

Health Services Advisory Group

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**MDS 3.0: CODING KEY
ITEMS**

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Hearing, Speech, and vision

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SECTION B

Intent

To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

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Bo200: Hearing

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- Poor hearing can affect behavior, ability to follow instructions
- Evaluate hearing with hearing appliances in place, if applicable
- Interview the resident about hearing function
- Observe resident in different environments
 - Note if resident needs quiet environment to hear
 - Notice if you must adapt speaking to be heard, such as speak more clearly, use louder tone, etc.
- If hearing deficits are overcome by hearing device, it is not a functional impairment - do not code it

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B0700: Makes Self Understood

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- Resident's ability to communicate essentially all types of daily information
 - Needs, opinions, preferences, social discussion, etc.
- Via any effective method
 - Orally, writing, sign language, gestures, etc.
- Interact with resident: Observe, listen to interactions with others in different settings and different circumstances
- Consult others who interact with resident
- Key item in determining if resident interviews for mood, pain, etc., should be conducted

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B0800: Ability to Understand Others

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- Comprehension of direct person-to-person communication whether spoken written, sign language, Braille
 - Includes ability to process and understand language
 - Can be due to receptive aphasia; confusion; decline in cognition, hearing, or comprehension
- Sources: Interaction with resident, interviews with others who interact with resident, medical record
- Answer options describe characteristics of decreasing levels of understanding others

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Cognitive Patterns

SECTION C

Intent

The items in this section are intended to determine the resident's ability to remember both recent and long-past events (i.e. short-term and long-term memory) and to think coherently. These items are crucial factors in many care-planning decisions.

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**Co100: Should BIMS (Co200-Co500)
Be Conducted?**

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- Conduct BIMS if resident is understood at least some of the time verbally or by writing (✓ B0700)
- Interview is not attempted if B0700, Makes Self Understood = 3, rarely/never understood
- Have interpreter available if needed
- Co100=0, No, means resident is rarely or never understood
 - Skip BIMS and go to Co700-C1000, Staff Assessment for Mental Status

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**Brief Interview for Mental Status
(Co200-Co500)**

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- Proper preparation is essential
 - Ensure privacy, quite environment
 - Be sure resident can hear you and/or has usual communication devices/techniques available
 - Introduce the BIMS
 - ✦ “I would like to ask you some questions. We ask everyone the same questions. This will help us provide you with better care. Some of the questions may seem very easy while others may be more difficult.”

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Co200: Repetition of Three Words

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- See scripted language on the form
- Code the number of words repeated based on the resident’s response to that question
 - The words can be in any order
 - Resident gets credit for the word regardless of whether he or she presents it in a list, a sentence, a phrase, or in some other way

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Co200: Repetition of Three Words

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- After resident responds and you code Co200, repeat the words using category cues up to two more times to foster learning, because he or she will be asked to recall them for Co400
 - “Sock, something to wear; blue, a color; bed, a piece of furniture”
 - Cue card with words and categories may be used
 - *Do not recode CO200 with the results*
 - Do not tell resident he/she will be asked to repeat them later

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Co300: Temporal Orientation

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- Orientation to current year, month and day of the week
- Ask each of the three questions, using language on the form, allowing up to 30 seconds for each answer
- Do not provide clues
- Might help to write answers in margins and determine correct code after interview

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Co400: Recall

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- See scripted language on form
- Allow up to 5 seconds for recall
- For any word not correctly recalled, provide the category cue
- Allow up to 5 seconds after category cueing for each missed word to be recalled
- Resident may include word in a sentence or, on the first try (before cueing), in a list

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Co400: Recall

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- 0. No
 - Could not recall even after cueing
 - Responds with nonsensical answer
 - Chooses not to answer
- 1. Yes – recalled after cueing
- 2. Yes – recalled and no cue was required
- If resident says correct word as part of a list:
 - Code 2, Yes, no cue required IF no cue was given
 - Code 0, No, could not recall if it was after a cue was given

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Co400: Recall

Example

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- Resident is asked to recall the three words.
- Resident: "Socks and shoes."
 - Interviewer: "One word was a color."
 - Resident: "Oh, the shoes were blue."
 - Interviewer: "One word was a piece of furniture."
 - Resident: "Of course – couch."
 - Coding
 - Co400A, sock = 2, yes, no cue required
 - Co400B, blue = 1, yes, after cueing
 - Co400C, bed = 0, No, could not recall

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Co500: BIMS Summary Score

Add the scores for questions Co200-Co400 (00-15)

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Summary of BIMS coding rules

1. Code each item based on the specific instructions for the item.
2. If the resident does not answer or declines to answer question, accept refusal, code that question as incorrect (0).
3. To be considered to be a completed interview, the resident had to attempt and provide relevant answers to at least four of the seven questions in Co200-Co400. Enter total of Co200 through Co400 in Co500

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Co500: BIMS Summary Score

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4. To be considered to be an incomplete interview, the resident did not answer or gave completely unrelated, nonsensical responses to four or more items in Co200-Co400.
5. Finish the interview after Co300 if the resident provided at least one relevant answer in Co200 and Co300.
6. If the interview is finished but incomplete, code:
 - o Any relevant responses according to the item's coding rules
 - o Nonsensical responses or no answer = 0
 - o Co500 = 99 indicating incomplete interview

