CHAPTER 3: ITEM-BY-ITEM GUIDE TO THE MDS

3.1 Overview to the Item-by-Item Guide to MDS

This Chapter is to be used in conjunction with Version 2.0 of the MDS assessment. Also included in this chapter are the instructions for the supplemental items in MDS Sections S, T, and U. Contact your State RAI Coordinator regarding your State's requirements for Sections S, T, and U, as well as for any additional State-mandated MDS assessment requirements.

This chapter provides information to facilitate an accurate and uniform resident assessment. Item-by-item instructions focus on:

- The intent of items included on the MDS.
- Supplemental definitions, instructions and clarifications for completing MDS items.
- Reminders of which MDS items require observation of the resident for other than the standard 7-day observation period.
- Sources of information to be consulted in completing specific MDS items.

Using This Chapter

Use this chapter alongside the MDS Version 2.0 data collection form keeping the form in front of you at all times. The amplifying information in this chapter should facilitate successful use of the MDS. The items from the MDS are presented in a sequential basis in this chapter. Where items are presented on a form other than the full MDS assessment form, this fact is noted in the text.

The chart that follows summarizes the recommended approach to assist you in becoming familiar with MDS Version 2.0. The initial time investment in this multi-step review process will have a major payback.

Recommended Approach for Becoming Familiar with the MDS

(A) First, review the MDS form itself.

- Notice how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Complete the MDS assessment for a resident at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS. Where your review could benefit from additional information, make note of that fact. ***Where might you acquire additional information?***

(B) Complete an initial review of this chapter.

- Review procedural instructions, time frames, and general coding conventions.
- Review clarifications, since they provide important information and context in response to questions from other MDS RAI Manual users.
- ***Are the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?***
- As you read this chapter, clarify questions that arose as you used the MDS for the first time to assess a resident. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- ***Once again, read the instructions that apply to a single section of the MDS. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same? It will take time to go through all this material. Do it slowly, carefully, without rushing. Work through the Manual MDS form one section at a time.***
- *Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?*
- *Would you now complete your initial case differently?*
- *Are there definitions or instructions that differ from current practice patterns in your facility? If so, discuss with your MDS coordinator or Director of Nursing to make sure that facility practices comply with the MDS requirements.*

(continued on next page)

Recommended Approach for Becoming Familiar with the MDS
(continued)

- Make notations next to any section(s) of this Manual you have questions about. Be prepared to discuss these issues during any formal training program you attend, or contact your State RAI Coordinator (see Appendix B).

(C) **In a second review of this chapter, focus on issues that seemed to you to be more difficult, problematic, or unfamiliar during the first pass.** Make notes on the MDS of issues that warrant attention.

(D) **The third chapter review may occur during the formal MDS training program at your facility.** It will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

(E) **Future use of information in this chapter:**

- Keep this chapter at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- This Manual is the primary source of information for completing an assessment. Use it to increase the accuracy of your assessments.
- Check the MDS 2.0 web site regularly for updates at:

  http://cms.hhs.gov/medicaid/mds20

Standard Format Used in This Chapter

To facilitate completion of Version 2.0 of the MDS assessment and to ensure consistent interpretation of items, this chapter presents the following types of information for many **(but not all)** items:

Intent: Reason(s) for including the item (or set of items) in the MDS, including discussions of how the information will be used by clinical staff to identify resident problems and develop the plan of care.

Definition: Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an item. Sources include:

- Discussion with facility staff - licensed and non-licensed staff members
- Resident interview and observation
- Clinical records, facility records, transmittal records (at admission) - physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g., vital signs, weights, intake and output), care plans, and any similar documents in the facility record system
- Discussion with the resident's family
- Attending physician.

Coding: Proper method of recording each response, with explanations of individual response categories.

Clarifications: ◆ Clarifications for MDS items provided by CMS. These clarifications apply to the MDS.

3.2 Coding Conventions

The coding conventions to be used when preparing the MDS are as follows:

- Use a check mark for white boxes with lower case letters in the box or before the item description, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences - boxes a. - m.).

- Use a numeric response (a number or preassigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)

- Darkly shaded areas remain blank; they are on the form to set off boxes visually.

