MDS version 2.0
Item by Item
Self Study Guide and
Quick Reference

REVISED
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QIPMO: University of Missouri Sinclair School of Nursing
MDS ITEM-BY-ITEM QUICK REFERENCE

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**Preface**

The attached quick reference tool for the MDS is the *revised draft* of an item-by-item guide to aid in consistent and accurate completion of the MDS forms utilized in Missouri.

This guide was originally developed in conjunction with the statewide committee formed at the request of the Department of Health and Senior Services in the spring of 1997. The goal was to “plan a statewide strategy to improve the accuracy and use of MDS data and provide direction for the development of MDS training and resource materials for providers of nursing home care.”

We have attempted to provide concise, specific direction to code each answer on the MDS. Directions cited come from several areas:

- References noted in the bottom left hand corner of each page and page references relate to Sections in “The Long-Term Care Resident Assessment Instrument User’s Manual for Version 2.0,” published by CMS (HFCA), December 2002.
- Other information regarding the MDS is available through the AHCA, AAHS, AHA or CMS Internet sites:  
- You will note additional guidance in italics within the content of the form (EX. *Focus is resident strength.*). These are not a part of the version 2.0 forms, but added guidance from the manual to assist you in completing the form accurately.
- An “R” has been added to the answer blocks of certain MDS items to remind you of the 108 MDS elements that affect the RUGS-III classifications.
- A “QI” symbol ♦ has been added to the answer blocks to remind you of the MDS Items that affect your MDS QI-QM reports.

Prior to using the guide, refer to the MDS coding conventions attached, from Section 3.2 of the December 2002 User’s Manual.

Always try to code for the “best response.”

We hope you find this information useful. The next page lists the committee members who have worked on this draft. Special thanks go to Margie Riddle of Delmar Gardens Enterprises for formatting this complicated document.

*Since the MDS/RAI will have periodic updates, you are urged to clarify and update instructions on an ongoing basis.*

For further information, you may contact your health care association or the Department of Health and Senior Services, through their web site. The final draft is available through the University of Missouri-Columbia, S438 Sinclair School of Nursing, Columbia, MO 65211, ATTN: Jessica Mueller, (573) 882-0241. Should you find an error or have a suggestion to improve this guide, please contact Jessica with your suggestions.
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* PLEASE NOTE that Health Care Financing Administration (HCFA) had a name change. The agency is now called CMS (Center for Medicare and Medicaid Services), but continues to use HCFA for older publications and websites

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Resident Assessment Instrument Self Study
and Case Study for MDS Training

and

MDS Version 2.0 Item-by-Item
Self Study Guide and Quick Reference

Acknowledgments

These tools were developed by members of the Statewide Committee to improve the reliability of MDS information for Missouri Nursing Homes.

The Committee was formed at the request of the Department of Health and Senior Services (formally the Division of Aging) by the University of Missouri Sinclair School of Nursing. A group of volunteer providers came together to develop a statewide educational strategy and teaching materials to improve the usefulness of the MDS and the quality of the information that can be derived from MDS data. The Resident Assessment Instrument Self Study and Case Study for MDS Training and the MDS version 2.0 Item-by-Item Self Study Guide and Quick Reference are now available for use in the state.

The Committee wants to acknowledge the leadership and hours of work of the following people who wrote and edited these materials:

The Resident Assessment Instrument Self Study and Case Study for MDS Training
- Lori Popejoy, MSN, RN
- De Minner, BSN, RN, BC
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As Facilitator of the Committee, I want to thank all members for their hours in meeting and hours working on materials to help the Committee meet its mission. You are truly dedicated to improving the care and services to residents in Missouri nursing homes.

- Marilyn Rantz, PhD, RN, FAAN
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DEFINITIONS

Resident Assessment Instrument (RAI) Assessment
A structured approach for applying a problem identification process in Long Term Care. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional status, strengths, weaknesses, and preferences and offers guidance on further assessment once problems or needs have been identified. The RAI consists of 3 basic components: the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and the Utilization Guidelines. Each component flows naturally into the next, leading to care plan development, implementation and evaluation. This is how the process looks as a pathway.

Minimum Data Set
A core set, of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

Resident Assessment Protocols (RAP’s)
The RAP’s are structured, problem-orientated frameworks for organizing MDA information, and examining additional clinically relevant information about an individual. RAP’s help identify social, medical and psychological problems and form the basis for individualized care planning. The 18 RAP’s are explained in detail in Appendix C (C-5 to C-104).

Triggers
Triggers are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation.

Trigger Legend
The Trigger legend summarizes all of the triggers for the 18 RAP’s. It is not a required form that must be maintained in the resident’s clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAP’s are triggered from a completed MDS assessment.

RAP’s Analysis
The RAP’s analysis is performed in accordance with the Utilization Guidelines. The in-depth review assists the staff members to draw a conclusion to proceed or not to proceed to the plan of care. (See Chapter 4, page 4-1 – 4-24)
RAP Summary Sheet
The RAP Summary Sheet documents the decisions made during this evaluation process on whether or not to proceed to care planning. Information from Section V of the MDS is documented on the RAP Summary Form which:

- Identifies the location of information derived from RAP’s about the residents status in the triggered area. As appropriate for the resident, information may include the nature of problems. Complications and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems.
- Provides a means for collecting data on triggered RAPs and documenting care plan decisions
- Provides a method for staff to certify the accuracy and completeness of the RAP assessment (i.e., signature and date).

Utilization Guidelines
Instructions concerning when and how to use the RAI, also known as the RAI Manual. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information.

Common Definitions
Standardized instructions (Found in Chapter 3 for how to interpret each element specified in the MDS.

MDS Coding Conventions/Coding Categories
Levels of measurements for each element included in and used when preparing the MDS form.

Quarterly Review
Each state’s includes, at a minimum, CMS’s required Quarterly assessment items. Not all MDS items appear on the Quarterly assessment form. In Missouri the form is the 1997 RUGs-III Quarterly Assessment Form. The quarterly assessment is used to track the resident’s status between comprehensive assessments, and to ensure monitoring of crucial indicators of the gradual onset of significant changes in resident assessments. The timing of these assessments are to be no less frequently than once every three months (92 days) to assure the continued accuracy of care planning.

Discharge Tracking
Includes Section Aa (Identification Information), a subset of codes from Item 8 (Reason for Assessment) and Item 9 (Signatures). The form also includes Section R related to discharge status and date, along with two items from Section AB, that are required only for individuals whose stay is less than 14 days. This form is completed whenever a resident is discharged from the facility for any reason other than a temporary visit, another type of therapeutic or social leave, or observational stays of less than 24 hours when the resident is not admitted to the hospital. This is the only form required at the time of discharge, when the resident physically leaves the facility.
Re-entry Tracking Form
Includes Section Aa (Identification Information), a subset of codes from Item 8 (Reason for Assessment) and Item 9 (Signatures). The reentry tracking form contains items from Section A related to the date and point of reentry. This form is completed whenever a resident re-enters the nursing home following temporary admission to a hospital or other health care setting, even if the resident’s clinical record was not formally closed, or the resident discharged from the facility. This form must be competed for residents “re-entering” the facility in order to re-enter the resident into the database.

Correction Request Form
Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS discharge or Re-entry Tracking from record that has been previously accepted in the State MDS Database; (2) to identify the inaccurate record; and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

PPS – Prospective Payment System
A daily (per-diem) payment rate paid to skilled nursing facilities that is applicable to all covered skilled nursing and therapy services. The payment is deemed by the patient’s care needs derived from MDS assessment items and definitions.

Resource Utilization Groups (RUGs) Patient Classification System
The Resource Utilization Groups (RUG-III) case-mix classification system was developed to capture resource use of nursing home patients and to provide an improved method of tracking the quality of care.

RUG-III is a 53-group model for classifying nursing home patients into homogeneous groups according to the amount and type of resources they use. The RUG-III groups are the basis for the payment indices used to establish equitable prospective payments levels for patients with different services use. Information regarding a patient’s characteristics and care needs is derived from the MDS, a set of core screening and assessment items and item definitions.

Medicare Prospective Payment System Assessment Form (MPAF)
A SNF PPS assessment that is a shorter version of the MDS that may be used by skilled nursing facilities in the place of a full MDS for Medicare Assessments – the MPAF consists of a subset of the MDS items including items for resident identification, items necessary to complete the Resource Utilization Group (RUG-III) calculation, and the items needed to calculate the Quality Indicators and Quality Measures. The MPAF optional cannot be used when OBRA assessments are due.

Encoding Process
After completing the clinical assessment process, the facility has the next 7 days to encode (enter) all MDS responses in a computerized file and verify that all responses in the computer file match the responses on the paper form.
Editing Process
The facility is responsible for running encoded MDS data against CMS and State specific edits (software check system). Each MDS response must be within the required range and consistent with other item responses. An assessment is considered complete only if 100% of required edits are passed.

Locking Process
After passing the CMS edits and the record is accepted into the state database, a record is then “locked.” Individual MDS records must not contain any “fatal” information for the record to be accepted in the state database. At this point, the record cannot be changed by the facility. A facility must, at least on a monthly basis, electronically transmit to the State MDS database encoded, accurate and complete MDS assessments conducted during the previous months. It is recommended that facilities transmit at least every 2 weeks or more if a large volume of MDS’s is completed.

Validation Reports
Once data is received at the state agency, the MDS system will validate the file structure and data content. These validations are based on the MDS 2.0 record specification. The system generates two reports: an Initial Feedback Report and the Final Validation Report. Both reports are formatted as text files with column specifications so that they may be easily read, printed, or downloaded.

Initial Feedback Reports
Indicates that the MDS system has performed a basic validation check on your file and whether your submissions has been accepted or rejected. If rejected, the Initial Feedback Report includes the rejection error. The Initial Feedback Report should be received shortly after submitting the file while you remain online.
- the number of Records Processed will indicate the number of records per file that have been processed
- The number of Records Rejected, the number of Duplicate Records, the number of 0_00 Records, the number of Records with Errors, and the total Number of Errors are not displayed on the Initial Feedback Report. Once the entire file has been validated, these lines and the Report Detail will be completed in the Final Validation Report.
- It is not necessary to retain this report.

Final Validation Reports
Will be generated within 24 hours of submission of the file. The report is created after the MDS System performs data validation, timing checks, sequence checks, and calculated element validations. The timing and sequence of the MDS records are verified against customized State schedules. You will not receive a Final Validation Report if your Initial Feedback Report indicated that your batch has been rejected.
- Retain this report. The department of Health and Senior Services recommends 15 months retention consistent with retention of active MDS’ in the medical record.
**MDS QI/QM’s**

MDS QI/QM’s are derived from the Minimum Data Set are markers that may indicate the presence or absence of potentially poor care practices in nursing home care. The MDS QI/QM’s are not absolute markers of care problems or poor quality; rather they indicate a need for further review of clinical care in the facility.

The new MDS QI/QM reports are similar to the MDS QI reports from the CHRSA system with a few variances. The new reports contain quality measures in addition to the quality indicators. The QM’s are identical to those contained in the Nursing Home Compare public reporting system. The same QI’s that are not duplicated by QM’s are present in the report.

The reports can be retrieved through the CASPER system via the internet on the same site as MDS transmission. These reports are facility-specific and can be compared to state and national averages. The RUGs-III Quarterly QIs are generated into a report known as the Department of Health and Senior Services/University of Missouri Show-Me Reports and provides facility specific information longitudinally over 15 months (or 5 quarters). The Show-Me Reports provide facility specific data that is graphed according to expert-set thresholds and is most useful for quality improvement efforts at the facility level. At this time, the Show-Me Reports are exclusive to Missouri nursing homes.

**Quality Measures**

Quality Measures (QM’s) are derived from the Minimum Data Set by the Centers for Medicare and Medicaid Services (CMS) Nursing Home Quality Initiative (NHQI). The measures are currently related to specific clinical areas of care. The Quality Measures are intended to provide a set of objective measures by which an individual may determine how well the nursing home is managing various aspects of care being provided to their residents. The public may view these reports at [www.medicare.gov/nhcompare/home.asp](http://www.medicare.gov/nhcompare/home.asp).

