# Welcome to MDS 3.0 Training 2026 Session #4

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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**

# Objectives
# Participants will:

Review Sections

- L- Oral/Dental Status
- M- Skin Conditions
- N- Medications
- O- Special Treatments, Procedures, and Programs
- P- Restraints and Alarms

# 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_ltcf.pdf

# Section L: Oral/Dental Status

L0200B: No natural teeth or tooth fragments (edentulous). This means complete tooth loss.

Dentures are not natural teeth.

Implants are permanently affixed hardware and are considered natural teeth as they are not removable.

# Section L (continued)

Residents who have some, but not all of their natural teeth, that do not appear damaged, broken, loose, or with obvious or likely cavity and do not have any other conditions in L0200 A-G should be coded at L0200Z, a none of the above.

Many residents have dentures or partials that fit well and work properly. For individualized care planning purposes, consideration should be taken to make sure residents are in possession of their dentures or partials and that they are being utilized properly for meals, snack, med pass and social activities. Also, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

# Regulation F790 & F791
# Routine/Emergency Dental Services

**The facility must assist residents in obtaining routine and 24-hour emergency dental care.**

A dentist must be available for each resident. The dentist can be employed by the facility, or the facility can have a contractual agreement with a dentist. The facility may also have a written agreement for services from a dental clinic, dental school or a dental hygienist all of whom are working within Federal and State laws and under the direct supervision of a dentist.

For Medicare and private pay residents, facilities are responsible for having the services available, but may bill an additional charge for the services.

For Medicaid residents, the facility must provide all emergency dental services and those routine dental services to the extent covered under the Medicaid state plan. The facility must inform the resident of the deduction for the incurred medical expense available under the Medicaid State plan and must assist the resident in applying for the deduction.

# MDS 1.20.1 Section M

Skin Conditions

# Quality Measure: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (SS)

This quality measure is calculated using the SNF Quality Reporting Program measure Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

# Quality Measure: Percent of Residents With Pressure Ulcers

This measure captures the percentage of long-stay residents with Stage II-IV or unstageable pressure ulcers.

# Regulation F686
# Treatment/Services to Prevent/Heal Pressure Ulcers

Skin Integrity, Pressure ulcers

Based on the comprehensive assessment of a resident, the facility must ensure that—

- A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
- A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

# F686 Intent

The intent of this requirement is that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to:

- Promote the prevention of pressure ulcer/injury development;
- Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and
- Prevent development of additional pressure ulcer/injury.

**Instructions to Surveyors:** In addition to actual or potential physical harm, always *observe for visual cues of psychosocial distress and* consider whether psychosocial harm has occurred when determining severity level [of the citation].

# F686 Treatments/Services to Prevent/Heal Pressure Ulcers

**The Kennedy Terminal Ulcer (KTU)**

The facility is responsible for accurately assessing and classifying an ulcer as a KTU or other type of PU/PI and demonstrate that appropriate preventative measures were in place to prevent non-KTU pressure ulcers.

KTUs have certain characteristics which differentiate them from pressure ulcers such as the following:

- KTUs appear suddenly and within hours;
- Usually appear on the sacrum and coccyx but can appear on the heels, posterior calf muscles, arms and elbows;
- Edges are usually irregular and are red, yellow, and black as the ulcer progresses, often described as pear, butterfly or horseshoe shaped; and
- Often appear as an abrasion, blister, or darkened area and may develop rapidly to a Stage 2, Stage 3, or Stage 4 injury.

# Section M: Skin Conditions

If a Pressure Ulcer heals on or before the ARD, it is not captured.

Wounds do not heal in reverse. Page M-7 discusses backstaging.

M0300E: Unstageable-Non-removable dressing/device: Known but not stageable due to non-removable dressing/device. Only code with supporting documentation in the record.