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Co500: BIMS Summary Score

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7. Once started, stop interview after completing Co300C, if:
 - o Every BIMS response to this point was nonsensical
 - o There was no response to any BIMS question to this point
 - o To Co300C, all BIMS responses were either nonsensical or there were no responses
8. If the interview is stopped, code:
 - o Co200 and Co300 = 0
 - o Co400 = (-) dashes
 - o Co500 = 99 indicating incomplete interview
9. For incomplete interviews, Co500=99 and Staff Assessment for Mental Status (Co600-C1000) is completed

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Co500: BIMS Summary Score

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- Assuming the resident can hear and is not delirious, the following distributions are suggested:
 - o 13-15 Cognitively Intact
 - o 08-12 Moderate Impairment
 - o 00-07 Severe Impairment
- BIMS does not diagnose
 - o Tool for physician and physician extenders
 - o Comparison of current to previous BIMS

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BIMS Documentation

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- Single point in time interview
- Resident interview is only source for coding Co200-Co500
- Other documentation, interviews, and observations during look-back are not taken into account for BIMS coding, but are relevant to care planning

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Co600: Should Staff Assessment for Mental Status be Conducted?

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- Screening item to determine if BIMS results indicate that Staff Assessment must be completed
- If resident completed BIMS, Co600 = No, indicating staff interview items are to be **skipped**
- If BIMS Summary Score = 99, Co600 = 1, Yes, indicating Staff Assessment must be completed (Staff assessment also completed if Co100=0, No, indicating BIMS was skipped)

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Staff Assessment for Mental Status

Co700. Short-Term Memory OK

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- Direct testing
 - Ask about a recent event, such as breakfast meal or an activity just completed, or
 - Ask resident to repeat 3 words after 5 minutes
 - Use structured short-term memory test
- Also observe resident, talk to staff on all shifts, all disciplines, family, other visitors
- Code the most representative level of function based on all information collected

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Staff Assessment for Mental Status
Co800. Long-Term Memory OK

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- Data collection about long-term memory
 - Engage resident in conversation about the past
 - Ask questions about the past that can be validated with the resident’s family or friends or via the medical record
 - Review memorabilia from the resident’s past
 - Interview staff and significant others
 - Review medical record for indications of long-term memory status

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Staff Assessment for Mental Status
Co900: Memory/Recall Ability

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- Assessor may rely on indicators other than precise answers that resident recalls this information, such as:
 - Resident can take you to his room or says, “It’s right next to the utility room”
 - For season, resident describes the weather for the season rather than naming the season
 - For staff names and faces, resident is able to distinguish staff from his family or friends

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Staff Assessment for Mental Status
Cognitive Skills for Daily Decision-Making

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- Assess actual performance in making decisions, such as selecting clothing; how to get to dining room; using clocks and activity calendars; acknowledging need to use walker; using environmental cues, such as clocks and calendars for planning; seeking information appropriately to plan the day
 - Identify decisions resident made during look-back period
 - Determine the quality of the decisions in the context of the resident’s own lifestyle, culture, and values
 - Exercising right to decline treatment should not be captured as impaired decision-making

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Signs and Symptoms of Delirium
(C1300)

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- This item is adapted from the Confusion Assessment Method (CAM)

Delirium: Mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations

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Signs and Symptoms of Delirium
(C1300)

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- Information sources
 - Observations during the BIMS
 - Interviews with staff, family, others who were in contact with resident during look-back period
 - Medical record review
- Pay close attention to definitions C1300A-D
- Based on definitions and all info in look-back period, select correct code

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Acute Onset of Mental Status Changes
(C1600)

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- Compare resident's status during look-back period to his or her baseline
- May indicate delirium or other serious medical complications
 - May be reversible if detected and treated timely
 - May cause decline or death if not treated promptly

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Mood

SECTION D

Intent

The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among elderly nursing home residents because these signs and symptoms can be treatable.

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Do100: Should Resident Mood Interview be Conducted?

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- Conduct PHQ-9 if resident is understood at least some of the time verbally or by writing (✓ B0700)
- Interview is not attempted if B0700, Makes Self Understood = 3, rarely/never understood
- Have interpreter available if needed
- Do100=0, No, means resident is rarely or never understood
 - Skip PHQ-9 and go to C0700-C1000, Staff Assessment for Mental Status

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Do200: Resident Mood Interview (PHQ-9[©])

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- Standardized, structured, scripted depression interview
- PHQ-9 is copyrighted by Pfizer, but CMS' permission to use it extends to NH providers
- Asking resident to look back two weeks from the day of the interview
- Interview should be conducted prior to and as close to the ARD as possible*

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Do200: Resident Mood Interview (PHQ-9[®])
The Items

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- **Two columns**
 - 1. Symptom Presence
 - ✦ 9 symptoms (A-I)
 - 2. Symptom Frequency

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Do200: Resident Mood Interview (PHQ-9[®])
The Coding

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- If resident reports symptom was present over the last two weeks, column 1 = 1, Yes, then ask about frequency
- If column 1 = 0, No, column 2 = 0, never or 1 day

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Do200: Resident Mood Interview (PHQ-9[®])
The Coding

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- Code column 1 with a 9, indicating no response, and leave column 2 blank if:
 - Resident was unable or chose not to answer a question
 - Resident responded nonsensically, and/or
 - Facility was unable to complete the assessment
- If resident unable to choose between two frequency levels, code the higher frequency

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Do200: Resident Mood Interview (PHQ-9[®])
The Interview

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1. Explain in simple terms what the process is for the interview

I'm going to ask you some questions about your mood and feelings over the past two weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them This will help us provide you with better care.

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Do200: Resident Mood Interview (PHQ-9[®])
The Interview

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2. Review column 2 response options; using a cue card or paper with them printed in large print can be a big help to the resident

I'm going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card. (Say while pointing to cue card): 0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day.