**DAVE (Data Assessment and Verification Program)**

The objective of the DAVE program is to assess the accuracy and reliability of assessment data submitted by nursing homes. The review process is done as an off site review process using facility submitted medical records or by an on-site review. The information obtained is reported as nation wide trends. A national rollout began in January 2004 with the original DAVE program. In the Spring of 2006, DAVE 2 began.
STANDARD FORMAT FOR MDS ITEMS

To facilitate completion of Version 2.0 of the MDS assessment and to ensure consistent interpretation of items, this section presents the following types of information for many (but not all) items:

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

**Definition:** Explanation of key terms.

**Process:** Sources of information and methods for determining the correct response for an item. Sources include:
- Discussion with facility staff – licensed and non-licensed staff members.
- Resident interview observation.
- Clinical records, facility records, transmittal records (at admission) – physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g. vital signs, weights, intake and output), care plans, and any similar documents in the facility record system.
- Discussion with the resident’s family.
- Attending physician.

**Coding:** Proper method of recording each response, with explanations of individual response categories.

**Clarifications:** ♦ Clarifications for MDS items provided by CMS. These clarifications apply to the MDS.
MDS CODING CONVENTIONS

The coding conventions to be used when preparing the MDS are as follows:

- Use a check mark for white boxes with lower case letters in the box or before the item description, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences – boxes a. – m.)

- Use a numeric response (a number or preassigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)

- Darkly shaded areas remain blank; they are on the form to set off boxes visually.

**The convention of entering “0”:** In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero (“0”) is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a resident whose ADL codes are almost all coded “0” is a self-sufficient resident; the resident whose ADLs have no “0” codes indicates a resident that receives help from others.

- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.

- **Dates:** Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2003 is recorded as:

  - Month: 01
  - Day: 03
  - Year: 2003

- **The standard no-information code is a “dash” (-).** This code indicates that all available sources of information have been exhausted; that is the information is *not available,* and despite exhaustive probing, it remains unavailable.

- **NONE OF THE ABOVE** is a response item to several items (e.g., MDS Item I2, Infections, box m.) *Check this item where none of the responses apply; it should not be used to signify lack of information about the item. If “none of the above” is not present and none of the items apply (i.e., H2 Bowel Elimination on MPAF), simply leave all the boxes blank.

- **“Skip” Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items.** The instructions direct the assessor to “skip” over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to “skip” to Section G. if B1 is answered “1” – “Yes.” **The intervening items from B2 - F3 would not be coded.** If B1 was recorded as “0” – “No,” then the assessor would continue with item B2.)

A useful technique for visually checking the proper use of the “skip” pattern instructions is to circle the “skip” instructions before going to the next appropriate item.
• **The “8” code is for use in MDS Section G., Physical Functioning and Structural Problems only.** The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident’s performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period of observation. When the “8” code is entered for self-performance, it should also be entered for support.

• **Coding for Section J:** Disease Diagnosis Specific instructions for entering ICD-9-CM codes apply to this section. See coding instructions in Chapter 3. Section I (pages 3-127 to 3-137.) Coders in Long Term Care should also refer to the most recent volumes of ICD-9-CM codes for guidance in assigning and reporting code numbers.
### Medicaid and Medicare MDS Completion

<table>
<thead>
<tr>
<th>Medicaid Certified Beds</th>
<th>Medicaid and Medicare Dual Certified Beds</th>
<th>Medicare Certified Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete, record, encode and transmit a MDS for every resident in a MEDICAID CERTIFIED bed.</td>
<td>Complete, record, encode and transmit a MDS for every resident in a MEDICAID/MEDICARE DUAL CERTIFIED bed.</td>
<td>Complete, record, encode and transmit a MDS for every resident in a MEDICARE CERTIFIED bed.</td>
</tr>
<tr>
<td>If the resident’s care is being paid for by Medicaid: Follow -------- MDS REGULATORY completion schedule.</td>
<td>If the resident’s care is being paid for by Medicaid: Follow -------- MDS REGULATORY completion schedule.</td>
<td>If the resident’s care is being paid for by Medicare Part A: Follow -------- MEDICARE MDS/PPS completion schedule.</td>
</tr>
<tr>
<td>If the resident’s care is being paid for by another payor source: Follow-------- MDS REGULATORY completion schedule</td>
<td>If the resident’s care is being paid for by Medicare Part A: Follow -------- MEDICARE MDS/PPS completion schedule.</td>
<td>If the resident’s care is being paid for by another payor source: Follow -------- MDS REGULATORY completion schedule.</td>
</tr>
<tr>
<td></td>
<td>If the resident’s care is being paid for by another payor source: Follow -------- MDS REGULAROTY completion schedule.</td>
<td></td>
</tr>
</tbody>
</table>

Provided by:
Sharon McGauly
Quality Improvement Consultations
# MDS Regulatory and Medicare/PPS Assessments

<table>
<thead>
<tr>
<th>MDS OBRA Assessments</th>
<th>MDS Medicare/PPS Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Type</strong></td>
<td><strong>Assessment Type</strong></td>
</tr>
<tr>
<td>• Admission (Initial) Assessment (Comprehensive)</td>
<td>• 5 Day Assessment (Comprehensive or Full)</td>
</tr>
<tr>
<td>• Annual Reassessment (Comprehensive)</td>
<td>• 14 Day Assessment (Comprehensive if not completed on the 5 day or Full)</td>
</tr>
<tr>
<td>• Significant Change in Status Reassessment (Comprehensive)</td>
<td>• 30 Day Assessment (Full)</td>
</tr>
<tr>
<td>• Quarterly Assessment (Three Page)</td>
<td>• 60 Day Assessment (Full)</td>
</tr>
<tr>
<td>• Significant Correction of a Prior Full Assessment</td>
<td>• 90 Day Assessment (Full)</td>
</tr>
<tr>
<td>• Significant Correction of a Prior Quarterly Assessment</td>
<td>• Readmission/Return Assessment (Full)</td>
</tr>
<tr>
<td>• Discharge Tracking Assessment</td>
<td>• Other Medicare Required Assessment (OMRA) (Full)</td>
</tr>
<tr>
<td>• Re-entry Tracking Assessment</td>
<td></td>
</tr>
<tr>
<td>NURSING FACILITIES PRIVACY ACT STATEMENT – HEALTH CARE RECORDS</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

**THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.**

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY.** Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act. Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits the information to CMS. Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED** The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. **ROUTINE USES** The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose. The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION** The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

Revised--December 2002
SECTION AA. IDENTIFICATION INFORMATION

This form must be submitted with every Full Assessment (admission, annual, significant change, and significant correction of prior full assessment) and Quarterly Assessment as well as assessments required for Medicare PPS. This form provides key information necessary to identify residents in a computerized environment. The discharge and re-entry tracking forms have been developed to contain the same items, therefore Section AA Is not required to be submitted with either the discharge or re-entry tracking forms.

1. If the resident has no middle initial, leave 1b blank (pg. 3-6)

4. If the resident is unable to respond and no family member is available, or if the resident does not appear to fit into any of the categories, the assessor should assign the category they feel is most appropriate (pg. 3-6)

5. a.b. In rare instances, there will not be a Medicare or Social Security Number. When this occurs, another type of basic identification number (i.e., railroad retirement insurance number) may be substituted. Enter the number itself, one digit per box beginning with the left most box. A Medicare number always starts with a number and the first 9 characters must be digits (0-9) (pg. 3-6).

6. a. This number always starts with a 10 and is 9 digits long in Missouri. Some Medicare only facilities will not have a state number. If none, leave blank. (pg. 3-8)

6. b. The Federal number always starts with 26 and is 6 digits long in Missouri. There must always be a federal provider number (pg. 3-8)

7. A + is entered if the resident has applied for Medicaid but has not received a number yet. Enter a N if resident does not have Medicaid. An N/A or blank is not an accepted response.

8. a. Please note section A.8 on the Full Assessment requires the same responses.

8. b. Special codes for use with Medicare patients. It is possible to select a code from both 8a & 8b.

(a complete review of 8. Reasons for assessment is found on pages 3-9, 10)

REFERENCE: Chapter 3, Section AA
9. Formal attestation statement and signature lines for individual staff completing any portion of the RAI to sign and certify the accuracy of the portion(s) they completed.

Item AA9 is used to record signatures, titles and dates of completion, as well as accuracy, for all parts of MDS assessments and tracking forms from Sections AA and A through W. All persons completing part of this assessment must sign their names in the appropriate locations at item AA9. To the right of the name, enter title and the letters that correspond to the sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. (pg. 1-25, 26) (pg. 3-11)

NOTE: The label of MDS Item AA9 was revised, and formal attestation language has been added above the signature lines. The identical change was made to Item AA9 as it appears on all tracking forms (The Basic Assessment Tracking form, the Discharge Tracking form, the Reentry Tracking form, and MPAF). Item AA9 will be used to record signatures and dates of completion, as well as attestation of accuracy, for all parts of MDS full assessments, quarterly assessments, tracking forms, and MPAF, from section AA and A through V. Signatures should be included at Item AA9 for these sections of the MDS, including sections T, U, V, and W.
SECTION AB. DEMOGRAPHIC INFORMATION/FACE SHEET (Sections AB, AC, and AD)

This form is completed one time only except whenever additional information not originally known to the facility becomes available OR resident is readmitted after permanent discharge. If changes are made to the face sheet data, it is to be updated and transmitted with the next assessment. (pg. 3-12)

1. Enter the date when the person first becomes a resident in your facility. Use all boxes for date, i.e., 01-05-1998. The admission date does not change until the resident is discharged - return not anticipated (pg. 3-12, 13)

2. This area helpful in care planning: Signal issues, i.e., delirium (from acute stay), grief (loss of home), or need for home health resources related to relocation status and may suggest others to contact for additional information. Code 3 if admitted from a licensed Residential Care facility in Missouri. Code 4 Nursing Home also includes admissions from hospital swing beds. Refer to pgs. 3-14 and 3-15 for guidance to code “in other facility.”

5. Check if the resident did not have a primary residence to return to while living in those settings. (pg. 3-17)

6. Establishes familiarity in how to address resident (i.e., Doctor) or for care planning purposes. If resident is under 18 or never employed, code NONE.

8. Code what resident currently speaks and understands.

9. Document a primary or secondary diagnosis of psychiatric illness or MR/DD that results in functional limitations in life activities (do not include dementia). See definition, next page, for guidance.

10. For any item 10b - 10f to be checked, condition must be documented in medical record. See definition, next page, for guidance.

11. Should reflect the date that form is completed or amended.

This form remains in the chart throughout the course of stay

REFERENCE: Chapter 3, Section AB

---

### SECTION AB. DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DATE OF ENTRY</td>
<td>Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date</td>
</tr>
<tr>
<td>2. ADMITTED FROM</td>
<td>1. Private home/apt. with no home health services</td>
</tr>
<tr>
<td>AT ENTRY</td>
<td>2. Private home/apt. with home health services</td>
</tr>
<tr>
<td></td>
<td>3. Board and care/assisted living/group home</td>
</tr>
<tr>
<td></td>
<td>4. Nursing home</td>
</tr>
<tr>
<td></td>
<td>5. Acute care hospital</td>
</tr>
<tr>
<td></td>
<td>6. Psychiatric hospital, MR/DD facility</td>
</tr>
<tr>
<td></td>
<td>7. Rehabilitation hospital</td>
</tr>
<tr>
<td></td>
<td>8. Other</td>
</tr>
<tr>
<td>3. LIVED ALONE</td>
<td>0. No</td>
</tr>
<tr>
<td>PRIOR TO ENTRY</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. In other facility</td>
</tr>
<tr>
<td>4. ZIP CODE OF PRIOR PRIMARY RESIDENCE</td>
<td>Prior to any nursing home stay.</td>
</tr>
<tr>
<td>5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY</td>
<td>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 Above)</td>
</tr>
<tr>
<td></td>
<td>Prior stay in nursing home</td>
</tr>
<tr>
<td></td>
<td>Stay in other nursing home</td>
</tr>
<tr>
<td></td>
<td>Other residential facility-board and care home, assisted living, group home</td>
</tr>
<tr>
<td></td>
<td>MH/psychiatric setting</td>
</tr>
<tr>
<td></td>
<td>MR/DD setting</td>
</tr>
<tr>
<td></td>
<td>NONE OF ABOVE</td>
</tr>
<tr>
<td>6. LIFETIME OCCUPATION(S)</td>
<td>(Put 1/2 between two occupations)</td>
</tr>
<tr>
<td></td>
<td>1. No schooling</td>
</tr>
<tr>
<td></td>
<td>2. 8th grade/less</td>
</tr>
<tr>
<td></td>
<td>3. 9-11 grades</td>
</tr>
<tr>
<td></td>
<td>4. High school</td>
</tr>
<tr>
<td></td>
<td>5. Technical or trade school</td>
</tr>
<tr>
<td></td>
<td>6. Some college</td>
</tr>
<tr>
<td></td>
<td>7. Bachelor's degree</td>
</tr>
<tr>
<td></td>
<td>8. Graduate degree</td>
</tr>
<tr>
<td>7. EDUCATION</td>
<td>(Code for correct response)</td>
</tr>
<tr>
<td>Highest Level Completed</td>
<td>a. Primary Language</td>
</tr>
<tr>
<td></td>
<td>0. English</td>
</tr>
<tr>
<td></td>
<td>1. Spanish</td>
</tr>
<tr>
<td></td>
<td>2. French</td>
</tr>
<tr>
<td></td>
<td>3. Other</td>
</tr>
<tr>
<td></td>
<td>b. If other, specify</td>
</tr>
<tr>
<td>8. LANGUAGE</td>
<td></td>
</tr>
<tr>
<td>9. MENTAL HEALTH HISTORY</td>
<td>Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td>10. CONDITIONS RELATED TO MR/DD STATUS</td>
<td>Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)</td>
</tr>
<tr>
<td>(may code more than one)</td>
<td>Not applicable - no MR/DD (Skip to AB11)</td>
</tr>
<tr>
<td></td>
<td>MR/DD with organic condition</td>
</tr>
<tr>
<td></td>
<td>a. Down’s syndrome</td>
</tr>
<tr>
<td></td>
<td>b. Autism</td>
</tr>
<tr>
<td></td>
<td>c. Epilepsy</td>
</tr>
<tr>
<td></td>
<td>d. Other organic condition</td>
</tr>
<tr>
<td></td>
<td>e. MR/DD with no organic condition</td>
</tr>
<tr>
<td></td>
<td>f.</td>
</tr>
<tr>
<td>11. DATE BACKGROUND INFORMATION COMPLETED</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Month</td>
</tr>
<tr>
<td></td>
<td>Day</td>
</tr>
<tr>
<td></td>
<td>Year</td>
</tr>
</tbody>
</table>

