MDS Boot Camp

Level 1 Week 3

Minimum Data Set (MDS) Coding Sections B-F

Section B – Hearing, Speech, and Vision

Section C – Cognitive Patterns

Section D - Mood

Section E - Behavior

Section F – Preferences for Customary Routine and Activities

5.19.21

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MDS Boot Camp
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Sections B-F
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"HHI **C.A.R.E.S. a**bout Care"

C.A.R.E.S.™

HHI C.A.R.E.S. About Care

Compliance | Analysis | Audit | Regulatory | Rehabilitation
Reimbursement | Education | Efficiency | Survey

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About Kris

Kris Mastrangelo OTR/L, LNHA, MBA

President and CEO

Owns and operates
Harmony Healthcare International (HHI) a Nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E.S.
There are no nonfinancial disclosures to share.

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About Joyce

Joyce Sadewicz PT, RAC-CT

Senior VP Field Operations

Employed by Harmony Healthcare International (HHI) for over 10 years, managing a diversified team of HHI Specialists with extensive knowledge in the areas of MDS 3.0, PDPM, Compliance, Documentation, Therapy Program development, as well as expertise in Medicare and Medicaid Reimbursement and Documentation. There are no nonfinancial disclosures to share.

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Educational Activity Completion

Requirements for Successful Completion

1 contact hour will be awarded for this continuing nursing education activity. **Criteria for successful completion includes:**

Attendance for 100% of the 1-day course or individual, 3-hour module (2- and 3-day trainings requires at last 80% attendance). Contact hours will be awarded for time

Must complete post course exam within 1 week of the course and course/teacher evaluation.

Clearly demonstrate the learning outcome of the program.

Participants will receive a certificate of completion immediately following completing the above requirements.

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CEU Disclosure

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Approval of this continuing education activity does not imply endorsement by AOTA and NAB of any commercial products or services.

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Speaker and Planning Committee Disclosure

- **Disclosures**: The planners and presenters of this educational activity have no relationship with commercial entities or conflicts of interest to disclose. Please visit https://www.harmony-healthcare.com/hhi-team for all speaker's financial and nonfinancial disclosures
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- **Presenter:**
  - Kris Mastrangelo, OTR/L, LNHA, MBA
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  - Cheryl DuBois, RN

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Learning Objectives

1. Summarize coding instructions for **Sections B through F**. Section B – Hearing, Speech, and Vision, Section C – Cognitive Patterns, Section D – Mood, Section E – Behavior, Section F – Preferences for Customary Routine and Activities.
2. Articulate the **intent** of each MDS 3.0 section, and **correct coding strategies** for each item.
3. Identify newly updated MDS 3.0 **coding guidelines** as they relate to care and reimbursement.

Section B
Hearing, Speech and Vision

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Section B
B0100: Comatose

B0100. Comatose	
Enter Code ☐	**Persistent vegetative state/no discernible consciousness** 0. **No** → Continue to B0200, Hearing 1. **Yes** → Skip to GG0100, Prior Functioning: Everyday Activities

- **Code 0, no:** If a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period. Continue to B0200 Hearing.
- **Code 1, yes:** If the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to Section G0110, Activities of Daily Living (ADL) Assistance.

Section B
Definition of Comatose

- A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists
- The person is unresponsive and cannot be aroused, he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain)

Section B
Definition of Persistent Vegetative State

- Sometimes residents who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain), from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition
- Their eyes are open, and they may grunt, yawn, pick with their fingers and have random body movements
- Neurological exam shows extensive damage to both cerebral hemispheres
- PVS would be coded as “coma” on the MDS 3.0

Section B
B0700: Makes Self Understood

B0700. Makes Self Understood	
Enter Code ☐	**Ability to express ideas and wants,** consider both verbal and non-verbal expression 0. **Understood** 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** - ability is limited to making concrete requests 3. **Rarely/never understood**

- Assess using the resident's **preferred language**
- Ability to express or communicate requests, needs, opinions, conduct social conversation in primary language
- Observe his or her interactions with others in different settings and circumstances

Section B
Definition: Makes Self Understood

- Able to express or communicate **requests, needs, opinions** and to conduct social conversation in his or her **primary language**, whether in speech, writing, sign language, gestures or a combination of these
- Deficits in the ability to make oneself understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing

Section B
B0700: Makes Self Understood

- **Key Point:** This item cannot be coded as Rarely/Never Understood if the **resident completed any of the resident interviews,** as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.
- While B0700 and the resident interview items **are not directly dependent on one another,** inconsistencies in coding among these items should be evaluated.
- Section F interview may be done with family/significant other if patient is rarely/never understood

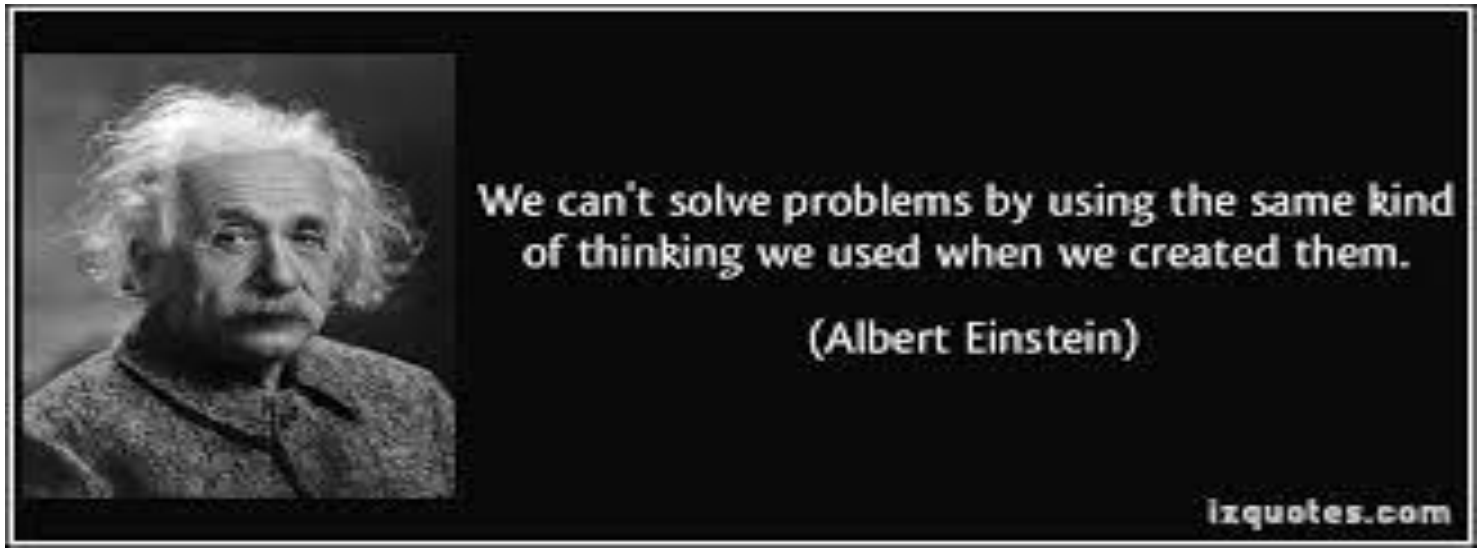
Section B
B0700: Makes Self Understood

- Code 0, understood
- Code 1, usually understood: If the resident has difficulty communicating some words or finishing thoughts but is able if prompted or given time. Responses may be delayed, or resident may require some prompting to make self understood.