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Do200: Resident Mood Interview (PHQ-9[®])
The Interview

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3. Begin the interview

Over the last two weeks, have you been bothered by any of the following problems? and state the symptom just as it is stated in Do200A: ...little interest or pleasure in doing things.

- If resident reports symptom presence, code 1, yes, regardless of what you or the resident might think the cause might be

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D0200: Resident Mood Interview (PHQ-9[®])
The Interview

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4. Then ask symptom frequency, repeating the answer options and pointing to them on the cue card
5. Repeat this same process for all 9 symptoms
 - Stick to the script, asking questions as written on the form
 - Review the answer options with resident each time
- If resident has difficulty choosing between to frequency levels, code the higher frequency
- *Interview techniques will be the focus of our August 24 session.*

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D0200: Resident Mood Interview (PHQ-9[®])
Interview Documentation

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- Resident responses are documented directly on the MDS 3.0; not necessary to document them elsewhere in chart
- Other medical record documentation, interviews, and observations during the look-back period do not enter into the coding decision
- PHQ-9 is just one source of information for overall clinical assessment; all available information should be taken into account for care planning

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D0300: Total Severity Score

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- Total Severity Score is sum of all Symptom Frequency (column 2) scores when resident responded to at least 7 of the 9 items
- Incomplete interview: Symptom Frequency is blank for 3 or more items (indicating no response)
 - Enter 99 in D0300
 - Complete Staff Assessment of Mood

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D0300: Total Severity Score

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- Score does not diagnose mood disorders but can be important tool for physicians and physician extenders
- Also can be used to track changes in severity over time:
 - 1-4 minimal depression
 - 5-9 mild depression
 - 10-14 moderate depression
 - 15-19 moderately severe depression
 - 20-27 severe depression

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D0350: Safety Notification

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- If resident reported thoughts of being better off dead or of hurting self in some way (D0200I1=1), appropriate facility clinical staff and physician or other primary care provider must be notified. This documents that follow-up.
- Leave blank if D0200I is not coded "1," Yes

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D0500: Staff Assessment of Resident Mood (PHQ-9-OV[®])

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- 14-day look-back period; for new admission, collect information from significant others for preadmission days captured in look-back
- Interview staff from all disciplines and shifts who know the resident
- Questions are similar to PHQ-9 with one added: Being short-tempered, easily annoyed
- Use same interview techniques
- Same coding rules as PHQ-9

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Do600: Total Severity Score

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- Add all Symptom Frequency scores from Do500 column 2 when staff members respond to at least
- Does not diagnose mood disorder
 - Provides valuable information for clinicians and mental health specialists
 - Can be used to track changes over time

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Do650: Safety Notification

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- If Do500I indicates that resident states life isn't worth living, wishes for death, or attempts to harm self, appropriate facility clinical staff and physician or other primary care provider must be notified. This documents that follow-up
- Leave blank if Do500I is not coded "1," Yes

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Behavior

SECTION E

Intent

The items in this section identify behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident himself or herself.

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Introduction

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- Capture behavior that actually occurred during 7-day look-back period
 - Coding behaviors is based on the presence of the behavior and not on medical diagnoses
- Code regardless of what staff or others believe the cause or intent of the behavior to be
- If the behavior occurred during look-back, code it regardless of how long it has been present
- If behavior occurred and it meets the definition, it must be coded

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E0100: Psychosis

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- Information sources: Medical record, interviews with staff and others who interact with and observe resident, direct observation of resident in varied situations
- Hallucination: The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch
 - To code it, assessor must validate that it is not actually real

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E0100: Psychosis

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- Delusion: A fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary
 - If the belief cannot be shown to be false or it is not possible to determine if it is false, do not code it as a delusion
 - If it is a delusion but resident readily accepts reality when it is explained, do not code it as a delusion (in that case, it is not "fixed")

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E0200: Behavioral Symptoms
Presence & Frequency

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- Behavioral Symptoms
 - E0200A - Physical behavioral symptoms directed toward others, such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually
 - E0200B - Verbal behavioral symptoms directed toward others, such as threatening others, screaming at others, cursing at others

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E0200: Behavioral Symptoms
Presence & Frequency

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- Behavioral Symptoms (continued)
 - E0200C - Other behavioral symptoms not directed toward others, such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, or other disruptive sounds
- Code based on number of days they occurred
- Code an episode regardless of frequency or intensity

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E0300: Overall Presence
of Behavioral Symptoms

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- Purpose of this item is to determine whether E0500, Impact on Resident, and E0600, Impact on Others, should be completed
- Skip pattern: if E0300=0, No, indicating none of the behaviors in E0200 occurred, E0500 and E0600 are skipped

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E0500: Impact on Resident

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- E0500A - Put resident at significant risk for physical illness or injury
- E0500B - Significantly interfere with the resident's care
 - Necessary or essential care required to achieve resident's goals for health and well-being and which cannot be received safely, completely, or in a timely way without more than a minimal accommodation, such as a simple change in care routines or environment
- E0500C - Significantly interfere with the resident's participation in activities or social interaction

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E0500: Impact on Resident

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- Key concept
 - **Significant:** Effects, results, or consequences that materially affect or are likely to affect an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status

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E0600: Impact on Others

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- E0600A - Put others at significant risk for physical injury
- E0600B - Significantly intrude on the privacy or activity of others
 - Violating privacy or interrupting other residents' performance of activities of daily living or limiting engagement in or enjoyment of informal social or recreational activities to such an extent that it causes the other residents to experience distress (e.g., displeasure or annoyance or inconvenience, *whether or not the other residents complain*)