Note: If information is updated, must complete all items. Exception is the requirement to complete AB5 a-f with the MPAF form (pg. 3-21).
SECTION AB. DEMOGRAPHIC INFORMATION - Definitions

9. Mental Health History

To document a primary or secondary diagnosis of psychiatric illness or developmental disability, resident has one of the following:
- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- Not a primary diagnosis of dementia, including Alzheimer’s disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual’s developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Review the resident’s record only. For a “Yes” response to be entered, there must be written documentation (i.e. verbal reports from the resident or resident’s family are not sufficient).

10. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities)

To document conditions associated with mental retardation or developmental disabilities.

For item 10e, “Other organic condition related to MR/DD” - examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrencephaly, meningomyelocele, congenital hydrocephalus, etc.

Review the resident’s record only. For any item (10b through 10f) to be checked, the condition must be documented in the clinical record.

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

- If an MR/DD condition is not present, check item 10a (“Not Applicable - No MR/DD”) and skip to item AB-11.

- If an MR/DD condition is present, check each condition that applies.

- If an MR/DD condition is present but the resident does not have any of the specific conditions listed, check item 10f (“MR/DD with No Organic Condition”)
SECTION AC. CUSTOMARY ROUTINE

This is one of the most important sections of the MDS in relation to accommodation of needs and is used to individualize care plans. It gives clues to resident’s functional level prior to any nursing home admission.

* Check actual routines and usual lifestyle in community rather than their future preferences and goals (this differs from MDS SECTION F Psychosocial, i.e. F3c “Resident perceives that daily routine is very different”)

This is a good opportunity to begin to build relationships through interview. For interview tips, refer to User’s Manual Chapter 3, Section AC (pg. 3-24 - 25) and appendix D. (Guidelines for Interviewing Resident)

If an individual item in a particular category is not known, code NA.

Check None of the Above (h, l, r, and x) only if no items are marked in each section.

y. Check here only if information is unavailable for all items in entire section (all other boxes in Section AC must be blank to code here). For assistance, review definitions Chapter 3, Customary Routine, Section AC (pg. 3-22 - 27).

REFERENCE: Chapter 3, Sections AC
SECTION AD. FACE SHEET SIGNATURES

The RN Assessment Coordinator must enter his or her signature on the date it is completed.

Must enter signature, title, sections they completed, and date on the day this MDS face sheet is complete. (pg. 3-27, 28)

Only sign if you completed any part of Section AB or AC, include your title and sections completed.

The FACE SHEET must remain in active chart throughout resident=s entire stay.

This verbage is the same as Item AA9 - formal attestation statement and signature line as found on the Basic Assessment Tracking Form.

If, for some technical reason, such as computer or printer breakdown, the Background (face sheet) Information at Admission cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record. (pg 3-27)

REFERENCE: Chapter 3, Section AD
SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

The full assessment form contains Sections A through W. The full assessment must be completed on admission, annually, with significant change and significant correction of prior full assessment. Section T is required for residents whose stay is covered by Medicare or any time a full assessment is required. MDS’s completed for Medicare reimbursement (PPS) only may be submitted as either a full MDS assessment or the short MPAF.

3. a. This is a critical concept and often misunderstood. The ARD is the common date on which the MDS observation period ends. (Refers to the end or last of observations for the MDS items. It also is referred to as the end of the look back period. Refer to Chapter 3, Section A.3 and your facility policy). This establishes the common observation period for all members of the interdisciplinary team.

   Anything that happens after the ARD will not be captured on that MDS. Refer to pgs. 3-29 to 3-31.

3. b. Enter a (00) in this item. See Chapter 5 for information on the correction process.

4. a. If not hospitalized within the last 90 days, leave blank.

7. Check with business office for all payment sources that cover the daily per diem or ancillary services for the resident’s stay in the nursing facility over the last 30 days. Don’t rely on medical records alone to complete this section as the resident’s clinical condition may trigger different sources of payment over time. Refer to pg. 3-33, 34 for guidance.

7. a. Check this item if Medicaid is pending.

NOTE: The day of admission is counted as day one when calculating the Resident Assessment Instrument (RAI) due date.

REFERENCE: Chapter 3, Section A
8.

1. An initial comprehensive assessment including RAPs, completed within 14 days of a patient’s admission. In some instances, the same assessment that is completed and electronically transmitted to meet PPS requirements, may also be used to meet the OBRA clinical requirements. The facility may use either the Medicare 5 day or the Medicare 14 day assessment (whichever one included the RAPs) to meet both the requirements for PPS, and the clinical requirement for completing and transmitting an Initial Admission assessment. The OBRA clinical requirements for MDS completion do not provide a grace period for completion of the Initial Admission assessment to correspond with the grace period that the PPS rules allow for the Medicare 14 day assessment.

PLEASE NOTE that the code for Initial Admission assessment is also used when an individual returns to the facility subsequent to a prior discharge where return was not anticipated.

2. A comprehensive reassessment required within 12 months (366 days) of the most recent full assessment. If a resident has a significant change in status at the time of the annual, code 8a=3. DO NOT code as an Annual assessment. The MDS schedule “restarts” and the next comprehensive assessment would be due within 366 days of the significant change assessment.

3. A comprehensive reassessment prompted by a “major change” that is not self-limited, that impacts on more than one area of the resident’s clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. (refer to Chapter 2, pgs. 2-7 to 2-13).

PLEASE NOTE: For instances in which the resident continues to make steady progress under the current course of care, reassessment is only required when the condition has stabilized. With a terminal condition, a full reassessment is optional. Refer to the next page for additional comments.

REFERENCE: Chapter 3, Section A

<table>
<thead>
<tr>
<th>Reason for Assessment</th>
<th>Reason for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admission assessment (required by day 14)</td>
<td></td>
</tr>
<tr>
<td>2. Annual assessment</td>
<td></td>
</tr>
<tr>
<td>3. Significant change in status assessment</td>
<td></td>
</tr>
<tr>
<td>4. Significant correction of prior full assessment</td>
<td></td>
</tr>
<tr>
<td>5. Quarterly review assessment</td>
<td></td>
</tr>
<tr>
<td>6. Discharged — return not anticipated</td>
<td></td>
</tr>
<tr>
<td>7. Discharged — return anticipated</td>
<td></td>
</tr>
<tr>
<td>8. Discharge prior to completing initial assessment</td>
<td></td>
</tr>
<tr>
<td>9. Reentry</td>
<td></td>
</tr>
<tr>
<td>10. Significant correction of prior quarterly assessment</td>
<td></td>
</tr>
</tbody>
</table>

4. A comprehensive assessment completed at the facility’s prerogative, because the previous assessment was inaccurate or completely incorrect. This differs from a significant change in status assessment, in which there has been an actual change in the resident’s health status (refer to pgs. 2-13 to 2-14).

5. The subset of MDS items required by the State, which must be completed no less frequently than once every 3 months (92 days) (i.e., between required full assessments). Ensures that changes in the resident’s status are noted, and incorporated into the care plan, so that it remains current and appropriate in meeting the needs of the resident. If a significant change in status is noted at the time of a resident’s quarterly review assessment, replace with a significant change in status assessment. Use code 8a=3. Do not code as a Quarterly review assessment. The requirements for PPS specify that a Medicare 90 day assessment must be completed for each patient whose stay is still covered under Medicare. To minimize burden on facility staff, the full assessment that is completed at day 90 of a Medicare Part A stay to meet PPS requirements, may also be used to meet the clinical requirements for completion of a Quarterly Review Assessment, as long as it is completed no later than 92 days after completion of the prior assessment. In this case, the Reason for Assessment would be coded both as a Quarterly Review Assessment (8a=5), and as a Medicare 90 day assessment (8b=4).

6. and 7. These are not codes used on this form; they are used on the “Discharge Tracking Form” only.

8. Use this code when a resident is discharged during the first 14 days of residency AND an admission assessment has not been completed. A subset of information contained on the Discharge Tracking Form must be completed for all individuals admitted to the facility regardless of length of stay. This form must also be completed following a resident’s transfer to another facility, or death.

9. This is not a code used on this form; it is used on the Re-entry Tracking Form only.

10. A quarterly review assessment completed at the facility’s prerogative, because the previous quarterly review assessment was inaccurate or completely incorrect.

0. Use this code when none of the codes in 8a apply, but the facility is required to complete an assessment for Medicare PPS or by the State. If 0 is checked at 8a, a code must be selected at 8b.

Be consistent. Responses here must be the same as in Section AA.8.a. It is possible to select a code from both 8a & 8b.
Additional Comments on Significant Change Assessment

Facilities have an ongoing responsibility to assess the resident’s status and intervene to assist the resident to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. Staff have the responsibility of deciding whether a change they have noted (either an improvement or decline) is significant.

A “significant change” is defined as a major change in the resident’s status that:
- Is not self-limiting;
- Impacts on more than one area of the resident’s health status; and
- Requires interdisciplinary review and/or revision of the care plan.

The following indicate conditions under which a significant change reassessment is required. The terms referenced are based on items (and definitions) found in Version 2.0 of the MDS. Other situations can apply; this list is not exhaustive, and other situations may also meet significant change definition. [Note C in an end stage disease status, a full reassessment is optional, depending on a clinical determination of whether or not the resident would benefit from the reassessment.]

A significant change may occur at any point during the resident’s stay, although facilities may most commonly identify that a significant change has occurred while constructing the resident’s scheduled quarterly review. Over a six-month period, depending on the resident population, one in five residents typically decline in two or more of these areas. The goal of the significant change reassessment is to ensure that residents are being appropriately monitored and necessary changes in care instituted. Also see discussion in Chapter 2.

### SIGNIFICANT CHANGE CRITERIA*

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
</tr>
</thead>
</table>
| **DECLINE** | Any decline in ADL physical functioning where a resident is newly coded as 3, 4, or 8 (Extensive assistance; Total dependency; Activity did not occur.) (Item G1a)  
- Increase in number of areas where Behavioral symptoms are coded as not easily altered (increase in number of code 1’s for E4B)  
- Resident’s decision making changes from 0 or 1 to 2 or 3. (Item B4)  
- Resident’s incontinence pattern changes from 0 or 1 to 2, 3, or 4 (Item H1a or b), or placement of an indwelling catheter. (Item H3d)  
- Emergence of sad or anxious mood as a problem that is not easily altered. (Item E2)  
- Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days.) (Item K3a)  
- Begin to use a trunk restraint or a chair that prevents rising for a resident when it was not used before. (Item P4c, e)  
- Emergence of a condition/disease in which resident is judged to be unstable. (Item J5a)  
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at that stage or higher. (Item M2a)  
- Overall deterioration of resident’s condition; resident receives more support. (e.g., in performing ADLs, or in decision making). (Item Q2 = 2) |
| **IMPROVEMENT** | Any improvement in ADL physical functioning were a resident is newly coded as 0, 1, or 2, when previously scored as a 3, 4, or 8. (Item G1a)  
- Decrease in number of areas where Behavioral symptoms of sad or anxious mood are coded as not easily altered. (Item E2, E4B)  
- Resident’s decision making changes from 2 or 3 to 0 or 1. (Item B4)  
- Resident’s incontinence pattern changes from 2, 3, or 4 to 0 or 1. (Item H1a or b)  
- Overall improvement of resident’s condition; resident receives fewer supports. (Item Q2 = 1) |

*This is not an exhaustive list. (pg. 2-8, 9)
All of the following codes, with the exception of 8.b.6, designate only assessments required under Medicare PPS for residents whose stay is covered by Medicare. Grace periods apply to Medicare PPS assessments only. The schedule for PPS assessments is distinct from the OBRA clinical assessment requirements.

