# Overview of New MDS

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## Countdown to October 1, 2023




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## Objectives

- Understand the changes to the MDS v1.18.11 effective October 1, 2023
- Understand the importance of social determinants of health.
- Develop action steps to partner with client facilities to support skilled services.

- ***Note: This training does not include <u>all</u> the revisions made to the RAI Guidance Manual.***

***https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual***



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## Global Changes to the MDS 3.0 RAI Manual

- Content updated with gender-neutral language.
- Minor updates to wording to enhance understanding.
- Coding examples modified to improve clarity.
- Quality Improvement and Evaluation System (QIES) was changed to iQIES.
- Revisions made pertaining to legal/proxy information for family member, significant other, and/or guardian/legally authorized representative to provide consistency.


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## Changes in V1.18.11

- Section A: Social Determinants of Health
- Section B: New Data Elements
- Section C: Changes in Cognitive Patterns Guidance
- Section D: Resident Mood Interview and Total Severity Score
- Section G: Functional Status
- Section GG: Functional Abilities and Goals


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## Changes in V1.18.11

- Section J: Health Conditions
- Section K: Swallowing/Nutritional Status
- Section N: Medications
- Section O: Special Treatments, Procedures, and Programs
- Section Q: Participation in Assessment and Goal Setting


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## 26 Deleted Items

| Item | Abbreviated Item Name | Item | Abbreviated Item Name |
|---|---|---|---|
| A0300 | Optional State Assessment | G0110H | Eating |
| A1000 | Race/Ethnicity | G0110I | Toilet Use |
| A1800 | Entered From | G0120 | Bathing |
| A2100 | Discharge Status | G0300 | Balance During Transitions & Walking |
| D0200 | PHQ9 | G0900 | Functional Rehab Potential |
| D0300 | Total Severity Score | J0500 | Pain Effect on Function |
| G0100A | Bed mobility | N0410 | Medications Received |
| G0110B | Transfer | O0100 | Special Treatments. Procedures, & Programs |
| G0110C | Walk in room | O0600 | Physician Examinations |
| G0110D | Walk in corridor | O0700 | Physician Orders |
| G0110E | Loco on unit | Q0100 | Participation in Assessment |
| G0110F | Loco off unit | Q0300 | Resident's Overall Expectations |
| G0110G | Dressing | Q0600 | Referral |



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## 5 Items Moved

| Item | Abbreviated Item Name | Moved to |
|---|---|---|
| A1100 | Language | A1110 (order of the responses flipped) |
| G0110J | Personal Hygiene | GG0130I (oral hygiene removed) |
| G0400 | Functional limit in ROM | GG0115 |
| G0600 | Mobility Devices | GG0120 |
| J0400 | Pain Frequency | J0410 |



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## 3 Items Revised

| Item | Abbreviated Item Name | Revised to |
|---|---|---|
| K0510 | Nutritional Approaches | Added Column ***1. On Admission***<br>Column 1, ***While Not a Resident*** is now Column 2<br>Column 2, ***While a Resident*** is now Column 3<br>Added Column ***4. At Discharge*** |
| Q0500 | Return to Community | New Q0500C to indicate the source of information for Q0500B: resident, family, significant other, legal guardian, other legally authorized representative, none of the above |
| Q0550 | Resident's Preference to Avoid Being Asked Question Q0500B | New Q0550C to indicate the source of information for Q0500B: resident, family, significant other, legal guardian, other legally authorized representative, none of the above |



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## 24 New Items

| Item | Abbreviated Item Name | Item | Abbreviated Item Name |
|---|---|---|---|
| A1005 | Ethnicity | D0700 | Social Isolation |
| A1010 | Race | GG0170FF | Tub/shower transfer |
| A1250 | Transportation | J0410 | Pain Frequency |
| A1805 | Entered From | J0510 | Pain Effect on Sleep |
| A2105 | Discharge Status | J0520 | Pain Interference with Therapy Activities |
| A2121 | Provision of Current Med List to Provider | J0530 | Pain Interference with Day-to-Day Activities |
| A2122 | Route of Med List Trans | N0415 | High-Risk Drug Classes: Use & Indication |
| A2123 | Provision of Current Med List to Resi at DC | O0110 | Special Treatments. Procedures, and Programs |
| A2124 | Route of Med List Trans | Q0110 | Participation in Assmt & Goal Setting |
| B1300 | Health Literacy | Q0310 | Resident's Overall Goal |
| D0150 | PHQ2 to 9 | Q06010 | Referral |
| D0160 | Total Severity Score | Q0620 | Reason Referral to Local Contact Agency (LCA) Not Made |



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## Many More Items Count Towards APU Compliance Threshold

| Item | Abbreviated Item Name | Item | Abbreviated Item Name |
|---|---|---|---|
| A1005 | Ethnicity | D0700 | Social Isolation |
| A1010 | Race | GG0170FF | Tub/shower transfer |
| A1250 | Transportation | J0410 | Pain Frequency |
| A1805 | Entered From | J0510 | Pain Effect on Sleep |
| A2105 | Discharge Status | J0520 | Pain Interference with Therapy Activities |
| A2121 | Provision of Current Med List to Provider | J0530 | Pain Interference with Day-to-Day Activities |
| A2122 | Route of Med List Trans | N0415 | High-Risk Drug Classes: Use & Indication |
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| B1300 | Health Literacy | Q0310 | Resident's Overall Goal |
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| D0160 | Total Severity Score | Q0620 | Reason Referral to Local Contact Agency (LCA) Not Made |



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## FY 2024 SNF PPS Final Rule

- Beginning with FY SNF QRP, the data completion threshold to avoid the 2% payment penalty is **raised from 80% to 90%**
- Beginning January 1, 2024, **100% of the required MDS data must be completed** (i.e. no 'dash') **on at least 90%** of assessments

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## SOCIAL DETERMINANTS OF HEALTH (SDOH)


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## The SDOH Data Elements

- Five of the six SDOH standardized patient assessment data elements are in Sections A, B, and D:
- A1005. Ethnicity.
- A1010. Race.
- A1250. Transportation.
- B1300. Health Literacy.
- D0700. Social Isolation.


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## What are SDOH?

- Social Determinants of Health (SDOH)
  - Are the conditions in which people live, work, learn and play
  - Affect a wide range of health risks and outcomes
- Adopted in the FY 2020 SNF PPS Final Rule
  - Delayed due to the COVID-19 public health emergency
- Already collected in other post-acute care (PAC) settings


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## Why are SDOH important to collect?

- Capturing standardized SDOH data helps to:
  - Understand factors at the individual, community, and population levels.
  - Improve quality of care and health outcomes.
  - Document and track health disparities.
  - Allow for comparison of SDOH data within and across PAC settings.
  - Support the collecting/sharing of data across certification, policy, and coordination agencies and stakeholders.


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## SECTION A


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## Section A:

- INTENT: The intent of this section is to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident potential care needs including access to transportation, and the home in which they reside.
- RATIONALE: The ability to improve understanding of and address ethnic disparities in health care outcomes requires the availability of better data related to SDOH, including ethnicity.


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## A1005: Ethnicity

NEW

**A1005. Ethnicity**
Are you of Hispanic, Latino/a, or Spanish origin?

| ↓ | Check all that apply |
|---|---|
| ☐ | A. No, not of Hispanic, Latino/a, or Spanish origin |
| ☐ | B. Yes, Mexican, Mexican American, Chicano/a |
| ☐ | C. Yes, Puerto Rican |
| ☐ | D. Yes, Cuban |
| ☐ | E. Yes, another Hispanic, Latino/a, or Spanish origin |
| ☐ | X. Resident unable to respond |
| ☐ | Y. Resident declines to respond |


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## A1005: Steps for Assessment

1. Ask the resident to select the category or categories that most closely correspond to their ethnicity from the list in A1005.
   - Individuals may be more comfortable if this question is introduced by saying, *"We want to make sure that all our residents get the best care possible, regardless of their ethnic background. We would like you to tell us your ethnic background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care"* (Baker et al., 2005).
2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
3. Ethnic category definitions are provided only if requested in order to answer the item.


