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Thank you for holding, your conference will begin shortly. Thank you for your patience.

Look into the key to successfully coding MDS section G H and J.

I will be your operator. All participants are in a listen only mode. We will conduct question-and-answer sessions. I would like to turn the call over to pat.

I would like to welcome everyone to today's webinar. I am from mention Pacific quality health Wyoming and I will be hosting today's program along with Julia VanDyke and Laura Hudson in the Wyoming office of health care licensing and survey. We are pleased to be able to bring our program entitled keys to successfully coding sections G HVAC and -- HVAC and G -- H and J The sections that will be reviewed today include 3 areas which members of the national nursing home quality care collaborative are working diligently on to improve their quality measures. They include long stay residents with moderate to severe pain, residents who need help that have increased and low risk long stay residents with bladder incontinence. Please pay particular attention to ensure that your answers are correct so that you can be assured that your quality measures are being calculated correctly.

The handouts were distributed by email

[Indiscernible -- Low volume] and for them shortly. Please also put your comments and questions in the chat box and we will be sure to answer those questions. All of our lines are muted today and they will be opened at the end of the program for a question and answer period. The format for today's program will allow participants to stay actively engaged. Our speaker will present a scenario and you have the opportunity to answer how you think the NBS should be answered. Following polling they will provide an explanation for correct answers. At the exit, there will be added value -- evaluation. Please take the opportunity to complete it so we know how to improve this for next time and how it has been a value to you. Now I would like to introduce Julia who will be introducing today's speakers. Julie?

Thank you and good afternoon. Health care licensing and surveys are very pleased to once again have Jennifer Pettis providing education for our stakeholders. She currently works for Abt Associates as a nurse researcher and also the University of Albany school of Public health as an instructor. She previously worked for the centers for Medicare and Medicaid services as an expert. I personally have had the pleasure of hearing her speak several times and have found that she has an extraordinary knack for making MDS information understandable and accessible. Ladies and gentlemen please welcome Jennifer Pettis.

Thank you very much Julia and thank you to part at Mountain Pacific quality health and Julia and Laura at the office for health care licensing and surveys. I've been partnering with these ladies for six or seven years and I always appreciate them having me provide you folks with

information and I always appreciate how interactive all of you who join us on these webinars are. Your participation in the polling will hopefully keep you on your toes and give you opportunity to really reflect on your abilities or strengthening. So let's get started.

Session objectives and you are and we are going to look at all of them. How to guide your coding, 80 also performance and interpret the criteria on the MDS and we will talk about steps for assessing resident pain as well. They will be able to tell us -- for residents who can tell about their pain and those who cannot. The sections we are going to focus on I'd like to discuss a few principals who are -- that are essential to help you understand when you are assessing your residents. Let's take a look.

The first if you have ever been on a webinar or training you have seen this slide. We're looking at information that is up to date so as of March in 2016 and certainly the most up to date source of information to guide your coding is always the resident assessment instrument users manual which is available publicly, for free on the centers for Medicare and Medicaid website and that link is provided. Keep in mind that every state has a coordinator that are individuals like Julia in your state agency when the manual cannot answer your question, the coordinators are the folks who can help you with that. You can help provide the contact information on that link as well.

The look back period is the time period over which the condition of the residence or status captured on a particular MDS. They are going to be captured and if it did not occur, the generally 7 day period but made different generally than it is likely to be captured on the MDS.

The assessment reference date refers to the last day of the observations are look back period

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It also covers the time period and the facility is required to set the assessment reference date, we set those right in the computer and you are required to set it within the timeframe that the allowable window for that assessment is. It's going to vary based on the assessment as well.

I alluded to this already which is a standard look back period, 7 days unless it says otherwise.

The look back period generally does not include the hospital stay so does not begin until the resident enters the nursing home.

There are a few conventions that are important to inform how your different item sets will look. Based on how you code one particular item, it will direct you to skip over additional items or leave them blank. A great example is if you code a resident is being comatose you will skip all the information for the rest of section D and continue on the assessment in section G so you skip all of those things for comatose resident and move on to section G. Most sections allow you to use a --. The way to find out exactly which items those are, you can go to the data specifications and those are available on the website and it tells you which items will or will not allow a --. Usually they are set up to help you with that as well.

Let's move on and take a look at section G.

To assess the need for assistance with activities of daily living, we look at gate and balance and range of motion. Also and only on admission or the first when you are conducting on a resident, the opinions about the potential functional rehab improvement are coded there as well.

Let's start by defining the ADLs according to the users manual. The first is ADL and the other is aspects of ADL. They are a task that relates to personal care and if any of the items listed in G0100 a through J and also G and also G0120. They are components of ADL activity and it is important to understand there's -- we will go through those but when you are coding the only activities that you should consider are the aspects or components of those particular ADLs. Mobility includes how they move to and from a lying position, turns side to side and positions their body in bed or alternate set furniture like if they were to sleep in a recliner. That is what is included. Nothing else. You are always targeting those things. We will talk about personal hygiene and I will give you another example there to consider.