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Eo600: Impact on Others

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- Eo600C - Significantly disrupt care or living environment
 - Interfering with staff ability to deliver care or conduct organized activities, interrupts receipt of care or participation in organized activities by other residents and/or causes other residents to experience distress or adverse consequences

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Eo600: Impact on Others

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- Impact may be a direct effect on another resident, such as grabbing things from a resident or verbally threatening a resident
- Effect could be more general, such as requiring constant attention from staff members, diverting them from other residents, or yelling during group activities

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Eo600: Impact on Others

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- Staff observations of residents' reactions to behavior of another resident is key
- Information sources: medical record, interview with staff and others who observe residents' interactions and reactions, direct observation by assessor

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Eo800: Rejection of Care

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The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision-maker. (CMS, 2009, p. E-15)

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Eo800: Rejection of Care

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- Residents with decision-making capacity have the legal right to decline care, services, and treatment
 - They have a right to make their choice, even when the choice might not seem logical to others
- When a resident who lacks decision-making capacity rejects care, services, or treatment, if the rejection is consistent with that individual's values, culture, lifestyle, or goals for health care, it should not be identified as a problem or coded as rejecting care

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Eo800: Rejection of Care

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- The question:
 - Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being?
 - Do not capture if:
 - ✦ The behavior already has been addressed (e.g., by discussion or care planning with the resident or family)
 - ✦ Rejection is consistent with resident values, preferences, or goals
 - If resident would have wanted the care when he or she had decision-making capacity, this is rejection of care

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E0800: Rejection of Care

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Resident tells staff he would rather receive care at home. The next day he calls for a taxi and exits the nursing facility. When staff try to persuade him to return, he firmly states, "Leave me alone. I always swore I'd never go to a nursing home. I'll get by with my visiting nurse service at home again." He is not exhibiting signs of disorientation, confusion, or psychosis and has never been judged incompetent.

- Coding: E0800 would be coded 0, behavior not exhibited.

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E0800: Rejection of Care

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A resident who recently returned to the nursing home after surgery for a hip fracture is offered physical therapy and declines. She states that she wants to walk again but is afraid of falling. This occurred on 4 days during the look-back period.

- Coding: E0800 would be coded 2, behavior of this type occurred 4-6 days.

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E0900 - Wandering

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- Walking or locomotion in a wheelchair from place to place without a specified course or known direction
 - May be aimless
 - Resident may be oblivious to his or her physical or safety needs
 - Resident may have a purpose, such as searching to find something, but persists without knowing the exact direction or location
 - May or may not be driven by confused thoughts or delusional ideas

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E1000 – Wandering Impact
Skip this item if E0900=0, behavior not exhibited

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- E1000A – Risk of getting to potentially dangerous place or situation
 - Outside into traffic or into room of physically aggressive resident
- E1000B – Significantly intrude on privacy or activities of others
 - Violates other residents’ privacy or interrupts their performance of ADLs or limits their engagement in or enjoyment of social or recreational activities

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E1100: Change in Behavioral or Other Symptoms

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- Compare section E items on current MDS with same items on most recent prior MDS (OBRA or PPS)
- Some issues may have improved, some may have worsened, some may have stayed the same
→ clinical judgment based on resident’s overall behavior status

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Preferences for Customary Routine and Activities

SECTION F

Intent

The intent of items in this section is to obtain information regarding the resident’s preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences.

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F0300: Should Interview for Daily and Activity Preferences be Conducted?

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- Conduct interviews if resident is understood at least some of the time verbally or by writing (✓B0700)
- Interview is not attempted if B0700, Makes Self Understood = 3, rarely/never understood
- Have interpreter available if needed

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F0300: Should Interview for Daily and Activity Preferences be Conducted?

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- If B0700 indicates resident is rarely/never understood, a significant other should be asked to participate
 - This is not the case with Mood and Pain interviews
- F0300=0, No, means resident is rarely or never understood AND significant other not available
 - Skip F0400 and F0500 and go to F0800, Staff Assessment of Daily and Activity Preferences

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F0400: Interview for Daily Preferences
F0500: Interview for Activity Preferences

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- Structured, standardized, scripted interview
- No specific look-back period - asks about preferences while in nursing home
- Effective preparation is essential
- Responses are starting point for discussion
 - Facility process will determine when follow-up questions will be asked and by whom

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F0400: Interview for Daily Preferences
 F0500: Interview for Activity Preferences

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- Response options assign level of importance to items to assist with prioritizing for care planning (see options on MDS)

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F0400: Interview for Daily Preferences
 F0500: Interview for Activity Preferences

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- Option 5 – Important, but can't do or no choice
 - Means the issue is important to the resident, but he feels he is not able do it in the nursing home, perhaps because he isn't able to do it physically anymore or maybe because the option is not offered in the facility

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F0400: Interview for Daily Preferences
 F0500: Interview for Activity Preferences

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1. Explain the process

I'd like to ask you a few questions about your daily routines and preferences. The reason I'm asking you these questions is that the staff here would like to know what's important to you. This helps us plan your care around your preferences so that you can have a comfortable stay with us. Even if you're only going to be here for a few days, we want to make your stay as personal as possible.

