more frequent of the 2 responses.
Two Pain Scales

**Numeric 1 - 10**

**Verbal**
- Mild
- Moderate
- Severe
- Very severe, horrible

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**Pain Intensity**

**Numeric (J600A)** (leave blank if not used)

**Verbal (J0600B)** (leave blank if not used)
- Mild
- Moderate
- Severe
- Very severe, horrible

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**Section J - Fall History on Admission/Entry or Reentry**

Review =180 days (6 months) prior to admission, looking back from the resident’s entry date (A1600). Ask resident and family or significant other about a history of falls. Check transfer, medical records
Section J Any Falls Since Admission or Prior Assessment

- Has the resident had falls since arriving at the facility or since the prior assessment (PPS or OBRA)
- Code for the type of fall

Section K – Swallowing/Nutritional Status

**Intent**
- Assess the many conditions that could affect resident’s ability to maintain adequate nutrition and hydration
- Items cover
  - Swallowing disorders
  - Height and weight
  - Weight change
  - Nutritional approaches

Section K - Assessment

**K Swallowing Disorder**
- Ask resident about any difficulty swallowing during the look-back period
- Ask about each symptom
- Observe resident to identify any symptoms
  - During meals
  - At times resident is eating, drinking, or swallowing
- Interview staff members across all shifts
- Review medical record – nursing, physician, dietician, ST notes, dental history or problems
Section K – Swallowing

Section K – Weight Loss/Gain

Section K – Weight Changes
Section M – Skin Conditions
- Risk assessment
- Imperative to determine etiology of all wounds and lesions
- Staging
  - No “reverse” staging
  - Deepest pressure ulcer
  - Worsening pressure ulcer
  - Separate items for unstageable and suspected deep tissue injury pressure ulcers
- Pressure ulcer present on admission/reentry
- Date of oldest Stage 2 pressure ulcer
- Dimensions in centimeters
- Type of tissue

Clinician Skills Needed
- Risk assessment
- Pressure ulcer staging
- Ulcer measurement
- Wound identification
- Skills needed – staging is an art – determine training needs and/or resources for the facility

Section M Determination of Pressure Ulcer Risk
- Reflects multiple approaches for determining a resident’s risk for developing a pressure ulcer
  - Presence or indicators of pressure ulcers
  - Assessment using a formal tool
  - Physical examination of skin and/or medical record

RM100. Determination of Pressure Ulcer Risk
- Check all that apply
  - A. Resident has a stage 1 or greater, a sore over bony prominence, or a non-removable dressing/remove
  - B. Formal assessment instrument/bed (e.g., Roden, Norton, or other)
  - C. Clinical assessment
  - D. None of the above
Section M Risk of Pressure Ulcers
- Recognize and evaluate each resident’s risk factors
- Identify and evaluate all areas at risk of constant pressure
- Based on items reviewed for M0100 determine if resident is at risk

Pressure Ulcer Staging is Within Scope of Nursing Practice
- Skin assessment part of health status
- Skin assessment includes:
  - Differentiating from other wounds
  - Staging – provides a description of the extent of visible tissue damage or palpable bone and informs expectations for healing times
- Purpose is to determine nursing care needs and plan of care

ADAPTED NPUAP Pressure Ulcer Definitions
- CMS has adapted the NPUAP 2007 definition of a pressure ulcer as well as categories/staging. The definitions do not perfectly correlate with each stage as described by NPUAP. Facility must code the MDS according to the instructions in the RAI Manual
- A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction
Present on Admission

- Review record for history of ulcer.
- Review for location and stage at the time of admission or reentry. If PU present on admission and worsened to a higher stage during the resident’s stay, the pressure ulcer is coded at that higher stage and that higher stage should not be considered as “present on admission.”
- If PU unstageable on admission, but becomes stageable later, it should be considered as “present on admission” at the stage at which it first becomes stageable. If then worsens to a higher stage, that higher stage should not be considered as “present on admission.”