When you get into transfer, that includes how the resident moves between surfaces and how we go from a chair to bed to a wheelchair to a standing position it excludes how they moved to and from the toilet but I want to stress that transfer is a separate activity from ambulation. If the resident is in a wheelchair, that resident would be sitting in the chair and you will assist them and maybe one person, maybe two and they get ready together and they stand up. Now they are up to the Walker and ready to begin that activity to move ahead. Getting from suited to a standing position to get ready to walk is a transfer. Once it is up, then ambulation begins. They are two separate activities, city to city -- a standing to sitting, that up his ambulation. How the resident walks to be locations in his or her room. If we think about walking and then consider what about locomotion on and off the unit, it includes ambulation and how they move around in a wheelchair or other field devices.

Locomotion is how you move between locations in locations in their room or quarters on the same for. Note the distinction, not to other units or locations but if in a wheelchair you will consider self-sufficiency once they are in the chair, locomotion off the unit is how they moves to and returns from off unit locations. They may go to areas off the unit and if the facility is all situated on one floor, consider how the resident moves to and from distant areas on the floor. Consider self-sufficiency.

Think about how they take on and off articles of clothing, it also includes putting on and changing pajamas or how stresses. Because it is putting on and taking off close including pajamas this will capture the status of the resident in the morning or night as they dress for bad. It is quite likely that a status is going to differ between those if folks are a little more tired in the evening and require a little more help. Perhaps pajamas are more easy to take on -- put on -- dressing in the evening.

For eating, it includes how resident eats and drinks regardless of skill. Is not to include eating or drinking during a med pass and we often make residence more dependent than perhaps they need to be with medication so we want to make sure not to include that. It includes intake of nourishment by other means than just orally. They are administered for nutrition and hydration so if you are giving an IV but if you are providing fluids for that purpose.

Toilet use is listed next and I think they would be -- it would be more appropriate to be named management of elimination. It can include a toilet but doesn't have to. It can include how they use a toilet room or Komodo, it includes transfers on and off and have a cleanse themselves, any changing and managing of pads or how they are just clothing. Do not include emptying of the bedpan [Indiscernible -- Low volume]

For personal hygiene this includes how the resident maintains personal hygiene including calming their hair, brushing teeth, shaving applying makeup washing and drying face and hands and that is all. This is the one I mentioned that I would stress more about those aspects. Don't try to fit other grooming tasks into this. If the resident gets perineal care as a routine washing, that does not go into personal hygiene. Only what goes in is what is listed on the items that and in the manual. When you are coding this is not applying deodorant it is those items that are listed here. Including the ADLs when you are including prosthetics, you include braces and swings? No. They are not listed, it is prosthetic devices that are included.

There are 3 overarching steps for assessment. The first is to review the documentation and the second is to talk to the direct care staff to learn what the resident does during each episode as well as the type and level of help that the staff provides. Remind the staff that you are focusing only on that look back. The performance is likely going to vary from day to day or shift to shift. You want together various perspectives about how they are performing the ADLs.

The resident is observed. When you are interviewing staff, ask probing questions. Begin with general questions and proceed. For instance you may say tell me how she handles herself lying in bed. Well how about when she goes from setting up to lying down or the reverse, from lying down to sitting up. Really ask at the very specific questions about ADL performance.

When you are coding ADLs consider all episodes over the 24 hour period of those and keeping in mind those variations. There are many variations -- possible reasons why it occurs, maybe they physically cannot help you are cognitively they cannot understand, so you need to perform a little more or they may simply not be willing to do something at a particular time. Any is appropriate to capture what actually happens. Remember you are always coding what actually happened, but they could or should do but what actually happened. If they use adaptive equipment, maybe a dressing stick, the code based on the level of assistance even when they are using those things and an important consideration is when you are completing this section you are only coding based on what facility staff due for that resident. They are direct employees or something along those lines. They are still compensated by the facility but you cannot include folks that work outside of that. You cannot include hospice staff or the assistance of the family. You cannot have them come to your facility and provide care, it cannot be captured on this. So it goes back to who is paying for this staff and who is funding it. Who is the facility, then they are considered the facility staff even if they are a contract.

There is an algorithm and the intent of this was to augment, not replace the instructions, if I get a new piece of technology equipment like a new printer, they give you kind of this cheat sheet of a few pictures that show you the direction but I can't take that cheat sheet and understand everything I need to understand. The same is true with the algorithm. In order to use it you need to have a solid understanding of the instructions and the ADLs definition. You want to make sure

that you are using that only as a reminder and a tool, not as a standalone document. There are many pages so I can't stress enough to use that in conjunction with, not to place the instructions.

