

## AHFSA Panel Oct-Dec 2012

**1. Question:** A resident admitted to us on 8/1/12 on Medicare A, and discharged return anticipated on 8/7/12 due to hospitalization. We performed Entry record on 8/1/12, and then 5-day MDS combined with Discharge Return Anticipated on 8/7/12. When he returned on 8/8/12, entry record was done, and then on 8/15/12 – Readmission MDS, on 8/21/12 – 14-day, and 9/4/12 – 30-day. He is hospitalized again from 10/2/12 to 10/12/12, and when he returns, I find that the Admission was missed in the first place. Admission Assessment was missed due to the system glitch (we use an electronic medical record) and it was overlooked. Staff would like to find out – what are the actions as of this point. Can I schedule an Admission MDS with ARD of 8/7/12 (his first stay with us), as I have all the info needed for it (we do all interviews automatically on everybody, and they were done), and have it as a late completion and late submission? Or maybe I can do Admission MDS with an ARD of 8/15/12 (his Readmission to us, as we also performed all the interviews and I have all info available)?

**Answer:** For OBRA MDSs, the ARD for a missed/late assessment may be set no sooner than the current day with the exception of the OBRA Discharge ARD which must be the date of discharge. The Admission assessment should be completed for this resident with the ARD set no sooner than the current date. When submitted, you should expect warning notices due to the timing of the assessment and due to it being out of sequence; however, none of these are fatal errors. If the team had initiated another assessment in the interim (that is, since they discovered this error) but it has not yet been completed, that they should set that assessment aside (and retain it in the record) and complete an Admission assessment instead.

**2. Question:** OT, PT, and ST are treating a resident at RVC. On 10/1, PT has a planned discharge with FMP in place. The patient then has a 3 day gap on 10/2, 10/3, and 10/4 with OT and ST resuming at the same intensity on 10/5.

- Would an EOT/R be appropriate since the PT discharge was planned prior to the three day gap if the same RUG level was achieved?
- If the facility chooses to do an EOT only, is a therapy discharge and new evaluation required even though there is no change in medical status or could OT and ST continue with the previous plan of care?

**Answer:** All disciplines have to resume at the exact same level that they were for the prior RUG score for an EOT-R. If all three were involved for the RVC, then all three would have to resume for an EOT-R to be appropriate. If the three days with no therapy coincided with PT ending, then the provider must complete an EOT. Because, in the scenario you describe the therapies are not restarting at exactly the same level, an SOT OMRA (rather than an EOT-R) is required to classify the resident back in a RUG-IV therapy group and a new therapy evaluation is required as well.

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**3. Question:** PT & OT are treating a resident at RVC and a three day gap occurs with no change in medical status so an EOT/R is requested. If by day 7 after the resumption date, the patient

does not meet the same RUG level, would it be appropriate to complete a COT or should the facilities hold the assessment open to allow for changes to the assessment type and perform an EOT only?

**Answer:** Because you indicated there is no change in the medical status but did not mention if the therapy was planned to resume at exactly the same level for all disciplines involved, it is important to mention that the EOT-R would only be used in such a situation. Assuming that the resident did resume the same therapy plan (e.g., same disciplines involved at the same planned number of days and minutes), the correct thing to do in the scenario would be to do an EOT-R and then a COT seven days later when it was noted that the resident did not meet the planned intensity of therapy.

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**4. Question:** A third facility had the intentions of completing a significant change in assessment on a resident but instead completed a quarterly. Two more quarterly were completed since then making a total of six quarterly in a row done for this resident without a comprehensive OBRA assessment in between. Their missing assessment reports do not indicate the comprehensive assessment was missed. What should the facility do? Should they complete a comprehensive assessment now and go forward with the OBRA assessments schedule or should they go back to where the comprehensive assessment should have been done and inactive one quarterly as the wrong reason for assessment?