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## A1005: Steps for Assessment *(cont)*

4. Respondents should be offered the option of selecting one or more ethnic designations.
5. Only use medical record documentation to code A1005, Ethnicity if the resident is unable to respond and no family member, significant other and/or guardian/legally authorized representative provides a response for this item.
6. If the resident declines to respond, do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).


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## A1005: Coding Instructions *(cont)*

- If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.
- Code X, Resident unable to respond if:
  - The resident is unable to respond, and
  - No other resources provided the necessary information
- Code Y, Resident declines to respond if:
  - The resident declines to respond
  - Do not code based on other resources (family, significant other, legally authorized representative or medical records)


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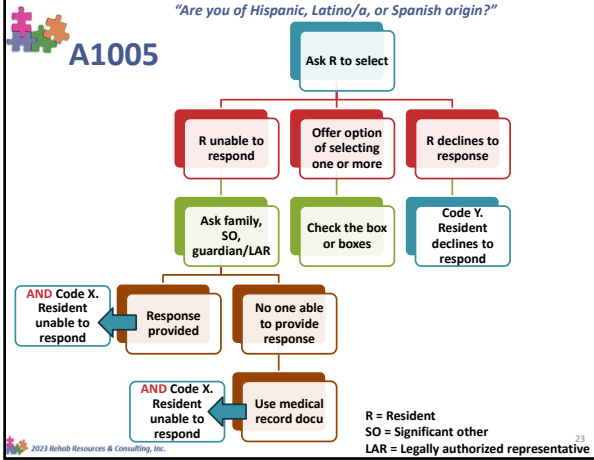
## A1005

*"Are you of Hispanic, Latino/a, or Spanish origin?"*




R = Resident
SO = Significant other
LAR = Legally authorized representative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## A1010: Race

NEW

**A1010. Race**
What is your race?

| ↓ | Check all that apply |
|---|---|
| ☐ | A. White |
| ☐ | B. Black or African American |
| ☐ | C. American Indian or Alaska Native |
| ☐ | D. Asian Indian |
| ☐ | E. Chinese |
| ☐ | F. Filipino |
| ☐ | G. Japanese |
| ☐ | H. Korean |
| ☐ | I. Vietnamese |
| ☐ | J. Other Asian |
| ☐ | K. Native Hawaiian |
| ☐ | L. Guamanian or Chamorro |
| ☐ | M. Samoan |
| ☐ | N. Other Pacific Islander |
| ☐ | X. Resident unable to respond |
| ☐ | Y. Resident declines to respond |
| ☐ | Z. None of the above |


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## A1010: Item Rationale

- The ability to improve understanding of and address racial disparities in health care outcomes requires the availability of better data related to SDOH, including race.
- Collection of race data provides data granularity important for documenting and tracking health disparities.
- Collection of race data is an important step in improving quality of care and health outcomes.
- Standardizing self - reported data collection for race allows for the equal comparison of data across multiple post - acute - care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.


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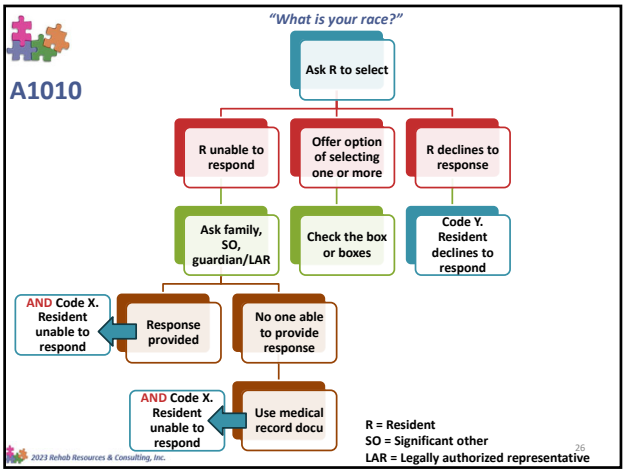
## A1010





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## A1250: Transportation

NEW

**A1250. Transportation (from NACHC©)**
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1

| ↓ | Check all that apply |
|---|---|
| ☐ | A. Yes, it has kept me from medical appointments or from getting my medications |
| ☐ | B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| ☐ | C. No |
| ☐ | X. Resident unable to respond |
| ☐ | Y. Resident declines to respond |




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## A1250: Item Rationale

- **Health - related Quality of Life**
  - Access to transportation for ongoing health care and medication access needs is essential for effective care management.
  - Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.
- **Planning for Care**
  - Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.


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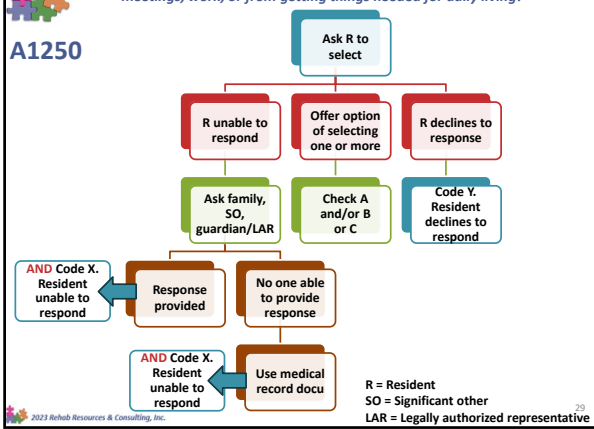
*"Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?"*

## A1250




R = Resident
SO = Significant other
LAR = Legally authorized representative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## SECTION B


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## B1300: Health Literacy

NEW

**B1300. Health Literacy**
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐ How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

*The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.*

- Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

**This is a self-report item.**
**No other source should be used!**


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## B1300: Item Rationale

- Poor or low health literacy
  - Interferes with communication between provider and resident.
  - Can affect residents' ability to understand and follow treatment plans, including medication management.
  - Is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use.


- Planning for Care
  - Assessing for health literacy will facilitate better care coordination and discharge planning.


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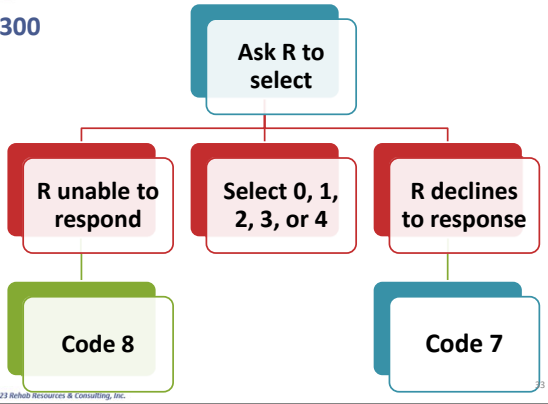
## B1300

*"How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"*





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## SECTION D




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## Section D: Intent, Rationale

- The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity.
- It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.
- Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness and a predictor of mortality, and is important to assess in order to identify engagement strategies.




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## D0700: Social Isolation

NEW

**D0700. Social Isolation**

Enter Code ☐ How often do you feel lonely or isolated from those around you?

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

- Refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

This is a self-report item.
No other source should be used!