A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable. Page M-8

# Present on Admission

If a wound was present upon admission, then becomes unstageable, or at a higher stage, then new category was NOT present upon admission. RAI page M-8

If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as "present on admission." RAI page M-9

*If a pressure ulcer/injury was unstageable on admission/entry or reentry and then becomes unstageable for another reason,* ***it should be considered "present on admission" at the new unstageable status.*** *For example, if a resident is admitted with a deep tissue injury, but later the injury opens, the wound bed is covered with slough, and the wound is still unstageable, this wound would still be considered "present on admission." RAI page M-9*

# Section M (continued)

M1040 D Open lesion(s) other than ulcers, rashes, cuts: that are not coded elsewhere and develop as a result of a disease process should be coded here.

Cuts, lacerations, and abrasions are not coded on the MDS.

M1040 H Moisture Associated Skin Damage (MASD): Superficial skin damage. If MASD if present with a PU, only code the pressure ulcer. If the tissue damage extends into the subcutaneous tissues, then code as a pressure ulcer.

Kennedy Terminal Ulcers (KTU) and Skin Failure are not coded in section M. RAI page M-6

# Section M (continued)
## M1200 Skin and Ulcer/Injury Treatments

M1200 H Applications of ointments/medications other than to feet: Includes barrier creams and skin prep.

Skin prep to the heel for prevention is not captured on the MDS.

If skin prep is being used on the heel to treat a DTI, code at M1200 E, Pressure ulcer/injury care.

Band aids are not coded as dressings.

# Section N: Medications

Look back period is 7 days or since admission if less than 7 days. The look back does not extend into the preadmission period.

N0415 High-Risk Drug Classes: Use and Indication: Code according to how the medication is classified and not how it is used.

Examples: Compazine- is an antipsychotic and often used to treat nausea and vomiting.

Symbyax is a combination medication- fluoxetine (antidepressant) and olanzapine (antipsychotic). Code both medication categories.

Benzodiazepines: some are classified as anxiolytic and some as hypnotic. Be sure to know which one should be counted where.

Watch for combination medications like Zestoretic which has HCTZ.

# Quality Measure: Percent of Residents Who Newly Received an Antipsychotic Medication (SS)

This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.

# Quality Measure: Prevalence of Antianxiety/Hypnotic Use

This measure reports the percentage of long-stay residents who are receiving antianxiety medications or hypnotics but do not have evidence of psychotic or related conditions in the target period.

# Quality Measure: Percent of Residents Who Received an Antipsychotic Medication

This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period.

# N0350 Insulin

For sliding scale orders:

— A sliding scale dosage schedule that is written to cover different dosages depending on lab values **does not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

— If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days **can** be counted and coded.

• For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

# Section N
# N0415 High Risk Drug Classes: Use and Indication

Is taking- check column 1 if the resident is taking any medication by classification listed.

Indication noted for all medications in the drug class. RAI page N-6

The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.

Indications for initiating are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s) since a diagnosis alone may not warrant treatment with medication. RAI Panel 8/23/23

# N0450: Antipsychotic Medication Review Gradual Dose Reduction (GDR)

Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

See F605 Right to be Free from Chemical Restraints.

# N0415: High-Risk Drug Classes: Use and Indication

## Tips and Special Populations

*Facilities may wish to identify a resource that their staff consistently use to identify pharmacological classification as assessors should be able to identify the source(s) used to support coding the MDS 3.0.*

*Assessors should consult the manufacturer's package insert, which may contain the medication's pharmacological classification. They can also work with the resident's pharmacist to confirm the medication classification(s) for a resident's medication(s).* *N-9*

# Antipsychotic Medication Review

N0450A- Did the resident receive antipsychotic medications since admission/entry or the prior OBRA assessment, whichever is more recent?

- 0. No, not received
- 1. Yes, received on a routine basis only
- 2. Yes, received on a PRN basis only
- 3. Yes, antipsychotics were received on a routine and PRN basis

# Gradual Dose Reduction (GDR) N0450 Antipsychotic Medication Review

N0450B: Do not include Gradual Dose Reductions completed prior to admission.

No not count as a GDR an antipsychotic medication reduction performed for the purpose of switching from one antipsychotic to another.

Discontinuation of an antipsychotic, even without a GDR process, should be coded in N0450B

The date of the GDR in N0450C is the first day the of the dose reduction attempt.