**Answer:** If the resident met the criteria for a Significant Change in Status Assessment (SCSA) and the assessment has not been completed, one should be initiated with the ARD set no sooner than the current date. This comprehensive assessment will then serve as the basis for scheduling future OBRA-required assessments.

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**5. Question:** If a resident is on a therapeutic or home leave of absence (LOA) from the facility for one night and the next day, prior to return to the facility, the resident has an accident or is ill and taken to the ER/ED for less than 24 hours from the time they left the therapeutic/home leave location and is not admitted, and then the resident returns to the facility, is the resident required to be discharged because they were out of the facility and not a resident for greater than 24 hours?

**Answer:** No, a resident on a therapeutic or home leave is still a resident of the facility. If a resident on therapeutic/home leave is sent to the ER/ED, is not admitted, and returns to the facility within 24 hours from the time he/she left the leave location until the time he/she returns to the facility, a discharge assessment is not required. Please review the LOA requirements on page 2-8, review Chapter 6 and contact your State RAI for any state specific LOA requirement.

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**6. Question:** Would you consider Chlorhexidine Gluconate (aka Hibiclense) a medication in M1200H? The solution is used to wash a rather large wound on the resident's neck.

**Answer:** The instructions for M1200H Application of Ointments/Medications Other than to Feet state:

- *Do NOT code application of ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers here; use Pressure Ulcer Care, item (M1200E).*
- *This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).*
- *Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.*
- *This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).*

Medicated wound cleansers can be considered as medications in M1200H when used to cleanse wounds other than pressure ulcers.

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**7. Question:** Can a Kennedy ulcer be staged and coded on the MDS?

**Answer:** Determining the etiology of the ulcer is critical when coding Section M. Only ulcers that have pressure as the primary etiology should be coded in M0300.

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**8. Question:** I have a question about coding for section K, Nutritional Approaches. For K0510D (Therapeutic diet) -- do you check if the patient has a food allergy. We have been having more residents coming in with food allergies and wanted to make sure I am coding correctly. Here are a few examples:

A resident with celiac disease, receives a gluten free diet.

A resident with a corn allergy, we eliminated corn related products from diet.

Or a resident with a strawberry allergy, we eliminate strawberries from the diet.

**Answer:** Yes. From page K-11 of the *RAI User's Manual*, "THERAPEUTIC DIET - A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011)."

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**9. Question:** A resident is transferred via Hoyer Lift. The resident does not assist with the transfer in any way. The resident does not stand, scoot over the sling, or help position once on the sling. The resident cannot remove themselves from the sling once the transfer is over, staff must do it. However, once in the device, the resident hands on placed on the bar in front or crossed in front of them either by the resident themselves or by staff. This in no way assists

with the transfer process. Therefore, the self-performance for this activity should be coded as Total Dependence (full staff performance). However, some MDS educators are telling NF staff if the resident or the staff place the resident's hands on the bar or crossed in front of them, it is extensive assistance because the resident assisted in a part of the ADL activity of transfer. Which is correct?

**Answer provided by CMS staff:** If the person is able to perform actions that are part of the transfer (e.g., sits on the edge of the bed and assists with sliding onto the transfer sling; partially weight-bear stands and sits on the transfer sling; or positions themselves in the sling), that would be considered assisting in ADL aspects that are part of the transfer activity. A person who simply folds their hands across their chest or puts their hand on a bar while in the sling lift is not performing actions that can be considered as assisting with a transfer.

The coding instructions from page G-5 of the *RAI User's Manual* state that extensive assistance is coded "if resident performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:

- Weight-bearing support provided three or more times.
- Full staff performance of activity during part but not all of the last 7 days."

Continuing on page G-5, total dependence is coded "if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period."

Therefore, since the resident is not participating in the ADL aspects that are part of the transfer activity, and the facility staff are providing the components that are part of the ADL activity of transfer every time the transfer occurs during the 7-day look-back period, the correct code would be total dependence.