8.b
1. The first assessment in the Part A stay. The assessment reference date will fall within the first 5 days of the stay (unless one of the grace days is being used). May be either a full assessment, MPAF, or, if used as the required OBRA Initial Admission Assessment (AA8a=01), complete a comprehensive assessment.
2. The third scheduled assessment in a Part A stay. The assessment reference date will fall on any day 21 through 29 of the stay unless one of the grace days is being used.
3. The fourth scheduled assessment in a Part A stay. The assessment reference date will fall on any day 50 through 59 (unless grace days are used).
4. The fifth scheduled assessment of the Part A stay. The assessment reference date will fall on any day 80 through 89 of the stay (unless one of the grace days is being used). If this assessment is also the required Quarterly Assessment (AA8a=4), it must be completed within the 92 days of the prior comprehensive assessment.
5. This is coded when a beneficiary is discharged from a SNF stay to another inpatient setting and is then readmitted to the SNF. The Readmission/Return assessment reference date must fall within the first 5 days of the new stay.

EXAMPLE:
If resident was Discharged - return anticipated, complete a Full Assessment if no significant change. Complete a Comprehensive Assessment if resident had a significant change. If resident was Discharged - return not anticipated, complete a Comprehensive Assessment, treat as an initial admission.

REFERENCE: Chapter 3, Section A

6. DO NOT USE in Missouri.
7. The second scheduled assessment in a Part A stay. Must have an assessment reference date that falls on any day 11 through 14 (unless a grace day is used). May be a full assessment or MPAF unless this assessment is also the OBRA Initial Admission Assessment (AA8a=01) in which case it must be a comprehensive assessment and must be completed by day 14. (No grace days allowed)
8. This assessment type is performed on the 8th, 9th, or 10th day after all of the beneficiary’s rehabilitative therapy services are discontinued. This is only required if the beneficiary is still in the facility in a Part A stay. (pg. 2-31)

NOTE that it is possible to select a code from both 8a and 8b (e.g., Item 8a coded 3) (Significant Change in Status assessment), and Item 8b coded 3 (60-day assessment).

---

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<table>
<thead>
<tr>
<th>REASONS FOR ASSESSMENT</th>
<th>(Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Codes for assessments required for Medicare PPS or the State</td>
<td></td>
</tr>
<tr>
<td>1. Medicare 5 day assessment</td>
<td></td>
</tr>
<tr>
<td>2. Medicare 30 day assessment</td>
<td></td>
</tr>
<tr>
<td>3. Medicare 60 day assessment</td>
<td></td>
</tr>
<tr>
<td>4. Medicare 90 day assessment</td>
<td></td>
</tr>
<tr>
<td>5. Medicare readmission/return assessment</td>
<td></td>
</tr>
<tr>
<td>6. Other state required assessment</td>
<td></td>
</tr>
<tr>
<td>7. Medicare 14 day assessment</td>
<td></td>
</tr>
<tr>
<td>8. Other Medicare required assessment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPONSIBILITY/LEGAL GUARDIAN</th>
<th>(Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Living will</td>
<td></td>
</tr>
<tr>
<td>b. Do not resuscitate</td>
<td></td>
</tr>
<tr>
<td>c. Do not hospitalize</td>
<td></td>
</tr>
<tr>
<td>d. Organ donation</td>
<td></td>
</tr>
<tr>
<td>e. Autopsy request</td>
<td></td>
</tr>
<tr>
<td>f. Feeding restrictions</td>
<td></td>
</tr>
<tr>
<td>g. Medication restrictions</td>
<td></td>
</tr>
<tr>
<td>h. Other treatment restrictions</td>
<td></td>
</tr>
<tr>
<td>i. NONE OF ABOVE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADVANCED DIRECTIVES</th>
<th>(For those items with supporting documentation in the medical record, check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to Chapter 3, pgs. 3-37 to 3-40</td>
<td></td>
</tr>
<tr>
<td>a. Feeding restrictions</td>
<td></td>
</tr>
<tr>
<td>b. Medication restrictions</td>
<td></td>
</tr>
<tr>
<td>c. Other treatment restrictions</td>
<td></td>
</tr>
<tr>
<td>d. NONE OF ABOVE</td>
<td></td>
</tr>
</tbody>
</table>

9. May have multiple answers. To check in this area, must have documentation in the medical record; if no legal documentation is available, assume that the resident is the responsible party. See definitions pgs. 3-36 to 3-37.

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

To clarify Item 10, you may refer to Missouri Long Term Care Facility Regulations and Licensure Law 13 CSR-15-18.010 or Federal Regulations at F152 and F156.
SECTION B. COGNITIVE PATTERNS

Determines the resident’s ability to remember, think coherently, and organize daily self-care activities, as these areas are crucial factors in care planning. With aphasic residents, use your best clinical judgment to assess nonverbal clues. Check with caregivers for their observations at different times of day or during differing activities. Be cognizant of possible cultural differences that may affect your perception of the resident’s response (pg. 3-41, 42).

1. Refer to pg. 3-42 to 3-43, for guidance re: physician’s diagnosis of coma or persistive vegetative state. To check YES, must be documented in clinical record by physician.

2. a. & b. Use a “-” if the information is not available because it cannot be assessed (pgs. 3-43 to 3-45).

3. Ability to recall within environmental setting.

4. Focus on whether the resident is actively making decisions about tasks or activities of daily living and not whether the staff may believe they are capable of doing so. The intent of this item is to record residents performance not staff support.

5. Delirium is often manifested behaviorally and often caused by a treatable illness. See examples, pg. 3-49.

6. Reflect changes in B1-B5 above; may be permanent or temporary changes, causes may be known or unknown. If new admission, note changes prior to admission. Refer to pg. 3-50.

### SECTION B. COGNITIVE PATTERNS

<table>
<thead>
<tr>
<th>1. COMATOSE</th>
<th>(Persistent vegetative state/no discernible consciousness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>1. Yes (If yes, skip to Section G)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. MEMORY</th>
<th>(Recall of what was learned or known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Short-term memory OK—seems/apparent to recall after 5 minutes</td>
<td></td>
</tr>
<tr>
<td>b. Long-term memory OK—seems/apparent to recall long past</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. MEMORY/RECALL ABILITY</th>
<th>(Check all that resident was normally able to recall during last 7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current season</td>
<td>a. That he/she is in a nursing home</td>
</tr>
<tr>
<td>Location of own room</td>
<td>b. NONE OF ABOVE are recalled</td>
</tr>
<tr>
<td>Staff names/faces</td>
<td>c. NONE OF ABOVE are recalled</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING</th>
<th>(Made decisions regarding tasks of daily life)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. INDEPENDENT—decisions consistent/reasonable</td>
<td></td>
</tr>
<tr>
<td>1. MODIFIED INDEPENDENCE—some difficulty in new situations only</td>
<td></td>
</tr>
<tr>
<td>2. MODERATELY IMPAIRED—decisions poor, cues/supervision required</td>
<td></td>
</tr>
<tr>
<td>3. SEVERELY IMPAIRED—never/rarely made decisions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS</th>
<th>(Code for behavior in the last 7 days.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)</td>
<td></td>
</tr>
<tr>
<td>b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)</td>
<td></td>
</tr>
<tr>
<td>c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)</td>
<td></td>
</tr>
<tr>
<td>d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)</td>
<td></td>
</tr>
<tr>
<td>e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)</td>
<td></td>
</tr>
<tr>
<td>f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. CHANGE IN COGNITIVE STATUS</th>
<th>Resident’s cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No change</td>
<td>1. Improved 2. Deteriorated</td>
</tr>
</tbody>
</table>

REFERENCE: Chapter 3, Section B
SECTION C. COMMUNICATION/HEARING PATTERNS

Documents the resident’s ability to hear (with assistive devices, if used), understand, and communicate with others. Evaluate resident’s ability to hear with environmental adjustments as necessary. (i.e., reducing noise volume on T.V. or radio, installing amplification device on T.V.)

1. Refer to last 7 days if time frame not indicated.

1.2 Includes use of hearing enhanced telephone

3. Denotes the ability to express self or communicate both verbally and nonverbally. (Expressive ability)

4. Ability to express requests, needs, opinions, urgent problems and social conversation by any method-even in writing.

5. Reflects quality of speech only (not content or appropriateness).

6. Denotes ability to understand others. Measures ability to hear messages and also to process and understand language. Able to comprehend by any method, orally, by writing, or in sign language, or by braille. (Receptive Ability)

Note: Problem understanding others may be due to functional problems or that the resident uses a different language.

May use speech/language pathologist to consult regarding ability to express or receive information.

### SECTION C. COMMUNICATION/HEARING PATTERNS

<table>
<thead>
<tr>
<th>1. HEARING</th>
<th>(With hearing appliance, if used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. HEARS ADEQUATELY—normal talk, TV, phone</td>
<td></td>
</tr>
<tr>
<td>1. MINIMAL DIFFICULTY—when not in quiet setting</td>
<td></td>
</tr>
<tr>
<td>2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly</td>
<td></td>
</tr>
<tr>
<td>3. HIGHLY IMPAIRED—absence of useful hearing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. COMMUNICATION DEVICES/TECHNIQUES</th>
<th>(Check all that apply during last 7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aid, present and used</td>
<td>a.</td>
</tr>
<tr>
<td>Hearing aid, present and not used regularly</td>
<td>b.</td>
</tr>
<tr>
<td>Other receptive comm. techniques used (e.g., lip reading)</td>
<td>c.</td>
</tr>
<tr>
<td>NONE OF ABOVE</td>
<td>d.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. MODES OF EXPRESSION</th>
<th>(Check all used by resident to make needs known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech</td>
<td>a. Signs/gestures/sounds</td>
</tr>
<tr>
<td>Writing messages to express or clarify needs</td>
<td>b. Communication board</td>
</tr>
<tr>
<td>American sign language or Braille</td>
<td>c. NONE OF ABOVE</td>
</tr>
<tr>
<td></td>
<td>d.</td>
</tr>
<tr>
<td></td>
<td>e.</td>
</tr>
<tr>
<td></td>
<td>f.</td>
</tr>
<tr>
<td></td>
<td>g.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. MAKING SELF UNDERSTOOD</th>
<th>(Expressing information content—however able)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. UNDERSTOOD</td>
<td>a.</td>
</tr>
<tr>
<td>1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts</td>
<td>b.</td>
</tr>
<tr>
<td>2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests</td>
<td>c.</td>
</tr>
<tr>
<td>3. RARELY/NEVER UNDERSTOOD</td>
<td>d.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. SPEECH CLARITY</th>
<th>(Code for speech in the last 7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. CLEAR SPEECH—distinct, intelligible words</td>
<td>a.</td>
</tr>
<tr>
<td>1. UNCLEAR SPEECH—slurred, mumbled words</td>
<td>b.</td>
</tr>
<tr>
<td>2. NO SPEECH—absence of spoken words</td>
<td>c.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. ABILITY TO UNDERSTAND OTHERS</th>
<th>(Understanding verbal information content—however able)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. UNDERSTANDS</td>
<td>a.</td>
</tr>
<tr>
<td>1. USUALLY UNDERSTANDS—may miss some part/intent of message</td>
<td>b.</td>
</tr>
<tr>
<td>2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication</td>
<td>c.</td>
</tr>
<tr>
<td>3. RARELY/NEVER UNDERSTANDS</td>
<td>d.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. CHANGE IN COMMUNICATION/HEARING</th>
<th>Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No change</td>
<td>a.</td>
</tr>
<tr>
<td>1. Improved</td>
<td>b.</td>
</tr>
<tr>
<td>2. Deteriorated</td>
<td>c.</td>
</tr>
</tbody>
</table>

REFERENCE: Chapter 3, Section C 12
SECTION D. VISION PATTERNS

Records resident’s visual abilities and limitations assuming adequate lighting and assistance of visual appliances, if used.