It is a two-part invite -- evaluation and column to that is is really recommended that happens after you have coded column 1 and its entirety. Most software's are not set up to allow that. Most will not let you go through and code all of column one but all of -- been all of: two that bed mobility for some performance, then for support rather than moving down south. Based on what the resident actually does and not what they would could or should do.

Those are a few hints, so let's move on and talk about the coding instructions for G -- G0100 column 1 which is ADLs of performance.

For coding zero, this would mean independence. They have completed that activity with no health -- help or oversight. Everything that occurred, every shift, every occurrence and the activity happened at least 3 times. They are providing oversight encouragement are queuing. Looking and talking but not touching. If it was provided three or more times during the last seven days. If the resident is highly involved in the activity or received physical help and guided maneuvering three or more times, think about guided maneuvering as nonweightbearing. If they are eating, it would be that the resident is able to lift the fork to the level of their mouths and you need to help them steer to get the fork from the side of the mouse centered better to where they can take a bite of food.

An example of lifting would be that the residents -- the hand is on the fork and at the level of their plight and you need to help get it up to their mouths and guided back and forth or help lift it but it is all about the difference of lifting and I think we need to be really careful looking at limited assistance. Limited sounds like a little an extensive sounds like a lot, but it is really not that way. It is are you bearing any part of their weight or not? Extensive is if they performed part of the activity over the last seven days, that could be weight-bearing support or full staff performance of the activity 3 or more times. I want to draw your attention to, it says weight-bearing support provided three or more times or full staff performance provided 3 or more times. It does not say weight-bearing support or full staff performance so you cannot combine weight-bearing support or full staff performance unless we will get to this, but as you are looking at the definitions, you're looking for three or more times. Did they have weight-bearing support three or more times? But not every time. That is the definition of extensive. When you are coding total dependence it means it was full staff performance with no participation by the resident and any of the aspects included in that and the ADL happened 3 or more times. If they participates, they cannot be total assistance for that ADL.

We have to codes that if the thing did not happen three times you will use these, that is a code of seven if it only occurred once or twice so fewer than three times or if the activity did not occur at all or family or not facility staff provided the care of the entire seven-day look back then you would code 8. They are relatively rare with the exception of ambulation, otherwise most of those are probably happening.

What about the rule of three? Is a method that was developed to help determine an appropriate -- appropriate coding for the cell performance. It only applies to the first column. G0100 column 1.

Accuracy depends on you having a solid understanding of the definitions and the rule of three. Correctly applying that role is dependent on first noting which ones occur, how many times they occurred, what type and level of support is required and I cannot stress enough we are looking at instances of ADL, not shifts and the whole time one CNA took care of them. For eating, your resident probably has 3 meals a day and a few snacks and some drinks at the bedside. All of those count into instances of eating. Don't overlook that and it is important to capture instances of ADLs.

There are 4 exceptions which are independence, total dependence, activity only occurred once or twice or the ADL did not occur. Please understand these are exceptions in that in order to code these the exact level must be met. You do however, if you have episodes of independence or total dependence you are counting those when you are determining if something happened three or more times. If the ADL happened six times and five of them were independent, the thing still happened six times.

We're going to review this rule and I want to stress that on these slides I have included shortened versions of the instructions. While I'm going to review them, what is on the slide are truly excerpts of more comprehensive versions of these directions that you will see in the users manual.

Let's go through this rule. When an ADL occurs three or more times you will apply the steps to the rule of three keeping the coding definitions for exceptions in mind to determine how you will code column 1. They are not multiple choice and you begin at the top and work your way through that meet your coding scenario. If number one applies it is not a multiple-choice and it is the first one to apply. If an activity occurs at anyone level code, if there are three instances, the code of three would be the correct one. When an activity occurs, could the most dependent level that could occur three or more times, an example would be if there are three instances a limited assistance and three of extensive. The assessor would choose the highest code that occurred three or more times and in that scenario you would code extensive. The third rule is the one that has caused folks the most confusion. The third will only be applied when the first or second does not fit the scenario. The third rule is when an activity occurs for your more times at multiple -- three or more times multiple levels but not three times at any given level. If you have any ADL that has occurred three times at any single level you are going to be coding that level. There is an exception. We will get to that in a minute.

The third rule is when an activity occurs, and then you apply the following. This would be an example where perhaps the resident was only there one day and two times you had to help them totally with bed mobility and two times they participate in a little bit. They had for total instances, 2 were number three and 2 were number 4. You combine them and they become extensive for coding.