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**10. Question:** When performing a modification of a comprehensive assessment and an item is corrected that causes triggering of a CAA, should the CAA and CP decision be worked through? If yes, what signature dates should be provided in Section Z, as well as V0200B2 and V0200C2 (e.g. original or new) since it is a modification assessment?

**Answer:** Yes, the CAA and CP decision would need to be worked through. In addition, staff should update Z0400 after any modification to items on the MDS, as the original answer has been changed. Because there is no way to update the dates in Z0500, V0200B or V0200C without indicating the assessment was not complete, the CAAs not worked or the care plan not created/updated as required per the timelines in the *RAI User's Manual*, these dates are not changed. In addition to the modification, a Significant Correction of a Prior Comprehensive would be required unless another comprehensive assessment accurately reflecting the status of the resident and triggering the appropriate CAA(s) has since been completed.

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**11. Question:** Upon an MDS audit, we discovered that a dietician was checking "yes" for mechanically altered diet when it was a regular, cut diet. She stated that the food was cut in the kitchen prior to sending it to the floor at mealtime. There is an MD order for the regular, cut diet and this is care planned. In the RAI Manual April 2012 page K-11, mechanically altered diet is defined as, "a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed solids, ground meat and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet." Is a regular, cut diet mechanically altered? To clarify, I got the answers to a few questions:

- Did the MD order the diet to be cut to a specific size such as diced, sized cubes, or other specific details, etc.? NO, THE ORDER STATED "REGULAR, CUT" ONLY
- Did the MD order the diet for a specific reason? ON 10/3, THE DATE OF THE ORDER, THE RN-NURSE MANAGER WROTE A PROGRESS NOTE STATING, "RESIDENT PREFERS CUT DUE TO PAIN IN R ARM DUE TO BREAST CA, SEE NEW ORDER"

**Answer:** Simply cutting food does not constitute mechanically altering a diet as it is not changing the texture or the consistency of the food. The regular, cut diet would not be coded as a mechanically altered diet.

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**12. Question:** I have a provider with a question related to coding O0100F – ventilator or respirator. Can ventilator be coded if the resident is receiving non-invasive ventilation? The resident requires a ventilator to ensure continued respiratory support, but does not require an ET tube or trach. The provider stated this procedure is becoming more and more popular.

**Answer:** If the resident has BiPAP or CPAP as a ventilatory mode and a non-invasive delivery method (e.g. mask) is used, then BiPAP/CPAP is coded. Ventilator support is different from the support provided by BiPAP/CPAP. Ventilators directly support the resident's respiratory effort and assist in breathing. BiPAP/CPAP helps to keep the airways open so the individual can breathe on their own. Non-invasive ventilation just means that the mode of delivery is non-invasive, that is, it is not done through an artificial airway such as an endotracheal tube. CPAP and BiPAP are types of ventilatory modes that are used with both non-invasive and invasive interfaces (i.e. an endotracheal tube or mouth pieces, masks, etc.). What is important in coding the BiPAP/CPAP item is that it is the ventilatory mode being used to provide respiratory support that is being delivered via a mask and not an endotracheal tube.

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**13. Question:** Would you code a lap buddy as a trunk restraint or a chair that prevents rising, assuming of course it met the definition of a restraint?

**Answer:** If it meets the definition of a physical restraint, the "Lap Buddy" would be coded as a P0100G, Chair prevents rising. From Page P-6 of the *RAI User's Manual* states, "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, or a chair that is soft and low to the floor. Included here are chairs that have a cushion placed in the seat that prohibit the resident from rising."

**14. Question:** When coding MDS 3.0 version for an amputation (Unilateral or bilateral, or more) should the actual weight or adjusted weight be used for section K0200B?

**Answer:** The weight entered on the MDS should always reflect the resident's actual weight.

From page K-3 of the RAI User's Manual:

*Steps for Assessment for K0200B, Weight*

- 1. Base weight on the most recent measure in the last 30 days.*
- 2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).*
- 3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment.*
- 4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again.*
- 5. If the resident's weight was taken more than once during the preceding month, record the most recent weight.*