# N0450 Antipsychotic Medication Review (continued)

N0450B- Has a gradual dose reduction (GDR) been attempted?

0. No- skip to physician documented GDR as clinically contraindicated (this needs to be documented at least annually)

1. Yes- continue to date of last attempted GDR

N0450C- Date of last attempted GDR

Should be physician documented at least annually

# N0450 Antipsychotic Medication Review Continued

## N0450D Physician documented GDR as clinically contraindicated

- 0. No- GDR has not been documented by a physician as clinically contraindicated.
- 1. Yes- GDR has been documented by a physician as clinically contraindicated, continue to date physician documented GDR as clinically contraindicated

## N0450E- Date physician documented GDR as clinically contraindicated

# Section N: N2001-2005 continued

N2001 Drug Regimen Review: Only on the 5-day PPS. Were there any medication issues identified?

N2003 Medication Follow-up: Only on the 5-day PPS. If any medication issues were identified, was the physician contacted and were actions to correct this issue completed by the next day?

N2005 Medication Intervention: Only on the PPS discharge. Had any medication issues been identified, the physician contacted, and an action taken since the admission?

Clinically Significant: wrong medication, dose, time, omission, interactions, duplicate therapy, known allergy, ineffective therapy.

## Section N Resources

The following resources and tools provide information on medication classifications. Providers are responsible for coding each medication's pharmacological/therapeutic classification accurately.

Page N-12:

- GlobalRPh Drug Reference, https://globalrph.com/drugs/a/

- USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcareprofessionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50v40#Guidelines6.

Directions: Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"

- Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html

# Drug Regimen is Free From Unnecessary Drugs F757

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—

In excessive dose (including duplicate drug therapy); or

For excessive duration; or

Without adequate monitoring; or

Without adequate indications for its use; or

In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

Any combinations of the reasons stated.

# F757 Intent

*The intent of these requirements is to ensure each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.*

# F758 Free from Unnecessary Psychotropic Medications/PRN Use moving to F605 Right to be Free from Chemical Restraints

**Respect and Dignity. The resident has a right to be treated with respect and dignity, including:**

- **The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.**

**The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.**

- **This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.**

# F605 The Facility Must-

**Ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.**

***A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:***

***Anti-psychotic  Anti-depressant  Anti-anxiety  Hypnotic***

***Unnecessary drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—***

- ***(1) In excessive dose (including duplicate drug therapy); or***
- ***(2) For excessive duration; or***
- ***(3) Without adequate monitoring; or***
- ***(4) Without adequate indications for its use; or***
- ***(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or***
- ***(6) Any combinations of the reasons.***

# F605 *Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-*

***(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;***

***(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;***

***(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and***

***(4) PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, they should document their rationale in the resident's medical record and indicate the duration for the PRN order.***

***(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.***

# F605 Intent

*The intent of these requirements is to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.*

*Also, residents must only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated.*

*Additionally, medication should only be used to treat resident's medical symptoms and not used for discipline or staff convenience, which would be deemed a chemical restraint.*

# Section O:
# Special Treatments, Procedures, and Programs

The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

# O0110: Coding Tips

Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff.

Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

# O0110 Special Treatments, Procedures, and Programs

a. On Admission- Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B

b. While a Resident- Performed while a resident of this facility and within the last 14 days

c. At Discharge- Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

# O0110A1-O0110A10 Chemotherapy O0110B1 Radiation

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item.

Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment.

- For example, megestrol acetate is classified as an antineoplastic drug. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item.
- Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.

IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K05210A (Parenteral/IV), O0110H (IV Medications), or O0110I (Transfusions).

O0110B1. Radiation: Includes intermittent radiation therapy, as well as radiation administered via radiation implant.

# O0110C Oxygen Therapy

Code continuous or intermittent oxygen administered delivered to a resident to relieve hypoxia.

Do not code hyperbaric oxygen for wound therapy in this item.