When there is a combination of full staff performance that totaled three or more times you will code extensive. When there's a combination of full staff performance and weight-bearing assistance or nonweightbearing assistance you will code that is limited. If they are independent but then you had to help them you cannot cut them independent. Every other level only happened one time, I can't code them as limited because they only happened once and I can't cut them as

extensive. It defaults to supervision. That is an example of when none of the above are met. Once we go through the whole scenario, you will have a few seconds to click on your answers and we welcome your participation. We have 66 of you in attendance, 66 phone lines, we really want to hear from you. So here we go, supervision was provided 9 times. Limited assistance was provided three times. Extensive was provided once and total assistance was provided twice. At this time we are going to ask you to use the pool -- the poll to select how you would code G0 110. Which would you code? You will have about 20 seconds to code this so it is all anonymous, we will debrief that answer.

Can you tell me how we see the answers? Is that possible?

We have 5 seconds.

A lot of you did really well. The second whirl of three applies when an activity occurs three times at multiple levels to code the most dependent levels. They had 2 of self performance. Supervision and limited. Limited is the correct answer. Tempted to code the one occurrence of extensive and combined with the total, that is not how it works. We had the resident with supervision, limited assistance 3 times. That is the resident has two levels and we have the most dependent of those and that is limited.

That is one little change, you will notice that been provided three times it was only provided twice. Our documentation says that the president has the following so performance levels. Extensive assistance was provided once, and total assistance was provided twice. At this time and again going to ask you to choose the correct code. The same: we just look at, code 34 extensive and 4 for total. You have 15 seconds last -- left to record your answer.

I appreciate the participation. We will debrief this in just a moment. The correct answer is supervision. The first rule applies, when an activity occurs, code the level. The only one that they had occur three or more times was supervision. Great job with that.

The good news is that column 2 is a whole lot easier and the bad news is it is completely difference then column 1. All you are going to do is code for the most support provided over all three ships. You are looking for the single level of support provided and you code this column regardless of how the column was coded. Really important to remember that.

We are going to use no set up a physical help, this is set up help only and that would be a code of one, a code of two would be one person physical assist and the resident needs help from one person. A code of eight mins the activity did not occur.

Some general tips here, if you are coding bed mobility if they sleep in an alternative bed or a recliner or something you would code that. As far as supervision of close proximity, if they are getting individual supervision that is going to be counted general supervision of a dining room, that is your policy to only have a staff member that would not be captured. You did not include the NTN of that depends or others in toilet use.

With two feedings, I think the important point is that you will consider not only how they received that hydration and nutrition but do they participate in oral nutrition crack's -- nude -- nutrition?

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110 if they work with a speech therapist and it helps them -- they help them try fruit for pleasure, maybe they don't even participate very heartily but they do participate, you will not code that person is dependent. If they did not participate in that but they participate in oral feeding them they will be totally dependent if they have either totally to Fed or did not have any aspect of oral nutrition or participate in any aspect of their nutrition in any way.

The lesson is don't forget your oral feeding?

The resident had no elimination for seven days and it probably does not happen often, the resident maybe was on bed rest and did not move around at all the whole 7 days. They had absolutely no food or fluid for the entire 7 days, very unlikely. And any ADL if the family or not facility staff provided help every time for the entire 7 days, I would argue chances are that does not happen all that often.

Let's move on to bathing. The definition is noted here, how the resident takes a full body bath and includes transfers in and out of the bath or shower. It does not include washing the back or hair and very different from the ones we look at. You will code the maximum amount of help they had during all episodes of bathing.

You code independent if they required no help from staff, supervision if they only had oversight help, physical help limited to the transfer only is a 2 so they could perform the bathing activity but needed help with the transfer. Physical help means the resident had help with at least some aspect of bathing. They could have had help with the transfer there as well, total dependence if they don't participate in the transfer in and out of the bath, and the ADL did not occur with a coat of eight or other staff provided other bathing or showers.

Your support codes for bathing are exactly like they are for G0 110 which is no set up or physical help. Number one Mac is help only, -- set up hopefully, 2 is one person, 3 is more than two physical system and 8 ADL activity did not occur. This is an important one other bathing supervision, if it is your nursing home policy that all residents are supervised or they are never left alone in the bathroom for a shower or tub bath regardless of capability you can code the resident so performance as supervision even if it is precautionary because they are being individually supervised for the bathing.

Let's take another look at the scenario. For one bath, the resident received physical help of one person to position themselves in the bathtub. Because of her fluctuating mood she received total help for her other bath from one staff member. How would you code this? One Mac for supervision 2 for supervision limited to transfer only, physical help and part of bathing activity, or 4 total dependence? Code this item.

I appreciate your participation in these.

With bathing remember that directions state to code the most dependent level of so performance and support. For our resident that most dependent level was total help. They received total help so the correct answer would be total dependence.

This is different. Code D is the correct answer.