Section B
B0700: Makes Self Understood

- **Code 2, sometimes understood:** If the resident has limited ability but is able to **express concrete requests regarding at least basic needs** (e.g., food, drink, sleep, toilet)
- **Code 3, rarely or never understood:** If, **at best**, the resident's **understanding is limited** to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet)

Section C
Cognitive Patterns



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Section C
Cognitive Patterns

- Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information
- These items are crucial factors in many Care Planning decisions
- The assessor should also use the structured interview process to assess for signs and symptoms of **delirium**

Section C
Interview Techniques

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Section C
CMS Has Expressed Concern…

- Overuse or inappropriate use of dashes on assessments
- Skipped interviews
- Per CMS, "**Every assessment must be completed as fully as possible with all available information at the time of the assessment**"

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Section C
The Importance of Accurate Interviews

- CMS stresses the importance of the interviews and the need to make every attempt to complete them
- State survey agencies have verified that, in some cases, interviews are not completed when the resident could participate
- Failure to complete the interviews places the facility at risk for citation during survey

Section C
The Importance of Accurate Interviews

- Resident interviews are an important aspect of the entire Care Planning process
- All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives
- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent on item B0700, Makes Self Understood.

Section C
The Importance of Accurate Interviews

- Several MDS 3.0 sections require direct interview of the resident as the primary source of information
- Self-report is the single most reliable indicator of these topics
- Resident interview should be part of a supportive care environment that assists residents to fulfill their choices over aspects of their lives
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, the item must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.
- Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.

Section C
The Importance of Accurate Interviews

Bottom Line:

It’s all about the Resident

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Section C
The Importance of Accurate Interviews

- There are RAI resources available to increase the relevancy of your interviews
- Appendix D offers some tips and techniques for more successful resident interviews
- Appendix E offers PHQ-9 scoring rules and instructions for administering the BIMS in writing

Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - **Introduce yourself** to the resident
  - Be sure the resident **can hear what you are saying**
  - Ask whether the resident would like an **interpreter** (language or signing)
  - Find a **quiet, private area** where you are not likely to be interrupted or overheard

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Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - **Sit where the resident can see you clearly and you can see his or her expressions:**
    - Ask the resident where you should sit so that he or she can see best
  - **Establish rapport and respect**
  - **Explain the purpose of the questions to the resident**

Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - **Say and show the item responses**
  - **Ask the questions** as they appear in the questionnaire

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Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - Break the question apart if necessary:
    - **Unfolding** refers to the use of a general question about the symptom followed by a sequence of more specific questions if the symptom is reported as present

Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - Break the question apart:
    - **Disentangling** refers to separating items with several parts into manageable pieces

Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - **Clarify using echoing:**
    - Echoing means simply restating part of the resident's response
  - **Repeat** the response options as needed
  - **Move on to another question** if the resident is unable to answer

Section C
Steps to Prepare for a Successful Interview

- Interview approaches:
  - **Break up the interview** if the resident becomes tired or needs to leave for rehabilitation, etc.
  - **Do not try to talk a resident out of an answer**

Section C
Steps to Prepare for a Successful Interview

- Record the resident's response:
  - Do not record what you believe he or she should have said
- If the resident becomes sorrowful or agitated sympathetically respond to his or her feelings:
  - Allow emotional expression
  - You may need to finish the interview later

Section C
Steps to Prepare for a Successful Interview

- Remember that resident preferences may be influenced by many factors
- A resident's physical and/or psychological state or environment may play a role in current preferences
- Resident preferences can be a challenge to discern

Section C
Steps to Prepare for a Successful Interview

- A simple, performance-based assessment of cognitive function can quickly define a resident's cognitive status
- Most residents, even those with moderate to severe cognitive impairment, can answer simple questions within the interview structure

Section C
Steps to Prepare for a Successful Interview

- In other words, the interview items may be coded using the responses provided by the resident on a previous assessment only if the date of the interview responses from the previous assessment, as documented in item Z0400, were obtained no more than 14 days prior to the date of completion for the interview items on the unscheduled assessment, as documented in item Z0400, for which those responses will be used.

Section C
Interviews for a Standalone OMRA

- When completing a **standalone** unscheduled PPS assessment (IPA), the interview items may be coded using the responses provided by the resident on a previous assessment, if the interview responses from the previous assessment were obtained no more than 14 days prior to the date those responses will be used

Section C
Interviews for a Standalone OMRA

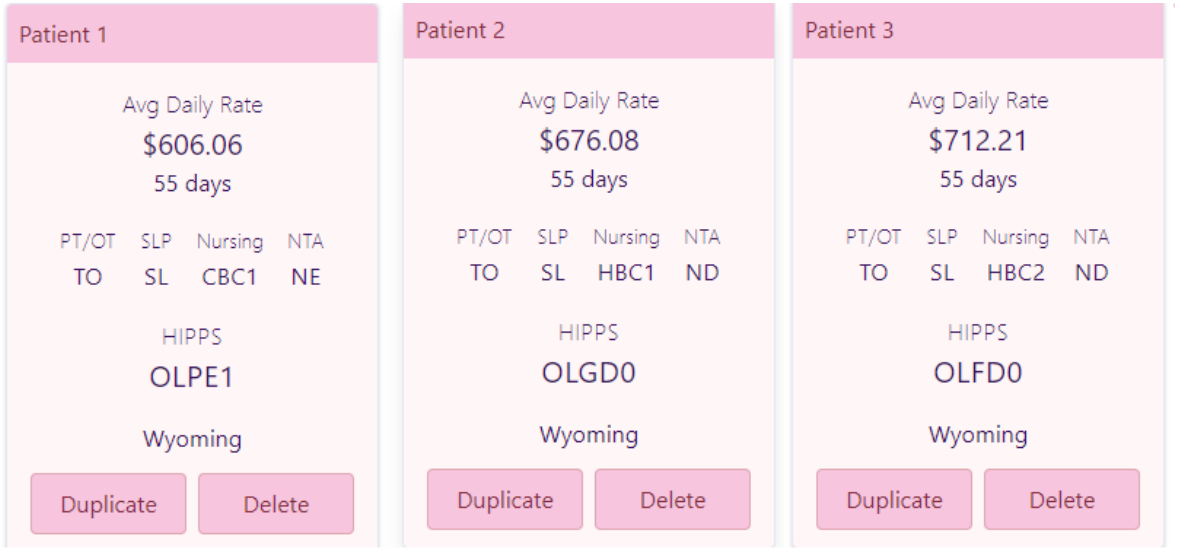
Example: Facility completes an OBRA Admission assessment combined with a 5-Day PPS assessment and the resident interview items are completed the day of the ARD (day 8):