The convention of entering "0": In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero ("0") is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a resident whose ADL codes are almost all coded "0" is a self-sufficient resident; the resident whose ADLs have no "0" codes indicates a resident that receives help from others.

- **When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.**

- **Dates** - Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2002 is recorded as:

0	1		0	3		2	0	0	2
Month			Day			Year			

- **The standard no-information code is a "dash" (-).** This code indicates that all available sources of information have been exhausted; that is the information is not available, and despite exhaustive probing, it remains unavailable.

- **NONE OF ABOVE** is a response item to several items (e.g., MDS Item I2, Infections, box "m"). **Check this item where none of the responses apply; it should not be used to signify lack of information about the item. If "None of Above" is not present and none of the items apply, e.g., H2 Bowel Elimination on MPAF), simply leave all boxes blank.**

- **"Skip" Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items.** The instructions direct the assessor to "skip" over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to "skip" to Section G. if B1 is answered "1" - "yes". **The intervening items from B2 - F3 would not be coded.** If B1 were recorded as "0" - "no", then the assessor would continue with Item B2.).

  A useful technique for visually checking the proper use of the "skip" pattern instructions is to circle the "skip" instructions before going to the next appropriate item.

- **The "8" code is for use in MDS Section G., Physical Functioning and Structural Problems only.** The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident's performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period of observation. When the "8" code is entered for self-performance, it should also be entered for support.

3.3 Section AA. Identification Information for MDS

AA1. Resident Name

Definition: Legal name in record.

Coding: Use printed letters. Enter in the following order:

a. First Name
b. Middle Initial; if the resident has no middle initial, leave Item 1b blank,
c. Last Name, and
d. Jr./Sr.

AA2. Gender

Coding: Enter "**1**" for Male or "**2**" for Female.

AA3. Birthdate

Coding: Fill in the boxes with the appropriate birthdate. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 1918 should be entered as:

0	1		0	2		1	9	1	8
Month			Day			Year			

AA4. Race/Ethnicity

Process: Enter the race or ethnic category the resident uses to identify him or herself. Consult the resident, as necessary. For example, if parents are of two different races, consult with resident to determine how he or she wishes to be classified.

Coding: Choose only one answer.

Clarification:

- Item AA4 uses the race/ethnicity categories mandated by the Executive Office of Management and Budget (OMB) in 1996 when MDS Version 2.0 was implemented nationally. OMB guidelines require self-identification of race/ethnicity. This means that the resident should be asked to select the category that most closely corresponds to her race/ethnicity from the list in AA4. If the resident is unable to respond, a family member should be asked to make the selection. If the resident is unable to respond and no family member is available, or if the resident does not appear to fit into any of the categories, the assessor should assign whichever category they feel is most appropriate. For example, an individual of Indian origin (i.e., Far East descent) is generally considered to be Asian (AA4 = 2).

AA5. Social Security and Medicare Numbers

Intent: To record resident identifier numbers.

Process: Review the resident's record. If these numbers are missing, consult with your admissions office.

Coding: Enter one number per box starting with the left most box. Recheck the number to be sure you have entered the digits correctly.

Social Security Number - If no Social Security number is available for the resident (e.g., if the resident is a recent immigrant or a child), leave it blank or enter the standard "no information" code (**-**).

Medicare Number (or comparable railroad insurance number) - Enter a Medicare number or railroad number exactly as it appears on the beneficiary documents. A Medicare number always starts with a number. If the first character is numeric (Medicare), then the first 9 characters must be digits (0-9). It is important to remember that the Medicare Health Insurance number may be different from the resident's social security number (SSN). For example, many residents may be receiving Medicare benefits based on a spouse's Medicare eligibility.

In rare instances, the resident will have neither a Medicare number nor a social security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. Railroad retirement numbers contain 12 characters. Enter the number itself, one digit per box beginning with the left most box. CMS had required the letter "C" to be placed in the first box in front of the railroad retirement number. Effective October 1, 2002, CMS instructed facilities that the letter "C" is not to be placed

before the railroad retirement number. Enter the complete 12 characters starting with the left-most box.

AA6. Facility Provider Numbers

Intent: To record the facility identifier numbers.