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F0400: Interview for Daily Preferences
 F0500: Interview for Activity Preferences

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2. Explain the response options, pointing to them on a cue card as you review them

*I am going to ask you how important various activities and routines are to you **while you are in this home**. I will ask you to answer using the choices you see on this card [read the answers while pointing to cue card]: 'Very Important,' 'Somewhat important,' 'Not very important,' 'Not important at all,' or 'Important, but can't do or no choice.'*

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F0400: Interview for Daily Preferences
 F0500: Interview for Activity Preferences

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3. Explain "important but can't do/no choice" option

You can select this answer if something would be important to you, but because of your health or because of what's available in this nursing home, you might not be able to do it. So, if I ask you about something that is important to you, but you don't think you're able to do it now, answer 'Important, but can't do or no choice.' If you choose this option, it will help us to think about ways we might be able to help you do those things.

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F0400: Interview for Daily Preferences
 F0500: Interview for Activity Preferences

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4. Ask the questions as they are written on the MDS
While you are in this facility, how important is it to you to choose what clothes to wear?
5. Review the answer options with resident using cue card as visual aid
6. Use techniques discussed with Mood interview to help to elicit meaningful responses
7. Record response
8. Repeat process, including step 5, for all 8 questions

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F0600: Daily and Activity Preferences Primary Respondent

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- Determines source of information for F0400 and F0500
 1. Resident
 2. Family or significant other
 9. Interview could not be completed by resident or family/significant other
 - ✦ This would be selected if code 9, no response, was entered in 3 or more items
 - ✦ If interview was incomplete, staff assessment must be completed

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F0700: Should Staff Assessment of Daily and Activity Preferences be Conducted?

77

- Screening item to determine if Staff Assessment must be completed
- If resident/significant other completed preferences interviews, F0700 = No, indicating staff interview items are to be **skipped**
- If 3 or more of the 16 Preference interview items were not completed = 1, Yes, indicating Staff Assessment must be completed
(Staff assessment also completed if F0300=0, No, indicating Preferences interview was skipped)

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F0800: Staff Assessment of Daily and Activity Preferences

78

- 7-day look-back period
- Staff in all disciplines and shifts who interact with or observe resident should provide input for these items
- Resident was unable to complete Preferences interview but still might be able to express some preferences
- If not, if resident appears happy or content during an activity listed, that items should be checked

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Functional Status

SECTION G

Intent

Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

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MDS Coding

80

- Must be based on observations
 - Of all disciplines, including direct care staff
 - Over a 24 hour period each day
 - For entire assessment period
- Include assistance provided by *nursing home staff* only
- If rehab is treating resident, include input in making coding decision

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MDS Coding

81

- Do not capture preadmission data
- Information contained in the clinical record must support MDS coding
 - Documentation that furnishes a picture of the resident's care needs and response to treatment is accepted standard of practice, is part of good resident care and staff care planning

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ADL Activity Definitions

82

A. Bed Mobility
How resident moves **to and from a lying position**, turns side to side, and position body while in bed or alternate sleep furniture

B. Transfer
How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position. Excludes to/from bath and toilet.

C. Walk in room
How resident walks between location in his/her room.

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ADL Activity Definitions

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D. Walk in corridor
How resident walks in corridor on unit.

E. Locomotion on unit
How resident moves between locations in his or her room and adjacent corridor on the same floor. If in wheelchair, self-sufficiency once in the chair.

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

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ADL Activity Definitions

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G. Dressing
How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedress.

H. Eating
How the resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).

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ADL Activity Definitions

85

I. Toilet Use

How the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag, or ostomy bag.

J. Personal Hygiene

How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands. Excludes baths and showers.

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G0110(1) ADL Self-Performance

86

- Scales are used to record actual level of involvement
 - Do not record resident's capacity
 - Do not record type and level of assistance "should" receive

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Coding G0110(1)

87

0 Independent

No help or staff oversight at any time

1 Supervision

Oversight, encouragement, or cueing (no hands-on assistance)

2 Limited Assistance

Resident highly involved in activity, staff provided guided maneuvering of limbs or other non-weight-bearing assistance

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Coding Section G0110(1)

88

3 Extensive Assistance

Resident performed part of the activity and staff provided

- ✦ **Weight-bearing support OR**
- ✦ **Full staff performance of activity or a component of the activity during part (but not all) of 7-day look-back period**

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Guided maneuvering vs. weight bearing

89

Determine who is supporting the weight

- Putting hat on resident's head → non weight-bearing
- Lifting arm into sleeve → weight-bearing
- Supporting some of weight of resident's hand and, with resident, lifting a spoon or cup to mouth → weight-bearing
- Resident lifts utensil or cup, but staff must guide it to mouth → guided maneuvering

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Coding G0110(1)

90

4 Total Dependence

Full staff performance of the activity during the entire 7 day period. Complete non-participation by the resident in all aspects of the ADL task. If criteria are met, code 4 may be used only if the resident was unwilling or unable to perform any part of the activity. If resident performed any part of the activity, it would not be coded 4.

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Coding G0110(1)

91

7. Activity Occurred Only Once or Twice
The ADL activity occurred only one or two times in the look-back period

8 Activity did not occur during the entire 7-day period
The activity (or any part of the ADL activity) was not performed by resident or staff at all over the entire 7-day period

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G0110(1) ADL Self-Performance

92

- Coding is based on knowing resident's level of performance for each episode of each ADL activity that occurred
- ✦ As long as the activity occurred at least 3 times, code the most dependent level that occurred 3 or more times within the 7-day look-back period (see exception for Dependent on later slide)

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G0110(1) ADL Self-Performance

93

- Performance for a particular component of an ADL activity may be the deciding factor

Example

Resident performed hygiene tasks independently except was unable to shave his face because of hand tremor. Staff shaved his face for him each day. Because the staff performed a component of the activity for him at least 3 times, the code is Extensive Assistance (3).

