

# Welcome to MDS 3.0 Training 2026 Session #3

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH SERVICE REGULATION

**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**

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# Objectives:

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Review Section GG- Functional Abilities and Goals

Review Section H- Bladder and Bowel

Review Section I- Active Diagnoses

Review Section J- Health Conditions

# Code of Federal Regulations (CFR)

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

[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

# Section GG

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Intent: This section includes items about functional abilities and goals. It includes items focused on prior function, admission performance, current function, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

# Section GG: Functional Abilities and Goals

Completed for PPS 5-day, IPA, PPS Discharge, and OBRA Admission, Quarterly, Annual, SCSA, SCPC and SCPQ assessments.

This section assesses the need for assistance with self-care and mobility activities at the beginning and end of a SNF PPS stay and OBRA assessments.

Section GG coding on admission should reflect the person's baseline admission functional status and is based on a clinical assessment that occurs soon after the resident's admission.

The PPS functional score is be based on section GG.

# Section GG: PPS assessments

5-day PPS MDS- Items focus on the resident's self-care/mobility performance at admission. This should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

The assessment period is days 1-3 of the SNF PPS stay starting with A2400B.

# GG0100, GG0110 Prior Functioning:

PPS assessments only

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## GG0100: Everyday Activities

- Self-Care
- Indoor Mobility (Ambulation)
- *Stairs For the GG0100C stair activity, “by any safe means”  
may include a resident scooting up and down stairs on their buttocks.*
- Functional Cognition

## GG0110: Prior Device Use

- Manual wheelchair
- Motorized wheelchair and/or scooter
- Mechanical lift
- Walker
- Orthotics/prosthetics
- None of the above

# GG0100: Prior Functioning

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Ask the resident, their family or caregivers about their prior functioning with everyday activities

Review the resident's medical records describing the resident's prior functioning with everyday activities.

# GG0100 Coding: Prior Functioning

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Code 3, Independent: if the resident completed the activities by themselves, with or without an assistive device, with no assistance from a helper.

Code 2, Needed Some Help: if the resident needed partial assistance from another person to complete the activities.

Code 1, Dependent: if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.

# GG0100 Coding: Prior Functioning (continued)

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Code 8, Unknown: if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.

Code 9, Not Applicable: if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

## **Coding Tips**

For **GG0110D**, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).

**GG0110C**, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body-style lifts.

*Clinical judgment may be used to determine whether other devices meet the definition provided.*

# GG0115

## Functional Limitation in Range of Motion

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The intent of GG0115 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places them at risk of injury.

When completing this item, staff members should refer to items in GG0130 and GG0170 and view the limitation in ROM, considering activities the resident is able to perform. RAI page GG-5

Steps for assessment RAI pages GG 6-7

# GG0115 Coding Tips

*Do not look at limited ROM in isolation. You must determine whether the limited ROM has an impact on functional ability or places the resident at risk for injury.*

*For example, if the resident has an amputation, it does not automatically mean that they are limited in function. A resident with an amputation may not have a particular joint in which a certain range of motion can be tested, however, that does not mean that the resident necessarily has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury.*

*This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.*

# GG0120 Mobility Devices

## Coding Instructions

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**GG0120A, Cane/crutch:** *if the resident used a cane or crutch, including single-prong, tripod, quad cane, etc.*

**GG0120B, Walker:** *if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with or without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.*

**GG0120C, Wheelchair (manual or electric):** *if the resident normally sits in a wheelchair when moving about. Include wheelchairs that are hand propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.*

**GG0120D, Limb prosthesis:** *if the resident used an artificial limb to replace a missing extremity.*

**GG0120Z, None of the above:** *if the resident used none of the mobility devices listed in GG0120 or locomotion did not occur during the observation period.*

# *GG0130: Self-Care and GG0170: Mobility*

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## **General coding tips**

*The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once.*

*A dash (–) indicates “No information.” CMS expects dash use to be a rare occurrence.*

*CMS does not provide an exhaustive list of assistive devices that may be used...*

## **Coding tips for coding the resident’s usual performance**

*If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent.*

# GG0130: Self Care and GG0170: Mobility Coding

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PPS and OBRA assessments

Code 06, Independent: if the resident completes the activity by themselves with no assistance from a helper.

Code 05, Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).