- A week after the ARD, on day 15, the resident goes out to the hospital and receives 2 units of PRBC, then returns to the facility later in the evening with orders for IV fluids.
- The MDS Coordinator reviews the Nursing Component and the NTA component and determines that an IPA is appropriate.
- The MDS Coordinator consults with the IDT and sets the ARD for day 16 to allow time to collect functional assessment data for Section GG
- Facility reviews the interview items and finds that the responses are still an accurate representation of the resident's current state
- Interview responses may be carried forward from the Admit/5 day to the IPA
- The date of the original interview is identified by the date signed in Z0400
- Date of the original interview will be entered on the EOT OMRA

Section C
Interviews for a Standalone OMRA

- For an IPA, never assume that the interview results would be the same:

Resident admitted from LTACH with hemiplegia after stroke. He has a mechanical soft diet and the nurse documented choking with medications. Speech is treating for dysphagia and aphasia. BIMS was 10. PHQ-9 was 3.



The Speech Therapist tells the IDT on day 17 that the resident's cognition is at baseline, but since the GI bleed and transfusion, the resident has made some hopeless comments about his recovery. The Social Services Director conducts another PHQ-9 and the resident's new PHQ-9 score is 12, indicating depression.

The IPA on day 17 after the transfusion on day 15 and IV fluids that started day 16 used the same interviews from day 8.

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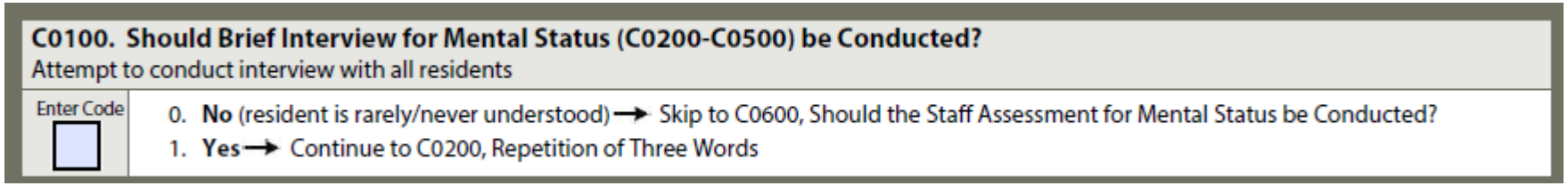
Section C
BIMS Interview

- **When** conducting the Brief Interview for Mental Status (BIMS):
  - Interviewers need to use the words and related category cues as indicated
  - If the interview is being conducted with an **interpreter** present, the interpreter should use the **equivalent** words and similar, relevant prompts for category cues

Section C
C0100: Should Brief Interview for Mental Status Be Conducted?



C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt to conduct interview with all residents	
Enter Code ☐	0. **No** (resident is rarely/never understood) → Skip to C0600, Should the Staff Assessment for Mental Status be Conducted? 1. **Yes** → Continue to C0200, Repetition of Three Words

- Determine if the resident is rarely/never understood **verbally or in writing** (B0700 = 3)
- If rarely/never understood **verbally or in writing,** skip the BIMS and proceed to C0700 –C0100 (Staff Assessment of Mental Status)
- BIMS is a structured interview, and must be conducted according to the script provided in the RAI User's Manual
- No cue cards for the BIMS (patient must recall words on their own)

Section C
C0200: Repetition of Three Words

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter Code ☐	Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."* **Number of words repeated after first attempt** 0. **None** 1. **One** 2. **Two** 3. **Three** After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

- Say to the resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are sock, blue, and bed."
- Immediately after presenting the three words, say to the resident: "Now please tell me the three words"

Section C
C0200: Repetition of Three Words

- **Code 0, none:** If the resident did not repeat any of the 3 words on the **first attempt**
- **Code 1, one:** If the resident repeated only 1 of the 3 words on the **first attempt**
- **Code 2, two:** If the resident repeated only 2 of the 3 words on the **first attempt**
- **Code 3, three:** If the resident repeated all 3 words on the **first attempt**

Section C
C0200: Repetition of Three Words

- After the resident's first attempt to repeat the words, regardless of coding, the following must be said: **"The words are sock, something to wear, blue, a color, and bed, a piece of furniture"** (category cues)
- Category cues serve as a hint that helps prompt residents' recall ability
- Putting words in context stimulates learning and fosters memory of the words that residents will be asked to recall in item C0400, even among residents able to repeat the words immediately

Section C
C0200: Repetition of Three Words

- If the resident recalled **two or fewer words**, say to the resident: **"Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words."**
- If the resident **still does not recall** all three words correctly, you may **repeat the words and category cues one more time**

Section C
C0200: Repetition of Three Words

- If words are repeated back in a sentence or **out of order** they are still counted as correct
- If staff identify that the resident‘s primary method of communication is writing, the BIMS can be administered in writing
- Administration of the BIMS in writing should be limited

Section C
C0200: Repetition of Three Words

- If the resident **does not repeat** all three words after **three attempts**, re-assess **hearing:**
  - If the resident can hear, move on the next question
  - If hearing is an issue, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding

Section C
C0300: Temporal Orientation

C0300. **Temporal Orientation** (orientation to year, month, and day)	
Enter Code ☐	Ask resident: *"Please tell me what year it is right now."* **A. Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
Enter Code ☐	Ask resident: *"What month are we in right now?"* **B. Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
Enter Code ☐	Ask resident: *"What day of the week is today?"* **C. Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**

Section C
C0300: Temporal Orientation

- Present each question separately
- Allow **30 seconds to respond**
- **Do not** provide clues
- If the resident asks for clues, say **"I need to know if you can answer the questions without help from me"**

Section C
C0300: Incorrect vs. Nonsensical

- **Stop the interview** after completing "Day of the Week" if:
  - There has been **no verbal or written response** to any of the questions up to this point, **or**
  - There has been no verbal or written response to **some questions** up to this point and for all others, the resident has given a **nonsensical response**