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Coding G0110(1)

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• Coding Summary

- When the ADL activity *did not occur even once* during the entire look-back period – Code 8
- When the ADL activity *occurred only once or twice* in the look-back period – Code 7

When the activity occurred 3 or more times:

- When the ADL activity was performed without oversight or hands-on physical assistance *every time it occurred* - Code 0 (Independent)
- When full staff assistance was provided *every time the activity occurred* – Code 4 (Total Dependence)

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Coding G0110(1)

95

• Coding scale 0 to 4 – Rule of 3

- When an activity occurs 3 or more times within a code category as the highest level of dependence in the observation period, code the activity at

Example ¹	Non-weight-bearing assistance x 2
	Supervision x 3
	No assistance x 2
Code:	Supervision

¹Except Total Dependence (Code 4)

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Coding G0110(1)

96

• Coding scale 0 to 4 – Rule of 3

- If activity occurs 3 or more times at multiple levels, code the most dependent level that occurred 3 or more times¹

Example:	Weight-bearing assistance x 2
	Non-weight-bearing assistance x 5
	Supervision x 6
Code:	Limited assistance

¹Except Total Dependence (Code 4)

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Coding G0110(1)

97

- Coding scale 0 to 4 – Rule of 3 (continued)
 - When an activity occurs at least 3 times and occurs at multiple levels *but not three times at any one level*:
 - Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance, this is total dependence)

Example:	Full staff performance x 1	3
	Weight-bearing assistance x 2	
	Non-weight-bearing assistance x2	
Code:	Extensive assistance	

Coding G0110(1)

98

- Coding scale 0 to 4 – Rule of 3 (continued)
 - When an activity occurs at least 3 times and occurs at multiple levels but not three times at any one level:
 - When there is a combination of full staff performance/weight-bearing assistance and non-weight-bearing assistance 3 or more times, code 2, Limited Assistance

Example:	Full staff performance x 1	3
	Weight-bearing assistance x 1	
	Non-weight-bearing assistance x 1	
Code:	Limited assistance	

Coding G0110(1)

99

- Coding scale 0 to 4 – Rule of 3s (continued)
 - When an activity occurs at least 3 times and occurs at multiple levels but not three times at any one level:
 - When the staff performs a part of a component of the activity for the resident 3 or more times as the highest level of assistance, code Limited assistance

Example:	Resident completes all of her dressing tasks each day but is unable to button her blouse because of arthritis in her fingers. Staff buttons the blouse for her.
Code:	Limited assistance

Coding G0110(1)

100

- Use the MDS 3.0 ADL Decision Flow Sheet from CMS (see handout)
 - Provides step-by-step guide to get to the right answer
 - Always start at the top of the flow chart
 - If you get to the bottom and none of the codes apply, the correct code is 1, Supervision

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Coding G0110(1) Using the ADL Flow Diagram

101

Example: Non-weight-bearing x 2
Independent x 20

- Code: ???

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Examples

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- RAI User's Manual has excellent examples for review and staff training in the G0110 instructions.
- Code all of column 1 before starting on column 2 due to different coding rules

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Section G0110(2) ADL Support

103

- Records the type and highest level of support received in each ADL over last 7 days.
 - Based on input from all shifts, all disciplines
- Measures the highest level of support provided by staff, even if that level only occurred once.
- This is a **different scale**, and is entirely separate from ADL Self-Performance on column (A).

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G0110(2) ADL Support Coding

104

- 0 No setup or physical help from staff
- 1 Setup Help only
 - Resident provided with materials or devices necessary to perform activity of daily living independently (see examples next slide)
- 2 One Person Physical Assist
- 3 Two + Persons Physical Assist
- 8 Activity Did Not Occur During Entire 7 days
 - If "8" in column 1 then "8" in column 2

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Definition

105

- Set-up help – preparation for activity
- **Handing the resident the bar on a trapeze**
 - **Applying ½ rails and then providing no further help.**
 - **Giving the resident a transfer board or Locking the wheels on wheelchair for safe transfer**
 - **Retrieving clothes from closet and placing on bed**
 - **Handing resident a shirt**
 - **Cutting meat and opening containers to eat**
 - **Handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach**
 - **Placing bathing articles at tub side within resident reach; handing the resident a towel upon completion of bath**

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G0300: Balance During Transitions and Walking

106

- These mobility activities tend to be most hazardous for residents
- Staff should be trained to observe residents performing these activities during normal course of daily activities throughout the 7-day look-back period
 - Coding may be based on these observations or on a single observation

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G0300: Balance During Transitions and Walking

107

- Residents should be observed using assistive devices they would normally use for these activities
- Residents might spontaneously perform multiple activities at a time – each would be captured and coded
 - Example: Stand up from chair, walk to bathroom, turn around, sit down on toilet, rise when finished
- *RAI User's Manual* has suggested process for guiding resident through movements if formal evaluation is preferred

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G0300: Balance During Transitions and Walking

108

- Observe residents using assistive devices they would normally use for these activities
- Coding
 - 0. Steady at all times
 - 1. Unsteady at some point but able to stabilize without human assistance
 - 2. Unsteady at some point, only able to stabilize with human assistance
 - 8. Activity did not occur

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Bladder and Bowel




SECTION H

Intent

The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment and services to achieve or maintain as normal elimination function as possible.

