



Oklahoma State
Department of Health
Creating a State of Health

NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271 5278
Nancy Atkinson, Chief



Special points of interest:

- Visual Function—Section D—The Assessment Process
- MDS Accuracy Quick Check—Section D
- Section D2/D3—Visual Limitations/Difficulties/Appliances
- Automation Tips, Reminders & Updates

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**Visual Function—Section D
The Assessment Process**

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The aging process leads to a gradual decline in visual acuity which can be defined as a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark, and diminished ability to discriminate color. The aged eye requires about 3 to 4 times more light in order to see well than the younger eye.

The leading causes of visual impairment in the elderly are macular degeneration, cataracts, glaucoma, and diabetic retinopathy. In addition, visual perceptual deficits (impaired perceptions of the relationship of objects in the environment) are common in the nursing

facility population. Such deficits are common consequence of cerebrovascular events and are often seen in the late stages of Alzheimer’s disease and other dementias. The incidence of all these problems increases with age.

Nineteen percent of adults older than the age of 70 are visually impaired. Studies evaluating residents in long term care settings demonstrate a prevalence rate of visual impairment of 40% to 54%. *Vision loss is a major concern for your residents.*

The consequences of vision loss are wide-ranging and can seriously affect physical safety, self-image,

and participation in social, personal, self-care, and rehabilitation activities.

The **INTENT** of Section D is to record the resident’s visual abilities and limitations over the past seven days, assuming adequate lighting and assistance of visual appliances, if used. (Continued on page 2)



GOAL
**Highest Practicable
Level of Functioning**

MDS Accuracy Quick Check—Section D

Is D2b = checked?

Is the staff aware if the resident is experiencing any of the following?

- Halos or rings around lights?
- Flashes of light?
- Floaters or curtains?

Cataracts can cause increased sensitivity to glare such as halos or rings around bright lights.

Retinal detachment symptoms include floaters &

flashes in the eye due to vitreous gel shrinkage.

Floaters are spots, specks, & lines that float through the field of vision. Flashes are brief sparkles or lighting streaks that are most often seen with the eyes closed. If these symptoms are present, referral to a specialist is recommended.

Reference RAI Manual
Chapter 3, page 58-59

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Visual Function—Section D *(continued from page 1)* The Assessment Process

The aged eye requires 3 to 4 times more light in order to see well.

As the MDS coordinator, you must evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses, magnifying glass).

Ask direct staff over all shifts if the resident has manifested any change in usual patterns over the past seven days— e.g., is the resident still able to read newsprint, menus, greeting cards, etc?

- Ask the resident about his or her visual abilities.

- Test the accuracy of your findings by asking the resident to look at regular size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.

- If the resident is unable to

communicate or follow directions for testing vision, observe the resident's eye movements carefully to determine if their eyes seem to follow movement and objects. These are gross measurements of visual acuity and they may assist in whether or not the resident has any visual ability.

Reference : RAI Manual, Chapter 3, page 3-58

Be sensitive to the fact some residents are not literate or are unable to read English.

Section D2 Visual Limitations/Difficulties Section D3 Visual Appliances

The **INTENT** of item D2 is to document whether the resident experiences visual limitations or difficulties related to diseases common in aged persons (e.g., cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurological diseases). It is important to identify whether or not these conditions are present. Some eye problems may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the resident's residual visual abilities.

a. Side Vision Problems-

Observe the resident:

- Eating
Is the resident spilling food?
Is the resident leaving food on one side of the tray?

- Ambulating
Is the resident bumping into objects and people as they attempt to motor down the hallway, or misjudges placement of chair when seating self?

b. Experiences Any of the Following-

- Ask the resident directly if he/she is seeing halos or rings around lights, flashes or floaters, or "curtains" over the eyes?

Be sure and ask staff members if the resident complains about any of these problems.

c. None of the above

Check all that apply. If none apply, check c.

Encourage the use of good lighting in residents room and avoid glare.

The **INTENT** of item D3 is to determine if the resident uses visual appliances on a regular basis.

Definition of Visual Appliance:

Glasses; contact lenses; magnifying glass. This includes any type of corrective device used at any time during the last seven days.

To Code Item D3:

Enter "1" if the resident used glasses, contact lenses, or a magnifying glass during the past seven days.

Enter "0" if none apply.

Reference: RAI Manual Chapter 3, page 60-61.



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MDS HELP DESK
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Sensory Vision-Section I/Disease Diagnosis

Is the resident able to live the quality of life they desire?

Has the environment been adapted to the resident's needs?

- Is I1j=checked?

Does the staff know that cataracts can cause a decrease in contrast sensitivity, a dulling of colors and increased sensitivity to glare?

Contrast sensitivity is a problem with several eye conditions, including cataracts, glaucoma, and macular degeneration. Adding contrast to fixtures in the resident's room if light switches blend into the sink can create a safer and more functional environment.

- Is I1ll=checked?

Does your staff know that Glaucoma is the leading cause of blindness and is more common in older adults?

Again, a decline in contrast

sensitivity impacts the resident's ability to distinguish when one step ends and another begins, reading materials not printed in large contrast font, and the ability to indentify the buttons on the TV remote control. Intact contrast sensitivity is important for day-to-day functioning within the resident's surroundings.