Section C
C0300: Incorrect vs. Nonsensical

- A nonsensical response is any response that is unrelated, incomprehensible or incoherent
- A nonsensical answer is not informative with respect to the item being rated
- An incorrect answer is an answer that is incorrect, but related to the question

Section C
C0300: Temporal Orientation

- If the interview is stopped:
  - Code a **– (dash)** in C0400A, C0400B, and C0400C
  - Code **99** in the summary score in C0500
  - Code **1, yes** in C0600 (Should Staff Assessment for Mental Status be Conducted)
  - Complete Staff Assessment

Section C
C0400: Recall

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code ☐

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

Section C
C0400: Recall

- "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
- For any word that is not correctly recalled after 5 seconds, provide a category cue
- Category cues only used after the resident is unable to recall one or more of the three words
- Allow up to 5 seconds after category cueing for each missed word to be recalled

Section C
C0400: Recall

- **Code 0, no—could not recall:** If the resident **cannot recall** the word even after being given the **category cue** or if the resident responds with a **nonsensical answer** or chooses not to answer the item
- **Code 1, yes, after cueing:** If the resident requires the **category cue** to remember the word
- **Code 2, yes, no cue required:** If the resident **correctly** remembers the word spontaneously **without cueing**

Section C
C0400: Recall

- If on the first try **(without cueing),** the resident names multiple items in a category, one of which is correct, they should be coded as correct for that item
- If, however, the **interviewer gives the resident the cue** and the resident then names multiple items in that category, the item is coded as could not recall, even if the correct item is in the list

Section C
C0500: Summary Score

C0500. BIMS Summary Score	
Enter Score ☐☐	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the resident was unable to complete the interview**

- Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:

  13-15: Cognitively intact

  8-12: Moderately impaired

  0-7: Severe impairment

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Section C
Staff Assessment of Cognition
C0700: Short-Term Memory

C0700. Short-term Memory OK	
Enter Code ☐	Seems or appears to recall after 5 minutes 0. Memory OK 1. Memory problem

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Section C
Staff Assessment of Cognition
C0700: Short-Term Memory

- Determine the resident's short-term memory status by asking him or her to describe an event **5 minutes** after it occurred (if you can validate the resident's response), or to follow through on a direction given 5 minutes earlier
- Observe the resident's cognitive functioning in varied daily activities
- Observe across all shifts and departments
- Review the medical record for clues to the resident's short-term memory during the look-back period
- Code the most representative level of function

Section C
C0700: Short-Term Memory

- **Code 0, memory OK**: If the resident recalled information **after 5 minutes**
- **Code 1, memory problem**: If the most representative level of function shows the **absence** of recall **after 5 minutes**

Section C
C0800: Long-Term Memory

C0800. Long-term Memory OK	
Enter Code ☐	Seems or appears to recall long past 0. Memory OK 1. Memory problem

- Determine resident's long-term memory status by engaging in conversation and/or reviewing memorabilia with the resident or observing response to family who visit
- Ask questions for which you can validate the answers from review of the medical record, general knowledge, the resident's family, etc.
- Code 0, memory OK: If the resident accurately recalled long past information
- Code 1, memory problem: If the resident did not recall long past information or did not recall it correctly

Section C
C0900: Memory/Recall Ability

C0900. Memory/Recall Ability	
↓ Check all that the resident was normally able to recall	
☐	A. Current season
☐	B. Location of own room
☐	C. Staff names and faces
☐	D. That he or she is in a nursing home/hospital swing bed
☐	Z. None of the above were recalled

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Section C
C0900: Memory/Recall Ability

- **C0900A:** Current season
- **C0900B:** Location of own room
- **C0900C:** Staff names and faces
- **C0900D:** That he or she is in a nursing home
- **C0900Z:** None of the above was recalled
- Check all responses that apply
- May indicate the need for additional signs, directions, pictures, or verbal reminders to promote resident independence

Section C
C1000: Cognitive Skills for Daily Decision-Making

C1000. Cognitive Skills for Daily Decision Making	
Enter Code ☐	**Made decisions regarding tasks of daily life** 0. **Independent** - decisions consistent/reasonable 1. **Modified independence** - some difficulty in new situations only 2. **Moderately impaired** - decisions poor; cues/supervision required 3. **Severely impaired** - never/rarely made decisions

- The intent of this item is to record what the resident is doing
- Focus is on whether the resident is actively making these decisions and **not** whether staff believes the resident can do so
- Observations should be made by staff across all shifts and departments

Section C
C1000: Cognitive Skills for Daily Decision-Making

- Focus on the resident's actual performance
- Where a staff member takes decision-making responsibility away from the resident, or the resident does not participate in decision-making, the resident should be coded as impaired in decision-making

Section C
C1000: Cognitive Skills for Daily Decision-Making

- Choosing items of clothing
- Knowing when to go to scheduled meals
- Using **environmental cues** to organize and plan (e.g., clocks, calendars, posted listings of upcoming events)
- In the absence of environmental cues, **seeking information appropriately** (i.e., not repetitively) from others in order to plan the day

Section C
C1000: Cognitive Skills for Daily Decision-Making

- Using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary)
- Acknowledging need to use an appropriate assistive equipment, such as a walker

Section C
C1000: Cognitive Skills for Daily Decision-Making

- **Code 0, independent:** The resident's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values
- **Code 1, modified independence:** The resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations

Section C
C1000: Cognitive Skills for Daily Decision-Making

- **Code 2, moderately impaired**: The resident's decisions were poor, the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines
- **Code 3, severely impaired**: The resident's decision-making was severely impaired, the resident never (or rarely) made decisions

Section C
C1000: Cognitive Skills for Daily Decision-Making

- If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, **code 3, severely impaired**
- If the resident makes decisions, although poorly, **code 2, moderately impaired**
- Exercising the right to decline treatment or recommendations by interdisciplinary team members should not be coded as impaired decision-making in Item C1000

Section C
C1310: Delirium

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?