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Section H: Bladder and Bowel



- Incontinence should be investigated to determine underlying causes and resident-specific plan for fostering continence should be developed, implemented, monitored, evaluated, and revised as necessary
- Coding focuses on objective presence of incontinence, catheter use, and programs and appliances

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H0200: Urinary Toileting Program



- Purpose
 - To determine if incontinent resident has attempted toileting program trial since admission or reentry
 - If resident was not incontinent on admission or reentry, to determine if toileting program trial was attempted since incontinence was first noted in facility

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H0200: Urinary Toileting Program

112

- Look-back to most recent of the following:
 - Admission/readmission assessment
 - Prior assessment
 - When incontinence was first noted in this facility

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H0200: Urinary Toileting Program

113

- Captures 3 aspects of toileting program or trial
 - Toileting trial
 - At least 3 days of observing toileting patterns with prompting to toilet and recording results in a bladder record or voiding diary
 - Code 0, No, is correct code for any resident who did not participate in a toileting trial for any reason, including that the resident was continent or had a catheter or urinary ostomy.
 - Response
 - Whether toileting program or trial is currently in place
 - Code 0, No: Toileting interventions in progress, but were used less than 4 of the 7 days. Also if no toileting interventions are being used
 - Code 1, Yes: Program implemented at least 4 days

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H0200: Urinary Toileting Program

114

- To be captured as toileting program or trial, must include specific approach that is organized, planned, documented, monitored, evaluated, consistent with facility's policies and current standards of practice
- Possible interventions
 - Prompted voiding
 - Individualized scheduled toileting program
 - Bladder retraining program

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H0200: Urinary Toileting Program

115

- Not acceptable as interventions
 - Changing incontinence pads or linens every two hours when wet
 - Toileting every two hours by facility policy
 - Assisting to toilet on as needed bases

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H0300: Urinary Continence

116

- Continence: Any void into a commode, urinal, or bedpan that occurs voluntarily or as the result of prompted toileting, assisted toileting, or scheduled toileting
- Coding options are based on number of incontinent episodes in 7-day look-back period
- Indwelling or condom catheter, urinary ostomy, or no urine output for the entire 7 days → Code 9, not rated

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H0400: Bowel Continence

117

- Code based on frequency of episodes of bowel incontinence due to any cause
 - Code 0 – No bowel incontinence
 - Code 1 – One incontinent episode regardless of amount or time of day
 - Code 2 – Incontinent more than once but had at least one continent BM
 - Code 3 – No continent BMs
 - Code 9 – Had ostomy or no BM entire 7 days

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HO500: Bowel Toileting Program

118

- Medical record indicates:
 - Implementation of individualized, resident-specific bowel toileting program based on assessment of resident's unique bowel pattern
 - Evidence program was communicated to staff and resident
 - Notations of resident's response and subsequent evaluations

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HO600: Bowel Patterns

119

- Constipation:
 - Two or fewer bowel movements or
 - For most bowel movements, stool is hard and difficult to pass, no matter what the frequency of bowel movements
- Fecal Impaction
 - Large mass of dry, hard stool, can develop in rectum *due to chronic constipation*. May be so hard that resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out

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Health Conditions

120

SECTION J

Intent

The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls.

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Section J: Health Conditions

121

- Pain is significant clinical issue with major impact on health and quality of life
- 5-day look-back period
- Resident interview is gold standard for pain assessment
- If resident screened out of interview, staff observation is completed

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JO100: Pain Management

122

- JO100A – on a *scheduled* pain medication
 - Pain med order defines dose and specific time interval for administration
 - Code 1, Yes, if even one dose of scheduled pain med was received
 - If scheduled pain med ordered but refused by resident, who therefore received no scheduled pain med, code 0, No.

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JO100: Pain Management

123

- JO100B – *PRN* pain medication received or offered
 - Pain med order specifies dose and indicates med may be given on as needed basis at specified time interval
 - If PRN pain med was received *or was offered and declined*, code 1, Yes

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Jo100: Pain Management

124

- Jo100C – non-medication pain management interventions received
 - Documentation must demonstrate that non-pharmacological interventions were:
 - Scheduled as part of care plan
 - Received by the resident
 - Assessed for effectiveness

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Jo200: Should Pain Assessment Interview be Conducted?

125

- Conduct interview if resident is understood at least some of the time verbally, with gestures, or in writing (✓Bo700)
- Interview is not attempted if Bo700, Makes Self Understood = 3, rarely/never understood
- Have interpreter available if needed
- Jo200=0, No, means resident is rarely or never understood
 - Skip interview and go to Jo800-Jo850, Staff Assessment for Pain

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Jo300-Jo600: Pain Assessment Interview

126

- Scripted questions
- Conduct interview near end of look-back
- If resident does not answer a question or gives nonsensical response, code 9 and go to next question
- Stop interview and go to Staff assessment if:
 - Resident is unable to answer Jo300, Pain Presence
 - Resident is unable to answer Jo400, Pain Frequency

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JO300-JO600: Pain Assessment Interview

127

- Proper preparation is essential
- Utilize interview techniques discussed earlier
- Explain what you're going to do

I'd like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain.

- Be sure resident understands what you mean by "pain," i.e., hurting, aching, burning, etc.

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JO300: Pain Presence

128

- Ask question as it appears on the form.
- This is about objective presence of pain: Did it occur or did it not?
 - If it did, JO300 = 1, Yes, regardless of pain management interventions, cause, or timing of the pain
 - If it did not, JO300 = 0, No, regardless of the reason, and skip to J1100

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JO400: Pain Frequency

129

- Ask question as it appears on the form.
- Answer options should be offered via visual aid as well as verbally
- Definitions are not provided for the time frequencies – resident's perception/definition is what matters
 - If resident unable to choose between two levels, code higher frequency

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Jo500: Pain Effect on Function

130

- Be careful not to extrapolate a precise answer from a general response, for example:
 - Resident responds, “That’s been a problem for me for years.” Might sound like a “yes,” but it doesn’t answer the question, “Over the past 5 days, has pain made it hard for you to sleep at night?”
 - You echo and clarify, “Pain has made it hard for you to sleep at night for years. Does that include the last five days?”