We will move quickly through the rest of section G and highlight these.

Next item is balance during transitions and walking. What I want to stress with all of these transitions that the interdisciplinary team members need to observe and document, observations during all of these transitions during that look back and if they have not been systematically documented in the record and then there is a test in the user's manual that redefines how they should be tested and there is an algorithm to help you code this. When you are coding all these transitions you need to reflect the least steady episode. If they use an assistive device it should reflect the status of use with that device.

Steady at all times, study but able to stabilize without staff assistance, and remember you are looking at least steady so if it happened in any time that was not steady you will code that. Only able to stabilize with staff assistance is a code of 2 and the activity -- if they activity did not occur it is 8. I will direct you to the user's manual for all of the details of those sections in the essence of time.

Functional limitation and range of motions, it is important to understand how it is defined in the users manual. It is defined as functional limitation and range of motion is limited ability to move a joint that interferes with daily functioning particularly with ADL places the resident is -- risk for injury. This is a three-step process. Determining if the resident has a limitation so testing upper and lower extremity range of motion and if they have a limitation you review the ADL's and directly observe the resident status and determine if the limitation interferes with function and places them at risk for injury and you code this is appropriate. -- As appropriate.

A code of zero is no impairment, full functional range of motion on the right and left side, one Mac if they have an impairment on one side that interferes a function or places them at risk for injury, code 2 if they have impairment on both sides. I want to give you an example of a resident who has mobility of limitation in there right elbow -- in the right elbow, they have lived with that and are able to brush their hair and teeth, feed themselves, do everything they could otherwise do which is not limiting functional mobility but maybe on the inside of their arm because of the tendon and skin you're worried about a pressure ulcer injury. That places them at risk for injury. Maybe you are doing special skin care. That would be functional limitations and even though they are brushing their hair you are saying we are concerned about the health of the resident.

If they have less severe of a contractual you are not worried about the skin. If they are getting around find it's not going to be a functional limitation.

So it is really not is there a limitation alone, it is all about function.

With mobility devices, we have a cane crutch walker, a cane would include like a tripod cane or a quad cane. A wheelchair would be manual or electric, limb prosthesis or none of the above so I have a question for you guys. We can bring this up relatively quickly, a simple yes or no question. Mrs. Smith sits in a Jerry chair when out of bed. It propels to all destinations. Should this be included in G in G0 600 see?

Yes you should or no you shouldn't. It is only wheelchairs.

Yes her Jerry chair -- her chair has wheels so we coded or know it is only wheelchairs?

This is not a question you would find in your manual unless it has been updated and I have not seen it but I don't think that is the case. It has been answered by CMS and I want to share the answer because I have been on the receiving end and that is only limited to coding wheelchairs. It is one of those examples where you do not include any chair because it has chairs with wheels, so it is not included. Only wheelchairs whether they are motorized are not motorized, you will include them but no others.

Our last question -- our last item is functional rehab potential and only going to be completed with over admission assessment. There are 2 questions when you are in G 0900 a, if they believe they are capable of improvement, they indicate whether staff believe they, the resident is capable of potential improvement. So zero is no, one is yes, 9 is unable to determine and that is only an option when you are addressing the belief of the resident.

Let's move on to section 8. You are looking at bowel and bladder and gathering information about appliances, urinary and bowel incontinence, training programs, and patterns as well.

I realize we have two sections to continue to move through but these should move a bit quicker than ADLs. The first item is appliances. Indwelling catheters, we will include nephrostomy's, external catheter is B and ostomy will include several. Intermittent catheterization is captured and it is not going to capture one-time catheterization like in order to obtain a urine specimen, it is to manage urinary output.

The next item we go to is a -- program. The most recent admission entry or reentry or urinary incontinence as first noted in the facility. There needs to be evidence of that trial that includes observations of at least 3 days of patterns with prompt recording of results simply track incontinence and incontinence does not count for this. It needs to be individualized resident centered programs. With this you will code 0, yes if they did, it is resident centered, 9 if you are unable to determine or you cannot determine if one happened or code 9, if you cannot determine you will skip the next item. If that is the case. You would skip H 200 be , they are very self-explanatory. The one I want to mention is a 9 if you could not determine what the response was you cannot determine it yet because the trial is still in progress.

Current toileting program or trial is exactly what it sounds like. You have the program going on but it needs to be individualized resident specific program. There is evidence that it was communicated to the staff is appropriate to the resident verbally and the care plan, you have a

written report and notations and evaluations, so what happened as a result of it? There is information in appendix C that you will find helpful. Stomach urinary incontinence --

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When we talk about incontinence I want to stress that we are looking at episodes, not ships or days -- shifts or days. Usually if they have a UTI in our complete the continent, they have incredible urgency and frequency and are running to the bathroom and are a little bit what, they go 15 times that day because of a urinary tract infection, that resident has had 7 or more episodes, it will be frequency -- frequently incontinent so you are looking here at specific directions. Always incontinent is what it sounds. A coat of one is occasionally incontinent. Less than seven episodes of incontinence, frequently incontinent, they have been incontinent at least once but have had 7 or more episodes three, they are always incontinent and nine is not rated. That includes that they have a catheter or they have a urinary ostomy or no output for the entire 7 days.