0. **No**
1. **Yes**

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ **C. Disorganized Thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Section C
C1310: Delirium

- **Definition:** A mental disturbance characterized by **new or acutely worsening** confusion, disordered expression of thoughts, change in level of consciousness or hallucinations
- Delirium can be misdiagnosed as dementia
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion

Section C
C1310: Delirium

- Delirium is associated with:
  - Increased mortality
  - Functional decline
  - Development or worsening of incontinence
  - Behavior problems
  - Withdrawal from activities
  - Rehospitalizations and increased length of nursing home stay

Section C
C1310: Delirium

- Assess the patient for:
  - Inattention
  - Disorganized thinking
  - Altered level of consciousness
  - Psychomotor retardation

Section C
C1310: Acute Onset of Mental Status Change

- Prompt detection of Mental Status Change is essential in order to identify and treat or eliminate the cause
- Interview the resident's family or significant others
- This is the overall clinical judgment of the assessor, based on information gathered to complete Section C

Section C
C1310: Acute Onset of Mental Status Change

- **Code 0, no:** If there is no evidence of acute mental status change from the resident's baseline
- **Code 1, yes:** If resident has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline

Section D
Mood

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Section D
Mood

- The signs and/or symptoms of mood distress are identifiable and treatable
- The completion of this Section does not diagnose depression or other mood disorder
- Facility staff should incorporate these indicators when developing individualized Care Plans

Section D
D0100: Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents	
Enter Code ☐	0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV) 1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)

- Determine if the resident is understood at least sometimes as defined by item B0700 **Makes Self Understood** (B0700 = 0, 1, or 2)
- Review **Language** item (A1100) and determine if the resident needs/wants an interpreter to communicate with doctors or health care staff (A1100 = 1):
  - If the resident needs or wants an interpreter, complete the interview with an interpreter

Section D
D0100: Mood

- If it is not possible for a needed interpreter to be present the day before or day of the ARD, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D0650
- Coding Instructions:
  - Code 0, no
  - Code 1, yes

Section D
D0150: Mood Interview (PHQ-9©)

D0150. Resident Mood Interview (PHQ-2 to 9©)		
Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*" Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.		
1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank) **2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

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Section D
D0150: Mood Interview (PHQ-9©)

- Look-back period = 14 days
- Looks back may include prior to admission
- Conduct the interview preferably the day before or day of the ARD
- Conduct interview in a private setting
- **Suggested language:** "Over the last 2 weeks, have you been bothered by any of the following problems?"

Section D
D0150: Mood Interview (PHQ-9©)

- For each question in Resident Mood Interview (D0200), **read the item as it is written**
- Do not provide definitions because the meaning **must be** based on the resident's interpretation
- For example, the resident defines for himself what "tired" means. The item should be scored based on the resident's interpretation.

Section D
D0150: Mood Interview (PHQ-9©)

- Each question **must be asked in sequence** to assess presence (column 1) and frequency (column 2) before proceeding to the next question
- **Enter code 9** for any response that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated

Section D
D0150: Mood Interview (PHQ-9©)

- **Coding Instructions for Column 1. Symptom Presence:**
  - **Code 0, no:** If resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
  - **Code 1, yes:** If resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
  - **Code 9, no response:** If the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.

Section D
D0150: Mood Interview (PHQ-9©)

- **Coding Instructions for Column 2. Symptom Frequency:**
  - **Code 0, never or 1 day:** If the resident indicates that he or she has never or has only experienced the symptom on 1 day
  - **Code 1, 2-6 days (several days):** If the resident indicates that he or she has experienced the symptom for 2-6 days
  - **Code 2, 7-11 days (half or more of the days):** If the resident indicates that he or she has experienced the symptom for 7-11 days
  - **Code 3, 12-14 days (nearly every day):** If the resident indicates that he or she has experienced the symptom for 12-14 days

Section D
D0150: Mood Interview (PHQ-9©)

- Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood
- Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician

Section D
D0150: Mood Interview (PHQ-9©)

- If the resident uses his own words to describe a symptom, this should be briefly explored
- If it is determined that the resident is reporting the intended symptom but using his own words, ask them to tell you how often they were bothered by that symptom
- Select only one frequency response per item
- If the resident has difficulty selecting between two frequency responses, code for the **higher frequency**

Section D
D0150: Mood Interview (PHQ-9©)

- Some items contain more than one phrase
- If a resident gives different frequencies for the different parts of a single item, select **the highest frequency** as the score for that item
- Residents may respond to questions verbally, by pointing to their answers on the cue card or by writing out their answers

Section D
D0160: Total Severity Score

D0160. Total Severity Score	
Enter Score	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

- The **Total Severity Score** does not diagnose a mood disorder or depression
- May indicate a need for follow-up with a mental health professional
- The **Total Severity Score** is a summary of the frequency scores on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessments and track symptoms and how they change over time

Section D
D0160: Total Severity Score

- **Steps for Assessment:**
  - After completing D0200 A-1:
    1. Add the numeric scores across all frequency items in **Resident Mood Interview** (D0200) Column 2
    2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
    3. The **maximum resident score is 27**

    (9 × 3)

Section D
D0160: Total Severity Score

- Coding Instructions:
  - The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©
  - If symptom frequency is blank for 3 or more items, the interview is deemed to be **incomplete**. **Total Severity Score** should be coded as "99" and the **Staff Assessment of Mood** should be conducted.
  - Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27.**
  - **"99"** is coded if symptom frequency is blank for 3 or more items

Section D
D0160: Total Severity Score

- PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:

1-4:	Minimal depression
5-9:	Mild depression
10-14:	Moderate depression
15-19:	Moderately severe depression
20-27:	Severe depression

D0350: Follow-up to D0200I

- Complete item D0350 **only** if item D0200I **Thoughts That You Would Be Better Off Dead, or of Hurting Yourself in Some Way** = 1, indicating the possibility of resident self-harm:
  - **Code 1, no:** If responsible staff or provider was not informed that there is a potential for resident self-harm
  - **Code 2, yes:** If responsible staff or provider was informed that there is a potential for resident self-harm

Section D
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

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Section D
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

- Staff should complete the PHQ-9-OV© **Staff Assessment of Mood** to ensure that signs or symptoms of mood, behavior distress are identified and treated in patients who are unable or unwilling to complete the PHQ-9© **Resident Mood Interview**
- If the resident is **not able to complete the PHQ-9©, because of communication/refusal or inability to participate** then a scripted interview with staff who knows the resident well should be completed to provide critical information to understand the mood and for Care Plans

Section D
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

- Interview **staff from all shifts** who know the resident best. Conduct interview in a location that protects resident privacy.
- Encourage staff to report symptom frequency, **even if the staff believes the symptom to be unrelated to depression**
- If frequency cannot be coded because the resident has been **in the facility for less than 14 days**, talk to family or significant other and review transfer records to inform the selection of a frequency code

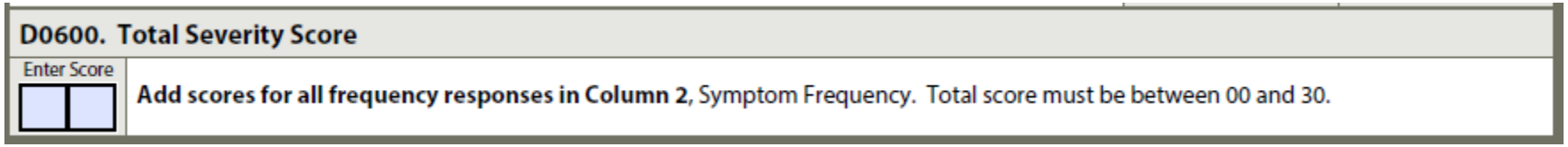
Section D
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