Present on Admission

- If resident with a PU is hospitalized and returns with that PU at the same stage, the pressure ulcer should not be coded as “present on admission” because it was present at the facility prior to the hospitalization.
- If a current PU worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and should be coded as “present on admission.”

Section N Medications Received

<table>
<thead>
<tr>
<th>Medication Received</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Antipsychotic</td>
<td></td>
</tr>
<tr>
<td>B. Antidepressant</td>
<td></td>
</tr>
<tr>
<td>C. Antihypertensive</td>
<td></td>
</tr>
<tr>
<td>D. Agranulocytosis</td>
<td></td>
</tr>
<tr>
<td>E. Antibiotic</td>
<td></td>
</tr>
<tr>
<td>G. Steroid</td>
<td></td>
</tr>
</tbody>
</table>

Not ASA, Aggrenox, Plavix
Section P – Restraints

Definition:
- Any manual method, physical or mechanical device, material or equipment
- Attached or adjacent to the resident’s body that the individual cannot remove easily
- Which restricts the freedom of movement or normal access to one’s body

Must meet all three criteria to be considered a physical restraint for the purpose of the MDS 3.0

Determine the effect of the device (not type, intent, or reason)

Section P – Restraints

Definition:
- Removes easily – can be removed intentionally by the resident in the same manner as it was applied by the staff
- Freedom of movement – any change in place or position for the body or any part of the body that the person is physically able to control or access

Exclude devices, materials or equipment that are typically used in the provision of medical care: catheters, drainage tubes, traction, leg, arm, neck or back braces, abdominal binders and bandages that are serving in their usual capacity to meet medical needs

Examples of Physical Restraints

Include, but not limited to:
- Leg restraints
- Arm restraints
- Hand mitts
- Soft ties or vests
- Lap cushions
- Lap trays the resident cannot remove easily

Facility practices:
- Side rails that keep resident from getting out of bed
- Tucking in or using Velcro to hold a sheet, fabric or clothing tightly
- Placing a chair or bed so close to wall that wall prevents the resident from rising out of chair or voluntarily getting out of bed
Key Areas With the Potential to Impact Reimbursement

Areas with Largest Impact

Section D – Personal Health Questionnaire – Mood – affects RUG categories Special Care High/Low and Clinically Complex
Section E – allows for grouping in the behavioral category
Section G – impacts all RUG categories
Section K – enteral and parenteral grouping
Section M – all the skin (pressure ulcer) is derived from this section
Section O – most skilled services appear here
Section E - Behaviors

Behaviors may indicate:
- Unrecognized needs
- Preferences
- Illnesses

Includes behaviors that are potentially harmful to the resident

Identification of frequency and impact of symptoms is critical

Must distinguish between behaviors that constitute problems from those that are NOT problematic

Section E

Focus on the resident’s actions

Do **not** focus on the intent of the behavior

Staff may become used to the behavior
- May under-report problematic behaviors
- Minimize behavior by presuming intent

Section E

<table>
<thead>
<tr>
<th>R110: Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviors may indicate</td>
</tr>
<tr>
<td>✔ a. Hallucinations (perceptual experience in the absence of external sensory stimuli)</td>
</tr>
<tr>
<td>✔ b. Delusions: false beliefs that are firmly held (ranging from mild to delusional)</td>
</tr>
<tr>
<td>✔ c. None of the above</td>
</tr>
</tbody>
</table>

Behavioral Symptom:

- Frequency of symptoms and their impact

Coding:
- 1. Behavior not exhibited
- 2. Behavior of this type occurred 1 to 3 times
- 3. Behavior of this type occurred 4 to 6 times, but not daily
- 4. Behavior of this type occurred daily

Enter Code in Box:
A. Physical behaviors directed toward others (e.g., hitting, slapping, punching, pushing, shoving, kicking)
B. Factual hallucinations directed toward others (e.g., insulting others, screaming at others, causing problems)
C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as writing or scratching oneself, eating, going to the bathroom, social acts in public, terminal or unusual or bizarre, unusual or abnormal behavior)
Section E