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Jo600: Pain Intensity

131

- Use either Numeric Rating Scale or Verbal Descriptor Scale; skip the one not used
- Review response options with resident
 - Offer visual aid displaying options for the scale you’re using

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Jo700: Should Staff Assessment for Pain be Conducted?

132

- Resident interview is complete if resident reported no pain (Jo300=No) or resident reported pain and also answered Jo400
- Complete Staff Assessment if:
 - Resident answered “Yes” to Jo300, Pain Presence, but did not answer Jo400, Pain Frequency
 - The Pain Assessment Interview was skipped altogether because Jo200 was coded 0, No, indicating resident is rarely/never understood

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Jo800: Indicators of Pain or Possible Pain

133

- 5-day look-back period
- Code based on observations of all staff who interact with or observe resident
- Medical record must support MDS coding
- Jo850 captures frequency

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J1700: Fall History on Admission

Complete on Admission assessments and first assessment since reentry

134

- What is a fall?
 - Unintentional change in position coming to rest on the ground, floor, or next lower surface (e.g., onto a bed, chair, or bedside mat)
 - May be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or ground
 - Falls include any fall, regardless of where it occurred

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J1700: Fall History on Admission

Complete on Admission assessments and first assessment since reentry

135

- What is a fall?
 - Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident or knocked down by a car or object)
 - Intercepted fall: The resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person
 - This is considered to be a fall

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J1800: Any Falls Since Admission or Prior Assessment (Most recent of OBRA, PPS, or Discharge)

136

- Documents any falls that occurred at any location since admission or most recent assessment, whichever is most recent
- If J1800=0, No: Skip to K0100

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J1900: Number of Falls

Since admission or prior assessment (OBRA or PPS), whichever is more recent

137

- Determine number of falls
- Code them according to the number that fall into each category according to severity of fall-related injury
 - Any documented injury that occurred as a direct result of, or was recognized within a short period of time (e.g., hours to a few days) after, the fall and attributed to the fall

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Swallowing/Nutritional Status

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SECTION K

Intent

The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. Nurse assessors should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

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K0300: Weight Loss

139

- Weight loss is based on change of 5% or more in last 30 days and 10% or more in last 180 days
- Compares two snapshots in time: Compare the weight in the current observation period to:
 - The weight taken in the 30-day period prior to the ARD
 - AND
 - The weight in the observation period 180 days prior to the ARD

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K0300: Weight Loss

140

- **5% weight loss in 30 days:** Weight from prior observation period X .95 (or 95%) = 5% loss. If current weight \leq the resulting figure, K0300 = Yes
- **10% weight loss in 180 days:** Weight from 180 days ago X .90 (or 90%) = 10% loss. If current weight \leq the resulting figure, then K0300 = Yes
- Weight loss may have occurred in between these two points in time and should have been managed at that time, but they are not coded on MDS

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K0300: Weight Loss

141

- Answer options
 - 0. No or unknown
 - 1. Yes, on physician-prescribed weight-loss regimen
 - 2. Yes, not on physician-prescribed weight-loss regimen

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K0300: Weight Loss

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- Physician-prescribed weight-loss regimen
 - Weight reduction plan ordered by physician
 - With care plan goal of weight reduction; weight loss is intentional
 - May employ calorie-restricted diet or other weight loss diets and exercise
 - Includes planned diuresis.

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K0500: Nutritional Approaches

143

- Check K0500A-D
 - If received in 7-day look-back regardless of where they were received
 - *Only* if chart reflects a nutrition or hydration need
- Include any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home or at a hospital as an outpatient or as an inpatient, provided they were administered for nutrition or hydration

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K0500: Nutritional Approaches

144

- K0500A, Parenteral/IV, interventions may be:
 - IV fluids, hyperalimentation, TPN
 - IV fluids running at KVO (Keep Vein Open)
 - IV fluids administered via heparin locks
 - Hypodermoclysis and subcutaneous ports in hydration therapy

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K0500: Nutritional Approaches

145

- K0500A - Do not include:
 - IV medications
 - IV fluids used to reconstitute and/or dilute medications for IV administration
 - Unless there is a documented need for additional fluid intake for nutrition and/or hydration

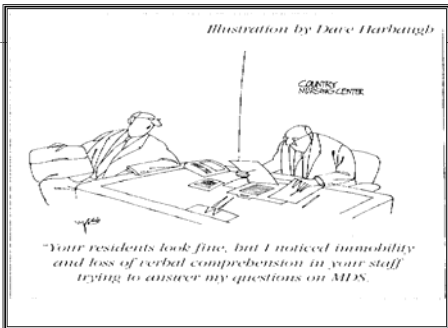
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K0500: Nutritional Approaches

146

- K0500A - Do not include:
 - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
 - IV fluids administered solely as flushes.
 - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
 - Additives to TPN or IV fluid, such as electrolytes, insulin

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Source: PPS Alert for Long-Term Care

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Resources

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CMS MDS 3.0 Information Site

www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

CMS SNF PPS Website

www.cms.hhs.gov/SNFPPS/01_overview.asp

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Thank You!!

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G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self-performance Coding Flow Diagram