# GG0130 Self Care and GG0170 Mobility Coding

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Code 04, Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.

Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

# GG0130 Self Care and GG0170 Mobility Coding

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Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.

# GG0130 and GG0170 Coding Activity Was Not Attempted

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Code 07, Resident refused: if the resident refused to complete the activity.

Code 09, Not applicable: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

Code 10, Not attempted due to environmental limitations: if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

# GG0130 & GG0170

## Steps for Assessment

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1. Assess the resident's self-care and mobility performance based on direct observation, the resident's self-report, and reports from clinicians, care staff, or family reports, documented in the resident's medical record during the 3-day assessment period.
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
3. If helper assistance is required because resident's performance is unsafe or of poor quality, score according to the amount of assistance provided.
  - If 2 or more helpers are required for safety, code as 01, Dependent.

Fastening, buttoning, tying shoes is touching assistance.

# Decision Tree page GG-16

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Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.

# GG0130 Functional Abilities and Goals- Admission Self-Care

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GG0130 Self-Care (Assessment period is the first 3 days of the stay)  
Complete if an Admission or 5-day PPS.

If the 5-day PPS, the stay begins on A2400B.

If not a PPS assessment, the stay begins on A1600

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

# Quality Measure:

## Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased

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This measure reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.

Last loss ADLs include

- Bed Mobility
- Transfer
- Eating
- Toilet Use

## Quality Measure:

# Percent of Residents Whose Ability to Walk Independently Worsened

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This measure reports the percent of long-stay residents who experienced a decline in the ability to walk independently during the target period.

- **Performance Coding Tips**

- **General coding tips**

- *The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once.*
- *A dash (–) indicates “No information.” CMS expects dash use to be a rare occurrence.*
- *CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.*
- *Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).*
- **Coding tips for coding the resident’s usual performance**
- *If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent.*

# Section GG: PPS Discharge or OBRA Discharge

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## Part A PPS Discharge

Completed when the Medicare Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility,

Or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or the day before the resident's discharge date (please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment).

# GG0130 Functional Abilities- Discharge Self-Care

Assessment period is the last 3 days of the stay.

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Complete only if A0310F=10 or 11 or A0310H=1.

- OBRA Return Not Anticipated, OBRA Return anticipated, Planned, Unplanned,
- or End of PPS

If A0310G is **not**= 2 (unplanned) **and**

A0310H= 1 (SNF Part A PPS DC Assessment) **and**

A2400C (end date of most recent Medicare stay) minus A2400B (Start date of most recent Medicare stay) is greater than 2 **and**

A2105 is not= 4 (Short-Term General Hospital), the stay ends on A2400C (end date of most recent Medicare stay)

For all other Discharge assessments, the stay ends on A2000 (Discharge Date)

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

# GG0170 Functional Abilities- Discharge Mobility

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Assessment period is the last 3 days of the stay.

Complete only if A0310F=10 or 11 or A0310H=1.

- OBRA Discharge Return Not Anticipated, OBRA Discharge Return Anticipated, Planned, Unplanned,
- or End of PPS

If A0310G is **not**= 2 (unplanned) **and**

A0310H= 1 (SNF Part A PPS DC Assessment) **and**

A2400C (end date of most recent Medicare stay) minus A2400B (Start date of most recent Medicare stay) is greater than 2 **and**

A2105 is not= 4 (Short-Term General Hospital), the stay ends on A2400C (end date of most recent Medicare stay)

For all other Discharge assessments, the stay ends on A2000 (Discharge Date)

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

# GG: Stand Alone OBRA Assessments

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Quarterly, Annual, Significant Change in Status, Significant Correction to prior assessment- Comprehensive or Quarterly.

The look back is the ARD plus the 2 previous days (days 5, 6 and 7).

Code the resident's usual performance. Use the 6-point scale or activity was not attempted codes.

Complete only column 5.

# GG IPA

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Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.

For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident.

The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.

The IPA does not affect the variable per diem schedule.

# PPS 5-day, IPA or Discharge Performance and OBRA Admission, Quarterly, Annual, SCSA, SCPC, SCPQ

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Code the resident's usual performance for each activity using the 6-point scale.

Start with the least assistance provided, then step through the levels until you reach one that matches the resident's usual performance.

If the activity was not attempted during the entire 3-day assessment period, indicate the reason. DO NOT DASH!