Here is a scenario. Mr. Albert has one incontinent void after a 70 look back. After the assistant assisted him to help with clothing all others were incontinent. How should H0 300 urinary continence be coded?

Is this zero, always incontinent, occasionally incontinent, frequently incontinent, always incontinent, or 9 not rated?

He had one urinary void and all the others were incontinent. You have about 10 seconds. I think you will have a couple more.

The resident had just one during the look back period, all the rest of his were incontinent. Let's see what the results were. Frequently incontinent, that's correct.

Bowel and continence, the coding instructions are similar. For occasionally incontinent it is one episode, frequently incontinent is 2 or more and at least one continent p.m., and number one is not rated. -- Number nine is not rated.

Bowel toileting program we will have the same requirements so it is individualized based on the needs of the resident and will be documented and communicated to staff. Do they have that? Yes or no?

A constipated? It is to find as 2 or fewer PMs or if the resident stool is difficult to pass regardless of frequency? That does it for section H and we are on to our final section which is Jay, health conditions. Here we will document a number of conditions that really impact functional status and quality of life. Pat mentioned the pain quality measure and pain management, so important as we look at managing their pain and assessing pain completely. They have some great information and great assessment tools so I encourage you to use this section to its full potential. There's a lot of great information and opportunities to help the resident I believe.

We will begin by determining all interventions for pain provided to the resident during the look back. Even if the resident currently denies pain, if you are doing a great job managing their pain that is wonderful but be sure to take credit for it. The first item is on a medication regime and

going to code know if the medical record does not contain documentation and one Mac yes if they do have the documentation that they received their pain medication,. Coding received PRN pain medication, you code know if the medical record does not contain documentation if it was received or offered. Code yes if the medication -- medical record contains documentation that appears in either received or was offered or declined. Even if you are offering your resident a medication that they say no thanks, you still take credit for offering that. To your records allow you to take credit for offering a pain medication? Then receive non-medication intervention for pain? It could be any non-medication pain intervention that was scheduled as part of the care plan, documented that that intervention was actually received and you evaluated the efficacy of that then you can capture it on your MDS. I have a scenario here for you. She is receiving an antidepressant that the physician has documented to manage her neuropathic pain. She has experienced great relief with the medication that is given daily. Can this be coded in J zero 100 a? This is a routinely ordered medication.

Meds can only recoded in the zero 100 -- a 100 or you can say yes the medication is specifically ordered for pain.

You have a few seconds left, this is a common question and there are some good examples in the users manual. In just a moment, coding will pop up. The answer to this is that yes, medications are coded and the meds that are coded are not limited to analgesics. In this case, many of you got this right. Your medication, they specifically document it to manage pain so you capture that. I want to remind you that you will code for antidepressants. What I want to caution you is you don't make the assumption that a resident is on a particular antidepressant medication to treat their medication and depression. Now they are feeling a little better with pain as well but there is only saying that the antidepressant. You are not coding that there. It has to be specifically documented to be treating that resident and the pain.

Then we look at pain assessment. All of the interviews have this gateway item. This is where you are looking at whether you should move on and interview your residents. I the able to be understood at least sometimes? If they have an interpreter, then you will go ahead and attempt to complete the interview as long as they are at least sometimes understood or have an interpreter or if they are not required obviously you would not. If the interpreter is required but not available and hopefully that is never the reason, you will skip to the indicators of possible pain and that is the staff assessment. You continue down your interview.

It consists of 4 items. The primary question is the presence item and 3 follow-up questions. Pain effect on function and pain intensity. If they are unable to answer the primary question about whether or not they have pain, you will skip to the staff assessment beginning with the indicators.

Because they asked the residents to recall about their pain you should be conducting this as close to the end of the look back as possible, preferably the day before so you are more accurately capturing their pain.

So J 0300, will you ask to -- have you had any pain or hurting? If they say no you are done with the pain interview. If they say yes you document yes and continue to pain frequency. If they

cannot answer a cannot respond, will not respond giving nonsensical response, skip the rest of the interview and go to indicators like in your staff assessment.

Then you go to zero 400 and simply say how much of the time have you experienced pain or hurting? There are cards you can use that will help give the resident something to point to, there is no predetermined definitions offered about frequency of pain. The response is based on the resident's interest -- interpretation of the frequency of these items. When you offer them occasionally, rarely, and they say what do you mean by occasionally? The answer is whatever it means to you. This is the perception of the resident.