- **Coding Instructions for Column 1: Symptom Presence:**
  - **Code 0, no:** If symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency.**
  - **Code 1, yes:** If symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency.**

Section D
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

- **Coding Instructions for Column 2. Symptom Frequency:**
  - **Code 0, never or 1 day:** If staff indicate that the resident has never or has experienced the symptom on only 1 day
  - **Code 1, 2-6 days (several days):** If staff indicate that the resident has experienced the symptom for 2-6 days
  - **Code 2, 7-11 days (half or more of the days):** If staff indicate that the resident has experienced the symptom for 7-11 days
  - **Code 3, 12-14 days (nearly every day):** If staff indicate that the resident has experienced the symptom for 12-14 days

Section D
D0600: Total Severity Score



D0600. Total Severity Score	
Enter Score ☐☐	**Add scores for all frequency responses in Column 2**, Symptom Frequency. Total score must be between 00 and 30.

- Steps for Assessment:
  - After completing items D0500 A-J:
    - Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2
    - Maximum score is 30 (3 × 10)

Section D
D0600: Total Severity Score

- PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:

1-4:	Minimal depression
5-9:	Mild depression
10-14:	Moderate depression
15-19:	Moderately severe depression
20-30:	Severe depression

D0650: Follow-up to D0500I

- **Steps for Assessment:**
  - Complete item D0650 only if item D0500I, **States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self** = 1 indicating the possibility of resident self-harm
- **Coding Instructions:**
  - **Code 1, no:** If responsible staff or provider was not informed that there is a potential for resident self-harm
  - **Code 2, yes:** If responsible staff or provider was informed that there is a potential for resident self-harm

Section E
Behavior

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Section E
E0100: Potential Indicators of Psychosis

E0100. Potential Indicators of Psychosis	
↓ Check all that apply	
☐	A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	Z. **None of the above**

Section E
E0100: Potential Indicators of Psychosis

- **Definitions**:
  - **Hallucination**: The perception of the presence of something this is not actually there. It may be auditory or visual or involve smells, tastes and touch.
  - **Delusion**: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary

Section E
E0100: Potential Indicators of Psychosis

- **Coding Instructions:**
  - Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply.
  - **Check E0100A, hallucinations:** If hallucinations were present in the last 7 days
  - **Check E0100B, delusions:** If delusions were present in the last 7 days
  - **Check E0100Z, none of the above:** If no hallucinations or delusions were present in the last 7 days

Section E
E0200: Behavioral Symptoms

Behavioral Symptoms		
E0200. Behavioral Symptom - Presence & Frequency		
Note presence of symptoms and their frequency		
Coding: 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**	↓ **Enter Codes in Boxes**	
	☐	**A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	☐	**B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
	☐	**C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

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Section E
E0200: Behavioral Symptoms

- **Intent:** The items in this section identify behavioral symptoms in the **last seven days** that causes:
  - Distress to the resident
  - Distressing or disruptive to facility **residents**, **staff members** or the **care environment**
- This section focuses on the resident's **actions** and **not the intent** of the behavior

Section E
E0200: Behavioral Symptoms

- **Physically Behavioral symptoms directed toward others:** Hitting, kicking, pushing, scratching or sexually abusing others
- **Verbally Behavioral symptoms directed toward others:** Threatening others, screaming at others, or cursing at others

Section E
E0200: Behavioral Symptoms

- **Other behavior symptoms not directed toward others**: Hitting, scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, verbal/vocal symptoms like screaming, disruptive sounds

Section E
E0200: Behavioral Symptoms

- Coding in this section is not solely based on documentation in the medical record. The process includes:
  - Resident interview and observation
  - Staff interview across all shifts and disciplines
  - Family and significant other interview
- Newly identified behavioral symptoms should be assessed, documented and Care Planned

Section E
E0200: Behavioral Symptoms

- Coding Instructions:
  - Code 0, behavior not exhibited: If the behavioral symptoms were not present in the last 7 days
  - Code 1, behavior of this type occurred 1-3 days: If the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days
  - Code 2, behavior of this type occurred 4-6 days, but less than daily: If the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days
  - Code 3, behavior of this type occurred daily: If the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days

Section E
E0300: Overall Presence of Behavioral Symptoms

E0300. Overall Presence of Behavioral Symptoms	
Enter Code ☐	**Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?** 0. **No** → Skip to E0800, Rejection of Care 1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

- To determine if E0500, **Impact on Resident**, and E0600, **Impact on Others**, are required to be completed:
  - **Code 0, no:** If E0200A, E0200B, and E0200C all are coded 0, not present. Skip to **Rejection of Care—Presence & Frequency** item (E0800).
  - **Code 1, yes:** If any of E0200A, E0200B, or E0200C were coded 1, 2, or 3. Proceed to complete **Impact on Resident** item (E0500), and **Impact on Others** item (E0600).

Section E
E0500: Impact on Resident

E0500. Impact on Resident	
Enter Code ☐	Did any of the identified symptom(s): A. Put the resident at significant risk for physical illness or injury? 0. No 1. Yes
Enter Code ☐	B. Significantly interfere with the resident's care? 0. No 1. Yes
Enter Code ☐	C. Significantly interfere with the resident's participation in activities or social interactions? 0. No 1. Yes

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Section E
E0500: Impact on Resident

- Coding Instructions for E0500A B C:
  - Did any of the Identified Symptom(s) put the resident at significant risk for physical illness or injury?
  - Did any of the Identified Symptom(s) significantly interfere with the resident's care?
  - Did any of the Identified Symptom(s) significantly interfere with the resident's participation in activities or social interaction?

Section E
E0500: Impact on Resident

- **E0500A:**
  - Code based on whether the risk for physical injury or illness is **known to occur commonly** under similar circumstances (i.e., with residents who exhibit similar behavior in a similar environment)
- **E0500B:**
  - Code if the impact of the resident's behavior is **impeding the delivery of essential care** (medical, nursing, rehabilitative or personal that is required to achieve the resident's goals for health and well-being) cannot be received safely, completely, or in a timely way without more than a minimal accommodation, such as simple change in care routines or environment

Section E
E0500: Impact on Resident

- **E0500C:**
  - Code if the impact of the resident's **behavior is limiting** or keeping the resident from engaging in solitary activities or hobbies, joining groups, or attending programmed activities or having positive social encounters with visitors, other residents or staff

Section E
E0600: Impact on Others

E0600. Impact on Others	
Enter Code ☐	Did any of the identified symptom(s): A. Put others at significant risk for physical injury? 0. No 1. Yes
Enter Code ☐	B. Significantly intrude on the privacy or activity of others? 0. No 1. Yes
Enter Code ☐	C. Significantly disrupt care or living environment? 0. No 1. Yes

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Section E
E0600: Impact on Others

- **Coding Instructions for E0600A:**
  - Did any of the Identified Symptom(s) put others at significant risk for physical injury?
  - Did any of the Identified Symptom(s) significantly intrude on the privacy or activity of others?
  - Did any of the Identified Symptom(s) significantly disrupt care or the living environment?