Coding a dash (-) indicates "No information"

Use of dashes in the Discharge Goals is allowed and does not affect the Annual Payment Update (APU), however, at least one discharge goal should be entered.

Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record.

# CMS GG Training Videos

[Lesson 1: Importance of Section GG for Post-Acute Care](#)

[Lesson 2: Section GG Assessment and Coding Principles](#)

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[Lesson 3: Coding GG0130.Self-Care Items](#)

[Lesson 4: Coding GG0170.Mobility Items](#)

[Coding GG0110. Prior Device Use with Information From Multiple Sources \(3:58\)](#)

[Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility \(11:56\)](#)

[Coding GG0130B. Oral Hygiene \(4:25\)](#)

[Coding GG0170C. Lying to Sitting on side of bed \(4:33\)](#)

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html>

<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/skilled-nursing-facility-quality-reporting-program/snf-quality-reporting-program-spotlights-and-announcements>

# F676 Activities of Daily Living/ Maintain Abilities

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**Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:**

**A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...**

# F676 (continued)

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**The facility must provide care and services for the following activities of daily living:**

**Hygiene –bathing, dressing, grooming, and oral care,**

**Mobility—transfer and ambulation, including walking,**

**Elimination-toileting,**

**Dining-eating, including meals and snacks,**

**Communication, including**

- **Speech,**
- **Language,**
- **Other functional communication systems.**

# F677 ADL Care Provided for Dependent Residents

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**A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene**

# Updated to include the MDS Section GG Self-Care and Mobility coding definitions

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*Independent: if the resident completes the activity by themselves with no assistance from a helper.*

*Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).*

*Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.*

*Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*

*Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*

## Section H: Bladder and Bowel

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H0100A: Indwelling Catheter: may code even if in only a brief time during the look back period.

H0300 and H0400 Urinary and Bowel Continence: If a resident has a change from occasional incontinent to frequently incontinent, this is a significant difference and needs to be investigated.

- Incontinence: any urine touching the skin, willful or not. Peeing in a brief is not continence.

## Quality Measure:

# Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder

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This measure reports the percentage of residents who have had an indwelling catheter in the last 7 days.

## Quality Measure:

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# Percent of Residents With New or Worsened Bowel or Bladder Incontinence

This measure reports the percent of long-stay residents with new or worsened bowel or bladder incontinence between the prior assessment and target assessment.

# Toileting Programs

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Toileting programs must include:

Evidence it was used during the look back period.

Must be individualized, resident specific, based on an assessment.

Evidence it had been communicated to the staff and the resident.

Would expect to see flow records, a care plan and written evaluations of the resident response.

This would include toileting trials.

Guidance found in Appendix C.

# F690 Bowel/Bladder Incontinence, Catheter, UTI

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**The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.**

**For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.**

**Surveyor guidance updated to observe for cues of psychological distress.**

# F691 Colostomy, Urostomy, or Ileostomy Care

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**The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.**

# Section I: Active Diagnoses

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The items in this section are intended to code diseases and conditions that have a direct relationship to current function, cognition, moods, behaviors, medical treatment, nursing monitoring, or risk of death.

One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

This section identifies active diseases and infections that drive the current care plan.

Diagnoses need to have been noted by the physician within the past 60 days and then narrow to the last 7 days if active (labs, monitoring, medications, therapy).

# I0020 Indicate the Resident's Primary Medical Condition Category PPS 5-day Assessment and OBRA Assessments

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I0020: Indicate the resident's primary medical condition category is coded when A0310A= 01, 02, 03, 04, 05, 06, A0310B=01

The *primary reason* for admission will determine the clinical grouping for each resident.

Indicate the resident's primary medical condition category that best describes the primary reason for the stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.

This is an active diagnosis indicating the primary reason for the SNF stay.

Examples start on RAI page I-3

# Section I: Active Diagnoses continued

*There are two look-back periods for this section:*

- Diagnosis identification (Step 1) is a 60-day look-back period.
- 

**1. Identify diagnoses:** The disease conditions in this section require a physician-documented diagnosis in the **last 60 days**.

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

- **Diagnosis status: Active or Inactive (Step 2)** is a 7-day look-back period (except for Item I2300 UTI).