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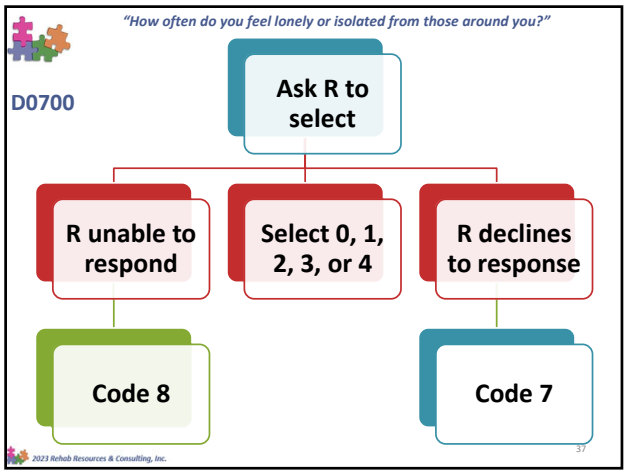
"How often do you feel lonely or isolated from those around you?"
D0700
Ask R to select
R unable to respond
Select 0, 1, 2, 3, or 4
R declines to response
Code 8
Code 7
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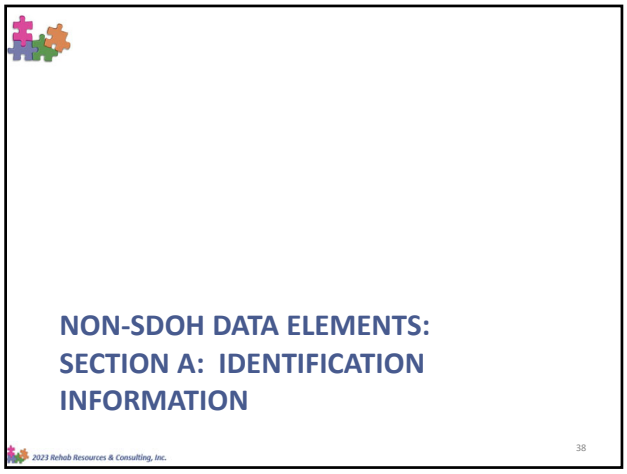
NON-SDOH DATA ELEMENTS: SECTION A: IDENTIFICATION INFORMATION
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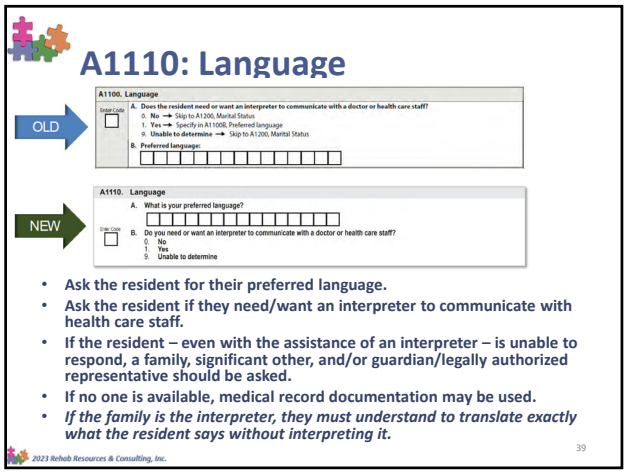
A1110: Language
OLD
A1100. Language
A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?
0. No → Skip to A1200, Marital Status
1. Yes → Specify in A1100B, Preferred language
9. Unable to determine → Skip to A1200, Marital Status
B. Preferred language:
NEW
A1110. Language
A. What is your preferred language?
B. Do you need or want an interpreter to communicate with a doctor or health care staff?
0. No
1. Yes
9. Unable to determine
Ask the resident for their preferred language.
Ask the resident if they need/want an interpreter to communicate with health care staff.
If the resident – even with the assistance of an interpreter – is unable to respond, a family, significant other, and/or guardian/legally authorized representative should be asked.
If no one is available, medical record documentation may be used.
If the family is the interpreter, they must understand to translate exactly what the resident says without interpreting it.
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## A1805: Entered From

OLD

**A1800. Entered From**

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehab**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Ca**
99. **Other**

NEW

**A1805. Entered From**

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

- **See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings.**



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## A2105: Discharge Status

OLD

**A2100. Discharge Status**

*Complete only if A0310F = 10, 11, or 12*

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric ho**
05. **Inpatient reh**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Ca**
99. **Other**

NEW

**A2105. Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

- **See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings.**



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## A2121 to A2124: Providing a Reconciled Medication at Discharge

NEW

- **Provision of List to Subsequent Provider**

**A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge**

Complete only if A0310H = 1 and A2105 = 02-12

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

**A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider**

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

| ↓ | Check all that apply<br>Route of Transmission |
|---|---|
| ☐ | A. **Electronic Health Record** |
| ☐ | B. **Health Information Exchange** |
| ☐ | C. **Verbal** (e.g., in-person, telephone, video conferencing) |
| ☐ | D. **Paper-based** (e.g., fax, copies, printouts) |
| ☐ | E. **Other methods** (e.g., texting, email, CDs) |



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## A2121 to A2124: Providing a Reconciled Medication at Discharge

NEW

- **Provision of List to Resident at Discharge**

**A2123. Provision of Current Reconciled Medication List to Resident at Discharge**
Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐ At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

**A2124. Route of Current Reconciled Medication List Transmission to Resident**
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

↓ **Check all that apply**

| | | Route of Transmission |
|---|---|---|
| ☐ | A. | **Electronic Health Record** (e.g., electronic access to patient portal) |
| ☐ | B. | **Health Information Exchange** |
| ☐ | C. | **Verbal** (e.g., in-person, telephone, video conferencing) |
| ☐ | D. | **Paper-based** (e.g., fax, copies, printouts) |
| ☐ | E. | **Other methods** (e.g., texting, email, CDs) |


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## A2121, A2123: Provision of Current Reconciled Medication at Discharge

- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care, and help subsequent providers reconcile medications, and it may mitigate adverse outcomes related to medications.
- Communication of medication information at discharge is critical to ensure safe and effective transitions from one health care setting to another.


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## Items Are Used in a New Quality Measure beginning 10/1/23

NEW

- Transfer of Health Information to the Provider
  - 2 items
  - 1. Did you provide the list?
  - 2. How
- Transfer of Health Information to the Patient
  - 2 items
  - 1. Did you provide the list?
  - 2. How
- Only <u>one</u> set of questions will be required at Discharge