1. Refer to last 7 days if time frame not indicated.

NOTE: Residents with cognitive impairments may not be able to participate in vision screening if they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to “track” or follow moving objects in their environment with their eyes. For residents who appear to do this, use code 3, Highly Impaired. This is the best assessment you can do under the circumstances.

2. Related to diseases common in the aged. Some of these may be treatable, others may be managed by interventions to maintain or improve visual ability. Check all that apply or **NONE OF ABOVE**.

3. Appliances must be used regularly to code here.

<table>
<thead>
<tr>
<th>1. VISION</th>
<th>(Ability to see in adequate light and with glasses if used)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. ADEQUATE—sees fine detail, including regular print in newspapers/books</td>
<td></td>
</tr>
<tr>
<td>1. IMPAIRED—sees large print, but not regular print in newspapers/books</td>
<td></td>
</tr>
<tr>
<td>2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects</td>
<td></td>
</tr>
<tr>
<td>3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects</td>
<td></td>
</tr>
<tr>
<td>4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. VISUAL LIMITATIONS/DIFFICULTIES</th>
<th>Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experiences any of following: sees halos or rings around lights; sees flashes of light; sees “curtains” over eyes</td>
</tr>
<tr>
<td></td>
<td><strong>NONE OF ABOVE</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. VISUAL APPLIANCES</th>
<th>Glasses; contact lenses; magnifying glass</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>1. Yes</td>
</tr>
</tbody>
</table>
SECTION E: MOOD AND BEHAVIOR PATTERNS

Mood distress is a serious condition and is associated with significant morbidity. The elderly respond readily to treatment for mood distress. Therefore, it is very important to identify the signs and symptoms.

1. Record the frequency of indicators observed, irrespective of the assumed cause of the behavior. It is important to note that coding the presence of indicators does not automatically mean the resident has a diagnosis of depression of anxiety.

Distress may be expressed nonverbally and observed in these areas during usual routines.

Observe changes in usual patterns of behavior.

Note: if an indicator of depression occurs twice in the last 30 days (not 2 times each week) it should be coded as “1” to indicate that the indicator of depression was exhibited up to 5 days a week, but less than 6 days a week. It does not need to occur each week to be coded (pg. 3-63).

An indicator of depression that occurs in the beginning of the 30 day period should be coded as occurring up to 5 days a week, but less than 6 days a week (pg. 3-63).

2. This item is looking at the last 7 days. During that specific period of time, were there depressed, sad, or anxious indicators? If so, could they be altered?

3. Reflects changes in number, frequency, or intensity of expressions or signs of distress.

REFERENCE: Chapter 3, Section E
Identifies frequency and alterability of behavioral symptoms that cause distress to the resident or that may be distressing or disruptive to other residents and staff.

a. WANDERING - see Section E, 4 for definition. Do not include pacing here (refer to Eln, previous page - repetitive physical movements).

b. Includes residents or staff

c. Includes residents or staff

e. RESISTS CARE - does not include exercise of rights to refuse care, i.e., informed choice. See pg. 3-66, 67.

Considers numbers, frequency, intensity or alterability of behavior. Asks for a snapshot of “today” as compared to 90 days ago (or since last assessment if less than 90 days) of the status of behaviors noted under E4. Please note however that behavioral symptoms for the entire 90 day period should be reviewed for care planning purposes.

PLEASE NOTE: Once frequency and alterability of individual behaviors has been determined, or assessed, subsequent documentation in the record should reflect the status of behavior and response to interventions.
SECTION F: PSYCHOSOCIAL WELL-BEING

Determines resident’s emotional adjustment to the facility, general attitude, adaptation to surroundings and change in relationship patterns. The resident’s strength(s) or problem(s)/need(s) can both be identified in this section. For care planning purposes, what is checked is as important as what is not checked.

Discrepancies can exist between how the resident sees him/herself and how he/she actually behaves.

Check all that apply in the last 7 days.

1. Assess degree resident is involved in nursing home life, takes initiative in participation, including solitary pursuits.

2. Indicates quality and nature of resident’s interpersonal contacts with others.

3. Documents resident’s recognition or acceptance of feelings regarding previous roles or status now that they are living in a nursing home. (May reflect resident’s strength).

Note: F1. Process for F1a-b – If resident not at ease interacting with others and/or doing planned and/or structured activities, it should be coded regardless of the suspected reason and regardless of whether or not this is the residents normal status.

Refer to definitions pgs. 3-71 to 3-72.
SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

Most nursing home residents are at risk for physical decline due to multiple chronic illnesses and/or other factors impacting self-sufficiency. A resident’s potential for maximum functionality may often be greatly underestimated by family, staff and the residents themselves. All residents are candidates for nursing-based rehabilitative care that focuses on maintaining and/or increasing self-involvement in ADLs. Individualized plans of care can be successfully developed only when the resident’s self-performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated.

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from independent to supervision to limited assistance, non-weight-bearing supervision or physical assistance MUST increase from one to two times up to three or more times during the least seven days. (See examples 3-83 to 3-89.)

(A) 0-4 Three or more times is an important part of determination of movement to the next level of dependency. See Chapter 3, Section G & ADL self-performance diagram (See pg 21 of handouts. See pg 22 of handouts for further explanation.)

(B) To promote highest level of function, must identify what resident actually does for self, noting when assistance is received and clarifying type of assistance provided.

NOTE: Since this section is in two parts, each using its own scale, it may help you to complete all of Section A first, then Section B - to avoid confusion.

Review ADL Self-Performance definitions and coding instructions pgs.3-76 to 3-82. See coding example pgs. 3-83 to 3-102.

*Code 8 is limited to situations where the activity was not performed, by the resident or staff over the last 7 days. Therefore, an objective assessment of the resident’s performance is not possible; when 8 is coded for self-performance, it should also be entered for support. Do not confuse a resident who is totally dependent in an ADL activity (Code 4 - Total Dependence) with the activity itself not occurring, i.e., a resident who is tube fed.

REFERENCE: Chapter 3, Section G

1. ADL SELF-PERFORMANCE—(Code for resident’s PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)
   a. INDEPENDENT—No help or oversight
   b. SUPERVISION—Oversight, encouragement or cueing
   c. LIMITED ASSISTANCE—Resident highly involved in activity
   d. EXTENSIVE ASSISTANCE—While resident performed part of activity
   e. TOTAL DEPENDENCE—Full staff performance of activity
   f. ACTIVITY DID NOT OCCUR during entire 7 days

2. ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident’s self-performance classification)
   a. Setup help only
   b. One person physical assist
   c. Two+ persons physical assist
   d. EXTENSIVE ASSISTANCE—While resident performed part of activity
   e. TOTAL DEPENDENCE—Full staff performance of activity

3. EXTENT OF SELF-PERFORMANCE—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident’s self-performance classification)
   a. BED MOBILITY—How resident moves to and from lying position, turns side to side, and positions body while in bed
   b. TRANSFER—How resident moves between surfaces
   c. WALK IN ROOM—How resident walks between locations in his/her room
   d. WALK IN CORRIDOR—How resident walks in corridor on unit
   e. LOCOMOTION ON UNIT—How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair
   f. LOCOMOTION OFF UNIT—How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair
   g. DRESSING—How resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis
   h. EATING—How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)
   i. TOILET USE—How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes
   j. PERSONAL HYGIENE—How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)
SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS, CONT’D.

Bathing is the only ADL activity for which the ADL self performance codes in item G1A do not apply. This is due to the frequency of baths carried out over a 7-day period. The ADL - Support Provided Codes given in item G1B, still apply. See pgs. 3-91 to 3-92.

2. Column (A) evaluates how the resident takes a full body bath, shower or sponge bath including transfers in and out of tub or shower. Score maximum amount of assistance resident received during bathing. The definition does not include the washing of back or hair.

Column (B) identifies the maximum level of support provided in bathing activities using the ADL Support Scale in Item G1B.

3. Residents with impaired sitting and standing balance are at a greater risk for falls. This evaluates resident’s balance abilities so that appropriate interventions can be implemented to prevent injuries.

Records resident’s ability to balance while standing (without assistance from a device or person) and balance while sitting (without using any type of support).

See method for testing in manual, Chapter 3, Section G, Item 3. “DO NOT attempt to test residents who cannot stand by themselves.” Code these residents as 3 (pg 102-104).

NOTE: The resident may decline balance test, but every attempt should be made to determine why the resident refuses. A short notation should be made on the MDS form regarding why the resident refused (pgs. 3-102 to 3-103).

See manual for assessing process, Chapter 3, Section G, Item 4. (pg 3-107 to 3-109)

This is a screening item to determine a need for a more intensive evaluation. It does not need to be performed by a physical therapist, but by a member of any clinical discipline in accordance with instructions. (pg 3-107)

4. Identifies presence of (A) functional limitation or that interferes with daily functioning or (B) loss of voluntary movement which places the resident at risk of injury. Voluntary movement is defined as intentional and purposeful functional movement.

See manual for assessing process, Chapter 3, Section G, Item 4. (pg 3-107 to 3-109)

This is a screening item to determine a need for a more intensive evaluation. It does not need to be performed by a physical therapist, but by a member of any clinical discipline in accordance with instructions. (pg 3-107)

4. a. It is proper to actively assist resident with cognitive impairment in ROM exercise to assess for limitations (See pg. 3-108). First determine if there is a limitation in active or active-assisted ROM. Then determine if the limitation in ROM interferes with function or place the resident at risk for injury.
5. Identifies the type(s) of appliances, devices, or personal assistance that resident uses (on and off the unit) during the last 7 days.
5. a. Cane/walker/crutch, includes resident pushing wheelchair, or merry walker.
5. b. Wheeled self includes hand-propelled or motorized wheelchair, resident is responsible for self-mobility.
5. c. Other person wheeled is another person pushing the resident.
5. d. Check here even if ambulatory but primarily dependent on wheelchair to get around. A merry walker is viewed as a walker if used to aid ambulation (pg. 3-111 and 3-199, 200).

6. Records type(s) of assistive devices resident uses for transferring and bed mobility during the last 7 days.
6. a. If resident bedfast in bed or recliner but out of room, location is crucial in coding here. If out of room most of day, do NOT check. The concept of bedfast is meant to capture residents who spend 22 hours or more in a bed or recliner in their own room regardless of their level of function.

7. Some residents become overwhelmed and anxious with expectations for greater independence. Identifies residents who are more involved and independent in personal care tasks because they have received help in breaking tasks down into smaller steps to make tasks easier.

Provides residents with directions for performing each step in an ADL activity through verbal cues, and/or physical cues. This information may be documented in nursing notes or therapy notes, or assessed by observing nurse assistant with resident during care.

8. Evaluates resident’s functional status to determine if he or she is capable of greater independence and involvement in self-care. Identify any variances in resident’s independence over all shifts during the last 7 days.

9. Documents any changes occurring in resident’s overall self-performance and the amount/type of support received by staff as compared to status 90 days ago, or since the last assessment. Review medical record and Section G from last assessment and compare findings.

REFERENCE: Chapter 3, Section G continued
a. Can include one or two events where received supervision, non weight-bearing assistance, or weight-bearing assistance.

b. Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a "2".

c. Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a "1".
ADL SELF-PERFORMANCE

MDS Section G 1(A)

0 - Independent
1 - Supervision (stand by assistance)
2 - Limited assistance (contact guard)
3 - Extensive assistance (min-mod-max assistance)
4 - Total dependence
5 - Activity did not occur

MDS Section G 1(B)

0 - No setup or physical help from staff
1 - Setup help only
2 - One person physical assist
3 - Two or more physical assist
4 - ADL activity itself did not occur
SECTION H: CONTINENCE IN LAST 14 DAYS

This section differs from other ADL items as the period of review is extended to 14 days. This time frame is viewed as the minimum required to assess an accurate picture of bowel patterns.

NOTE: See process instructions -- continence patterns over last 14 days, pgs. 3-119 to 3-120.

1. This item refers to control of urinary bladder function and/or bowel movement, distinct from ADL status and need for assist. Code one response for (a) Bowel Continence level and one response for (b) Bladder Continence.

   Use 5 point scale in User’s Manuals
   Chapter 3, Section H, Question 1. (pg 3-121)

2. Records effectiveness of the resident’s bowel function during the last 14 days. Refer to pg. 3-120.

3. Review medical record, consult with staff and residents, and check all incontinence appliances used and/or incontinence programs in place over last 14 days.

   a. There are 3 key ideas in H3a: 1) schedule, 2) toileting, and 3) program. Changing wet garments is not included in this concept.

   b. A retraining program where the resident is taught to consciously delay urinating. Residents are encouraged to void on a schedule rather than based on their urge to void.

   c. Intermittent catheterization by a licensed nurse or the resident.

   d. Do not include routine use of pads on beds if resident rarely incontinent.

   e. Document changes in the resident’s urinary continence status compared to 90 days ago or since the last assessment. Compare self-control categories, appliances or program changes.