Section E
E0600: Impact on Others

- **Coding Tips:**
  - For E0600A, code based on whether the behavior placed others at significant risk for physical injury
  - For E0600B, code based on whether the behavior **violates** other residents' privacy or **interrupts** other residents' performance of activities of daily living or **limits engagement** in or enjoyment of informal social or recreational activities to such an extent that it causes the other residents to experience distress (e.g., displeasure or annoyance) or inconvenience, whether the other residents complain

Section E
E0600: Impact on Others

- **Coding Tips:**
  - For E600C, code based on whether the behavior interferes with **staff ability to deliver care** or conduct organized activities, interrupts receipt of care or participation in organized activities by other residents, and/or causes other residents to experience distress or adverse consequences

Section E
E0800: Rejection of Care

E0800. Rejection of Care - Presence & Frequency	
Enter Code ☐	**Did the resident reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**

- Rejection of care is behavior that interrupts or interferes with the delivery or receipt of care
- Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care

Section E
E0800: Rejection of Care

- Evaluation of the rejection of care assists the nursing home in honoring the resident's care preferences in order to meet his desired health goals
- Follow up assessment should consider:
  - Whether established care goals clearly reflect the resident's preferences and goals
  - Whether alternative approaches could be used to achieve the resident's care goals

Section E
E0800: Rejection of Care

- **Coding Tips:**
  - Do not include behaviors that **have already been addressed** (e.g., by discussion or Care Planning with the resident or family) **and** determined to be **consistent with the resident's values, preferences, or goals**
  - Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care"

Section E
E0800: Rejection of Care

- Coding Instructions:
  - **Code 0, behavior not exhibited:** If rejection of care consistent with goals was not exhibited in the last 7 days. If no rejection of care consistent with goals has been exhibited, skip to **Wandering—Impact** item (E1000).
  - **Code 1, behavior of this type occurred 1-3 days:** If the resident rejected care consistent with goals 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days

Section E
E0800: Rejection of Care

- Coding Instructions:
  - Code 2, behavior of this type occurred 4-6 days, but less than daily: If the resident rejected care consistent with goals 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days
  - Code 3, behavior of this type occurred daily: If the resident rejected care consistent with goals daily in the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days

Section E
E0900: Wandering

E0900. Wandering - Presence & Frequency	
Enter Code ☐	**Has the resident wandered?** 0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days**, but less than daily 3. **Behavior of this type occurred daily**

- **Definition:**
  - Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction
  - Wandering may be aimless
  - The wandering resident may be oblivious to his or her physical or safety needs

Section E
E0900: Wandering

- **Definition:**
  - Alternatively, the resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place
  - The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff know is deceased)

Section E
E0900: Wandering

- **Coding Tips:**
  - Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering
  - Wandering may occur even if resident is in a locked unit
  - Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity) is not considered wandering

Section E
E0900: Wandering

- **Coding Instructions:**
  - **Code 0, behavior not exhibited:** If wandering was not exhibited during the 7-day look-back period. Skip to **Change in Behavioral or Other Symptoms** item (E1100).
  - **Code 1, behavior of this type occurred 1-3 days:** If the resident wandered on 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** Item (E1000).

Section E
E0900: Wandering

- Coding Instructions (Cont.):
  - **Code 2, behavior of this type occurred 4-6 days, but less than daily:** If the resident wandered on 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** Item (E1000).
  - **Code 3, behavior of this type occurred daily:** If the resident wandered daily during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** Item (E1000).

Section E
E1000: Wandering - Impact

E1000. Wandering - Impact	
Enter Code ☐	**A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place** (e.g., stairs, outside of the facility)? 0. **No** 1. **Yes**
Enter Code ☐	**B. Does the wandering significantly intrude on the privacy or activities of others?** 0. **No** 1. **Yes**

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Section E
E1000: Wandering - Impact

- **Coding Instructions for E1000A:** Does the wandering place the resident at significant risk of getting to a potentially dangerous place?
  - **Code 0, no:** If wandering does not place the resident at significant risk
  - **Code 1, yes:** If the wandering places the resident at significant risk of getting to a dangerous place (e.g., wandering outside the facility where there is heavy traffic) or encountering a dangerous situation (e.g., wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders)

Section E
E1000: Wandering - Impact

- **Coding Instructions for E1000B:** Does the wandering significantly intrude on the privacy or activities of others?
  - **Code 0, no:** If the wandering does not intrude on the privacy or activity of others
  - **Code 1, yes:** If the wandering intrudes on the privacy or activities of others (i.e., if the wandering violates other residents' privacy or interrupts other residents' performance of activities of daily living or limits engagement in or enjoyment of social or recreational activities), whether the other resident complains or communicates displeasure or annoyance

Section E
E1100: Change in Behavioral or Other Symptoms

E1100. Change in Behavior or Other Symptoms Consider all of the symptoms assessed in items E0100 through E1000	
Enter Code ☐	How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?** 0. **Same** 1. **Improved** 2. **Worse** 3. **N/A** because no prior MDS assessment

- Steps for Assessment:
  - Review responses provided to items E0100-E1000 on the current MDS assessment
  - Compare with responses provided on prior MDS assessment
  - Taking all these MDS items into consideration, make a global assessment of the change in behavior from the most recent to the current MDS
  - Rate the overall behavior as same, improved, or worse

Section E
E1100: Change in Behavioral or Other Symptoms

- Coding Instructions:
  - Code 0, same: If overall behavior is the same (unchanged)
  - Code 1, improved: If overall behavior is improved
  - Code 2, worse: If overall behavior is worse
  - Code 9, N/A: If there was no prior MDS assessment of this resident

Section E
E1100: Change in Behavioral or Other Symptoms

- **Coding Tip:** For residents with multiple behavioral symptoms, it is possible that different behaviors will vary in different directions over time
- One behavior may improve while another worsens or remains the same
- Using clinical judgment, this item should be rated to reflect the **overall** direction of behavior change, estimating the net effects of multiple behaviors

Section F
Preferences for Customary Routine and Activities

- **Current** preferences "while you are in this facility"
- There is no look-back provided for the resident
- These questions can be completed anytime within the 7-day look-back period

