

PPS ALERT

FOR LONG-TERM CARE

Examining Section E: Correctly code behaviors and rejections of care



Continuing Education | Learning Objectives

After reading this article and accompanying sidebar, you will be able to:

- ▶ Define hallucinations and delusions
- ▶ Determine whether a behavior has an impact on others
- ▶ Define rejection of care and provide examples of what is and is not considered a rejection of care
- ▶ Discuss coding tips for the items in Section E, especially for residents with cognitive impairment
- ▶ Provide the correct coding for Section E examples included in the *RAI User's Manual*

The intent of Section E of the MDS 3.0 is to identify behavioral symptoms that may cause distress to the resident and others. However, coding this section has caused distress for many facilities since the October 1,

2010, implementation. The majority of the challenges facilities have faced with this section are due to difficulties with cognitively impaired residents and some misunderstandings about how to code rejection of care.

Before coding Section E of the MDS 3.0, SNF staff members must know what behaviors they should be looking at, how to determine impact, and when a behavior is considered a rejection of care. Staff should also know how a resident's cognitive impairment can affect the behaviors

“Behaviors may or may not be issues. You really have to look at it on a case-by-case basis.”

—Michelle Pandolfi, MSW, LNHA

addressed in this section and be able to correctly code despite the challenges often raised by cognitive impairment.

Psychosis and behavior symptoms

Although items E0100, Potential Indicators of Psychosis, and E0200, Behavioral Symptom—Presence and Frequency, may seem relatively straightforward, some facilities are struggling to correctly code these items.

First of all, facility staff must know what type of behaviors they should be looking for. According to the *RAI User's Manual*, a hallucination is “the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes, or touch.” A delusion is defined as “a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.”

Hallucinations or delusions may be associated with delirium, dementia, adverse drug effects, psychiatric disorders, and hearing or vision impairment, so it is important to not only identify the presence of these indicators, but also determine and address the underlying cause.

“I think most people are getting hung up on this section when it comes to residents who have dementia or

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Section E

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cognitive impairment,” says **Michelle Pandolfi, MSW, LNHA**, education advisor at the Connecticut Association of Not-for-Profit Providers for the Aging in Berlin. “Residents with cognitive impairments may experience hallucinations or delusions, or exhibit the behavioral symptoms in E0200 frequently. So some people get in the habit of saying, ‘Well, that is this resident’s baseline,’ or, ‘The resident always does that.’ With the MDS, you have to code a hallucination or behavioral symptom every time it occurs, even if it is the norm for the resident, and care plan accordingly. That is going to be important in order to track changes over time.”

It is also important to note that Section E focuses on the resident’s actions, not the intent of his or her behavior.

“We have to code the exact behavior, regardless of the intent or justification,” Pandolfi says.

Impact on resident and others

Determining whether a behavior is an issue for the resident or others can be a little more complicated than simply identifying the behaviors.

“Behaviors may or may not be issues. You really have to look at it on a case-by-case basis,” Pandolfi says. “If a resident carries around a baby doll and takes care of it because she believes it is her daughter, you will code that as a delusion. However, the impact on the resident or others may not be significant. Items E0500–E0600 examine physical injury, care, privacy, social interaction, and activities related to the resident and others.”

However, if a resident paces incessantly during mealtime and cannot sit still long enough to feed himself or be fed a sufficient amount of food, items E0500A and E0500B would both be coded as 1, yes. This is because the resident’s behavior is interfering with his personal care of feeding and is putting him at risk for malnutrition.

“If a resident whose lifetime profession was a construction worker believes he is on a job and goes around banging on walls or trying to fix things, that would most likely have an impact on others,” Pandolfi says. “In this type of situation, you may code a 1, yes, under E0600, Impact on Others.”

Although it is important to observe how others react to a resident’s behavior, some behaviors should be coded as affecting others regardless of their reactions. According to the *RAI User’s Manual*, E0600B—Did any of the identified symptoms significantly intrude on the privacy or activity of others?—should be coded “based on whether the behavior violates other residents’ privacy or interrupts other residents’ performance of activities of daily living or limits engagement in or enjoyment of informal social or recreational activities to such an extent that it causes the other residents to experience distress (e.g., displeasure or annoyance) or inconvenience, whether or not the other residents complain.”