**2. Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active**. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

# Section I: Active Diagnoses

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I2300 Urinary Tract Infection (UTI) (Last 30 Days) includes Item I2300 Urinary tract infection (UTI): Code only if both of the following are met in the last 30 days:

- 1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, AND
- 2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable.

## Quality Measure:

The measure reports the percentage of long-stay residents who have a urinary tract infection within the last 30 days

Long-stay residents with a selected target assessment that indicates urinary tract infection.

# QSO-23-05-NH

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Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System:

**Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute**

<https://www.cms.gov/files/document/qso-23-05-nh.pdf>

1/18/2023

# Outcomes

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The 4 facilities which attested to having inaccurate schizophrenia documentation and agreed to implement a plan of correction:

- Overall QM and Long-Stay QM rating was suppressed for 6 months
- Short stay QM rating will be calculated and posted as normal
- Long stay antipsychotic use QM was suppressed for 12 months

The facility which underwent the CMS audit for schizophrenia resulted in:

- Overall QM and long-stay QM ratings downgraded to one star for 6 months
- Short stay QM ratings suppressed for 6 months
- Long-stay antipsychotic QM suppressed for 12 months

# 16000 Schizophrenia

## **Memorandum Summary Adjusting Quality Measure Ratings:**

CMS will be conducting audits of schizophrenia coding in the Minimum Data Set data and based upon the results, adjust the Nursing Home Care Compare quality measure star ratings for facilities whose audits reveal inaccurate coding.

CMS is concerned that some nursing homes have erroneously coded residents as having schizophrenia, which can mask the facilities' true rate of antipsychotic medication use.

Facilities that have coding inaccuracies identified through the schizophrenia MDS audit will have their QM ratings adjusted as follows:

- The Overall QM and long stay QM ratings will be downgraded to one star for six months (this drops the facility's overall star rating by one star).
- The short stay QM rating will be suppressed for six months.
- The long stay antipsychotic QM will be suppressed for 12 months.

# Section I: Active Diagnoses (continued)

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I5100 Quadriplegia. No functional use of all four limbs. Use only if spinal cord injury. Spinal cord injury must be a primary condition and not a result of another condition. DO NOT code functional quad here. If the resident has dementia or spastic quadriplegia due to cerebral palsy, stroke, contractures, brain disease the primary diagnosis should be coded and not the resulting paralysis or paresis from that condition.

I5600 Malnutrition. Requires physician diagnosis documentation.

I8000 Additional active diagnoses.

# Health Conditions Section J

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The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.

Item J2100 Recent Surgery Requiring Active SNF Care- completed for 5-day PPS and OBRA assessments.

J2300 – J5000 Surgical Procedures- complete only if J2100= Yes.

Documentation is needed to justify answers.

# J0100: Pain Management: Scheduled and PRN Pain Medication, Non-pharmacological Pain Interventions

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5-day look back period

Data to answer the 6 questions in this item come from the medical record review and interviews

Interventions are included as part of a care plan

There must be documentation that the intervention(s) were received, and results assessed

Interventions do not have to be successful to be counted

F697 SOM Appendix PP, Pain Management

# Non-Medication Pain Interventions

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Scheduled and implemented non-pharmacological interventions include, but are not limited to, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture.

Herbal or alternative medicine products are not included in this category.

Alternatives need to be carefully planned and evaluated for effectiveness.

# J0300-J0600: Resident Pain Interview

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The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.

Attempt to conduct the interview with all residents

The Pain Interview is not contingent upon B0700.

Use the resident's preferred language. If not verbal, offer writing, sign or cue cards.

Use the resident's terminology for pain-such as hurting, aching, burning.

Code for the presence or absence of pain regardless of main management efforts.

The resident's reported pain scale is independent of the medication received during the look-back.

# F697 Pain Management

**The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.**

## **Definitions of pain added:**

*“**Acute Pain**” refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery. (From the Centers for Disease Control and Prevention (CDC)).*

*“**Chronic Pain**” refers to pain that typically lasts greater than 3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause. (From the CDC).*

*“**Subacute Pain**” refers to pain that has been present for 1–3 months. (From the CDC).*

# J0700-J0850: Staff Assessment for pain

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Do not complete the Staff Interview if the resident interview should have been attempted and it was not attempted.

# J1100 Shortness of Breath

## **Item Rationale**

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Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.

Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.

Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.

