

Welcome to MDS 3.0 Training 2026 Session #2 part 2

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Disclaimer:

This presentation is not a substitute for reading and reviewing the

Long-Term Care Resident Assessment Instrument
3.0 User's Manual

Version 1.20.1, October 2025

Item Sets Version 1.20.4 October 2025

or

State Operations Manual Appendix PP

Revised 7/23/25

Objectives:

Review Section C- Cognitive Patterns

Review Section D- Mood

Review Section E- Behavior

Review Section Q- Participation in Assessment and Goal Setting

Section C: Cognitive Patterns

C0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's preferred language or primary method of communication. *DO NOT* consult B0700 to decide to do the interview or not.

If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.

If the assessment should have been done during the look back period and *WAS NOT*, code C0100 as YES and dash (-) the information.

C0500: Enter "99" if the resident was unable to complete the interview, do not dash.

Score: 13- 15 cogitatively intact, 8-12 moderately impaired, 0-7 severely impaired.

*Need documentation of examples

Section C (continued)

C0600: Staff assessment should only be completed if the resident refuses, has nonsensical responses or is rarely/never understood.

DO NOT complete a staff assessment if the resident interview *should have* been done and was not.

C1310: Signs and Symptoms of Delirium: This may alert you to a problem. Probe and document what was said, then make a decision about notifying the physician.

Section C Coding Tips from page C-2

Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments.

As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS.

In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

Section D: Mood

D0100 Should Resident Mood Interview be Conducted?

D0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's primary method of communication. DO NOT consult B0700 to decide to do the interview or not.

If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.

If the resident refuses, make several attempts.

If the assessment should have been done during the look back period and WAS NOT, code D0100 as YES and dash (-) the information.

Section D (PHQ-9)

D0150: Symptom presence and frequency may alert you to a problem. Probe and document what was said during the interview. Then make a decision to notify the physician or not.

D0150 I: Thoughts that would be better off dead- you must ask this question. If yes, find out why. Feeling ready to die is not the same as better off dead.

D0160 Total Severity Score: 1-4 Minimal depression, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 Severe depression.

Resident Mood Interview PHQ-2 to 9

Determine whether to ask the remaining seven questions Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions:

*If **both** D0150A1 and D0150B1 are coded 9, OR*

***both** D0150A2 and D0150B2 are coded 0 or 1, **end** the PHQ interview;*

otherwise continue.

*If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the PHQ-2© and leave D0160, Total Severity Score blank.*

*If **both** D0150A2 and D0150B2 are **coded 0 or 1**, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score.*

Section D (continued)

D0500: Staff assessment should only be completed if the resident is rarely/never understood.

DO NOT complete a staff assessment if the resident interview should have been done and was not.

Quality Measure: Percent of Residents Who Have Depressive Symptoms

The measure reports the percentage of long-stay residents who have had symptoms of depression during the 2-week period preceding the MDS 3.0 target assessment date.

D0700 Social Isolation

Resident self-reported item

A social determinant of health (SDOH)

What other risks are associated with feeling isolated for this resident?

- Nutrition?
- Incontinence?
- Accidents?

Help the resident identify activities they enjoy and implement.

Help connect them with others

Section E: Behavior

This section is based on observations during the look back period.

An increase in behaviors should be discussed with the physician, consider PASRR notification, or a possible SCSA.

Should seek to understand why the behavior is being exhibited: lonely, meaningless, helpless, boredom.

*Need documentation of dates and behaviors.

Section E (continued)

E0800 Rejection of Care: If the resident understands the ramifications of the lack of care, this would not be rejection.

When surveyors look at ADL care, facial hair, long nails, the rejection of care section of the MDS is also reviewed.

E0900 and E1000: Wandering. If the resident is out of the building without staff knowledge=elopement.

Not talking about alert and oriented who have been assessed as safe to go outside. Or confused residents who are allowed to wander into an enclosed, secured area.

If the resident has exit seeking behaviors, and this was prior knowledge, the facility is liable.

Quality Measure:

Prevalence of Behavior Symptoms Affecting Others

This measure reports the percentage of long-stay residents who have behavior symptoms that affect others during the target period.

Section Q: Participation in Assessment and Goal Setting

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.

Section Q ensures all individuals have the opportunity to learn about home and community-based services and to receive long term care in the least restrictive setting possible.

This is also a civil right for all residents. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Section Q

Language for Section Q

Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Puts emphasis on the resident's....

- Civil rights
- Right to request and receive information on community-based services
- Request to learn about home and community-based services is not a request for discharge
- Family support is not always necessary

Section 504 of the Rehabilitation Act prohibits discrimination based on disability

Office of Civil Rights- May 2016 Guidance to SNFs

When coding Q0310 Resident's Overall Expectation, the response selected must reflect the resident's perspective if they are able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.

Coding other than the resident's stated expectation is a violation of the resident's civil rights.

Unjustified segregation can include nursing home placement when a resident could live in a more integrated setting. 3/12/25

Q0310B, Q0500C, Q0550C Coding Instructions

- Code 1, Resident: if the resident is the source for completing this item.

- Code 2, Family: if a family member is the source for completing this item *because the resident is unable to respond*.
- Code 3, Significant other: if *a significant other of the resident* is the source for completing this item because the resident is unable to respond.
- Code 4, Legal guardian: *if a legal guardian of the resident is the source for completing this item because the resident is unable to respond*.
- Code 5, Other legally authorized representative: *if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond*.
- Code 9, None of the above: if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0310A = 9).

Q0400: Discharge Plan

Is active discharge planning already occurring for the resident to return to the community?