REFERENCE: Chapter 3, Section H

<table>
<thead>
<tr>
<th>SECTION H. CONTINENCE IN LAST 14 DAYS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CONTINENCE SELF-CONTROL CATEGORIES</td>
<td></td>
</tr>
<tr>
<td>(Code for resident’s PERFORMANCE OVER ALL SHIFTS)</td>
<td></td>
</tr>
<tr>
<td>a. CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool) does not include toilet ability (G1A)</td>
<td></td>
</tr>
<tr>
<td>b. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly</td>
<td></td>
</tr>
<tr>
<td>c. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week</td>
<td></td>
</tr>
<tr>
<td>d. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week</td>
<td></td>
</tr>
<tr>
<td>e. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time</td>
<td></td>
</tr>
</tbody>
</table>

| 2. BOWEL ELIMINATION PATTERN |   |
| a. WORST movement every three days |   |
| b. Fecal impaction |   |
| c. NONE OF ABOVE |   |

| 3. APPLIANCES AND PROGRAMS |   |
| a. Did not use toilet room/commode/urinal/bedpan |   |
| b. Pads/briefs used |   |
| c. Enemas/irrigations/ostomy irrigations |   |
| d. Ostomy present |   |
| e. NONE OF ABOVE |   |

| 4. CHANGE IN URINARY CONTINENCE |   |
| a. Resident’s urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days |   |
| b. No change |   |
| c. Improved |   |
| d. Deteriorated |   |
SECTION I: DISEASE DIAGNOSES

The disease conditions require a physician documented diagnosis in the clinical record, pgs. 3-127 to 3-130. In general, coded items should be conditions that drive the current plan of care.

1. The focus of the MDS is to generate an updated, accurate picture of the resident’s health status. Therefore, this section documents the presence of diseases that have a relationship to the resident’s current overall status. Do not include conditions/diagnoses that have been resolved or no longer affect the resident’s functioning or care plan. Utilize a review of the clinical records, clinical monitoring of the resident by a licensed nurse, interview of the resident and review of diagnoses with the resident’s physician.

2. Documents the presence of infections that have a relationship to the resident’s current overall status. Do not include infections that have been resolved or no longer affect the resident’s functioning or care plan. There should be supportive documentation in the medical record from a physician.

3. This item is an exception to the 7 day rule. If UTI in last 30 days, code even if no longer receiving treatment or monitoring during assessment period.

4. Identifies conditions not listed in Item I1 and I2 that affect the resident’s current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. Include more specific designations for general disease categories listed above.

May consult the medical record and/or the physician or resident to solicit input on inaccurate or missed diagnosis or infections.
SECTION J: HEALTH CONDITIONS

This section records conditions that could affect the resident’s health or functional status and identifies risk factors for illness, accidents and decline. This section also records the frequency and intensity of signs and symptoms of pain. This information can be used to identify indicators of pain as well as to monitor the resident’s response to pain management interventions for care planning purposes.

1. Record specific problems or symptoms that affect or have the potential to affect a resident’s health or functional status, and identify risk factors for illness, accident or functional decline. Check all that apply or NONE OF ABOVE if none apply. NOTE: review clinical signs of dehydration pg. 3-138.

2. a. Frequency of pain as described or manifested by resident.
2. b. Severity of pain as described or manifested by resident. NOTE: Code for presence or absence of pain, regardless of pain management efforts, i.e. breakthrough pain.

3. For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain is whatever the resident says it is, or may depend on observation and assessment because the resident will not or cannot verbalize.

4. Determines resident’s risk of future falls or injuries. Check all conditions that apply. If no conditions apply, check NONE OF ABOVE. See fall definition, pg. 3-146 to 3-147.

5. Used to determine if resident’s disease or health conditions present over the last 7 days are acute, unstable, or deteriorating. 5. a. denotes changing and variable nature of resident’s condition. Reflects degree of difficulty in balance between treatment for multiple conditions. 5. b. usually sudden onset, time-limited course, requiring physician evaluation and significant increase in licensed nurse monitoring.

5. c. Substantiate by well documented disease diagnosis and deteriorating clinical course. A doctor’s certification that the resident has 6 months or less to live must be present in the medical record (pg. 3-147.)
### SECTION K: ORAL/NUTRITIONAL STATUS

#### NOTE: Expanded information and new guidance provided; see pgs. 3-149 to 3-152.

1. Record any oral problems such as chewing or swallowing problems or mouth pain present in the last 7 days even when successful interventions have been introduced (pg. 3-149).

2. Round height and weights up to the nearest whole inch and whole pound respectively. Record height in inches; if last height recorded more than one year ago, measure again. Record most recent weight. (If weight is less than 100 lbs, use leading zero to fill all boxes, i.e., 097) If taken more than one month ago, weigh again. If the resident has experienced a decline in intake at meals, snacks, or fluid intake, weigh again. Use same scale and weigh at consistent time each month a.m. or p.m.

3. Record the variations in the resident’s weight over time. When calculating percentage of loss or gain, do not round up the resident’s weight. If there is no weight to compare to, enter the unknown code [-]. (pg 3-151)

4. Identifies specific problems, conditions, and risk factors for functional decline present in the last 7 days that could affect the resident’s health or functional status. See expanded process, pg. 3-153.

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

5. **a.** Include only fluid administered for nutrition or hydration. See pg 3-153 for examples to be included and excluded. See further clarification on pg 3-154 regarding hypodermoclysis and subcutaneous ports in hydration therapy.

5. **b.** Presence of any type of tube that can deliver food, fluids, or meds directly into the GI system.

5. **c.** Mechanically altered diet is not automatically considered a therapeutic diet. Enteral feeding formulas are not coded here.

5. **d.** Therapeutic diet: A diet ordered to manage problematic health conditions. Code entered feeding formulas here when they meet the definition.

#### SECTION K. ORAL/NUTRITIONAL STATUS

<table>
<thead>
<tr>
<th>1. ORAL PROBLEMS</th>
<th>Chewing problem (ask resident and observe at meals)</th>
<th>a.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. HEIGHT AND WEIGHT</td>
<td>Record (a.) <strong>HT</strong> (in.) and (b.) <strong>WT</strong> (lb.)</td>
<td>a. HT (in.)</td>
</tr>
<tr>
<td>3. WEIGHT CHANGE</td>
<td>a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days</td>
<td>0. No</td>
</tr>
<tr>
<td>4. NUTRITIONAL PROBLEMS</td>
<td>b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days</td>
<td>0. No</td>
</tr>
<tr>
<td>5. NUTRITIONAL APPROACHES</td>
<td>Complains about the taste of many foods</td>
<td>a.</td>
</tr>
<tr>
<td>6. PARENTERAL OR ENTERAL INTAKE</td>
<td>Leaves 25 % or more of food uneaten at most meals</td>
<td>c.</td>
</tr>
</tbody>
</table>

**5. b.** Documented purpose and goal is to facilitate weight gain or loss, i.e., double portions, high/low calorie

**6. DO NOT** answer this question if neither item K5a or K5b is checked. Record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last 7 days. (Amount actually received, not ordered.) See new process instructions, pg. 3-156.

6. **a.** Review Intake Record. If resident took no food or fluids by mouth, or just sips, stop here and code “4”. If more substantial oral intake consult with dietician to derive a calorie count received from parenteral or tube feedings (pg. 3-155).

To calculate, see Chapter 3, pg. 3-156.

6. **b.** Divide the weeks total intake by 7.

**NOTE:** A weight change of:
- **5% in 1 month** is significant; over 5% is severe
- **7.5% in 3 months** is significant; over 7.5% is severe
- **10% in 6 months** is significant; over 10% is severe

REFERENCE: Chapter 3, Section K
Documents the resident’s oral and dental status as well as any problematic conditions such as tooth decay or cavities. Check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>ORAL STATUS AND DISEASE PREVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Debris (soft, easily movable substances) present in mouth prior to going to bed at night</td>
</tr>
<tr>
<td></td>
<td>Has dentures or removable bridge</td>
</tr>
<tr>
<td></td>
<td>Some/all natural teeth lost—does not have or does not use dentures (or partial plates)</td>
</tr>
<tr>
<td></td>
<td>Broken, loose, or carious teeth</td>
</tr>
<tr>
<td></td>
<td>Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes</td>
</tr>
<tr>
<td></td>
<td>Daily cleaning of teeth/dentures or daily mouth care—by resident or staff</td>
</tr>
<tr>
<td></td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

REFERENCE: Chapter 3, Section L
SECTION M: SKIN CONDITION

For purposes of the MDS, code skin ulcers in terms of what is actually seen during the look-back period. If necrotic eschar/slough is present, code as Stage 4 until debrided to allow staging. If there are more than 9 ulcers at any one stage, enter 9 in the appropriate box.

1. Record the number of skin ulcers, at each ulcer stage, on any part of the body. Skin ulcers that develop because of circulation or pressure to be coded here. Review medical record, talk with direct care staff and do a full body examination using the ulcer staging scale definitions in the User’s Manual, Chapter 3, Section M, Item 1. See definitions and clarifications, pgs. 3-159 to 3-160.

2. Record the highest stage for 2 types of skin ulcers, Pressure and Stasis, that were present in the last 7 days using the ulcer staging scale definitions in the User’s Manual, Chapter 3, Section M, Item 1. Skin tears/shears are coded in item M4 unless pressure was a contributing factor, pg 3-159.

3. Determine if the resident previously had an ulcer that was resolved or cured during the last 90 days by reviewing clinical records including the last Quarterly Assessment, pg 3-165.

4. Document the presence of skin problems or lesions (other than pressure or ulcers caused by circulation conditions) and conditions that are risk factors for more serious problems, pgs. 3-165 to 3-166.

5. Document any specific or generic skin treatment the resident has received in the last 7 days, pgs. 3-167 to 3-168.

6. Document the presence of foot problems and care to resident’s feet in the last 7 days.

NOTE: For MDS purposes only, you must reverse stage ulcers, which may be contrary to documentation practices of the Pressure Ulcer Advisory Board and AHRQ Guidelines. Documentation in the record should reflect good clinical practice.

NOTE: A debrided skin ulcer is not a surgical wound. A skin ulcer that is repaired with a skin flap is now a surgical wound. If the graft fails, it is still a surgical wound.

REFERENCE: Chapter 3, Section M
SECTION N: ACTIVITY PURSUIT LEVEL

This section includes the amount and types of interests and activities that the resident currently pursues, or activities the resident would like to pursue that are not currently available in the facility.

1. Identifies those periods in a typical day over the last 7 days when resident was awake all or most of the time.
   -- the resident who is awake most of the time could be encouraged to become more involved in activities (solitary or group)
   -- the resident who naps a lot may be bored or depressed and may benefit from more activity involvement
   -- See explanation on intent of coding, pg. 3-170.

2. Determines the proportion of free time a resident, while awake, was actually involved in activity pursuits such as caring for plants, reading, visiting family, making phone calls, one on one or therapeutic recreation activities. Does not have to be structured activities. DO NOT include time spent in treatments, ADL activities, or nursing care. Eating is not to be counted as an activity.
   (pg 3-172)

3. Determines activity settings that resident prefers and/or appears to be at ease. Observe and interview resident, family and staff.

4. Determines which activities listed the resident would prefer to participate in. (Resident activity preferences) Do not limit choices by whether the resident currently engages in the activity or whether the activity is currently offered.

5. Determines if the resident has an interest in pursuing activities not offered at the facility (or off the nursing unit), or not made available to the resident. Code for residents preferences in daily routines/activities. Residents who resist attendance/involvement in activities offered at the facility are also included in this category in order to determine possible reasons for their lack of involvement. (pg 3-175)
SECTION O. MEDICATIONS

1. Count the number of different medications (not the number of doses or different dosages) administered by any route at any time during the last 7 days. Include any routine, prn, and stat doses given. Medications include topical preparations, ointments, creams used in wound care, eye drops, vitamins, and suppositories. Topical preparations that are used for preventive skin care (i.e., moisturizers, moisture barriers) are not coded here. Antigens and vaccines are counted here. Include any medication that the resident administers to self, if known. Antigens and vaccines are also counted here (pg. 3-176).

2. Identifies whether the resident is currently receiving medications that were initiated in the last 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code 0 (no new medication).