Identify if resident is exhibiting psychotic behaviors:

- Hallucination
  - Perception of the presence of something that is not actually there
  - May be auditory or visual or involve smells, tastes or touch

- Delusion
  - Fixed false belief not shared by others that the resident holds even in the face of evidence to the contrary

Resident Behavior Impact

Impact on Resident (E0500) and Impact on Others (E0600)

Behaviors assessed in E0200 can impact the resident and others:

- Create risk for illness or injury
- Interfere with provision of care
- Interfere with participation in activities or social interactions
- Intrude on privacy
- Disrupt living environment

Behavior Impact

<table>
<thead>
<tr>
<th>E0500</th>
<th>Impact on Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did any of the identified symptoms?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>A. Put the resident at significant risk for physical illness or injury?</td>
<td></td>
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<tr>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>B. Significantly interfere with the resident's care?</td>
<td></td>
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<tr>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>C. Significantly interfere with the resident's participation in activities or social interactions?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E0600</th>
<th>Impact on Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did any of the identified symptoms?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>A. Put others at significant risk for physical injury?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>B. Significantly intrude on the privacy or activity of others?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>C. Significantly disrupt care or living environment?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Rejection of Care

Rejection of Care – Presence and Frequency
Care rejection manifested by:
• Verbally declining or statements of refusal
• Physical behaviors
Behavior interrupts or interferes with the delivery or receipt of care (e.g., bloodwork, ADL assistance, taking medications)
NOT rejection of care based on choice made by the resident or on behalf of the resident by a family member or other proxy decision maker

Wandering

Wandering – Presence and Frequency
Wandering may be the result of:
• Pursuit of exercise or a pleasurable activity
• Related to tension, anxiety, or searching
Assess reason for wandering. Determine frequency and factors that trigger the behavior or that decrease the episodes
Assess for underlying tension, anxiety, psychosis, drug-induced psychomotor restlessness, agitation or unmet need
Wandering is the act of moving from place to place with or without a specified course or known direction
May be oblivious to physical or safety needs
May have a purpose (searching, finding something) but persists without knowing the exact direction or location


ADL Coding – Section G

Definitions:

- **ADL Aspects** = components of the task and listed next to the activity in the item set
- **ADL Self-Performance** = what the resident actually did over 7 days based on the performance scale
- **ADL Support** = highest level of support provided by staff over 7 days – even once

Section G – Functional Status

- **G Activities for Daily Living Assistance**
  - “Facility Staff” pertains to direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). This does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration. Therefore, facility staff does NOT include, for example, hospice staff, nursing/CNA students, etc. Supports the idea that facility retains primary responsibility for the care of the resident

Section G - Rule of Three

- The ADL Coding Flow Chart provides a step-by-step guide for determining how to code Column 1 Self-Performance using the Rule of Three
  - Start at the top of the flow chart
  - Work down until the coding option in the flow chart matches the ADL assessment
Rule of Three Instructions

- When an activity occurs three times at any given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity did not occur (8). Example: 3 times at extensive assistance and 3 times limited assistance; code = extensive assistance.
- When an activity occurs at various levels, but not for 3 or more times at any one level apply the following:
  - Combination of full staff performance and extensive assistance = extensive assist.
  - Combination of full staff performance weight bearing and/or non-weight bearing assistance = limited assistance.
- If none of the above are met, code supervision.

Rule of Three Reminder

Not necessary to know how many times the activity occurred but know whether or not activity occurred 3 or more times within the last 7 days.