The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

# J1100 Shortness of Breath continued

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## **Steps for Assessment**

Interview the resident about shortness of breath.

If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when he or she engages in certain activities.

Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing.

Observe the resident for shortness of breath or trouble breathing.

If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

# Free of Accidents Hazards/Supervision/Devices F689

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**The facility must ensure that –**

**The resident environment remains as free of accident hazards as is possible; and**

**Each resident receives adequate supervision and assistance devices to prevent accidents.**

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.

# J1300: Current Tobacco Use

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## **Includes tobacco used in any form**

- Does not include vaping, nicotine patches

## **Planning for Care**

This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.

If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.

# J1400: Prognosis

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## Coding Instructions

- Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
- Code 1, yes: if the medical record includes physician documentation:
  - that the resident is terminally ill; or
  - the resident is receiving hospice services.

# J1550 Other Health Conditions

## A. Fever

Defined as 2.4 degrees Fahrenheit higher than baseline. A temp of 100.4 F on admission is considered a fever. ~~Important to obtain baseline temperature. Establishment of a baseline temperature is important.~~

## B. Vomiting

## C. Dehydrated ***Does require documentation of 2 or more of the 3 potential dehydration indicators listed:***

1) Usually takes in less than 1500 cc of fluid daily.

2) One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc.

3) Fluid loss that exceeds amount of fluids taken in.

## D. Internal Bleeding

Do not include controlled nose bleeds, menses, UA with small blood. May include hematoma or ICH if can be proved it occurred during the lookback period.

## Z. None of the above

Documentation supports the coding decisions. Coding Tips J-28 through J-30

# J1700: Fall History on Admission or Reentry

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Falls, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls,

Ask the resident and family/significant other about falls in the last 6 months.

Review inter-facility transfer information.

Review all relevant medical records for evidence of one or more falls in the previous 6 months.

# J1800: Falls Since Admission/Entry or Prior Assessment (OBRA or Scheduled PPS)

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If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD.

If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the current ARD.

Any fall since the last MDS, even if it occurred while out in the community, in an acute hospital, or in the nursing home.

Review incident reports, fall logs and the medical record.

Ask the resident and family about falls during the look-back period even if not documented in the medical record.

# What are you calling a fall?

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Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) or the result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs is still considered a fall.

A resident found on the floor or ground without knowledge of how they got there, is a fall.

J1700: Fall History on Admission/Entry or Reentry (cont.)

The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.

Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.

CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. *However, if there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall. J-33*

# J1900: Falls Since Admission or Most Recent MDS Without or With Injury

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## J1900A-No injury

- No evidence of injury seen; no c/o pain or injury, no change in resident behavior after the fall.

## J1900B-Injury (except major)

- Includes, *but is not limited to*, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

## J1900C-Major Injury

- Includes, *but is not limited to, traumatic* bone fractures, joint dislocations/*subluxations, internal organ injuries, amputations, spinal cord injuries*, head injuries, *and crush injuries*.

# Quality Measure: Percent of Residents Experiencing One or More Falls with Major Injury

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This measure reports the percent of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period.

# Quality Measure: Prevalence of Falls

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This measure reports the percentage of long-stay residents who have had a fall during their episode of care.

# Language at J1900

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It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.

Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results) and ensure that this information is used to code the assessment.

## **Coding Tips**

If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Internet Quality Improvement and Evaluation System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall.

*Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.*

Examples updated

# J2000-5000: Prior Surgery, Recent Surgery, and Surgical Procedures

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J2000: Only completed for 5-day PPS assessments

- Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:
- 1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the SNF
- 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

J2100: Recent Surgery Requiring Active SNF Care completed on PPS 5-day and OBRA assessments.

Need to determine if this surgery requires active care during this stay.

J2300 through J5000 Surgical Procedures, completed only if J2100= 1 (Yes). Documentation in the medical record is required to justify answers.

# Section J: J2100

## Recent Surgery Requiring Active SNF Care

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Complete only for PPS 5-day or OBRA assessments.

For PPS: Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. Did that surgery require active care?

For OBRA: Was the resident an inpatient in an acute care hospital for at least one day, and the surgery carried some degree of risk to the resident's life or the potential for severe disability within 30 days of the ARD. Did that surgery require active care? RAI page J-38

Documentation is needed to justify answers.

If 1. Yes, proceed to J2300-J5000.