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Take rummaging, for example. If a resident wanders into another resident's room and rummages through the other person's things, facility staff needs to code E0600B as 1, yes, even if the other resident doesn't mind or complain. This is because the behavior is still an invasion of the other resident's privacy.

Rejection of care

One of the most problematic items in Section E is most likely item E0800, Rejection of Care. In this item, facility staff members are to code whether the resident rejected evaluation or care during the look-back period that is necessary to achieve the resident's goals for health and well-being.

"Item E0800 is one area that I think may be causing a lot of confusion because the item set has not been changed to match the wording in the RAI," says **Ann Spenard, RN, MSN**, director of business development at Qualidigm in Rocky Hill, CT.

Currently, the item set says, "Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and/or determined to be consistent with resident values, preferences, or goals." However, the manual was revised to remove the word "or" from "and/or." According to Spenard, CMS plans to do the same with the item set when it makes revisions.

"So even though the item set has 'and/or' in the directions, it really has to be that you do not code behaviors as rejections of care if you talked and planned for this behavior *and* determined that it is in line with the resident's values, preferences, or goals," she says.

So, for example, if a resident states that he doesn't want therapy, has a valid reason, and has discussed the issue with you, you would change the resident's goals to reflect his informed choice to forgo therapy services, Pandolfi explains. Then, if he ever refuses therapy in the future, it would not be considered a rejection of care because the refusal has been addressed in the care plan and is consistent with the resident's values, preferences, and goals.

"We get a lot of resistance or rejection of care from cognitively impaired residents, often because they just

can't process what we are doing to them. They don't understand that we are just trying to help them, wash them, or get them dressed, so they resist care or act out," Spenard says. "We will probably see rejection of care much more frequently in someone who is cognitively impaired compared to someone who is cognitively intact."

Coding rejections of care from residents with cognitive impairment can be a challenge because these residents cannot always tell SNF staff why they are rejecting care. In these situations, facility staff should approach the resident's family, significant other, or guardian to determine whether the resident's current behavior is consistent with his or her preferences or past routine.

"For example, every time you go to give a resident a shower, she lashes out and tries to kick or hit you. But when you talk to the family, you learn that the resident never showered—she always took a bath," Spenard says. "So you start giving the resident baths, and she is a lot calmer. So now you have care planned for the resistant behavior, it is consistent with the resident's goals, and she is no longer rejecting the care, so it would be a resolved issue. Therefore, you would not code the rejection of showers on the next MDS."

E is for examples

Although coding Section E can present some challenges, the *RAI User's Manual* contains in-depth instructions and examples to help facilities code all sections of the MDS 3.0.

"Don't ever think that you have memorized the manual," Pandolfi says. "Our interpretation may be

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Section E

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different or what we recall may be incorrect; our memories aren't perfect, so we constantly need to refresh ourselves and review the manual."

Spenard agrees: "Most of the answers to people's questions can be found in the instructions and examples included in the manual." (*Note:* See below to read some of the Section E examples included in the manual.)

It is also extremely important for facilities to keep an eye out for changes to the *RAI User's Manual* and item set.

"CMS has said there will be an update to the manual in the spring, and the team is working on updates and clarifications to the manual right now. Not only do people have to keep reading the current manual, but they need to keep their eyes out for updates, read the updates when they are released, and replace those pages in their manuals or do whatever they need to in order to keep their manuals current," Spenard says. "The MDS 3.0 will not be a stagnant form or manual, and keeping on top of the changes will be crucial to your facility's success." ■

Section E coding examples

The following are Section E coding examples taken directly from the *RAI User's Manual*.

Psychosis

1. A resident carries a doll that she believes is her baby, and the resident appears upset. When asked about this, she reports she is distressed from hearing her baby crying and thinks she's hungry and wants to get her a bottle.

Coding: E0100A and E0100B would both be checked.

Rationale: The resident believes the doll is a baby, which is a delusion, and she hears the doll crying, which is an auditory hallucination.

2. A resident reports that he heard a gunshot. In fact, there was a loud knock on the door. When this is explained to him, he accepts the alternative interpretation of the loud noise.

Coding: E0100Z would be checked.

Rationale: The resident misinterpreted a real sound in the external environment. Because he is able to accept the alternative explanation for the cause of the sound, his report of a gunshot is not a fixed false belief and is therefore not a delusion.