Definition: The identification numbers assigned to the nursing facility by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; i.e., Medicare-only facilities. Dually eligible facilities (i.e., facilities participating in both the Medicare and Medicaid programs) will have Federal (Medicare) and State (Medicaid) identification numbers. While some facilities participate only in the Medicaid program, these Medicaid-only facilities are issued Federal as well as a State Medicaid numbers. The Medicaid Federal number has a letter in the third box.

Process: You can obtain the nursing facility's Medicare and Medicaid numbers from the admission office. Once you have these numbers, they apply to all residents of that nursing facility.

Coding: The Medicare provider number is a 6-digit number. For Medicare and Medicaid dually-certified facilities, the first two digits are the State identifier followed by a numeric character that is either a "5" or "6" followed by three numeric characters. For Medicaid-only facilities, the Federal ID number consists of a two-digit State identifier followed by one alpha character and three numeric characters. Enter one number per box. Start with the left most box. Recheck the number to be sure you have entered the digits correctly. Do not enter imbedded dashes. There must always be a Federal provider number. Each State establishes the structure of its Medicaid provider numbers. The State Medicaid number is optional.

AA7. Medicaid Number (if applicable)

Coding: Record this number if the resident is a Medicaid recipient. Enter one number per box beginning in the left most box. Recheck the number to make sure you have entered the digits correctly. Enter a "+" in the left most box if the number is pending. If you get notified later that the resident does have a Medicaid number, just include it on the next assessment. It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment. If not applicable because the resident is not a Medicaid recipient, enter "N" in the left most box.

Clarification:

- The Medicaid number is a unique identifier assigned by the State Medicaid office. Questions regarding the Medicaid number should be referred to the State Medicaid office.

AA8. Reasons for Assessment [This item also appears and must be completed on the MDS Full Assessment Form, Section A, Item 8.]

Intent: To document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. **For detailed information on the scheduling and timing of the assessments, see Chapter 2, Section 2.2.**

a. Primary Reason for Assessment

Definition:

1. **Admission Assessment (required by day 14)**
2. **Annual Assessment**
3. **Significant Change in Status Assessment**
4. **Significant Correction of Prior Full (Comprehensive) Assessment**
5. **Quarterly Review Assessment**
6. **Discharged-Return Not Anticipated**
7. **Discharged-Return Anticipated**
8. **Discharged Prior to Completing Initial Assessment**
9. **Reentry**
10. **Significant Correction of Prior Quarterly Assessment**

0. ***NONE OF ABOVE*** - Use this code when preparing Medicare assessments or when your state requires you to complete one of the additional assessment types referenced in Item AA8b (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., case mix payment). Select the code under Item AA8b (below) that indicates the Medicare or State Reason for Assessment. Also, use this code when completing a PPS-only assessment or an assessment for another payer, such as an HMO.

Coding: Enter the number corresponding to the primary reason for assessment. This item contains 2 digits. For codes 1-9, leave the first box blank, and place the correct response in the second box. If you were coding this item for an OBRA-only assessment, you would not complete the Medicare Reasons for Assessment (AA8b). However, if you were combining an OBRA assessment with a Medicare assessment, you would have a code in both Items AA8a and AA8b.

b. Assessment Codes Used for the Medicare Prospective Payment System

Definition:

1. **Medicare 5-Day Assessment**
2. **Medicare 30-Day Assessment**
3. **Medicare 60-Day Assessment**
4. **Medicare 90-Day Assessment**
5. **Medicare Readmission/Return Assessment**
6. **Other State-Required Assessment**
7. **Medicare 14-Day Assessment**
8. **Other Medicare Required Assessment**

Coding: Enter the number corresponding to the assessment code used for the Medicare Prospective Payment System. It is possible to select a code from both AA8a and AA8b (e.g., Item AA8a = coded "3" [Significant Change in Status assessment], and Item AA8b = coded "3" [60-Day assessment]). See Chapter 2, Section 2.6 for details on combining assessments.

If there are two Medicare Reasons for Assessment, i.e., an OMRA combined with a regularly scheduled Medicare assessment, code Item AA8b = 8.

When the Primary Reason for Assessment is "00", and the Medicare Reason for Assessment is "6" or blank, the record is not edited or stored in the State MDS database. Facilities completing Medicare assessments on a standby basis should code AA8b as 1, 2, 3, 4, 5, or 7 to make sure that the assessments are properly edited and retained in the database.