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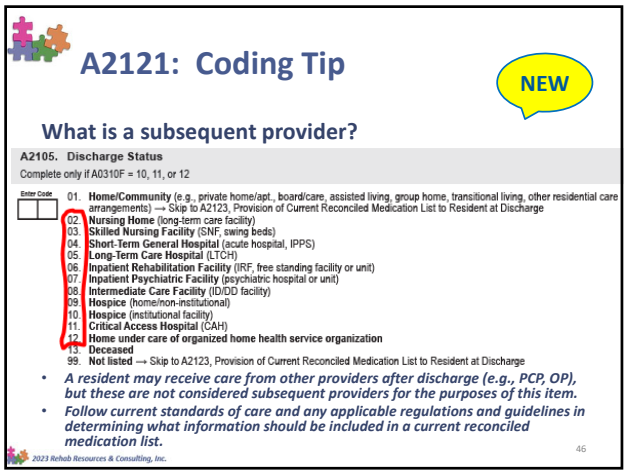
A2121: Coding Tip
NEW
What is a subsequent provider?
A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12
Enter Code
01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. Nursing Home (long-term care facility)
03. Skilled Nursing Facility (SNF, swing beds)
04. Short-Term General Hospital (acute hospital, IPPS)
05. Long-Term Care Hospital (LTCH)
06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit)
07. Inpatient Psychiatric Facility (psychiatric hospital or unit)
08. Intermediate Care Facility (ID/DD facility)
09. Hospice (home/non-institutional)
10. Hospice (institutional facility)
11. Critical Access Hospital (CAH)
12. Home under care of organized home health service organization
13. Deceased
99. Not listed → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
A resident may receive care from other providers after discharge (e.g., PCP, OP), but these are not considered subsequent providers for the purposes of this item.
Follow current standards of care and any applicable regulations and guidelines in determining what information should be included in a current reconciled medication list.
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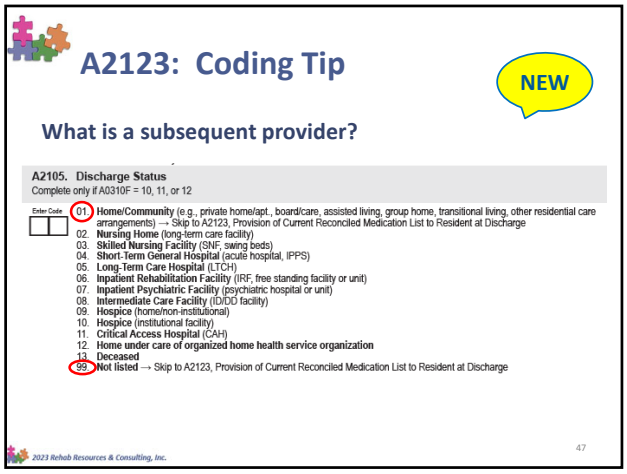
A2123: Coding Tip
NEW
What is a subsequent provider?
A2105. Discharge Status
Complete only if A0310F = 10, 11, or 12
Enter Code
01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. Nursing Home (long-term care facility)
03. Skilled Nursing Facility (SNF, swing beds)
04. Short-Term General Hospital (acute hospital, IPPS)
05. Long-Term Care Hospital (LTCH)
06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit)
07. Inpatient Psychiatric Facility (psychiatric hospital or unit)
08. Intermediate Care Facility (ID/DD facility)
09. Hospice (home/non-institutional)
10. Hospice (institutional facility)
11. Critical Access Hospital (CAH)
12. Home under care of organized home health service organization
13. Deceased
99. Not listed → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
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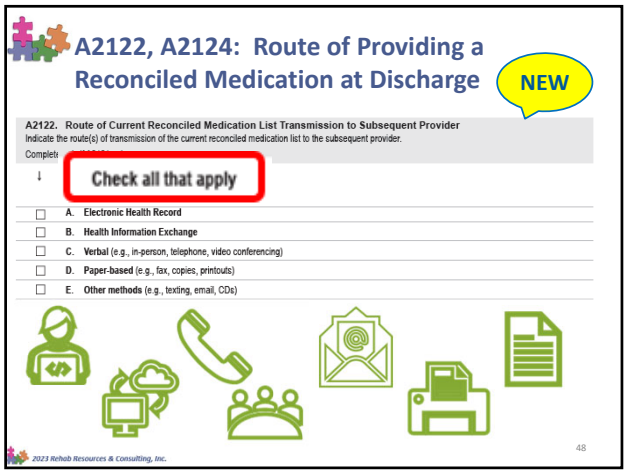
A2122, A2124: Route of Providing a Reconciled Medication at Discharge
NEW
A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Check all that apply
A. Electronic Health Record
B. Health Information Exchange
C. Verbal (e.g., in-person, telephone, video conferencing)
D. Paper-based (e.g., fax, copies, printouts)
E. Other methods (e.g., texting, email, CDs)
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## A2122, A2124: Route of Providing a Reconciled Medication at Discharge

- A. EHR/EMR: electronic version of resident's medical history (both discharging/receiving provider have common EHR (resident portal).
- B. Health Information Exchange (HIE): If you participate in a HIE and use it to electronically exchange the current reconciled list.
- C. Verbal: Verbally communicated the reconciled medication list (e.g., in-person, telephone, video conferencing).
- D. Paper-based: The reconciled medication list was transmitted using printout, fax or eFax.
- E. Other Methods: The reconciled medication list was transmitted using another method (e.g., texting, email, CDs).


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## SECTION C: COGNITIVE PATTERNS CHANGES TO GUIDANCE


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## General Changes to Section C

- **No new items!**
- Changes and updates were made to the cross-setting data element guidance to promote alignment with the other PAC settings.


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## SECTION C0200 – C0500: BRIEF INTERVIEW FOR MENTAL STATUS



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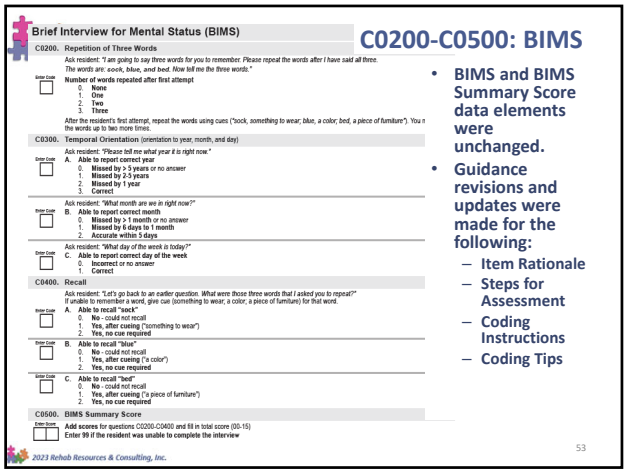
Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."

Number of words repeated after first attempt
0. None
1. One
2. Two
3. Three

After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You n the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: "Please tell me what year it is right now."

A. Able to report correct year
0. Missed by > 5 years or no answer
1. Missed by 2-5 years
2. Missed by 1 year
3. Correct

Ask resident: "What month are we in right now?"

B. Able to report correct month
0. Missed by > 1 month or no answer
1. Missed by 6 days to 1 month
2. Accurate within 5 days

Ask resident: "What day of the week is today?"

C. Able to report correct day of the week
0. Incorrect or no answer
1. Correct

C0400. Recall

Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"
0. No - could not recall
1. Yes, after cueing ("something to wear")
2. Yes, no cue required

B. Able to recall "blue"
0. No - could not recall
1. Yes, after cueing ("a color")
2. Yes, no cue required

C. Able to recall "bed"
0. No - could not recall
1. Yes, after cueing ("a piece of furniture")
2. Yes, no cue required

C0500. BIMS Summary Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview



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## C0200-C0500: BIMS

- BIMS and BIMS Summary Score data elements were unchanged.
- Guidance revisions and updates were made for the following:
  - Item Rationale
  - Steps for Assessment
  - Coding Instructions
  - Coding Tips

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## BIMS Steps for Assessment

REVISED

**Basic Interview Instructions for BIMS (C0200 – C0500):**

- Steps 1–2 and 4–8 remain unchanged (except for updates to gender - neutral language).

**Revised Guidance:**

- Step 3. Conduct the interview in a private setting, if possible.
- Step 9. If the resident chooses not to answer a particular item, accept their refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect/no answer or could not recall.
- If the interviewer is unable to articulate or pronounce any cognitive interview items clearly, for any reason (e.g., accent or speech impairment), have a different staff member conduct the BIMS.



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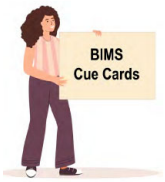
## Cue Cards for the BIMS in Writing




- When staff identify that the resident's primary method of communication is in written format, the BIMS can be administered in writing. The administration of the BIMS in writing should be limited to only this circumstance.
- CMS is offering a set of cue cards to assist providers in administering the BIMS in a written format.
- https://www.cms.gov/files/document/2023septembersnfbimscuecards.pdf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## Stopping BIMS: Incomplete Interview


Stop the interview after completing (C0300C) "Day of the Week" if:

- All responses up to this point have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated).
- OR
- There has been no verbal or written response to any of the questions up to this point.
- OR
- There has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.