Behavioral symptoms

1. Every morning, a nursing assistant tries to help a resident who is unable to dress himself. On the last four out

of six mornings, the resident has hit or scratched the nursing assistant during attempts to dress him.

Coding: E0200A would be coded 2, behavior of this type occurred four-six days, but less than daily.

Rationale: Scratching the nursing assistant is a physical behavior directed toward others.

2. A resident throws his dinner tray at another resident who repeatedly spit food at him during dinner. This is a single, isolated incident.

Coding: E0200A would be coded 1, behavior of this type occurred one-three days of the last seven days.

Rationale: Throwing the tray is a physical behavior directed toward others. Although a possible explanation exists, the behavior is noted as present because it occurred.

Impact on resident

1. A resident frequently grabs and scratches staff when they attempt to change her soiled brief, digging her nails into their skin. This makes it difficult to complete the care task.

Coding: E0500B would be coded 1, yes.

Rationale: This behavior interferes with delivery of essential personal care.

2. During the last seven days, a resident with vascular dementia and severe hypertension hits staff during incontinence care, making it very difficult to change her. During six of these days, the resident refuses all her medication,

including her antihypertensive. The resident closes her mouth, shakes her head, and will not take the medication even if re-approached multiple times.

Coding: E0500A and E0500B would both be coded 1, yes.

Rationale: The behavior interferes significantly with delivery of the resident's medical and nursing care and puts her at clinically significant risk for physical illness.

Impact on others

1. A resident, when sitting in the hallway outside the community activity room, continually yells, repeating the same phrase. The yelling can be heard by other residents in hallways and activity/recreational areas but not in their private rooms.

Coding: E0600A would be coded 0, no; E0600B and E0600C would be coded 1, yes.

Rationale: The behavior does not put others at risk for significant injury. The behavior creates a climate of excessive noise, disrupting the living environment and the activity of others.

2. A resident repeatedly enters the rooms of other residents and rummages through their personal belongings. The other residents do not express annoyance.

Coding: E0600A and E0600C would be coded 0, no; E0600B would be coded 1, yes.

Rationale: The rummaging is an intrusion and violates other residents' privacy regardless of whether they complain or communicate their distress.

Rejection of care

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

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

Rationale: The resident's departure is consistent with his stated preferences and goals for healthcare. Therefore, it is not coded as care rejection.

2. A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened during two of the past five days. The resident was previously fastidious, has recently expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

Coding: E0800 would be coded 1, behavior of this type occurred one-three days.

Rationale: The resident's care rejection behavior is not consistent with his values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.

Source: RAI User's Manual, Chapter 3, Section E, pp. E-3–E-17.

Breaking the ADL Code

Don't let inaccurate activities of daily living (ADL) scoring hinder your reimbursement under the MDS 3.0. Use this comprehensive, 20-minute video to train your entire nursing team—CNAs, RNs, and MDS coordinators—on the ADL documentation requirements under the MDS 3.0.

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For more information about Breaking the ADL Code: A Team Approach to MDS 3.0 Documentation, visit www.hcmarketplace.com/prod-8756.

Don't let the bed bugs bite: Proactive prevention

You've probably seen stories about these pests on the evening news or read about them online or in your local paper. In recent months, the United States has found itself in the middle of a bed bug resurgence, and no one is sure why.

The problem is most common in hotels. With a high turnover rate and occasionally less-than-stellar cleaning practices, bed bugs have been able to thrive in lodging locations nationwide. Homeless shelters have also been known as bed bug hot spots. But what are the chances of these apple seed-sized, flightless insects popping up in nursing homes and wreaking havoc among SNF residents?

Although infestations in nursing homes have been uncommon, they're not out of the question, according to **Libby Chinnes**, a consultant for IC Solutions, LLC, in Mt. Pleasant, SC. "There's not so much high turnover in nursing homes, but I feel like if it got started there that it could spread just like anywhere else," Chinnes says.

Lehigh Valley Hospital in Allentown, PA, has not directly faced a bed bug issue, but the hospital has admitted patients who have gotten bed bugs elsewhere, says **Terry Burger, MBA, BSN, RN, NE-BC, CIC**, director of infection control and prevention at the hospital.