Example

Mr. X was admitted to the nursing facility from an acute care hospital on 1/20/02. At the time of the admission assessment, he exhibited some signs of delirium that had begun post-operatively in the hospital. Functionally he required extensive assistance with all ADLs. It is now time for his Quarterly assessment. Cognitively, Mr. X's confusion has cleared to the point that the decisions he makes are now consistent and reasonable. His ADL performance has improved in all areas; he is either independent or receives some supervision. The Quarterly assessment should be coded as a Significant Change in Status assessment.

Example
(continued)

Coding: Enter the number corresponding to the primary reason for assessment. For Item AA8a, Primary Reason for Assessment, would be coded AA8a = 3, Significant Change in Status assessment. The assessment codes AA8b, used for the Medicare Prospective Payment System, would be left blank as this assessment is not being completed for Medicare purposes.

AA9. Signatures of Persons Completing These Items

Coding: All staff responsible for completing any part of the MDS, MPAF, and/or tracking forms must enter their signatures, titles, sections they completed, and the date they completed those sections. Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, MPAF, and/or tracking form is correct. Penalties may be applied for submitting false information.

MDS BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION SECTIONS AB., AC., AD.

This section is completed once, when the resident first enters the nursing facility. The face sheet is also required if the resident is admitted to the facility following a discharge return not anticipated. With any assessment, all background (face sheet) items in Sections AB and AC are optional in an all-or-none fashion. If using the MPAF, Items AB5a-f must be submitted alone or with the entire face sheet.

SECTION AB. DEMOGRAPHIC INFORMATION

AB1. Date of Entry

Intent: Normally, the MDS face sheet (Sections AB and AC) is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is reentering your facility after a discharge-return not anticipated (AA8a=6).

Do not complete the face sheet following temporary discharges to hospitals or after therapeutic leaves/home visits. If the face sheet was transmitted prior to the hospital stay, and none of the information has changed, a new face sheet is not required. If you identify changes to the face sheet data, you should update it and transmit the revised face sheet with your next assessment.

Admission and "bed-hold" policies vary among nursing facilities across the country. Likewise, the way in which facilities "open" and "close" resident's medical records also varies. Some facilities choose to "close" a record when a resident is transferred for an overnight stay at an acute care hospital, and "open" a new record when the resident returns to the nursing facility. Other nursing facilities maintain the resident's clinical record as open (current) even when the resident is transferred for a temporary hospital stay. **For MDS purposes, the date of entry is the date the resident first entered the facility for care,**

regardless of how the facility chooses to "open" or "close" its medical records during the course of the stay.

Definition: **Date the Stay Began** - The initial date of admission to the nursing facility. This date will not change on subsequent assessments until the resident is discharged with a return not anticipated. If the resident is discharged as a return not anticipated and returns at a later date, the resident will be considered a new admission and a new date of entry will be entered on the assessment.

Process: Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department at your facility.

Coding: *Use all boxes*. For a one-digit month or day, place a zero in the first box. For example: February 3, 2002, should be entered as:

0	2		0	3		2	0	0	2
Month			Day			Year			

Example

Mrs. F, a diabetic, had been living with her daughter when she fractured her left hip during a fall off a footstool. She spent a few days in the local hospital after surgery, followed by an admission to a nursing facility on 5/26/2001 for rehabilitation. Three weeks later, Mrs. F was transferred to the hospital for an infected incision. She was discharged with return anticipated on the Discharge Tracking form. Mrs. F returned to the nursing facility eight days later. No changes are necessary in the face sheet. The rationale being that she was discharged with a return anticipated.

0	5		2	6		2	0	0	1

Rationale: The face sheet sections of the MDS - AB and AC are completed only when the resident first becomes a resident of the facility. In this case there is no need to complete a new face sheet upon return readmission from a temporary hospital stay where the resident is expected to return to the nursing facility. Had she been discharged with return not anticipated, the record would be closed. When she returned to the facility, it would be considered a new admission with a new date of entry.

AB2. Admitted From (At Entry)

Intent: To facilitate care planning by documenting the place from which the resident was admitted to the nursing facility on the date given in Item AB1. For example, if

the admission was from an acute care hospital, an immediate review of current medications might be warranted since the resident could be at a higher risk for delirium or may be recovering from delirium associated with acute illness, medications or anesthesia. Or, if admission was from home, the resident could be grieving due to losses associated with giving up one's home and independence. Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification. For example, if the resident was admitted from a private home with home health services, telephone contact with a Visiting Nurse can yield insight into the resident's situation that is not provided in the written records.