***-O0110C2, Continuous***

*Check if oxygen therapy was continuously delivered for 14 hours or greater per day.*

*– **O0110C3, Intermittent***

*Check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day).*

*– **O0110C4, High-concentration***

*Check if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds a fraction of inspired oxygen FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute).*

*A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks) These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%. Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO2 of greater than 40%.*

*RAI page O-4*

# O0110D1 Suctioning
# O0110E1 Tracheostomy care

Suctioning: Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.

O0110D2 Scheduled- Check if suctioning was scheduled. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, guidelines.

O0110D3 As Needed- Check in suctioning was performed on an as-needed basis, as opposed to at regular scheduled intervals.

O0110E1 Tracheostomy care- Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs their own tracheostomy care and includes laryngectomy tube care.

# O0110F1 Invasive Mechanical Ventilator

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support their own respiration in this item. During invasive mechanical ventilation, the resident's breathing is controlled by the ventilator.

A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here.

Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

# O0100G1 Non-Invasive Mechanical Ventilator (O0110G2 BiPAP/O0110G3CPAP)

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual.

If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

# O0110H1- O0110H10 IV Medications

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do not code flushes to keep an IV access port patent, or IV fluids without medication here.

Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently, and they involve continuous administration of a substance. Subcutaneous pumps are not coded in this item.

Do not include IV medications of any kind that were administered during dialysis or chemotherapy.

Lactated Ringers given IV is not considered medications and should not be coded here.

# O0110H1 IV Medications

– Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.

Lactated Ringers given IV *is* not considered *a* medication and should not be coded here.

– ***O0110H2, Vasoactive medications***

*Check when at least one of the IV medications was an IV vasoactive medication.*

– ***O0110H3, Antibiotics***

*Check when at least one of the IV medications was an IV antibiotic.*

– ***O0110H4, Anticoagulation***

*Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.*

– ***O0110H10, Other***

*Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).*

# O0110 Coding Tips (continued)

O0110I1. Transfusions: Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.

O0100J1. Dialysis: Code O0110J2 Hemodialysis or O0110J3 Peritoneal which occurs at the nursing home or at another facility.

O0110K1. Hospice Care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

# O0110M1 Isolation or Quarantine for Active Infectious Disease

## Code for “single room isolation” only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.

2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.

3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.

4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

# O0110O1 IV Access

O0110O2. Peripheral- usually a short plastic catheter inserted into the hand, arm, antecubital region, foot or scalp

O0110O3. Midline- usually inserted into the antecubital region or upper arm, 8-12 cm long terminating just below the axilla.

O0110O4. Central- usually placed in the jugular, subclavian or femoral veins. PICC and subcutaneous ports are types of central lines.

# Quality Measure: Influenza Vaccine

***Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (SS)** The measure reports the percent of short-stay residents who are assessed and/or given, appropriately, the influenza vaccination during the most recent influenza season.

***Percent of Residents Who Received the Seasonal Influenza Vaccine (SS)** The measure reports the percent of short-stay residents who received the influenza vaccination during the most recent influenza season.

***Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine (SS)** The measure reports the percent of short-stay residents who are offered and declined the influenza vaccination during the most recent influenza season.

***Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine** The measure reports the percent of short-stay residents who did not receive, due to medical contraindication, the influenza vaccination during the most recent influenza season.

# O0250: Influenza Vaccine

Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.

Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.

Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm, http://www.cdc.gov/flu/weekly/usmap.htm, https://www.cdc.gov/flu/

Facilities can also contact their local health department website for local influenza surveillance information.

# Quality Measure: Pneumonia Vaccine

***This measure reports the percent of short-stay residents whose pneumococcal vaccine status is up to date during the 12-month reporting period.** This measure reports the percent of short-stay residents whose pneumococcal vaccine status is up to date during the 12-month reporting period.

***This measure reports the percent of short-stay residents who received the pneumococcal vaccine during the 12-month reporting period.** This measure reports the percent of short-stay residents who received the pneumococcal vaccine during the 12-month reporting period.

***This measure reports the percent of short-stay residents who were offered and declined the pneumococcal vaccine during the 12-month reporting period.** This measure reports the percent of short-stay residents who were offered and declined the pneumococcal vaccine during the 12-month reporting period.