- Is I1mm=checked?

Is your staff aware that excessive sunlight and smoking are major risk factors contributing to Macular Degeneration eye disease? This condition causes loss of central vision which allows one to see fine detail and colors. Activities like reading, watching TV and recognizing faces require good central vi-

sion.

Environmental Modifications

Residents whose vision cannot be improved by medical and/or surgical intervention may benefit from environmental modifications.

- Does the resident's environment enable maximum visual function (e.g., low-glared floors, table surfaces, and night lights)?
- Has the environment been adapted to resident's needs (e.g., large numbers on telephone, reading lamp with 100 watt bulb, or color coded tape on dresser drawer)?

Reference: RAI Manual, Chapter 3, page 3-59.

ALERT!

**MDS Manual Revision—
October, 2008
To download—
www.cms.hhs.gov/medicaid/mds20**

Nursing Home Goal Highest Practicable Level of Functioning Functional Need for Eye Exam/New Glasses

Many residents with limited vision will be able to use the environment with little or no difficulty, and neither the resident nor staff will perceive the need for new visual appliances. In other circumstances, needs will be identified, and for residents who are capable of participating in

a visual exam, new appliances, or surgery to remove cataracts, etc., can be considered.

- Does the resident have peripheral vision or other visual problem that impedes their ability to eat food, walk on the unit, or interact with others?
- Is resident's ability to recog-

nize staff limited by a visual problem?

- Does resident report difficulty seeing TV/reading material of interest?
- Has resident refused to have eyes examined? Does the facility need to make a referral to a vision specialist?

SCENARIO QUIZ Section D

Since admission two months ago, Mrs. T. has experienced increasing difficulty navigating her way around the facility hallway. Mrs. T. often "bumps" into staff and the food cart. The facility staff recently observed that she of-

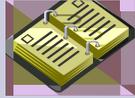
ten leaves food on the right side of the plate at mealtime. Although Mrs. T. is often restless and fidgety, this behavior is new for her. You speak with her daughter who relates that Mrs. T's mother had a history of "bumping" into objects and was

treated for an unknown eye condition. You check her chart and there is no documentation of an eye exam. How will you code MDS section D2a?

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MARK YOUR CALENDAR!



Upcoming MDS Training Tentative Dates

- Clinical Coding Chapter 3, January 29, 2009
- Clinical Coding March 19, 2009

See Training Calendar and Enrollment Forms

<http://qies.health.ok.gov>
 Click MDS, then click Educational Resources

Scenario Answer from page 3

D2a checked

Rationale:

Definition of Peripheral Vision relating to or situated at the periphery (the part of a body away from the center the outer part or surface). The resident may leave food on one side of the plate, of ten difficulty in ambulating , bumping into people and objects, misjudges placement of chair when seating self. Decreased peripheral vision often results in tunnel vision which is the loss of peripheral vision with retention of central vision, resulting in a constricted circular tunnel like field of vision. Often seen in residents with history of alcoholism.



MDS 3.0



Scheduled to Become Effective October 1, 2009.

Keep up with all the changes by going to www.qtso.com, click on MDS 3.0 and review tentative timelines, cross-walks, coding conventions, and more. Be aware that some consultants have started training on this material in other states and have confused some MDS coordinators. **Remember, these are draft documents. They have not been finalized by CMS.** CMS will begin training all State MDS coordinators on MDS 3.0 during May 2009. Oklahoma will begin MDS 3.0 training as soon as possible after the CMS training. During this transition period, I recommend that you go to the above referenced web address and review. This is not the final form and is **subject to change.**

The MDS 3.0 also has to be reviewed by Staff Time and Resource Intensity Verification (STRIVE) in the review of Resource Utilization Groups (RUGS) in order to evaluate and maintain the ability to construct RUGS.

Broadband In Effect

Broadband conversion is now in effect and has been for some time. CMS has stated “dial up will be eliminated February 1, 2009”. I strongly urge you to convert NOW.

Go to www.qtso.com click on MDCN AT&T client software. Download the new dialer instructions and (or) most current version of the dialer.

Contact QIES at 1-405-271-5278 or AT&T at 1-800-905-2069, if you need help.

MDS Automation Tips

Bob Bischoff—MDS/OASIS Automation Coordinator

Oklahoma’s Top 5 Automation Errors Directly linked to Timeliness and Increased Risk for Deficiencies. (Timeframe 1-1-2008 through 9-30-2008)

1 Message 377 Record submitted late (+31 days late)	7.71%
2 Message 70 Assessment completed late (+92 days late)	3.05%
3 Message 217 RAPS late (+14 days late)	.72%
4 Message 216 R2b late (+14 days late)	.67%
5 Message 393 Annual late (+366 late)	.57%

Order your MDS Error Summary Report through Certification And Survey Provider Enhanced Report, (CASPER) using the same date criteria above and see how you compare.

Automation Tip: Don t Jump the Gun, but do begin to get prepared.

Some facilities are calling and asking to code MDS 2.0 like it’s MDS 3.0. Don t do it. According to CMS, MDS 3.0 will not go into effect before October 1, 2009. These are two different instruments with different coding conventions. Right now, you must continue to follow all MDS 2.0 coding conventions.