The current care plan has goals specific to discharge

DC is in the near future (within 3 months)

Staff are taking active steps to accomplish discharge

If special equipment, money, etc. is needed then a referral may still be necessary –or-

Skip pattern if it is an uncomplicated/expected discharge

Q0610: Referral

Has a referral been made to the Local Contact Agency (LCA)?

For additional guidance, see CMS' Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting.

Available at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Discharge-Planning-Checklist.pdf>

Q0620 Reason Referral to LCA Not Made

Discharge Planning Collaboration

Nursing home staff are expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.

Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based, long-term care supports and services.

Nursing home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services.

The Office of Civil Rights

Recommends...

Review/Revise/Develop policies/procedures on Discharge Planning, MDS administration, and LCA referral process

Train all members of the IDT on Section Q, and what the area LCA has to offer

Invite the LCA and community-based service systems in to provide training

Discharge Planning Process should...

- Identify the needs and goals of ***this*** resident
- Include the resident as an active partner
- Emphasize value in moving back to the community
- Ensure a referral is made to the LCA if the resident indicates interest
- Include documentation if discharge to the community is not feasible
- ***Who decided and why***
- Be re-evaluated and updated as necessary

For NC statewide LCA questions:

Acentra Call Center

- [833-522-5429](tel:833-522-5429)

Local Contact Agency

- **NC Medicaid Clinical Section**
Phone: [919-855-4340](tel:919-855-4340)
NCLIFTSS [866-271-4894](tel:866-271-4894)

Money Follows the Person

- MFPinfo@dhhs.nc.gov
- or call [855-761-9030](tel:855-761-9030)

Code of Federal Regulations (CFR)

State Operations Manual Appendix PP revised 7/23/25:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_Itcf.pdf

Resident Rights

- F550-F586

Discharge Planning

- F622 (transfer), F624 (preparation), F626 (return), F660 (DC plan) and F661 (DC summary) have been moved into **NEW F627**

Behavioral Health

- F740-F745

F552 Right to be Informed/ Make Treatment Decisions

The resident has the right to be informed of, and participate in, his or her treatment, including:

The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

F561 Self Determination

The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice...

The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions...

The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

F561 Self Determination (continued)

During interviews with residents or their family and/or representative(s), determine if they are given the opportunity to choose and whether facility staff accommodate his or her preferences for:

- Activities that interest them;
- Their sleep cycles;
- Their bathing times and methods;
- Their eating schedule;
- Their health care options; and
- Any other area significant to the resident.

F578 Request/Refuse/Discontinue Treatment; Formulate Advanced Directive

The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

GUIDANCE

Facility staff should periodically review with the resident and resident representative the decisions made regarding treatments, experimental research and any advance directive and its provisions, as preferences may change over time.

***Surveyors are looking for evidence of Residents/RP being given information and the opportunity to formulate an Advanced Directive.**

F656 Comprehensive Care Plan

The facility must develop and implement a comprehensive person-centered care plan for each resident... The comprehensive care plan must describe the following —

The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required

Any services that would otherwise be but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations.

F656 Comprehensive Care Plan (continued)

In consultation with the resident and the resident's representative(s)—

The resident's goals for admission and desired outcomes.

The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements.

F627 Transfer and Discharge/Facility Requirements

A conglomeration of F622, F624, F626, F660 and F661

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**
- (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;**
- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;**
- (D) The health of individuals in the facility would otherwise be endangered;**
- (E) The resident has failed, after reasonable and appropriate notice, to pay... OR**
- (F) The facility ceases to operate.**

F627 Appeals for Transfer

The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer, or discharge would pose.

F627 DOCUMENTATION

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

Documentation in the resident's medical record must include:

- **The basis for the transfer.**
- **The specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).**

The documentation required for this section must be made by—

- **The resident's physician when transfer or discharge is necessary under paragraph (A) or (B) of this section;**
- **A physician when transfer or discharge is necessary under paragraph (C) or (D) of this section.**

F627 Orientation for Transfer or Discharge

A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

F627 Permitting Residents to Return to Facility

A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—

- **Requires the services provided by the facility; and**
- **Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.**

If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements as they apply to discharges.

F627 Readmission

Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part, the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously.

If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

F627 Discharge Planning Process continued

The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights as applicable and—

- **Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.**
- **Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.**
- **Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.**
- **Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.**
- **Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.**
- **Address the resident's goals of care and treatment preferences.**
- **Document that a resident has been asked about their interest in receiving information regarding returning to the community.**

F627 Discharge Planning Process

If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

For residents who are transferred to another SNF, HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

F627 DISCHARGE SUMMARY

Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

- **A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.**
- **The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.**

F627 Intent

INTENT • *These regulations and guidance address inappropriate discharges and:*

Specify the limited conditions under which a skilled nursing facility or nursing facility may transfer or discharge a resident,

the documentation that must be included in the medical record, and who is responsible for making the documentation.

Ensure policies are developed and implemented which allow residents to return to the facility following hospitalization or therapeutic leave.

Ensure a facility does not transfer or discharge a resident in an unsafe manner, such as a location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident's preferences and, therefore, should not have occurred.

Ensure the discharge planning process addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

F740 Behavioral Health Services

Each resident must receive, and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

F740 Behavioral Health Services (continued)

GUIDANCE

Providing behavioral health care and services is an integral part of the person-centered environment.

This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident.

Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

F743 No Pattern of Behavioral Difficulties

Unless Unavoidable continued

A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable...

F743 No Pattern of Behavioral Difficulties Unless Unavoidable

Facility staff must:

- Monitor the resident closely for expressions or indications of distress;
- Assess and plan care for concerns identified in the resident's assessment;
- Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;
- Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;
- Ensure appropriate follow-up assessment, if needed; and
- Discuss potential modifications to the care plan.

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