Definition:

1. **Private Home or Apartment** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

7. **Rehabilitation Hospital** - An Inpatient Rehabilitations Hospital (IRF) that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.

8. **Other** - Includes hospices and chronic disease hospitals.

Process: Review admission records. Consult the resident and the resident's family.

Coding: Choose only one answer.

Example

Mr. F, who had been living in his own home with his wife, was admitted to an acute care hospital with a CVA. From the hospital, Mr. F was transferred to this nursing facility for rehabilitation. Since Mr. F was admitted to your facility from the acute care hospital, "5" is the appropriate code.

AB3. Lived Alone (Prior to Entry)

Intent: To document the resident's living arrangements prior to admission.

Definition: **In Other Facility** - Any institutional/supportive setting, such as a nursing facility, group home, sheltered care, board and care home.

Process: Review admission records. Consult the resident and the resident's family.

Coding: If living in another facility (i.e., nursing facility, group home, board and care, assisted living) prior to admission to the nursing facility, code Item AB2 = 2.

If the resident was not living in another facility prior to admission to the nursing facility, enter "**0**" or "**1**", as appropriate.

Examples

- Mrs. H lived on her own and her daughters took turns sleeping in her home so she would never be alone at night. **Code "0" for No (did not live alone)**. If, however, her daughters stayed with her only 3-4 nights per week, **Code "1" for Yes (lived alone).**
- Mr. J lived in his own second-floor apartment of a two-family home and received constant attention from his family, who lived on the first floor. **Code "0" for No (did not live alone).**
- Mr. D lived with his wife in housing for the elderly prior to admission. **Code "0" for No (did not live alone).**
- Mrs. X was the primary caregiver for her two young grandchildren, who lived with her after their parent's divorce. **Code "0" for No (did not live alone)**.
- Mrs. K was admitted directly from an acute care hospital. She had been living alone in her own apartment prior to hospital stay. **Code "1" for Yes (lived alone)**.
- Mr. M, who has been blind since birth, was admitted to the nursing facility with his Seeing Eye dog, Rex. Mr. M. and Rex lived together for the past 10 years in housing for the elderly. **Code "1" for Yes (lived alone).**
- Mr. G lived in a board and care home. **Code "2" (In other facility).**

AB4. Zip Code of Prior Primary Residence

Definition: **Prior Primary Residence** - The community address where the resident last resided prior to nursing facility admission. A primary residence includes a primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another nursing facility or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing facility, etc.

Process: Review resident's admission records and transmittal records as necessary. Ask resident and family members as appropriate. Check with your facility's admissions office.

Coding: Enter first five digits of the zip code. Enter one digit per box beginning with the left most box. For example, Beverly Hills, CA 90210 should be entered as:

9	0	2	1	0

Examples

- Mr. T was admitted to the nursing facility from the local hospital. Prior to hospital admission he lived with his wife in a trailer park in Jensen Beach, Florida 34957. **Enter the 34957 for Jensen Beach.**

- Mrs. F was admitted to the nursing facility's Alzheimer's Special Care Unit after spending 3 years living with her daughter's family in Newton, MA 02458. Prior to moving in with her daughter, Mrs. F lived in Boston, MA for 50 years with her husband until he died. **Enter the 02458. Rationale:** Her daughter's home was Mrs. F's primary residence prior to nursing facility admission.

- Ms. Q was admitted from a State psychiatric hospital in Illinois where she had spent the previous 16 years of her life. Prior to that, Ms. Q lived with her parents in Kansas City, Kansas 66110. **Enter the Kansas City zip code 66110.**

AB5. Residential History 5 Years Prior to Entry

Intent: To document the resident's previous experience living in institutional or group settings.