Look at your tracking tool – does it record number of times or once per shift?
### Know the ADL Definitions of Self-Performance

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Independent</td>
</tr>
<tr>
<td>1</td>
<td>Supervision</td>
</tr>
<tr>
<td>2</td>
<td>Limited Assistance</td>
</tr>
<tr>
<td>3</td>
<td>Extensive Assistance</td>
</tr>
<tr>
<td>4</td>
<td>Total Dependence</td>
</tr>
<tr>
<td>7</td>
<td>Activity Occurred Only Once or Twice</td>
</tr>
<tr>
<td>8</td>
<td>Activity Did Not Occur</td>
</tr>
</tbody>
</table>

**INDEPENDENT (0)**

No help or staff oversight at any time during the last 7 days
- NO help from staff
- Resident did the ADL entirely on own EVERY time

**Activity Occurred 3 or More Times:**

**SUPERVISION (1)**

Oversight, encouragement or cueing
- Staff uses eyes and mouth – no hands
- Standing by
Know the ADL Definitions of Self-Performance

Activity Occurred 3 or More Times:

**LIMITED ASSISTANCE (2) =**
Resident highly involved in activity; staff provide PHYSICAL help in guided maneuvering of limbs or other NONWEIGHT bearing assistance.
- Staff uses hands to guide, but **not** bearing any weight of the resident
- Contact guard

**Tip:**
- Staff's hand on top

Know the ADL Definitions of Self-Performance

Activity Occurred 3 or More Times:

**EXTENSIVE ASSISTANCE (3) =** Resident performed part of the activity, over last 7-day days, help provided by staff:
- Weight-bearing support
- Full staff performance during part but not all of last 7 days
- Staff uses hands and muscles – bearing some/any of resident’s weight

Know the ADL Definitions of Self-Performance

**EXTENSIVE ASSISTANCE (3) (continued)**
- Staff lifted a part of the body – a hand, leg, foot, fingers
  - Min assist
  - Mod assist
  - Max assist

**Tip:**
- Staff’s hand underneath - hand, finger, arm, leg, hip, foot of resident

Levels of weight bearing by therapy
- Min assist
- Mod assist
- Max assist

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Know the ADL Definitions of Self-Performance

TOTAL DEPENDENCE (4) =
Full staff performance every time during the ENTIRE 7 day period
• Staff performs the entire task - each and every time
• Resident did not do anything to help

Activity Occurred 2 or Fewer Times:
ACTIVITY OCCURRED ONLY ONCE OR TWICE (7) =
activity did occur but only once or twice
ACTIVITY DID NOT OCCUR (8) =
if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

ADL Support Provided

Measure the most support provided for each ADL over the look-back period
Code for the type and HIGHEST level of support provided by staff over the last 7 days
Most support provided may occur only once
Coded separately from Column 1
Rule of Three does NOT apply to Column 2
Know the ADL Definitions of ADL Support Provided

(0) = NO setup or physical help from staff

(1) = Set up help only

(2) = ONE person physically assisted

(3) = TWO or more physically assisted

(8) = Activity did not occur during entire period

Know the ADL Definitions

<table>
<thead>
<tr>
<th>MDS</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>Independent</td>
</tr>
<tr>
<td>Supervision</td>
<td>Stand By Assist</td>
</tr>
<tr>
<td>Limited Assistance</td>
<td>Contact Guard</td>
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<tr>
<td>Extensive Assistance</td>
<td>Min</td>
</tr>
<tr>
<td></td>
<td>Assist</td>
</tr>
<tr>
<td>Total Dependence</td>
<td>Dependent</td>
</tr>
</tbody>
</table>

Impact of Understating of ADLs
What Is One Point Worth?

RUB 6-10 → $615.20
RUA 0-5 → $523.02

$92.18 x 14 days = $1290.52

Rural, Federal PPS Rates – 10/1/2014 through 9/30/2015
Section K

- Any and all nutrition and hydration received by the NH resident in the last 7 days either at the NH, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.