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## Coding BIMS: Incomplete Interview

If the interview is stopped, do the following:

1. Code (-), dash in C0400A, C0400B, and C0400C.
2. Code 99 in the BIMS Summary Score (C0500), and if the assessment being completed is a standalone Part A PPS Discharge, continue to C1310. Signs and Symptoms of Delirium. Otherwise, proceed to Step 3.
3. Code 1. Yes, in C0600. Should the Staff Assessment for Mental Status be Conducted?
4. Complete the Staff Assessment for Mental Status.

NOTE: If all responses to C0300A, C0300B, and C0300C are coded 0 because answers are incorrect, continue the interview.


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## C0500. BIMS Summary Score Coding Instructions

REVISED

Code 99, Unable to complete interview if:

- a) The resident chooses not to participate in the BIMS.
- b) Four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or
- c) Any but not all of the BIMS items is coded with a dash (-).

C0500. BIMS Summary Score

Enter Score: ☐☐ **Add scores** for questions C0200-C0400 and fill in total score (00-15)
**Enter 99 if the resident was unable to complete the interview**

NOTE: A 0 score does not mean the BIMS was incomplete. For the BIMS to be incomplete, a resident must choose not to answer or must give completely unrelated, nonsensical responses to four or more items. If one or more the 0s in C0200-C0300 are due to incorrect answers, the interview should continue.



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## SECTION D: RESIDENT MOOD INTERVIEW AND TOTAL SEVERITY SCORE



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## General Revisions to Section D

- Existing items were renumbered.
  - D0150. Resident Mood Interview (PHQ- 2 to 9©).
  - D0160. Total Severity Score.
- New guidance for D0100. Should Resident Mood Interview Be Conducted?
  - If a resident cannot communicate, then Staff Mood Interview (D0500 A – J) should be conducted, unless the assessment being completed is a stand - alone Part A Prospective Payment System (PPS) Discharge; if that is the case, then skip to D0700. Social Isolation.
- New data element, D0700. Social Isolation was covered earlier.



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## D0150: RESIDENT MOOD INTERVIEW



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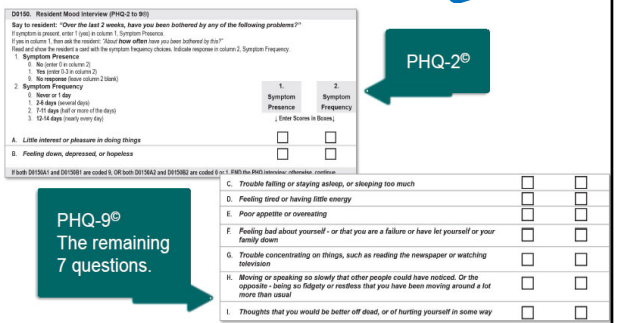
## D0150: PHQ-2 to 9©

REVISED






62

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## D0150: Steps for Assessment

REVISED

**Step 5. Be sure the resident can hear you.**

- Residents with a hearing impairment should be interviewed using their usual communication devices/techniques, as applicable during the interview.

**Step 9. Ask the first two questions (D0150A and D0150B) of the Resident Mood Interview (PHQ-2 to 9©).**

- Suggested language: "Over the last 2 weeks, have you been bothered by any of the following problems?"
- Each question must be asked in sequence to assess Symptom Presence (column 1) and Symptom Frequency before proceeding to the next question.



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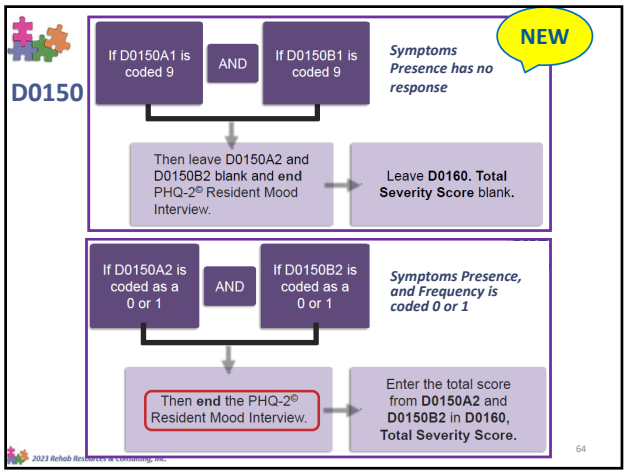
D0150
NEW
If D0150A1 is coded 9
AND
If D0150B1 is coded 9
Symptoms Presence has no response
Then leave D0150A2 and D0150B2 blank and end PHQ-2© Resident Mood Interview.
Leave D0160. Total Severity Score blank.
If D0150A2 is coded as a 0 or 1
AND
If D0150B2 is coded as a 0 or 1
Symptoms Presence, and Frequency is coded 0 or 1
Then end the PHQ-2© Resident Mood Interview.
Enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score.
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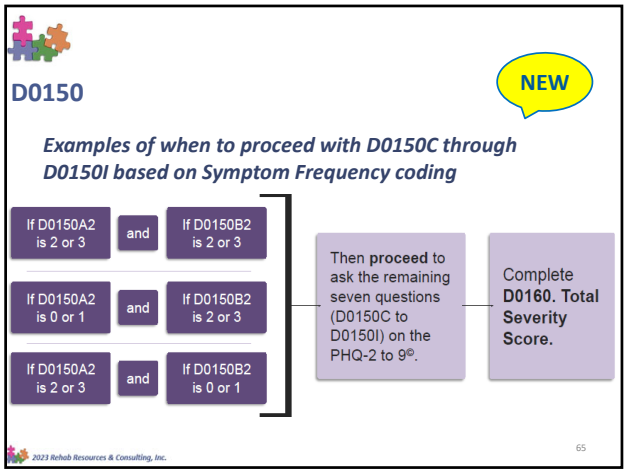
D0150
NEW
Examples of when to proceed with D0150C through D0150I based on Symptom Frequency coding
If D0150A2 is 2 or 3
and
If D0150B2 is 2 or 3
If D0150A2 is 0 or 1
and
If D0150B2 is 2 or 3
If D0150A2 is 2 or 3
and
If D0150B2 is 0 or 1
Then proceed to ask the remaining seven questions (D0150C to D0150I) on the PHQ-2 to 9©.
Complete D0160. Total Severity Score.
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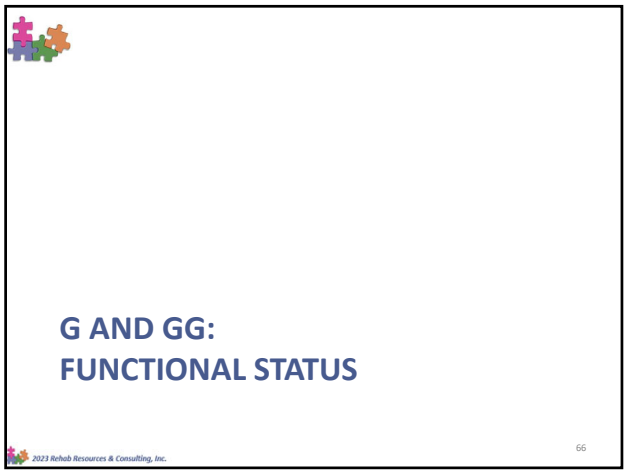
G AND GG:
FUNCTIONAL STATUS
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## Overview

| | |
|---|---|
| G0400. Functional Limitation ROM | GG0115 |
| G0600. Mobility Devices | GG0120 |
| G0110J. Personal Hygiene | GG0130I |
| G0120. Bathing | Tub/Shower transfer now GG0170FF |



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## GG0100. Prior Functioning

NEW

- Completing the stair activity for GG0100C indicates that a resident went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift) and/or with or without some level of assistance.
- Going up and down a ramp is not considered going up and down stairs for coding GG0100C.