"We have not identified a problem internally, but we have developed a policy so that if we did have to deal with it internally, we'd be sure that our employees knew exactly what to do," Burger says. She encourages SNFs to take the same proactive approach to prevention and management. It's impossible to prevent bed bugs entering the facility via a resident's luggage and other personal items, but if a facility is prepared to handle a bed bug problem, it's more likely to reduce its risk of infestation.

And as the bed bug epidemic persists, it may be just a matter of time before nursing homes are affected to some degree.

The bed bug resurgence

The exact cause of the bed bug resurgence in the United States is not known. Determining a specific, single cause

seems highly unlikely; instead, there is speculation that a handful of factors have contributed.

"The thought is that international travel, resistance to pesticides, changes to pest control practices—that's why we've seen the reemergence," Chinnes says.

Whatever the reasons for bed bugs' increased prevalence, they are pests that nursing homes must be aware of and defend against.

The presence of bed bugs is not determined by the cleanliness of the living conditions where they're found. This goes against the popular belief that dirtier environments welcome the bugs. Another belief is that bed bugs spread disease, but this also has not been deemed true.

"Somehow this has all been attached to infection control, which is pretty interesting when you think about it because bed bugs have nothing to do with infection control at all," says Burger. "They're not known for transmitting any bloodborne pathogen diseases, but because it's a bug, it naturally comes back to [infection control]. So we have to educate people that this is something for pest control. They need to get someone in who can deal with bed bug infestations."

Education is critical

Education is paramount when it comes to preventing and managing a bed bug outbreak.

"Part of [our policy] is education: making sure people know what they look like, what they're looking for, where they'd find them," Burger says. "So education is critically important, as is making sure they have a reference to go to in the event that they do identify them."

For early identification to take place, she adds, staff members need to have the information up front, especially when it comes to the signs and symptoms of a bed bug infestation, which include bite marks.

"They usually bite on the areas that wouldn't be covered by your pajamas at night—so face, neck, arms, and hands," says Chinnes. "It's a painless bite. They inject anesthetic when they bite, so you don't feel it."

It may take them about 10 minutes to feed and then they're gone."

Additional signs include:

- ▶ The bed bugs themselves in the folds of mattresses or sheets
- ▶ The bed bugs' exoskeletons after molting
- ▶ Rusty-colored blood spots due to the blood-filled fecal material that the bed bugs excrete
- ▶ A sweet, musty odor

Treating the bites and the bedroom

"We wanted to be able to give our staff the ability to identify [bed bugs] because obviously that's not the only bug that we have to deal with; there are lice and scabies and a number of other things," says Burger. "How you treat somebody with bed bugs is not how you treat somebody with scabies or lice. So it's important that somebody knows what they are identifying and recognizes the differences."

Whereas treatment for lice or scabies typically involves a topical neurotoxin, the standard treatment for bed bugs is usually hydrocortisone cream or an oral antihistamine, according to Chinnes. With persistent scratching, however, the bites could become infected and the individual could require an antibiotic.

"Some people have no reaction to the bites; some develop a red, itchy rash; and then others have a severe allergic reaction with severe itching and hives," says Chinnes.

Treatment doesn't end with the individual, however. The bed and room need to be treated as well, which includes washing and drying linens and clothing at high temperatures, disposing of unneeded items, bagging items such as stuffed animals and storing them at high temperatures for a prolonged period, and contacting a professional exterminator to treat the room.

The pest's tendencies

Bed bugs are capable of traveling over 100 ft. in one night, but they tend to live within 8 ft. of where people sleep. They remain in dark places during the day in a number of common, favorite spots.

"They'll hide in any nook or cranny—mattress bed frames, box springs, headboards, even picture frames, under peeling paint or wallpaper, on the carpet near the baseboard, in upholstered furniture, even under electrical outlets," says Chinnes. "They're so flat that they can get in the tiniest crack."

Eliminating all of the potential hiding places for bed bugs is impossible, but nursing homes can take one simple precautionary measure to help reduce the chances of a bed bug infestation: remove unnecessary clutter.

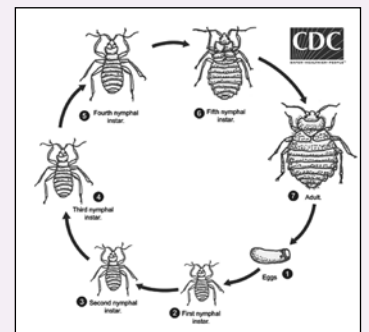
"Clutter is bad because it provides dark places to hide," says Chinnes. "We need to keep the room as de-cluttered as we can. If they did get started in there, it could really be bad."