***This measure reports the percent of short-stay residents who did not receive, due to medical contraindication, the pneumococcal vaccine during the 12-month reporting period.** This measure reports the percent of short-stay residents who did not receive, due to medical contraindication, the pneumococcal vaccine during the 12-month reporting period.

# O0300: Pneumococcal Vaccine

Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#table-age

“Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations. For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at

https://www.cdc.gov/vaccines/schedules/hcp/index.html http://www.cdc.gov/vaccines/hcp/acip-recs/index.html https://www.cdc.gov/pneumococcal/vaccination.html

1/16/24

# Pneumococcal Vaccine continued

If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.

Advisory Committee on Immunization Practices (ACIP) Vaccine Recommendations and Guidelines https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-schedule-vaccines.html

# Resident's COVID-19 vaccination is up to date

**Coding Instructions**

Code 0, No, resident is not up to date if the resident does not meet the CDC's definition of up to date.

- — This includes residents who have not received one or more recommended COVID-19 vaccine doses **for any reason** including medical, religious, or other qualified exemptions.
- — This includes residents for whom vaccination status cannot be determined.

Code 1, Yes, resident is up to date if the resident meets the CDC's definition of up to date.

A dash is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence

# F883
# Influenza and Pneumococcal Immunizations

The facility must develop policies and procedures to ensure that-

Before offering the immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period;

Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized

The resident or the resident's representative has the opportunity to refuse immunization; and

(continued next slide)

# F883 (continued)

The resident's medical record includes documentation that indicates, at a minimum, the following:

That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

That the resident either received the immunization or did not receive the immunization due to medical contraindications or refusal.

# F887 COVID-19 Immunization

**Infection control COVID-19 immunizations.**

**The LTC facility must develop and implement policies and procedures to ensure all the following:**

**When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless medically contraindicated or already immunized;**

**Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;**

**Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;**

# F887 COVID-19

**The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and**

**The resident's medical record includes documentation that indicates, at a minimum, the following:**

- **(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and**
- **(B) Each dose of COVID-19 vaccine administered to the resident, or**
- **(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.**

# F887 COVID-19 Immunization

**The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:**

**(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;**

**(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and**

**(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network**

# O0390 Therapy Services Coding Instructions

*Check each therapy service that was administered for at least 15 minutes per day on one or more days in the last 7 days. Check none of the above if the resident did not receive therapy services for at least 15 minutes per day on one or more days in the last 7 days.*

*A day of therapy is defined as skilled treatment for 15 or more minutes during the day.*

*Instructions start on RAI page O-21*

# O0400 Therapies

**Coding Instructions:**

**Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

# O0400D: Respiratory Therapy

Respiratory Therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.

**See Appendix A- Glossary page A-22 and Page O-25 for definitions**

**This item is required by NC Medicaid/Myers & Stauffer**

# O0425 Part A Therapies

Only completed for PPS Discharge

Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:

- Ordered by a physician (or an approved extender) based on a qualified therapist's assessment and treatment plan
- Documented in the resident's medical record, and
- Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.

Therapy can occur inside or outside the facility

# O0430 Distinct Calendar Days of Therapy

**Item Rationale**

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the Part A SNF stay.

Only completed for PPS Discharge assessments

# O0430 Coding Instructions

Enter the number of calendar days the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical therapy for at least 15 minutes during the SNF Part A stay.

If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding item O0430.

# F825 Provide/Obtain Specialized Rehab Services

**Specialized rehabilitative services. Provision of services.**

**If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity, are required in the resident's comprehensive plan of care, the facility must—**

**Provide the required services; or**

**Obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs.**

# F825 Intent

The intent of this regulation is to ensure that every resident receives specialized rehabilitative services as determined by their comprehensive plan of care to assist them to attain, maintain or restore their highest practicable level of physical, mental, functional and psycho-social well-being.

The intent is also to ensure that residents with a Mental Disorder (MD), Intellectual Disability (ID) or a related condition receive services as determined by their Preadmission Screening and Resident Review (PASARR).