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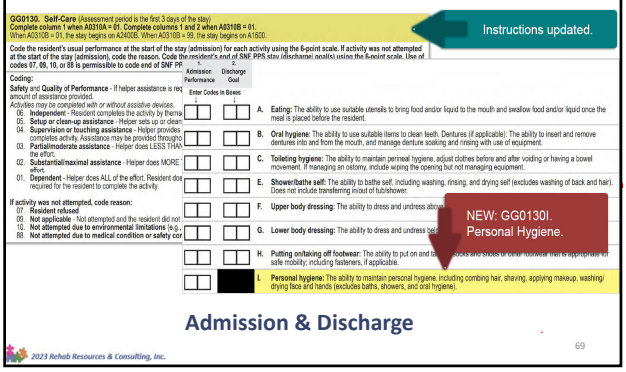
## GG0130. Self-Care
## GG0170. Mobility




Admission & Discharge



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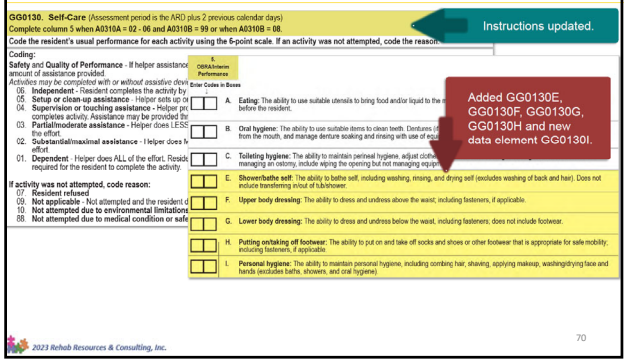
## GG0130. Self-Care OBRA/Interim




70

## GG0130 and GG0170 Steps for Assessment

REVISED

- For residents in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in A2400B. Start of Most Recent Medicare Stay. The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600. Entry Date.
- When completing an OBRA - required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.

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## GG0130 and GG0170 Steps for Assessment *(cont.)*

REVISED

- For residents in a Medicare Part A stay, the admission functional assessment, when possible, should be conducted prior to the benefit of services in order to reflect the resident's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

NOTE: "Prior to the benefit of services" means prior to provision of any care by facility staff that would result in more independent coding.

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## GG0130 and GG0170 Discharge

REVISED

- On standalone OBRA Discharge assessments (i.e., A0310F = 10 or 11 AND A0310H = 0), code the resident's usual performance during last 3 days of their stay (i.e., A2000. Discharge Date plus 2 previous calendar days).



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## GG0130 and GG0170 OBRA/Interim

REVISED

- For Section GG on the IPA or an OBRA assessment, providers will use the same 6-point scale and activity not attempted codes to assess the resident's usual functional performance during the 3-day assessment period.
- For Section GG on OBRA assessments other than the Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days).



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## GG0130 and GG0170 Discharge Goals

- *The FY 2024 SNF PPS Final Rule modified the requirement to set at least one Self-Care or Mobility Discharge Goal when A0310B=01.*
- *Effective October 1, 2023, this will no longer be required.*
- *A Discharge goal is not required for standalone OBRA assessments.*



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## GG0130 and GG0170 Coding Instructions

REVISED

- Guidance added to Code 04, Supervision or touching assistance.
  - Code 04, Supervision or touching assistance, if the resident requires only verbal cueing to complete the activity safely.
- Guidance added to Code 01, Dependent.
  - Code 01, Dependent, if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/standby assistance only and does not end up needing to provide hands - on assistance.
  - Code 01, Dependent, if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed).



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## GG0130A: Eating

Eating: ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is presented on a table/tray. Includes modified food consistency.

- The intent of GG0130A. Eating is to assess the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once themeal is placed before the resident.
- Assistance with tube feedings or parenteral nutrition is not considered when coding the item Eating.

- If a resident requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing.
- If a resident swallows safely without assistance, exclude swallowing from consideration when coding GG0130A. Eating.
- For a resident taking only fluids by mouth, the item may be coded based on the ability to bring liquid to the mouth and swallow liquid once the drink is placed in front of the resident.



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## GG0130C: Toileting Hygiene

Toileting Hygiene: Ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

- *When different levels of assistance are needed after voiding versus bowel movement, code based on amount of assistance required for the entire activity.*
- *If the resident has an indwelling urinary catheter and has bowel movements, code based on type/amount of assistance needed before and after moving their bowels.*

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## GG0130E: Shower/Bathe Self

**Shower/Bathe Self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.**

- ***Any location: Bed, At the sink, Shower/bath***
- ***If resident cannot bathe entire body, code based on amount of assistance to complete the entire activity.***



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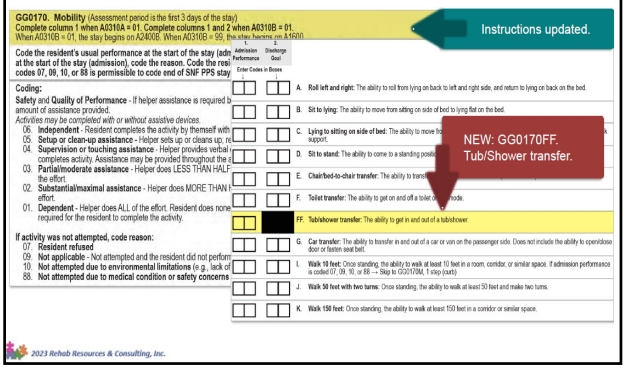
## GG0170: Mobility Admission and Discharge

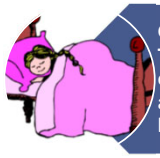





80

## GG0170A: Roll Left and Right

REVISED



**GG0170A – Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on the back on the bed.**

- ***If the resident doesn't sleep in a bed, clinicians should assess bed mobility activities using the alternative furniture that the resident sleeps on.***



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## GG0170C: Lying to Sitting on the Side of the Bed

REVISED

GG0170C - Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed ~~with feet flat on the floor,~~ and with no back support.

NOTE: GG0170C no longer includes "feet flat on floor" instruction.



82

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## GG0170E: Chair/Bed-to-Chair Transfer

Chair/Bed-to-chair Transfer: the ability to transfer to and from a bed to a chair (or wheelchair).

- *May be a stand-pivot, squat-pivot, or a sliding board transfer.*



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## GG0170FF: Tub/Shower Transfer

NEW to GG

Tub/Shower Transfer: Involves the ability to get into and out of the tub or shower. Do not include washing, rinsing, drying, or any other bathing activities in this item. If the patient does not get into or out of a tub/shower during the observation period, use one of he "activity not attempted" codes.



84

## GG0170G: Car Transfer

REVISED

Car Transfer: the ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

- *Does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening seat belt.*
- *If resident remains in a WC and does not transfer in/out of car/van seat, activity is not considered completed (use appropriate ANA code)*
- *Setup/clean-up of an assistive device used to get to/from car is not considered when coding the activity.*



85

## GG0170: WALKING ACTIVITIES

- Cannot occur without some level of resident participation that allows resident ambulation to occur for the entire stated distance.
- A helper cannot complete a walking activity for a resident.
- During a walking activity, a resident may take a brief standing rest break. If the resident needs to sit to rest, and is unable to complete the activity, use the appropriate "Activity not Attempted" code.
- Use clinical judgment if walking activities are combined.
- Walking on uneven surfaces can be assessed inside or outside.