Affect on function, we will ask over the past 5 days have pain -- has pain made it hard or limited your day-to-day activities? I want to stress that you want to make sure the resident understands that you're asking about pain affecting their sleep and not other things that are limiting those issues.

You will offer them either a numeric rating scale or a verbal descriptor to wait their pain. If they are unable to answer using one scale than a tent to use the other. Try to use the same one used on prior assessments. Read the question and options. Provide them with large print and ask them to wait -- right their pain on a numeric scale or the verbal descriptor scale.

Again with moderate severe mild, that is how the resident interprets those things.

The staff assessment is only going to be conducted if the pain interview was not completed. It is successfully completed if the resident reports no pain or if they report pain and also answers the follow-up question which is pain frequency. Even if they cannot tell you about the effect on function of pain or the pain intensity as long as they have answered of 300 and 0400 with relevant, not nonsensical answers, they have completed the pain interview.

For the staff assessment you will consider all sources that you have so interviewing staff, looking into medical records, and identify whether they have had nonverbal sounds of that indicate pain, vocal complaints, facial expressions like grimacing, clenched teeth, protected body movements where they are holding onto a particular part of their body or none of the above, then you will document the frequency of those things in the look back period. The number of days they have had that. One indicates one-two, two-four and potential pain, possible or actual pain daily.

Then we go to shortness of breath. They are just what they sound like shortness of breath or double -- trouble bleeding. Shortness of breath or trouble breathing while lying flat. I want to mention you can also code this if they avoid lying flat because of shortness of breath and the same is true with 1100 a. If they are unable to engage because of shortness of breath you would code that as well or none of the above.

Tobacco use, include tobacco in any form. Prognosis, you will code the item if the medical record includes documentation by the physician that the condition may result in a life expectancy of less than 6 months or if they have a terminal illness it should be coded yes if they are receiving hospice services. Then terminally ill is defined in the users manual as the prognosis of the life expectancy of the resident 6 months or less if the illness runs its normal course.

Conditions are listed and I want to define a couple of these. The first is fever, defined as a temperature of 2.4° higher than the baseline. If you have not -- not yet established baseline, a fever would be 100.4°. Dehydrated you will check if they have 2 or more of the following. They take in less than 1500 mL of fluid daily, they have one or more potential -- of dehydration or with internal bleeding I want to mention that it can be bright red blood or black by a positive stool.

Very important items here, we will begin by answering the question, have they had any falls in the last month prior to admission? Two-six months or if they had a fracture related to the fall. Of they are only going to be completed on the first assessment. And this is just going to, we're going to move along and evaluate whether they have had any falls and I want to point out how this question is worded. This is J 1700 assessing history on admission. But then on the assessments we are looking at falls since admission entry or reentry or the prior assessment, we are always capturing the full life of the resident and saying have they had any falls? If it is the first assessment you are looking at the time they have come into the facility to the ARD of the assessment. If it is not the first then you will be looking at the day after the prior assessment and go all the way, you are capturing 24 hours a day for life in the facility. Code know if they have not had any Andy if they have had one you will skip and note the number. It will say no evidence of any physical assessments, no change in the behavior, this will be skin tears, abrasions, lacerations, hematoma, any fall related injury, major injuries are bone fractures with altered consciousness and subdural hematoma. A key point is an injury related to a fall is defined as any documented injury that occurs as a result of or has recognized a short period of time after the fall and attributed to the fall. With that I will give you one final item and that is Mr. James fell on July 25 and complained of pain. And x-rays taken on the 25th and showed no fracture. A week later pain continued and the physician ordered additional testing. A fracture was identified. Is this a fall with major injury? Our options are no, it revealed no fracture, or yes it is situated to the fall. Take a couple of seconds to code this item.

We have a few seconds. Then we are going to wrap it up and have questions and answers.

Our answers will pop up.

In this case we have yes, it is attributed to the fall. Most of you answered that which is the correct answer. This is a resident who fell, had pain, the pain continued and this resident has been injury that was directly attributed to a fall. It was a fall with major injury. Excellent.

I want to offer my final reminder, don't forget about the users manual to be your go to source for information and I will turn it back over to your operator.

Would you give instructions of how folks can get into the queue for asking a question?

If you would like to ask a question please press*then one. If you're using a speakerphone you may need to pick up your handset. Please press*than one. Standing by for questions.

You have a couple in the chat if you're waiting for those questions.

I would like to answer them within the window, that is the problem.

If a resident has death emergency discharge, can I legally move it to the discharge date and complete the required MDS?