3. Record the number of days during the past seven days that the resident received any type of medication, antigen, or vaccine, by subcutaneous, intramuscular or intradermal injection.

4. Record the number of days that the resident received antipsychotics, antianxiety, antidepressants, hypnotics, or diuretics given by any route in any setting over the last 7 days. Determine if a specific long acting medication is still active based on physician, pharmacist or PDR input. See Appendix E for list of drugs by category. Code medications according to a drug’s pharmacological classification, not how it is used. Combination products, such as Corzide (which contains a diuretic and a beta blocker) are counted as one medication. (pg 3-177)

NOTE: Pg. 3-178. If B12 injections are given once per month, but outside the assessment period (i.e., prior) Code Under O.1. Code B12 injections under O.3 if given during observation period.

NOTE: To record IV fluids, refer to Section K5a. To record IV medications, refer to Section P1c.

For new admissions, may use documentation from referring facility, if clearly recorded. If transfer records are not clear or do not reference that the resident received one of these medications, record 0 (not used) in the corresponding box. If the resident did not use any medications from a drug category, enter 0.

REFERENCE: Chapter 3, Section O 29
SECTION P: SPECIAL TREATMENTS AND PROCEDURES

DO NOT code services that were provided solely in conjunction with a surgical or diagnostic procedure, the immediate post-operative recovery period, or post-procedure recovery period (pg. 3-182).

1. [a.] For Treatments - record treatments received by a resident either at the facility, as a hospital out-patient, or in-patient, etc. For Programs - record programs received within the nursing facility only. See clarification pg 3-182 for P1a, b, and c.

1. [b.] Record therapies that occurred after admission or readmission to the facility, ordered by a physician and performed by a qualified therapist. May include therapy done inside or outside facility. Record actual treatment time, not documentation time. Include only therapies based on a therapist’s assessment and treatment plan that is documented in the resident’s clinical record. Include only medically necessary therapies (see pg. 3-187).

3. [c.] Does not require physician’s order (see pg. 3-191). Must meet specific criteria:
1. Measurable objectives and interventions must be documented in the care plan and clinical record
2. Evidence of periodic evaluation by a licensed nurse must be present in the clinical record
3. Nurse Asst/Aides must be trained in the techniques that promote resident involvement in the activity
4. These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
5. This category does not include exercise groups with more than 4 residents per supervising helper or caregiver.

3. [d.] Clarification. See pg. 3-192.

3. [e.] Other: includes activities to improve or maintain resident self-performance in functioning, i.e., self-care with diabetes, self-administration of meds, ostomy care.

REFERENCE: Chapter 3, Section P

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**NOTE:** Passive Rom = the caregiver moves the body part around a fixed point or joint through the resident’s available range of motion; resident provides no assist. Active Rom = exercises performed by resident, with cueing or supervision by staff, planned and documented in medical record. If resident needs assistance with final stretch, still considered active ROM. See examples, pg. 3-196 to 3-197.
A physical restraint is any manual method or physical or mechanical device, material or equipment attached to, or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s own body -- Includes, but is not limited to, any article, device or garment that interferes with free movement of resident, or that resident is unable to remove easily. “Freedom of movement” is defined as the ability of the resident to move around within the context of the resident’s functional capacity, as assessed by the facility. Ask the question, “Does the item prevent the resident from performing an action they are otherwise capable of performing?” Code only those devices categorized as a restraint. See coding instructions pgs. 3-198 to 3-202.

4. Record frequency over last 7 days with which resident was restrained by any listed device, day or night. See definitions pg. 3-198 and clarifications pg 3-199 to 3-202.

5. If resident is a new admission to facility include admissions during period prior to admission.

6. A visit to an ER not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evals, transfusions, chemotherapy, etc.

7. Exam may be performed in facility or physician office. Frequency of visits may be indicative of clinical complexity. Does not include exams conducted in the emergency room. Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist working in collaboration with the physician qualifies (pg. 3-204).

8. Includes written, phone, fax, or consultation orders for new or altered treatment. Do not include admission orders, return admission orders, or order renewals without change. Change in condition orders on day of admission are counted, see pg. 3-205.

Note: See coding changes pgs. 3-205 to 3-206.

<table>
<thead>
<tr>
<th>4. DEVICES AND RESTRAINTS</th>
<th>Use the following codes for last 7 days:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Not used</td>
<td></td>
</tr>
<tr>
<td>1. Used less than daily</td>
<td></td>
</tr>
<tr>
<td>2. Used daily</td>
<td></td>
</tr>
<tr>
<td>Bed rails</td>
<td></td>
</tr>
<tr>
<td>a. — Full bed rails on all open sides of bed</td>
<td></td>
</tr>
<tr>
<td>b. — Other types of side rails used (e.g., half rail, one side)</td>
<td></td>
</tr>
<tr>
<td>c. Trunk restraint</td>
<td></td>
</tr>
<tr>
<td>d. Limb restraint</td>
<td></td>
</tr>
<tr>
<td>e. Chair prevents rising</td>
<td></td>
</tr>
<tr>
<td>Merry walker, lap buddy, bean bag</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. HOSPITAL STAY(S)</th>
<th>Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admission)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. EMERGENCY ROOM(ER) VISIT(S)</th>
<th>Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>7. PHYSICIAN VISITS</th>
<th>In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician or authorized assistant or practitioner examined the resident? (Enter 0 if none)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>8. PHYSICIAN ORDERS</th>
<th>In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician or authorized assistant or practitioner changed the resident’s orders? Do not include order renewals without change. (Enter 0 if none)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9. ABNORMAL LAB VALUES</th>
<th>Has the resident had any abnormal lab values during the last 90 days (or since admission)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

9. Only record lab tests performed after admission, not during hospitalization. *Abnormal as compared to standard values not what is abnormal for resident. Enter 0. (No) if there was no abnormal lab value noted or if no lab work was done (do not use Code 8 here - Code 8 is only used in Section G).

REFERENCE: Chapter 3, Section P
SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS

Identifies residents who are potential candidates for discharge within the next 3 months. Discharge can be to home, another community setting, another care facility or residential setting. A prognosis of death should not be considered as an expected discharge.

1. a. Ask resident of plans directly if new admission. The longer a resident lives in a facility, the harder it is to ask about preferences. Use careful judgment here to avoid unrealistic expectations. This section provides data on discharge potential. Depending on resident’s clinical status and circumstances, additional assessments to determine why the resident is not a candidate for discharge at this time and what care plan can be implemented to improve discharge potential may be warranted.

2. Monitors resident’s overall progress over time. If new admit, include changes prior to admission.

SECTION R. ASSESSMENT INFORMATION

2. a. The RN Assessment Coordinator signs and dates at Items R2a and R2b when all other assessors have finished their portions of MDS Sections A-W. The RN Assessment Coordinator’s signature certifies overall completion of portions of the MDS Section A-W in the record, not the accuracy of all portions of the assessment. (Date should be no earlier than assessment reference date (A3a). Starts clock dates for next assessment.) This date should be later than or the same as the completion dates in AA9 a-f for Sections A-W.

Note: Federal regulations require the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed (see pg. 3-212).
SECTION T: THERAPY SUPPLEMENT FOR MEDICARE PPS

Code ordered therapies under Sections P & T. These sections are not mutually exclusive. Therapy can occur inside or outside of facility as long as staff meets qualifiers. Section T is completed for all full PPS assessments or MPAF. Communication with therapies and nursing aides on all shifts is critical to complete Section T2.

1. **a.** Record therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program. Orders must include frequency, duration and scope of treatment by a state licensed or nationally certified therapeutic recreation specialist or assistant.

1. **b.** This section recognizes ordered and scheduled PT, OT, and ST services during the early days of the resident’s stay. Provides an overall picture of the amount of therapy that a resident will likely receive through the 15th day of admission.

1. **c. d.** Estimates total number of days therapy provided and total number of minutes therapy anticipated. To estimate, need physicians order, clinical knowledge of resident’s condition and tolerance of therapy, the amount already provided and number of days.

<table>
<thead>
<tr>
<th><strong>SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. SPECIAL TREATMENTS AND PROCEDURES</strong></td>
</tr>
<tr>
<td><strong>a. RECREATION THERAPY</strong> — Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)</td>
</tr>
<tr>
<td>D AYS</td>
</tr>
<tr>
<td>(A) = # of days administered for 15 minutes or more</td>
</tr>
<tr>
<td>(B) = total # of minutes provided in last 7 days</td>
</tr>
<tr>
<td><strong>b. ORDERED THERAPIES</strong> — Has physician ordered any of following therapies to begin in FIRST 14 days of stay — physical therapy, occupational therapy, or speech pathology service?</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td><strong>If not ordered, skip to item 2</strong></td>
</tr>
<tr>
<td><strong>c.</strong> Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.</td>
</tr>
<tr>
<td><strong>d.</strong> Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?</td>
</tr>
</tbody>
</table>

Note: Calculate the expected number of days through day 15, even if the resident is discharged prior to day 15. This calculation includes days of therapy already delivered. See examples, pg. 3-216.

Note: Do not include evaluation in minutes.
Do not count the evaluation day unless treatment is rendered in addition to the evaluation.

Note: When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered (pg. 3-216).

REFERENCE: Chapter 3, Section T
Therapy is often implemented to improve a resident’s ability to walk. It is important to monitor the gait pattern and walking progress for residents and how functional walking is integrated into the resident’s ADLs on the nursing unit. Monitor distance, amount of time taken to walk the distance, the amount of assistance and support received. View in combination with Section G.

2. a.-e. Captures information based on the same one episode when resident walked the farthest without sitting down - captures the single highest level of independence in observation period whether in therapy or on the nursing unit, any time on all shifts.

3. Case mix group - may be calculated by vendor software. Medicare: the first 3 boxes contain the Medicare case mix group (RUGS classification) and the last 2 boxes are the current CMS Medicare case mix version “07”. State: leave blank at this time for Missouri. Missouri is not currently a case mix state (see pg. 3-223).

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:
- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.2.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

Furthest distance walked without sitting down during this episode.
- 0. 150+ feet
- 1. 51-149 feet
- 2. 26-50 feet
- 3. 10-25 feet
- 4. Less than 10 feet

Time walked without sitting down during this episode.
- 0. 1-2 minutes
- 1. 3-4 minutes
- 2. 5-10 minutes
- 3. 11-15 minutes
- 4. 16-30 minutes
- 5. 31+ minutes

Self-Performance in walking during this episode.
- 0. INDEPENDENT—No help or oversight
- 1. SUPERVISION—Oversight, encouragement or cueing provided
- 2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
- 3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking

Walking support provided associated with this episode (code regardless of resident’s self-performance classification).
- 0. No setup or physical help from staff
- 1. Setup help only
- 2. One person physical assist
- 3. Two+ persons physical assist

Parallel bars used by resident in association with this episode.
- 0. No
- 1. Yes

NOTE: Sections T1a, T2 and T3 are required with every full assessment for Medicare Part A payment under PPS.

NOTE: Section T1b, T1c, and T1d are required only with the Medicare 5 day or readmission/return assessments.
## SECTION W: Supplemental MDS Items

Section W must be completed for all residents on all assessment types with ARD and all discharge tracking forms with discharge dates from October 1 through June 30.

1. The facility is encouraged to begin using this number once it has been assigned by CMS.

2. a. Code ‘yes’ if the resident received the Influenza vaccine, administered in your facility.
   
   b. Code why the resident did not receive the vaccine in your facility

3. See flow chart, pg. 3-244, on determining who needs pneumococcal vaccine.

4. Enter 1 if PPV status is up-to-date. Enter 0 if not up-to-date and complete W4b for reason is not up-to-date.

### Table: MDS Items

<table>
<thead>
<tr>
<th><strong>1. National Provider ID</strong></th>
<th>Enter for all assessments and tracking forms, if available.</th>
</tr>
</thead>
</table>

If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.