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## GG0170M: One, Step (Curb)
## GG0170N: Four Steps
## GG0170O: Twelve Steps

The ability to go up and down a curb and/or up and down one, four, twelve step(s).

- *Completing stairs means a resident goes up and down the stairs, by any safe means, with or without any assistive devices and with/without some level of assistance.*
- *Getting to/from stairs/curb is not included.*
- *Ascending/descending stairs does not have to occur sequentially or in one session.*
- *Resident may take a break between ascending/descending 4 or 12 steps.*
- *If there is not a place to complete 12 steps, going up/down 4 steps 3 x is acceptable.*



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## GG0170P: Picking up Object

**Picking up Object: the ability to bend/stoop from a standing position to pick up a small object from the floor.**

- ***Assistive devices may be used.***



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## GG0170R: Wheel 50 Feet with Two Turns
## GG0170S: Wheel 150 Feet

**Wheel Fifty Feet with Two Turns**

**Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns**

**Wheel 150 Feet**

- ***If resident used a WC prior to admission to facility, code 1, Yes to gateway question.***
- ***Responses to GG0170R and S may be different on subsequent assessments.***



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## J:
## HEALTH CONDITIONS



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## Pain Assessment Interview Items

- Updates were made to replace "5 - day look - back period" with "last 5 days."
- Minor changes were made to enhance the clarity of J0100. Pain Management and J0200. Should Pain Assessment Interview Be Conducted?
- J0410. Pain Frequency – revised response options and coding instructions.
- J0510. Pain Effect on Sleep
- J0520. Pain Interference with Therapy Activities
- J0530. Pain Interference with Day-to-Day Activities


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## J0200: Should Pain Assessment Be Conducted?

REVISED

- Attempt to complete with all residents.
- If it is not possible for an interpreter to be present during the look - back period, code J0200 = 0 (No) to indicate the Pain Assessment Interview was not attempted, skip the Pain Assessment Interview items (J0300–J0600), and complete the Staff Assessment of Pain item (J0800).


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## Cue Cards for Pain Assessment Interview

- Alternative approaches, such as cue cards, may be helpful communication approaches to consider for some items and some residents. When conducting the Pain Assessment Interview, presenting the response options for the Pain Assessment Interview written on a cue card may help the resident respond to these items.
- CMS is offering a set of cue cards to assist providers in administering the pain interview in a written format. https://www.cms.gov/files/document/2023septembersnfpainassessmentinterviewcuecards.pdf.
- Code based on resident's interpretation of the provided response options. If the patient cannot choose, the assessor should code for the option with the *higher frequency.*

NEW


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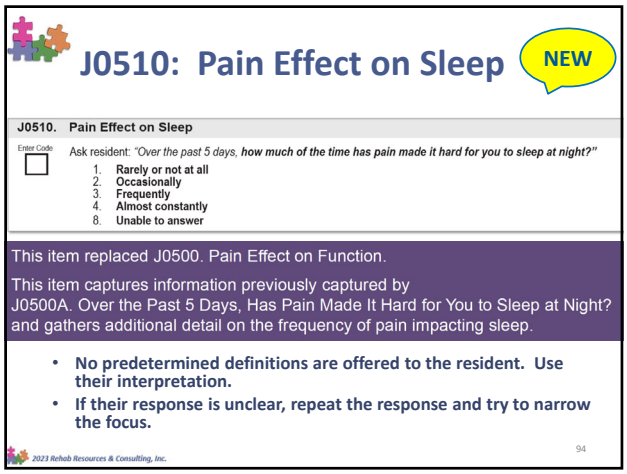
J0510: Pain Effect on Sleep
NEW
J0510. Pain Effect on Sleep
Enter Code
Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"
1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer
This item replaced J0500. Pain Effect on Function.
This item captures information previously captured by J0500A. Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night? and gathers additional detail on the frequency of pain impacting sleep.
• No predetermined definitions are offered to the resident. Use their interpretation.
• If their response is unclear, repeat the response and try to narrow the focus.
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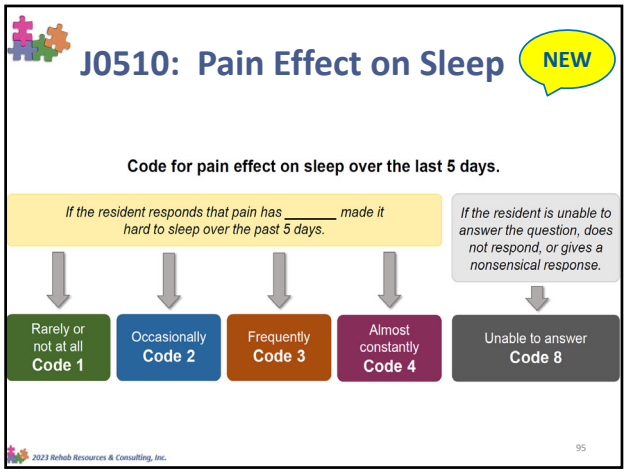
J0510: Pain Effect on Sleep
NEW
Code for pain effect on sleep over the last 5 days.
If the resident responds that pain has _____ made it hard to sleep over the past 5 days.
If the resident is unable to answer the question, does not respond, or gives a nonsensical response.
Rarely or not at all Code 1
Occasionally Code 2
Frequently Code 3
Almost constantly Code 4
Unable to answer Code 8
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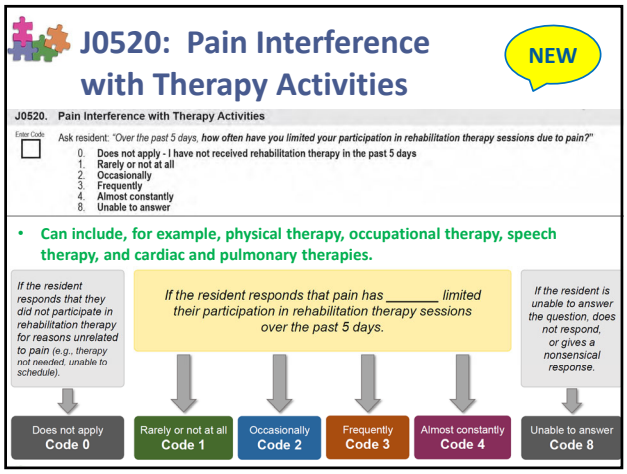
J0520: Pain Interference with Therapy Activities
NEW
J0520. Pain Interference with Therapy Activities
Enter Code
Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"
0. Does not apply - I have not received rehabilitation therapy in the past 5 days
1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer
• Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.
If the resident responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule).
If the resident responds that pain has _____ limited their participation in rehabilitation therapy sessions over the past 5 days.
If the resident is unable to answer the question, does not respond, or gives a nonsensical response.
Does not apply Code 0
Rarely or not at all Code 1
Occasionally Code 2
Frequently Code 3
Almost constantly Code 4
Unable to answer Code 8

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## J0530: Pain Interference with Day-to-Day Activities

NEW

**Code for pain interference with day-to-day activities over the last 5 days.**

*If the resident responds that pain has _____ limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.*

*If the resident is unable to answer the question, does not respond, or gives a nonsensical response.*

| Rarely or not at all Code 1 | Occasionally Code 2 | Frequently Code 3 | Almost constantly Code 4 | Unable to answer Code 8 |
|---|---|---|---|---|



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## K: NUTRITIONAL APPROACHES



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## K0520. Nutritional Approaches – Assessment Periods