Definition:

a. **Prior Stay at This Nursing Home** - Resident's prior stay was terminated by discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

b. **Stay in Other Nursing Home** - Prior stay in one or more nursing facilities other than current facility.

c. **Other Residential Facility** - Examples include board and care home, group home, and assisted living.

d. **MH/Psychiatric Setting** - Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

e. **MR/DD Setting** - Examples include mental retardation or developmental disabilities facility (including MR/DD institutions), intermediate care facilities for the mentally retarded (ICF/MRs), and group homes.

f. ***NONE OF ABOVE***

Process: Review the admission record. Consult the resident or family. Consult the resident's physician.

Coding: Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to (i.e., the place the resident called "home" at that time). If the resident has not lived in any of these settings in the past five years, check *NONE OF ABOVE*.

AB6. Lifetime Occupation

Intent: To identify the resident's role or past role in life and to establish familiarity in how staff should address the resident. For example, a physician might appreciate being referred to as "Doctor". Knowing a person's lifetime occupation is also helpful for care planning purposes. For example, a carpenter might enjoy pursuing hobby shop activities.

Coding: Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left-most box.

The lifetime occupation of a person whose primary work was in the home should be recorded as "Homemaker." *When two occupations are identified, place a slash (/) between each occupation*. A person who had two careers (e.g., carpenter and night watchman) should be recorded as "Carpenter/Night Watchman." *For a resident who is a child or an MR/DD adult resident who has never been employed, record as "NONE."*

AB7. Education (Highest Level Completed)

Intent: To record the highest level of education the resident attained. Knowing this information is useful for assessment (e.g., interpreting cognitive patterns or language skills), care planning (e.g., deciding how to focus a planned activity program), and planning for resident education in self-care skills.

Definition: The highest level of education attained.

1. **No Schooling**

2. **Grades 1-8 or Less**

3. **9-11 Grades**

4. **High School Graduate**

5. **Technical or Trade School:** Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g.,

carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

6. **Some College:** Includes completion of some college courses, junior (community) college, or associate's degree.

7. **Bachelor's degree:** Includes any undergraduate bachelor's level college degree.

8. **Graduate Degree:** Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

Process: Ask the resident and significant other(s). Review the resident's record.

Coding: Code for the best response. For MR/DD residents who have received special education services, code "**2**" (1-8th grade or less).

AB8. Language

Definition: **a. Primary Language** - The language the resident primarily speaks or understands.

Process: Interview the resident and family. Observe and listen. Review the clinical record.

Coding: Enter "**0**" for English, "**1**" for Spanish, "**2**" for French, "**3**" for Other. If the resident's primary language is not listed, code "**3**" for Other; and print the resident's primary language in Item 8b beginning with the left most box.

Example

Mrs. F emigrated with her family from East Africa several years ago. She is able to speak and understand very little English. She depends on her family to translate information in Swahili.

a. Primary Language – Code "3" for Other

b. If Other, specify

S	W	A	H	I	L	I			

AB9. Mental Health History

Intent: To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

Definition: Resident has one of the following:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but

- Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Process: Review the resident's record only. For a "yes" response to be entered, there must be written documentation (i.e., verbal reports from the resident or resident's family are not sufficient).

Coding: Enter "**1**" for Yes or "**0**" for No.

AB10. Conditions Related to MR/DD Status (Mental Retardation/ Developmental Disabilities)

Intent: To document conditions associated with mental retardation or developmental disabilities.

Definition: **For Item AB10e, "Other Organic Condition Related to MR/DD"** - Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

Process: Review the resident's record only. For any item (AB10b through AB10f) to be checked, the condition must be documented in the clinical record.

Coding: Check all conditions related to MR/DD status that were present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

- If an MR/DD condition is not present, check Item AB10a, Not Applicable - No MR/DD, and skip to Item AB11.
- If an MR/DD condition is present, check each condition that applies; AB10b, Down's syndrome; AB10c, Autism; AB10d, Epilepsy; AB10e, Other organic condition related to MR/DD.
- If an MR/DD condition is present but the resident does not have any of the specific conditions listed, check Item AB10f, MR/DD with No Organic Condition.

AB11. Date Background Information Complete

Intent: For tracking purposes, this item should reflect the date that the *Background (Face Sheet) Information At Admission* form is completed or amended.

Coding: Enter the date the *Background (Face Sheet) Information At Admission* form is originally completed. In some circumstances (e.g., if a knowledgeable family member is not available during the 14-Day assessment period), it is difficult to fill in all the background information requested on this form. However, the information is often obtained at a later date. As new or clarifying information becomes available, the facility may record additional information on the form or enter data into the computerized record. This item (AB 11) should then reflect the date that new information is recorded or existing information is revised.