Section F
Preferences for Customary Routine and Activities

- Explain each of the interview response choices and show the resident a **clearly written list or cue card** of the following response options:
  1. Very important
  2. Somewhat important
  3. Not very important
  4. Not important at all

Section F
Preferences for Customary Routine and Activities

5. Important but can't do or no choice. (This response indicates that the topic is important to the resident but that they are physically unable to participate or have no choice about participating because of the nursing home's schedules or resources.)
9. No response or non-responsive

Section F
Preferences for Customary Routine and Activities

- If the resident cannot report preferences, then interview family or significant others
- Only code “9” if the resident, family and significant other:
  - Refused to answer
  - Does not know the answer
  - Does not give an answer for several seconds, does not appear to be formulating answer
  - Provides an incoherent or nonsensical answer

Section F
Preferences for Customary Routine and Activities

- Stop the interview and skip to Item F0700 if:
  - The resident has given 3 nonsensical responses to 3 questions, **or**
  - The resident has not responded to 3 of the questions

Section F
Preferences for Customary Routine and Activities

- Code Yes, if the resident, family or significant other was **unable to answer 3 or more items** in both sections
- If the total number of unanswered questions in F0400 through F0500 is **equal to 3** or more, the interview is considered incomplete

Section F
F0800: Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences	
Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed	
Resident Prefers:	
↓ Check all that apply	
☐	A. Choosing clothes to wear
☐	B. Caring for personal belongings
☐	C. Receiving tub bath
☐	D. Receiving shower
☐	E. Receiving bed bath
☐	F. Receiving sponge bath
☐	G. Snacks between meals
☐	H. Staying up past 8:00 p.m.
☐	I. Family or significant other involvement in care discussions
☐	J. Use of phone in private
☐	K. Place to lock personal belongings
☐	L. Reading books, newspapers, or magazines
☐	M. Listening to music
☐	N. Being around animals such as pets
☐	O. Keeping up with the news
☐	P. Doing things with groups of people
☐	Q. Participating in favorite activities
☐	R. Spending time away from the nursing home
☐	S. Spending time outdoors
☐	T. Participating in religious activities or practices
☐	Z. None of the above

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Section F
F0800: Staff Assessment of Daily and Activity Preferences

- Steps for Assessment:
  - Observations of behaviors are to be made by:
    - All shifts
    - All departments
    - Others who have close contact with the resident

Homework

1. Describe a situation where staff interviews may be completed even though B0700 is **not** coded rarely or never understood.
2. During a staff interview for the PHQ9, a nurse tells you that the resident "**isn't interested in any activities**, but that's not because of depression. It's her **Dementia**. How would you **code the MDS**?
3. Explain the **difference** between a **delusion** and a **hallucination**.

Questions?

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BUT WAIT! There's More…

Coming Next Week

- Minimum Data Set (MDS) Coding Sections G through GG
  - Section G – Functional Status
  - Section GG – Functional Abilities and Goals

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Our Process

- Prescribed medical record review process that encompasses HHI's core business
- HHI Specialists provide expertise through teaching and training and an extensive chart audit process in order to ensure:
  - MDS Accuracy
  - MDS Supporting Documentation
  - Billing Accuracy
  - Nursing Documentation
  - Therapy Documentation
  - Clinically Appropriate Care

HHI
Services and Plans

Gold C.A.R.E.S.
2 Year Service Plan

Platinum C.A.R.E.S.
3 Year Service Plan

List of HHI Services

PDPM Training and Audits | Medicare | Compliance | Rehab Program Development | Seminars | MMQ Audits | Mock RAC Audits | Rehab Certification | Mock Health Inspection Survey | MDS Competency | Talent Management | Denials Management | Compliance Certification | Clinically Appropriate Stay | QAPI | QIS | Medicare Part B Program | MDSC Mentor Program | Case Mix Consulting | Professional Development | Leadership Trainings | Regulatory and Survey Assistance | Five Star | PBJ | Quality Measures | Analysis | Staff Training | Infection Control and More!

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https://www.harmony-healthcare.com/harmonyhelp

Live Support Available
8:00 a.m. – 5:00 p.m. EST

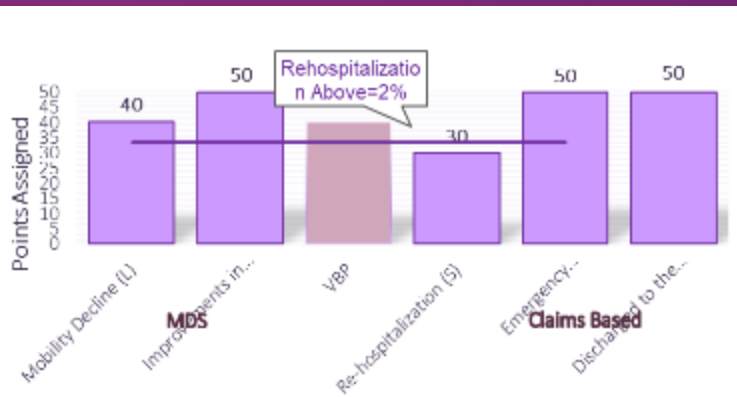
HarmonyHelp

With **HarmonyHelp**, Harmony Healthcare International (HHI) provides an invaluable resource for the entire interdisciplinary team. Imagine having questions answered by a HHI Specialist within minutes of the inquiry. Fill out the form on the right to learn more about HarmonyHelp and our various Service Plans.

The **Knowledge Center** is loaded with **information** that will assist with your daily responsibilities at your facility. This self-help site is broken up into **5 Sections:**

Manuals I Tools I C.A.R.E.S. Community I Hot Topics I FAQ (Frequently Asked Questions)

Month	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Total Part A Revenue	$189,711.70	$202,597.35	$228,482.48	$176,144.00	$192,332.99	$148,861.18
Rehab Revenue	$181,514.58	$201,631.41	$227,975.42	$175,546.71	$190,248.65	$146,559.14
Therapy Portion	$80,465.58	$83,667.77	$100,444.39	$79,055.93	$86,172.60	$67,534.29
% Therapy Portion	42.4%	41.3%	44.0%	44.9%	44.8%	45.4%
% Therapy of Total Revenue	95.7%	99.5%	99.8%	99.7%	98.9%	98.5%
% Therapy RUG Days (P)	93.9%	99.4%	99.6%	99.5%	98.6%	97.5%
Part A Rate	$442.22	$434.76	$464.40	$465.99	$453.62	$462.30
% of Max Rate	61.9%	60.9%	65.0%	65.3%	63.5%	64.8%
ADC	14.30	15.03	15.87	13.50	13.68	10.73



Complimentary HHI Offerings

- PDPM Revenue and Risk Analysis
- Medicare Part A Revenue and Risk Analysis
- Five-Star Quality Measure Points Analysis
- PEPPER Analysis

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