**K0520. Nutritional Approaches**

Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***
   Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

| | 1. On Admission | 2. While Not a Resident | 3. While a Resident | 4. At Discharge |
|---|---|---|---|---|
| | ↓ Check all that apply ↓ | | | |
| A. **Parenteral/IV feeding** | ☐ | ☐ | ☐ | ☐ |
| B. **Feeding tube** (e.g., nasogastric or abdominal (PEG)) | ☐ | ☐ | ☐ | ☐ |
| C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ | [redacted] | ☐ | ☐ |
| D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) | ☐ | | ☐ | ☐ |
| Z. **None of the above** | ☐ | ☐ | ☐ | ☐ |



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## K0520. Nutritional Approaches – Assessment Periods

| Column 1, On Admission | Column 2, While Not a Resident | Column 3, While a Resident | Column 4 |
|---|---|---|---|
| Check all approaches performed **during** the first 3 days of the SNF PPS Stay. | Check all approaches performed **prior to** admission/entry or reentry to facility and within the 7-day look-back period.<br><br>Leave Column 2 **blank if resident was admitted/entered or reentered the facility > 7 days** ago. | Check all approaches performed **after admission/entry or reentry to facility and within** the 7-day lookback period. | Check all approaches performed **within** the last 3 days of the SNF PPS Stay. |


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## K0520A. Parenteral/IV Feeding – Coding Tips

REVISED

- K0520A includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home or at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.
- Supporting documentation should be noted in the resident's medical record as defined by the facility policy and/or according to State and Federal regulations.

- Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B.
- Do not capture in K0520C a trial of mechanically altered diet during the observation period.

NEW


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## Questions?


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## IDENTIFYING NURSING SKILL



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## Special Care High

**Special Care High: D, E, F, G**

| Skilling Condition | Management & Evaluation of Care Plan | Observation & Assessment of Patient Condition | Teaching & Training |
|---|---|---|---|
| **Septicemia (I2100)** | • Infection control<br>• Balanced diet<br>• Mange drug therapy, interactions, side effects<br>• Monitor condition for worsening<br>• Monitor lab values | • Assess if antibiotics are working<br>• Monitor fluid balance, urinary input/output<br>• BP and HR<br>• Dependent peripheral edema | • Review disease process<br>• How to manage<br>• Possible points of infection entry<br>• Infection control<br>• ID early warning |
| **Diabetes (I2900)**<br>**+**<br>**Insulin injections x 7 days (N0350A)**<br>**+**<br>**Insulin order changes on 2+ days (N0350B)** | • Diet appropriateness<br>• Monitor condition for worsening<br>• Monitor lab values, including urine albumin<br>• Implement SSI orders | • Assess BG before meals & at bedtime<br>• Assess hyperglycemia<br>• Assess hypoglycemia<br>• Monitor effectiveness<br>• Skin changes<br>• Assess pattern of activity levels<br>• Assess bowel sounds | • Importance of diet, eating<br>• Self-management<br>• Risks of neuropathy |
| **COPD (I6200)**<br>**+**<br>**SOB while lying flat (J1100C)** | • Observe s/s infection<br>• Monitor pulse oximetry<br>• Monitor use of oxygen<br>• Document SOB while lying flat and positions of comfort<br>• Regular turning<br>• Administer medications as prescribed | • Assess & monitor respirations, breath sounds<br>• Auscultate breath sounds<br>• Observe for persistent, hacking, moist cough<br>• Incentive spirometry<br>• Abdominal & pursed lip breathing | • Teach behaviors for airway clearance, cough<br>• Smoking cessation if applicable<br>• Effective coughing |



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## Special Care Low

**Special Care Low: H, I, J, K**

| Skilling Condition | Management & Evaluation of Care Plan | Observation & Assessment of Patient Condition | Teaching & Training |
|---|---|---|---|
| **Respiratory failure (I6300)**<br>**+**<br>**o2 therapy while resident (O0100C.2)** | • Observe s/s infection<br>• Monitor pulse oximetry<br>• Document use of oxygen<br>• Regular turning<br>• Administer medications as prescribed | • Assess & monitor respirations, breath sounds<br>• Auscultate breath sounds<br>• Observe for SOB<br>• Incentive spirometry<br>• Abdominal & pursed lip breathing | • Teach deep breathing techniques<br>• Smoking cessation if applicable<br>• Encourage activity<br>• Effective coughing |
| **Wound Care:**<br>➢ **2+ Stage II PU w/treatment (M0300B)**<br>➢ **Any Stage III or IV w/treatment (M0300C,D)**<br>➢ **2+ venous or arterial ulcers w/treatments (M1030)**<br>➢ **1 Stage II PU + 1 venous or arterial ulcer w/treatment (M0300A + M1030)**<br>➢ **Foot infection, diabetic foot ulcer, other open lesion w/ dressings to feet (M1040A,B,C)** | • Infection control<br>• Balanced diet<br>• Offloading (as appropriate)<br>• Mange drug therapy, interactions, side effects<br>• Monitor wound healing for worsening<br>• Manage nutritional intake with RD | • Assess effectiveness of wound treatments<br>• Weekly wound measurements<br>• Activity levels<br>• Cleanliness of proximal areas to wound(s) | • Review wound healing<br>• Dressing changes<br>• Possible points of infection entry<br>• Infection control<br>• Nutritional importance |
| **Dialysis while a resident (O0100J.2)** | • Monitor for fluid imbalance<br>• Manage laboratory tests (K+, Na+, Ca+, Mg, BUN, Creatinine)<br>• Medication administration<br>• Monitor skin for changes in color, turgor | • Assess rate, rhythm, cardiac conduction<br>• Assess activity level, response to activity<br>• Sodium Restrictions<br>• Adequate nutritional intake<br>• Assess before/after hemodialysis<br>• Oliguria | • Importance of fluid management<br>• Activity levels post-HD<br>• Educate on dietary needs<br>• Teach purpose of meds<br>• Teach elevation of legs as indicated |

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## Clinically Complex

| Clinically Complex: L, M, N, O, P, Q | | | |
|---|---|---|---|
| **Skilling Condition** | **Management & Evaluation of Care Plan** | **Observation & Assessment of Patient Condition** | **Teaching & Training** |
| **Pneumonia (I2000)** | • Observe s/s infection<br>• Monitor pulse oximetry<br>• Document use of oxygen<br>• Regular turning<br>• Administer medications as prescribed | • Assess & monitor respirations, breath sounds<br>• Auscultate breath sounds<br>• Observe for SOB<br>• Incentive spirometry<br>• Abdominal & pursed lip breathing | • Teach deep breathing techniques<br>• Smoking cessation if applicable<br>• Encourage activity<br>• Effective coughing |
| **Surgical wounds (M1200F or M1200G or M1200H)** | • Infection control<br>• Balanced diet<br>• Offloading (as appropriate)<br>• Monitor wound healing for worsening<br>• Manage nutritional intake with RD | • Assess effectiveness of wound treatments<br>• Weekly wound measurements<br>• Cleanliness of proximal areas to wound(s) | • Review wound healing<br>• Dressing changes<br>• Possible points of infection entry<br>• Infection control<br>• Nutritional importance |
| **Any of the following while resident:**<br>➢ **Chemotherapy (O0100A.2)**<br>➢ **O2 therapy (O0100C.2)**<br>➢ **IV medications (O0100H.2)**<br>➢ **Transfusion (O0100I.2)** | • Monitor for effectiveness/lack of treatments<br>• Manage laboratory tests<br>• Medication administration<br>• Monitor skin for changes in color, turgor | • Assess response to treatments<br>• Assess before/after treatments | • Activity levels post-treatment<br>• Teach purpose of meds |


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## Questions?


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