<table>
<thead>
<tr>
<th><strong>2. Influenza Vaccine</strong></th>
<th>Did the resident receive the Influenza vaccine in this facility for this year’s influenza season (October 1 through March 31)?</th>
</tr>
</thead>
</table>
| a.                      | 0. No (If No, go to item W2b)  
                          | 1. Yes (If Yes, go to item W3) |

b. If Influenza vaccine not received, state reason:

   1. Not in facility during this year’s flu season
   2. Received outside of this facility
   3. Not eligible
   4. Offered and declined
   5. Not offered
   6. Inability to obtain vaccine

<table>
<thead>
<tr>
<th><strong>3. Pneumococcal Vaccine</strong></th>
<th>Is the resident’s PPV states up to date?</th>
</tr>
</thead>
</table>
| a.                          | 0. No (If No, go to item W3b)  
                          | 1. Yes (If Yes, skip item W3b) |

b. If not received, state reason:

   1. Not eligible
   2. Offered and declined
   3. Not offered
## SECTION AA. IDENTIFICATION INFORMATION

<table>
<thead>
<tr>
<th>1. RESIDENT NAME</th>
<th>a. (First)</th>
<th>b. (Middle Initial)</th>
<th>c. (Last)</th>
<th>d. (Jr/Sr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. GENDER</td>
<td>1. Male</td>
<td>2. Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. BIRTHDATE</td>
<td>Month</td>
<td>Day</td>
<td>Year</td>
<td></td>
</tr>
<tr>
<td>5. SOCIAL SECURITY AND MEDICARE NUMBERS</td>
<td>a. Social Security Number</td>
<td>b. Medicare number (or comparable railroad insurance number)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. MEDICAID NO.</td>
<td>Optional State Code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. (If pending, &quot;N&quot; if not a Medicaid recipient)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## SECTION AB. DEMOGRAPHIC INFORMATION

### [Complete only for stays less than 14 days] (AA8a = 8)

<table>
<thead>
<tr>
<th>1. DATE OF ENTRY</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

## SECTION R. ASSESSMENT/DISCHARGE INFORMATION

### 3. DISCHARGE STATUS

- a. Code for resident disposition upon discharge
  1. Private home/apartment with no home health services
  2. Private home/apartment with home health services
  3. Board and care/assisted living
  4. Another nursing facility
  5. Acute care hospital
  6. Psychiatric hospital, MR/DD facility
  7. Rehabilitation hospital
  8. Deceased
  9. Other
- b. Optional State Code

### 4. DISCHARGE DATE

Date of death or discharge

- Encode within 7 days after “event” (discharge)

**Section AB - Demographic Information**

Complete only for stays less than 14 days, when AA8a = 8. See definitions on pg 3-213, 214 under section R3.

9. Formal attestation statement and signature lines for individual staff completing any portion of the accompanying assessment or tracking form. Used to record signatures and dates of completion, as well as accuracy.

**NOTE:** Make sure all identification information on these subsets is the same as the information on corresponding sections. Also, the requirement for completing this form applies regardless of a facility’s policy and procedure for discharge, or opening and closing records and regardless of how long the individual was a resident of the facility.

Retention of form in active record is 15 months.
The following exceptions to CMS’s requirements for Discharge and Reentry are allowable, but are not federally required:

1. A “temporary” Discharge Tracking form using code 7 (return anticipated) can be followed by a “permanent” Discharge Tracking form using code 6 (return not anticipated) at the facility’s option. This option can be used if, after the temporary discharge, the facility gains knowledge that the resident will not return. This may be required in some states for Medicaid program purposes. This is not required in Missouri at this time, but is recommended by state RAI coordinator.

2. When an Initial Admission assessment is required, but the resident is discharged before Day 14 of the stay and the Initial Admission assessment has not been completed, then a Discharge Tracking form using code 8 (“discharged prior to completing initial assessment”) can be completed in lieu of the Initial Admission assessment.
Provides key information to uniquely identify each resident. Must be completed whenever a resident re-enters the nursing facility following a temporary admission to a hospital or other health care setting, or if the resident was discharged. **Encode within 7 days after “event” (reentry).** See manual, pg. 2-25.

The state system must receive this information to enter the resident back into the state database.

Section AA - Identification Information
Contains Items 1-9. Item 8, reasons for assessment has only one choice - 9. Reentry.

Section A - Identification and Background Information
Contains Items A4a, 4b and 6.

Item 4b. Has choices 1-8, to identify where the resident is admitted from at reentry.

**NOTE:** Make sure all identification information on these subsets is the same as the information on corresponding sections.

There are two conditions under which other forms accompany the re-entry tracking form. If the resident re-enters a facility following a temporary admission to a hospital or other healthcare setting and also meets significant change criteria, a comprehensive assessment must be completed, along with a basic assessment tracking form. If no significant change, a full assessment form must be completed along with the basic assessment tracking form.

**[Signature and Title Sections] [Date]**
MDS 2.0 Discharge and Reentry Flowchart

- Temporary home visit
- Temporary therapeutic leave
- Hospital observational stay < 24 hrs., where hospital does not admit and nursing home does not discharge

RESIDENT LEAVES NURSING HOME

Discharge or reentry tracking form NOT APPROPRIATE

- Permanent discharge to private residence
- Deceased in nursing home
- Nursing home discharges to hospital or other care setting
- Admitted to hospital (regardless of whether nursing homes discharges or formally closes record)
- Hospital observation stay > 24 hrs., regardless of whether hospital admits or

YES

Discharge tracking form REQUIRED

Initial Admission Assessment (AA8a = 1) completed for this stay?

NO

Discharge code = 7 on discharge tracking form

YES

Resident later returns to nursing home?

NO

- Further tracking NOT REQUIRED by Federal regulations
- Subsequent tracking may be completed at the nursing home’s option or as required by the State

- Further tracking NOT REQUIRED
- New Initial Admission assmt. (AA8a=1) REQUIRED
- Medicare 5-day assmt. REQUIRED if starting Medicare Part A covered stay

Discharge code = 6 on discharge tracking form

YES

Resident later returns to nursing home?

NO

- Reentry tracking form NOT REQUIRED
- Next scheduled assmt. REQUIRED if due or past due
- Significant change assmt. REQUIRED if significant change
- Medicare return/ readmission assmt. REQUIRED if Medicare Part A stay continuing
- Medicare 5-day assmt. REQUIRED if starting new Medicare Part A covered stay

- Reentry tracking form NOT REQUIRED
- Medicare return/ readmission assmt. REQUIRED if Medicare Part A stay continuing
- Medicare 5-day assmt. REQUIRED if starting Medicare Part A covered stay

- Further tracking NOT APPROPRIATE under Federal regulations

Discharge code = 8 on discharge tracking form

YES

Resident later returns to nursing home?

NO

- Reentry tracking form NOT REQUIRED
- Initial Admission assmt. (AA8a=1) REQUIRED
- Medicare return/ readmission assmt. REQUIRED if Medicare Part A stay continuing
- Medicare 5-day assmt. REQUIRED if starting Medicare Part A covered stay

- Further tracking NOT REQUIRED by Federal regulations
- Subsequent tracking may be completed at the nursing home’s option or as required by the State

YES

Return Anticipated?

NO

Discharge code = 7 on discharge tracking form

YES

Resident later returns to nursing home?

NO

- Further tracking NOT REQUIRED
- New Initial Admission assmt. (AA8a=1) REQUIRED
- Medicare 5-day assmt. REQUIRED if starting Medicare Part A covered stay

- Further tracking NOT REQUIRED
- Next scheduled assmt. REQUIRED if due or past due
- Significant change assmt. REQUIRED if significant change
- Medicare return/ readmission assmt. REQUIRED if Medicare Part A stay continuing
- Medicare 5-day assmt. REQUIRED if starting new Medicare Part A covered stay

- Further tracking NOT REQUIRED
- Initial Admission assmt. (AA8a=1) REQUIRED
- Medicare return/ readmission assmt. REQUIRED if Medicare Part A stay continuing
- Medicare 5-day assmt. REQUIRED if starting Medicare Part A covered stay

- Further tracking NOT REQUIRED by Federal regulations
- Subsequent tracking may be completed at the nursing home’s option or as required by the State
# Maximum Time Frames for MDS Completion, Data Entry, Editing, and Transmission

<table>
<thead>
<tr>
<th>RECORD TYPE</th>
<th>COMPLETE BY:</th>
<th>ENCODE AND EDIT BY:</th>
<th>CARE PLAN COMPLETION:</th>
<th>SUBMIT TO STATE BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Assessment (MDS &amp; RAPs)</strong></td>
<td>VB2</td>
<td>*VB2 + 7 Days</td>
<td>**VB4 + 7 Days</td>
<td>31 Days after Care Plan Completion Date</td>
</tr>
<tr>
<td><strong>Full Assessment without RAPs</strong></td>
<td>R2b</td>
<td>R2b + 7 Days</td>
<td>N/A</td>
<td>31 Days after Assessment Completion Date</td>
</tr>
<tr>
<td><strong>Quarterly Assessment</strong></td>
<td>R2b</td>
<td>R2b + 7 Days</td>
<td>N/A</td>
<td>31 Days after Assessment Completion Date</td>
</tr>
<tr>
<td><strong>Discharge Tracking Form</strong></td>
<td>R4 + 7 Days</td>
<td>R4 + 7 Days</td>
<td>N/A</td>
<td>31 Days after Form Completion Date</td>
</tr>
<tr>
<td><strong>Reentry Tracking Form</strong></td>
<td>A4a + 7 Days</td>
<td>A4a + 7 Days</td>
<td>N/A</td>
<td>31 Days after Form Completion Date</td>
</tr>
<tr>
<td><strong>Special Instructions</strong></td>
<td></td>
<td>*For comprehensive assessments, encode and edit MDS and RAP trigger information at VA(a) (RAP Summary - check if triggered)</td>
<td>**For comprehensive assessments, encode and edit care plan decisions at VA(b) (RAP Summary - Care Planning Decision)</td>
<td></td>
</tr>
</tbody>
</table>

**MDS Item VB2** = Date of the RN Coordinator’s signature on the RAP summary sheet (section V), indicating RAP analysis is complete.

**MDS Item VB4** = Date of the signature of person completing care planning decision on RAP summary sheet (section V), indicating which RAPs are addressed in the care plan.

**MDS Item R2b** = Date of RN assessment coordinator’s signature, indicating that the MDS is complete.

**MDS Item R4** = Date of death or discharge.

**MDS Item A4a** = Date of reentry.
The MDS Correction Request Form contains the minimum amount of information necessary to locate erroneous MDS records that have been accepted into the State MDS database.

The Prior Record Section must be completed EXACTLY as it appears in the erroneous record, even if the information is wrong. The information is necessary to locate the record in the State database.

Prior AA3 - Do not leave any boxes blank, if month or day is a single digit, fill in the first box with a 0.

Prior Date - Complete ONLY ONE.
If prior erroneous record is an assessment, complete A3a, Assessment Reference Date.
If prior erroneous record is a Discharge Tracking Form, complete R4, Discharge Date.
If prior erroneous record is a Reentry Tracking Form, complete A4a, Date of Reentry.
Fill in all boxes, if month or date is a single digit, fill in first box with a 0.

Refer to RAI Manual Chapter 5.
Correction Attestation Section

**AT1** - Denotes the number of successive correction requests.

**AT2** - Identifies whether correction request is being submitted to MODIFY or INACTIVATE a prior erroneous form.

**AT3** - Identifies the reason(s) for the error(s) that require modification of erroneous assessment or tracking from previously submitted and accepted by the State database.

**AT4** - Identifies the reason(s) requiring inactivation of an invalid assessment or tracking form previously submitted and accepted by the State database.

**AT5** - To identify the facility staff attesting to the completion and accuracy of the corrected information.

**AT6** - This date must be within 14 days of detecting an error in an MDS record that resides in the State MDS database. Fill in all boxes.

**AT7** - To identify the date the attesting facility staff certified the completion and accuracy of the corrected information.

**NOTE:** The date at AT6 must be the same or later than the dates at AT7.

Detailed instructions for determining when and how to use this form can be found in the “LTC Provider Instructions for Making Automated Corrections using the MDS Correction Request Form”. This manual can be downloaded from www.qtso.com/mdsdownload.htm
CORRECTION POLICY FLOWCHART

Data Correction
(Assessments and Tracking Forms)

Error Found in MDS Assessment or Tracking Form

Is Record Valid?²

Yes

Record Already ACCEPTED in State DB? Valid?

No

Is Record Valid?²

Yes

Send Inactive Request to State; Also Create and Submit New Record if Necessary

No

Send Modification Request to State

Clinical Correction
(Assessments Only)

Uncorrected Major Error?³

Yes

8+ Days > Final Completion⁴

No

Significant Change?

Yes

Perform and Submit Significant Change Assessment and Update Care Plan

No

Perform and Submit Significant Correction Assessment and Update Care Plan

For Assmts. Only

8

7

6

5

No Additional Action Required

No Additional Action Required

For Assmts. Only

---

¹Record has not been data entered, has not been submitted, or has been submitted and rejected.

²The record is valid if event occurred, resident and reasons for assessment are correct, and submission is required.

³The assessment in error contains a Major error that has not been corrected by a subsequent assessment.

⁴Final completion is Item VB4 for a comprehensive and R2b for all other assessments.