The issue of discharge assessment has been addressed by CMS and I'm going to pull out the manual and see if I can find the chapter and verse. With discharge assessments you are looking at the one exception to setting the ARD prospectively. The problem comes when you have a discharge assessment that you are also trying to combine with your 5 date assessment and I imagine, who answered this? With your five day assessment, you cannot adjust and ARD that has not yet been set. The short answer is if it is a discharge assessment only, you can set that to the day of discharge. It is always going to be to the date of discharge. You cannot move an assessment that has not previously been set so my advice would be you can set them on paper and sometimes that means printing out a particular page of the MDS. But the long and short is that you cannot do that with TPS assessments.

My next question is section J interviews. Speech is clear that they are unable to recall their experiences of pain and cannot recall their own experience over the last 5 days.

The instructions are that you interview the resident as long as they are understood or can make themselves understood at least some of the time, in this scenario you will interview the resident. The validation did look at how valid the interviews are. And they are more reliable than not interviewing residents. That does not mean when you have a care plan for your resident that you are not going to consider all the issues that they have had with pain and the interview but you do go ahead and interview the resident.

I have a clarification. The question I had about the discharge assessment, the long and short answer is that you cannot adjust and ARD that has not sent that's how the answer would currently be answered.

Back to the chair scenario, is it coded as Lizzie -- as Lizzie? If they are not using a wheelchair or walker or any other scenarios, then you would go to none of the above the. -- None of the above.

If you have a resident who have supervision for all encounters but had one time with limited assist, we have been set up for the next section in one time of help with one staff. My system will not let me put supervision in.

I'm not sure I understand the question but let me give it a shot. I think your timely that maybe your computer will not let you code supervision and column 2 and help me out. Is that what you are asking?

I want to commend you for doing the MDS correctly or at least attempting to. If they had one type of limited assist that if they provide hands-on help then you would absolutely be correct encoding supervision. I would say to that contact your vendors. That is a flaw and you are doing it right.

Pain scales to help quality measures, is it okay? No, it is not okay. You need to use 0 to 10 or the verbal descriptor sale. That is the role. Create some other scale. Let me stress you cannot create another skill for MDS, you can use any other pain scale for other assessment purposes although it makes sense are the verbal descriptor.

How is bladder and balance coded? [Indiscernible -- Low volume] there are some cases that status serves as a risk adjustment where they exclude the presidents from the measures but you have to look quality measure by quality measure. So Google the user manual and you should find that information.

Do you have any questions and queue?

Pamela of Mountain Pacific.

I get this question from my facilities. When you have a resident with significant dementia and it affects language comprehension and the right side, you look nice today and I'm enjoying the weather, that is very well retained. When you are there and you have to find out if the resident is rarely or never understood, you can say yes I understand them. But the coherency to say I need to go to the restroom that is not there, so if that is the case [Indiscernible -- Low volume]

The short answer is no. But I want to remind you with the cognitive interviews, section C that you are referring to, you are looking at, there are instructions for how to hinder -- handle nonsensical responses.

I'm going to say three words, please repeat the words., That Tommy the three words. If they say you look beautiful today, that has nothing to do with what you just asked. Please tell me what year it is right now and they say pizza instead, if they tell you it is 1932 is non--- not nonsensical, it is very wrong but not nonsensical. But if they say pizza it has nothing to do. There are directions for each interview and I want to stress -- not gibber us just absolutely nothing to do for what you're talking about.

My understanding is that it is their first attempt at the response, not after, but their first come back, correct?

Nonsensical with that, the response and the directions related to not go into with whether you queued them or not.

They said the three items to remember are the only ones you are -- the only times, if they said something to wear and the resident said something, repeat the items and they say my daughter is coming and you say the first item was something to wear and they say sock I would give them credit for that. I would not see the were able to answer that. So that is my opinion. The directions do not go into that.

I would give them the opportunity to be heard, my guess is that is not the scenario you are talking about. I would have it plastered all over the care plan and this needs to be asked the question.

Let's have one more question before we close.

Medicine Valley.

Maybe she gave up.

She was asking for the notes and put something in the chat so I wonder if --

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Dually have you on the line now?

Perfect. How do we download the notes from this?

It can be acquired from the representative and are located in the left-hand column of the page.

Another question?

I'm showing no additional questions.

I would like to thank all of you for joining us and especially for giving us a very informative presentation. Please complete the evaluation, we would certainly appreciate that. We need your feedback to assure that we are meeting your needs and our next events are scheduled for the 24th and that will be the third of our series on dementia and it is a use presented by Dr. Powers. I would like to thank you for doing such a great program for the office of healthcare licensing and surveys Julia and Laura for co-presenting.

Thank you for such great participation, we really appreciate your polling and feedback on the evaluation.

It concludes our rope -- the call and we thank you again for joining.

This concludes today's conference. Thank you for participating. You may now disconnect.

[event concluded]