They are “specialized” in that they are provided based on each resident’s individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel.

# F826 Rehab Services- Physician Order/Qualified Person

Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

DEFINITIONS:

“Qualified Personnel” means a physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician’s assistant, who is licensed or certified by the state to furnish therapy services. Qualified personnel may also include a physical therapist assistant (PTA), or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist.

# O0500: Restorative Nursing Programs continued

Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible.

A resident may be started on a restorative nursing program when they are admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy.

Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

# O0500: Restorative Nursing Programs

Must meet specific criteria prior to coding

- Measurable objectives and interventions documented in the care plan and medical record
- Periodic evaluation by a licensed nurse in the medical record
- Nursing assistants/aides/other staff/volunteers must be trained in the techniques that promote resident involvement
- A nurse must supervise the activities in a nursing restorative program
- Groups no larger than 4 residents per staff
- Cannot claim techniques that therapists claim

# Section P:
# Restraints and Alarms

Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7 day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.

***DEFINITION PHYSICAL RESTRAINTS:*** **Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body** (State Operations Manual, Appendix PP).

# Section P: Restraints and Alarms

Any manual method or physical or mechanical device should be classified as a restraint *only* when it meets the criteria of the physical restraint definition.

- This can *only* be determined on a case-by-case basis by individually assessing each and every method or device, attached or adjacent to the resident's body, *and* the effect it has on the resident.

Any manual method or physical or mechanical device, material, or equipment that *meets the definition* of a physical restraint *must* have:

- physician documentation of a medical symptom that supports the use of the restraint
- a physician's order for the type of restraint and parameters of use
- a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

# Restraints and Alarms (continued)

A clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom.

If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraint must be documented in the resident's medical record, ongoing assessments, and care plans.

There also must be a physician's order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician's order alone is not sufficient to employ the use of a physical restraint.

# Quality Measure: Percent of Residents Who Were Physically Restrained

This measure reports the percent of long-stay nursing facility residents who are physically restrained on a daily basis.

# Bed Rails

Bed rails include any combination of partial or full rails.

Bed rails used as positioning devices: If the use of bed rails meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint.

Bed rails used with residents who are immobile: If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation, the bed rails do not meet the definition of a physical restraint.

For residents who have no voluntary movement: Staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others.

# Bed Rails (continued)

Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed.

- When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered.

While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.

# Restraints (continued)

Chairs that prevent rising include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers.

For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual.

For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint.

# Alarms

An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.

While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.

The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.

Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

# Alarms continued

Steps for Assessment

- Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
- Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
- Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?

If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.

# Alarms (continued)

Bracelets or devices worn by or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm, whether or not the device activates a sound or alerts the staff.

Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when anyone (including visitors or staff members) exits the door.

When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section “Determination of the Use of Position Change Alarms as Restraints” of F604 in Appendix PP of the State Operations Manual.

# Restraints Federal Regulations

F604: Right to be free from Physical Restraints. Without medical justification/staff convenience.

F605: Right to be free from Chemical Restraints

F700: Bedrails: Accidents hazards, bedrail entrapment issues.

# F604 Right to be Free from Physical Restraints
# F605 Right to be Free from Chemical Restraints

**Respect and Dignity.**

The resident has a right to be treated with respect and dignity, including:

The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s medical symptoms.

# F700 Bedrails

The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements:

Assess the resident for risk of entrapment from bed rails prior to installation.

Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

Ensure that the bed's dimensions are appropriate for the resident's size and weight.

Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

*https://www.fda.gov/medical-devices/adultportable-bed-rail-safety/recommendations-consumers-and-caregivers-about-adultportable-bed-rails*

**Recommendations for Consumers and Caregivers about Adult Portable Bed Rails**

# F700 Bedrails continued

The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements:

Assess the resident for risk of entrapment from bed rails prior to installation.

Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

Ensure that the bed's dimensions are appropriate for the resident's size and weight.

Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

Use and monitoring of the bedrail should be included in the care plan.