If a SNF is seriously struggling with a bed bug problem, it could consider changing its furniture and décor. Bed bugs like wood and fabric more than metal and plastic. The problem is that the SNF is the resident's home and it shouldn't look like such a sterile environment, Chinnes explains. The biggest thing, she says, is being on constant watch for bed bugs and knowing what to look for, including the opportunity to decrease clutter and educate fellow staff members.

"It's critical to be proactive in looking for them," says Burger. ■

A closer look at bed bugs

Bed bugs (*Cimex lectularius*) are small, flat, parasitic insects that feed solely on the blood of people and animals while they sleep. Bed bugs are reddish-brown in color, wingless, range in size from 1 to 7 mm (roughly the size of Lincoln's head on a penny), and can live several months without a blood meal. The insects typically live for up to 10 months.



Source: CDC (www.cdc.gov/parasites/bedbugs/biology.html).

The discharge assessment: Frustration and the future

With the birth of the MDS 3.0, SNFs have faced a number of challenges, including the integration and management of multiple process changes. Entire assessment procedures and protocols in facilities across the country have needed to be reconsidered and often redone. Many of the adjustments hinge on the new assessment's patient-centered approach. In addition, the MDS 3.0 presents new documentation requirements. One of those comes in the form of the discharge assessment.

As outlined in CMS' 2010 "Train-the-Trainer" conferences, a discharge assessment must be completed by the SNF if a resident is discharged to a private residence (not a leave of absence), for admission to a hospital or other care setting, and in a hospital observation stay for greater than 24 hours.

There are two types of discharge assessments: return not anticipated (if the resident is not expected to return within 30 days; A0310F = 10) and return anticipated (if the resident is expected back at the SNF within 30 days; A0310F = 11).

Both types are similar to scheduled PPS assessments in terms of required information, so they should not be a major source of confusion—they may, however, be a source of frustration. With much of the information seemingly redundant, dedicating staff time to completing a planned discharge assessment may not be a welcomed choice.

But it's important to remember that completing the assessment is a requirement, and it's one that will likely hold substantial future benefits regarding resident well-being and the transition of care.

Breaking the assessment down

While facilities await those future benefits, SNF staff members need to understand how to complete the discharge assessment.

It will save facilities time if they remember that the discharge assessment can be combined with another

assessment, says **David Rokes**, chief operating officer at Post Acute Consulting, LLC, in New York City.

Although two scheduled PPS assessments can never be combined, a scheduled PPS assessment can be combined with an unscheduled assessment. In addition, any PPS assessment can be combined with any OBRA assessment, so long as the OBRA requirements are met.

"If you can combine them, go for it, because it's one less assessment that you'll have to do," Rokes says.

Combining appropriate assessments is one way to save time and energy. Staying organized and providing proper training is another.

"It's all about having a plan in place and making sure your team understands these assessments," says Rokes. "A lot of it has to do with the training they've had up to this point, too. Some people get a lot of internal training, external training; and others, it's almost like they're learning on the job. I think that's part of the issue with some folks—they just don't know what's expected."

To help explain and coordinate those expectations, Rokes says he advises all of his clients to take a few minutes at the end of their daily MDS meeting to cover all the bases, including due discharge assessments, with the appropriate staff members.

How to divide the responsibilities of the discharge assessment is up to individual facilities, says **Holly Sox, RN, RAC-CT**, MDS and staff development coordinator for NHC Lexington in West Columbia, SC. Some facilities have nursing complete all of the resident interviews, but Sox says her facility has chosen to split things up, which has served as an efficient method thus far.

"The way we have it set up here is that nursing does the pain assessment, social work does the BIMS and the PHQ-9, which is your cognitive and mood, and then activities does our daily preferences and activity preferences," she explains. "Then I can sit down with the chart and do the discharge assessment in 10–15 minutes."

Enter emergency discharges

But what about emergency discharges, when all of the assessments deemed necessary by the item set cannot be completed prior to the resident's discharge from the facility?