**TF requirements:**
1. K0700A is 51% or more of total calories OR
2. K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.
Other Skin Conditions

- Check if they apply
- Infection of the foot (e.g., ulcers, pseudomembrane)
- Wound healing (e.g., diabetic foot)
- Other open lesions on the foot
- Skin or bone biopsy (i.e., bone, muscle, other tissue)
- Ulcers (e.g., venous, diabetic)
- Wound care (e.g., dressing, debridement)
- Wound and tissue destruction (e.g., burn, sepsis, grafting, amputation)

Treatments

- Check if they apply
- Pressure-reducing devices for bed
- Pressure-reducing devices for chair
- Taping or bandaging program
- Nutritional or hydration interventions to manage skin problems
- Recreational care
- Surgical wound care
- Application of non-surgical dressings (i.e., bandages, other than to heat
- Application of dressings to heat
- Non-surgical treatments (i.e., bandages, other than to heat)
- Non-surgical treatments (i.e., bandages, other than to heat)

O0100

Do NOT count services that were provided solely in conjunction with a surgical procedure (including routine pre- and post-operative procedures).
Section O – Special Treatments, Procedures, and Programs

**Column 1 = While NOT a Resident**
- Documents treatments received before becoming a resident of the facility
- Check all treatments received by the resident
  - Prior to admission or reentry to the NF
  - Within the 14-day look-back period
- Applies to Care Planning only

Section O – Special Treatments, Procedures, and Programs

**Column 2 = While a Resident**
- Documents treatments received after becoming a resident of the facility
- Check all treatments received by the resident
  - After admission or reentry to the NF
  - Within the 14-day look-back period
- Impacts reimbursement

Section O – Isolation Coding

- Isolation or quarantine for active infectious disease
  - Code only when resident requires single room isolation or quarantine **alone** in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease. **All services brought to resident in their room.**
  - Resident does not leave their room.
  - Does not include standard body/fluid precautions
  - Do not include if the resident only has a history of infectious disease (e.g., MRSA or C-Diff with no active symptoms)
Section O - Considerations on Isolation

- If a facility transports a “single room isolation” resident to another healthcare setting to receive medically needed services (e.g., dialysis, chemo, transfusions), follow CDC guidelines for transport of patients with communicable disease. May still code O0100M for strict isolation since it is being maintained while the resident is in the facility.

- Review the resident’s status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident’s function and plan of care. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident’s plan of care will likely need to be completed.

Care Area Assessments and Care Plans

What are the CAAs?

- The MDS is a starting point. Collection of basic physical, functional, and psychosocial information about residents. When completed MDS provides framework for a more thorough assessment – identifies actual or potential areas of concern.

- CAA process framework: Guides the review of triggered areas and clarification of a resident’s functional status and related causes of impairments. Basis for additional assessment of potential issues, including related risk factors. The assessment of causes and contributing factors gives the IDT additional information to help develop a comprehensive plan of care.

- After completing the CAA evaluation and analysis, a clinical decision is made, based on the results, about whether the identified problem is, in fact a problem or relevant issue.
Why Use the CAAs?

When implemented properly, the CAA process should help staff:

• Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
• Identify areas of concern that may warrant interventions;
• Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident’s condition, choices, and preferences for interventions; and
• Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management

20 CAAs in the MDS 3.0

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychological Well-being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drug Use
18. Physical Restraints
19. Pain
20. Return to Community Referral
CAA Process

- Evaluate triggered areas, but CAAs do not provide exact detail on how to select pertinent interventions for care planning
  - Interventions must be individualized and based on effective problem solving and decision making approaches to all of the information available for each resident
- Care Area Triggers (CATs) identify conditions that require evaluation because of possible impact on specific issues and/or conditions, or the risk of issues and/or conditions
- Triggered items may or may not represent a condition that should or will be addressed in the care plan
- Significance and causes of any given trigger may vary for different residents or in different situations for the same resident
- Different CATs may have common causes, or various items associated with several CATs may be connected

CAA Process

- CATs provide a “flag” for the IDT
- Indicate care area needs to be assessed more completely prior to making care planning decisions
- Triggered care area assessment may identify causes, risk factors, and complications associated with the care area condition
- Plan of care addresses these factors with the goal of promoting the resident’s highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines
- A risk factor increases the chances of having a negative outcome or complication

Care Area Assessment

- No specific tool mandated for completing the further assessment of the triggered areas
- No specific guidance on how to understand or interpret the triggered areas
- Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (“critical thinking”) skills is imperative
CAA Documentation
- Helps explain basis for care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident.
- Indicate basis for decisions – why the findings require an intervention, and the rationale for selecting specific interventions.