"All of the interviews are pretty much the same as the other assessments. The thing is, if it's an emergency discharge, then you're not going to have those interviews done," says **Margaret Leverette, RN, RAC-CT**, clinical reimbursement specialist at Community Eldercare Services in Tupelo, MS.

In those cases, facilities need to fill out the assessment as best as possible and can use dashes to complete the discharge assessment. Sox reminds facilities that it is never permissible to manufacture interviews for the sake of completing the discharge assessment.

"If you didn't get it done, you didn't get it done," she says.

As frustrating as it may be to use dashes rather than provide information, CMS is well aware of the difficulties associated with completing emergency discharge assessments, Rokes says.

"If you come in on Monday and the resident was discharged to the hospital on Saturday, you have no way to interview the resident—the only thing you can do is use dash codes on your assessment," he says.

However, it is important to note that an overreliance on dashes is also unacceptable.

The next logical step

For now, SNFs may feel like the discharge assessment is a redundant burden that serves little purpose for either residents or facilities.

"Because of our frequent flyers, the folks that are in and out of the hospital so frequently and the ones that are on Medicare, likely you've just done several other assessments in a short amount of time, and now you need to fill this one out. And there's still a lot of information to be gathered," Rokes says. But, he notes, CMS' intention behind the discharge assessment was not to create unnecessary or repetitive work for SNFs.

"I don't think the data is going to waste," explains Rokes. "CMS certainly intends on using this data. They want a clean picture of what the resident looks like when they're discharging. That's really the full purpose of doing this assessment."

In addition, the discharge assessment has the potential to be extremely helpful down the road.

"A national database where all of this information would go and it could be retrieved by whatever setting the patient was in to allow transition of care and continuity of care—if that's what we're moving towards, then that's wonderful," says Sox, highlighting the benefit of sending the discharge assessment with the resident to his or her next setting, such as home health.

The creation of such a database is not unlikely given the use of pay for performance, Rokes says. When acute discharge information starts getting roped into payment and a resident's condition upon leaving a facility is easily available, there are various benefits, he notes.

There is even the possibility of CMS adjusting discharge assessment requirements in the future based on timing and frequency, says Rokes.

"We're all kind of hoping for that down the road," he says. "So if you just did an assessment for the resident and he or she then discharges within a certain time frame, is it necessary to complete the entire discharge assessment? For example, if you just did a 14-day assessment yesterday and now the person is discharging on day 15. But we need to wait for that."

For now, facilities should remain positive and diligent regarding discharge assessments. They may be frustrating and seem relatively useless now, but their potential importance and value in the future is limitless. ■

Questions? Comments? Ideas?

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MDS professor

Test your knowledge of the MDS by answering the following questions.

1. During an F0400 interview, sometimes respondents give long or indirect answers to interview items. To narrow the answer to the response choices available, it can be useful to summarize residents' longer answers and then ask them which response option best applies. This is known as _____.
 - a. narrowing
 - b. clipping
 - c. levying
 - d. echoing
2. In F0500, Interview for Activity Preferences, a code of 4 means _____.
 - a. not important at all
 - b. not very important
 - c. somewhat important
 - d. very important
3. All information related to activities of daily living (ADL) on the MDS 3.0 assessment form can be found in Section G, which includes the self-performance and _____ coding categories.
 - a. support preparation
 - b. self-support
 - c. support provided
 - d. support phase
4. Under RUG-IV, the ADL index is 0–16.
 - a. True
 - b. False
5. Which of the following is not one of the four late-loss ADLs?
 - a. Transferring
 - b. Dressing
 - c. Bed mobility
 - d. Eating
6. In the self-performance category, which measures residents' participation and the level of necessary assistance when completing an ADL, code 2 should be used if residents require _____ to complete the activity.
 - a. supervision, encouragement, or cuing
 - b. non-weight-bearing assistance
 - c. weight-bearing assistance
 - d. complete and total assistance
7. Under the MDS 3.0, code _____ has been added to the self-performance category. The new code means that the activity occurred only once or twice during the look-back period.
 - a. 0
 - b. 5
 - c. 6
 - d. 7
8. Which of the following ADLs describes how a resident moves between surfaces (e.g., to and from a bed, chair, or wheelchair; or to the standing position)?
 - a. Support provided
 - b. Bed mobility
 - c. Transfer
 - d. Support preparation
9. The MDS 3.0 specifies that IV fluids or tube feeding must be for nutrition or hydration purposes to qualify under the _____ ADL.
 - a. transfer
 - b. personal hygiene
 - c. locomotion on unit
 - d. eating

Are you stumped? Wondering whether you got the answers? Find the correct answers at the bottom of p. 12. ■

PPS Q&A

*Editor's note: This month's "PPS Q&A" was modified from the HCPro book The MDS Coordinator's Field Guide 3.0, written by **Ellen J. Mullins, RN, BSN, CRNAC**. For more information about this book or to order a copy, visit www.hcmarketplace.com/prod-7291 or call customer service at 800/650-6787. To submit a question for upcoming issues, e-mail Managing Editor MacKenzie Kimball at mkimball@hcpro.com.*

Q What constitutes a significant change and would require the completion of a significant change in status assessment (SCSA)?

A A SCSA is a misunderstood assessment type among providers and surveyors alike. These assessments are often conducted too frequently and in the absence of a true significant change as a defense mechanism to prevent a citation. According to the *RAI User's Manual*, a significant change is a decline or improvement in a resident's status that:

- ▶ Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions
- ▶ Is not "self-limiting" (for declines only)
- ▶ Impacts more than one area of the resident's health status
- ▶ Requires interdisciplinary review and/or revision of the care plan

The *RAI User's Manual* lists guidelines on pp. 2-22 and 2-23 that are to assist in deciding whether a significant change has occurred. These guidelines are as follows:

- ▶ A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions
- ▶ A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement

- ▶ If there is only one change, staff may still decide that the resident would benefit from a SCSA
- ▶ Other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that he or she would require a comprehensive assessment and care plan revision
- ▶ Changes in the resident's condition that would affect the resident's functional capacity and day-to-day routine should be investigated in a holistic manner through the RAI reassessment
- ▶ A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement
- ▶ A SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future

> *continued on p. 12*

Get hands-on training for the MDS 3.0

The MDS 3.0 Boot Camp® is an intensive training program that focuses on accurate completion of the MDS 3.0 assessment and links the assessment process to clinical standards of care, quality outcomes, and reimbursement. The Boot Camp is a fluid program that always reflects the most recent changes issued by CMS.

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PPS Q&A

< continued from p. 11

However, the guidelines are just that—guidelines. The decision should be made by the interdisciplinary team (IDT) for specific reasons based on clinical knowledge of the resident.

The key to determination of a significant change in status is to know your resident. As intimidating as surveys might be, you know your residents better than the surveyors. Don't be afraid of the survey process or the surveyor. The *RAI User's Manual* states: "The final decision regarding what constitutes a significant change in status must be based on the judgment of the IDT." Highlight this sentence in your manual and—don't forget—document your decision and its rationale in the medical record.

Q What should we do if residents are not responding to our incontinence interventions or toileting programs?

Inherent in the wording of the regulations and the MDS manual, CMS has clearly expressed the expectation that "many" residents with incontinence will respond to toileting programs. Facilities should carefully evaluate the lack of improvement for residents who do not respond.

Facilities with high numbers of incontinent residents who do not show improvement should aggressively evaluate existing programs and how they are implemented.

Lack of resident improvement with toileting programs may be related to:

- Types of resident problems (e.g., similar medical issues that often include incontinence)
- Failure to properly implement programs
- Programs that are facility-centered rather than resident-centered

It is incredibly easy for surveyors to identify deficiencies related to incontinence based on incomplete or inconsistent documentation, observation, and/or incontinence without improvement during a brief inspection visit. Citations related to incontinence are valid across many areas of the regulations, including quality of care and quality of life.

Clinical judgment is necessary when determining success (or lack thereof) of a toileting trial or program. Documentation of that clinical decision is crucial regardless of whether changes are made so that clinical decisions are clear and available for future reference (i.e., avoidable vs. unavoidable). Deficiencies can easily result from a lack of documented information, especially in the event of a resident's change in status. ■

MDS professor answer key

Below are the answers to the MDS quiz on p. 10:

- 1. d. 2. a. 3. c. 4. a. 5. b. 6. b. 7. d. 8. c. 9. d.**

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An Integrated Approach to the LTC Industry

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FOR LONG-TERM CARE

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