Relevant Documentation for Triggered CAA Describes:
- Causes and contributing factors;
- Nature of issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area;
- Risk factors related to the presence of the condition that affects the decision to proceed to care planning;

Relevant Documentation for Triggered CAA Describes:
- Factors considered in developing individualized care plan interventions, including decision to care plan or not
- Need for additional evaluation by the attending physician and other health professionals;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary) of the MDS.
Care Planning
- Good assessment forms the solid basis
- CAAs are the link between the MDS and care plan
- Plan of care is driven by resident problems, strengths, needs, preferences and choices
- Care plan by IDT
- Answer the “so what now” question
- No required format or structure

Care Planning
- Must have measurable goals and time tables
  - Goals should have a subject, verb, modifier and time frame
  - Mr. “B” will walk 50 ft 2X daily within the next 3 months
- Approaches should identify what staff are to do and when they are to do it – with focus on resident goals
  - Ambulate Mr. “B” to and from lunch and dinner with walker and standby assist only

Care Planning
What the care plan needs to do:
- Indicates interventions in place to prevent avoidable declines in functioning or functional levels
- Manage risk factors
- Address resident strengths
- Use current standards of practice in the care planning process
- Evaluate treatment objectives and outcomes of care
Care Planning

- Respect the resident’s right to refuse treatment
- Allows resident to establish own goals
- Offer alternative treatment
- Use an interdisciplinary approach to care plan development to improve the resident’s functional abilities
- Involve the family and/or other resident representatives, if OK with the resident

Care Planning

- Assess and plan for care sufficient to meet the care needs of new admissions
- Involve the direct care staff with the care planning process relating to the resident’s expected outcomes
- Address additional care planning areas that could be considered in the long-term care setting

General Care Planning Areas

Six General Care Planning Areas
- Functional status
- Rehabilitation/restorative nursing
- Health maintenance
- Discharge potential
- Medications
- Daily care needs
MDS Focus Survey
- Pilot was conducted in five states and concluded in August of this year
- Results have caused CMS to determine that full implementation will take place in early 2015 for nation
- States will determine which facilities will be targeted in each state

Preliminary Findings of MDS Coding Errors
- 24 out of 25 facilities had coding errors identified during the survey
- Errors consisted of inaccuracies related to:
  - Pressure ulcer coding
  - Antipsychotic medication use
  - Restraint use

MDS Focused Surveys
- CMS is to release a summary of findings – preliminary reasons identified for coding errors:
  - Coordinator turnover
  - Training issues with new coordinators
  - Timing issues
  - Policy issues
- Appendix PP of the SOM was updated November 26 including F 278 - Accuracy MDS
Pilot Surveys

- Consisted of approximately 2 days of survey with 2 to 4 surveyors
- Surveyors met with the Administrator and requested an alphabetical census with room numbers and floor plan
- OBRA assessments were reviewed (typically 10 most recently completed and submitted assessments with any subsequent corrections)

Conditions Targeted in Pilot

- Residents with conditions or devices used in previous 90 days:
  - Pressure ulcers
  - Indwelling catheters
  - Restraints routine and prn use – excluding side rails
  - UTIs
  - Antipsychotic medication
  - List of residents with falls in past 12 months

Survey Outcomes

- Non-compliance will result in
  - Citations related to assessments (F272 to F287)
  - Plan of correction required
- Non-compliance could result in
  - Extended survey – with routine survey team following up
  - Civil monetary penalties (CMPs)
Questions?

Resources

- Center for Clinical Standards and Quality/Survey & Certification Group, “S&C:15-06-NH”, October 31, 2014
- Kulus, Judi, AANAC, “CMS Expands MDS Focused Surveys Nationwide”, November 19, 2014

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