If any face sheet (AB) information is updated and submitted to the database, then all the face sheet items must be submitted. Do not submit just the updated items.

NOTE: The only exception to this "all-or-nothing" rule is the requirement to submit Items AB5a-f with the MPAF form. With the introduction of the MPAF form, CMS requires that Items AB5a-f be submitted with each MPAF assessment.

Examples

Mr. B was admitted to your facility on 12/03/2001 in a comatose state and therefore, unable to communicate on his own behalf. By reviewing transmittal records that accompanied him from the acute care hospital, you find that you are only able to partially complete Section AB (Demographic Information), and you are unable to complete Section AC (Customary Routine) because the records are scanty in these areas. You decide to complete what you can by day 14 of Mr. B's residency (the date the MDS assessment is to be completed) and enter the date 12/16/2001 for Item AB 11. On 12/24/2001 Mr. B's only relative, a daughter, visits and you are able to obtain more information from her. Enter the new information (e.g., demographic or customary routines) on the form and then enter the date 12/24/2001 for Item AB11.

SECTION AC. CUSTOMARY ROUTINE

AC1. Customary Routine (In the year prior to DATE OF ENTRY to this nursing facility, or year last in community if now being admitted from another nursing facility)

Intent: These items provide information on the resident's usual community lifestyle and daily routine in the year prior to DATE OF ENTRY (AB1) to your nursing facility. If the resident is being admitted from another nursing facility, review the resident's routine during the last year the resident lived in the community. The items should initiate a flow of information about cognitive patterns, activity preferences, nutritional preferences and problems, ADL scheduling and performance, psychosocial well-being, mood, continence issues, etc. The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the MDS that focus on particular functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized plan of care.

Facilities have flexibility in determining who should participate in the assessment process as long as the MDS 2.0 is accurately conducted. A facility may assign the Customary Routine section to one person or to several members of the interdisciplinary team. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. All staff that completed any part of Sections AB - AC must sign their names and identify the sections they have completed in Section AD.

Engaging the resident and or the family member in a discussion about the resident's routines in the year prior to the date of entry is an excellent means of obtaining important information and starting the therapeutic relationship between facility clinicians and the resident and family. Information about the resident's prior routines in areas such as bathing, dietary preferences, and usual social activities or hobbies can be used by the facility staff to develop a care plan that is specific to that resident's needs and preferences. Through the completion of Section AC, the nursing facility staff begins the assessment of areas such as speech patterns, hearing, vision, cognition, decision-making, and others.

Process: Engage the resident in conversation. A comprehensive review can be facilitated by a questioning process, such as described in Guidelines for Interviewing Resident that follows. Also see Appendix D.

If the resident cannot respond (e.g., is severely demented or aphasic), ask a family member or other representative of the resident (e.g., legal guardian). For some residents you may be unable to obtain this information (e.g., a demented resident who first entered the facility many years ago and has no family to provide accurate information, etc.).

Guidelines for Interviewing Resident

Staff should regard this step in the assessment process as a good time to get to know the resident as an individual and an opportunity to set a positive tone for the future relationship. It is also a useful starting point for building trust prior to asking difficult questions about urinary incontinence, advance directives, etc.

The interview should be done in a quiet, private area where you are not likely to be interrupted. Use a conversational style to put the resident at ease. Explain at the outset why you are asking these questions ("Staff want to know more about you so you can have a comfortable stay with us." "These are things that many older people find important." "I'm going to ask a little bit about how you usually spend your day.")

Begin with a general question - e.g., "Tell me, how did you spend a typical day before coming here (or before going to the first nursing facility)?" or "What were some of the things you liked to do?" Listen for specific information about sleep patterns, eating patterns, preferences for timing of baths or showers, and social and leisure activities involvements. As the resident becomes engaged in the discussion, probe for information on each item of the Customary Routine section (i.e., cycle of daily events, eating patterns, ADL patterns, involvement patterns). Realize, however, that a resident who has been in an institutional setting for many years prior to coming to your facility may no longer be able to give an accurate description of pre-institutional routines. Some residents will persist in describing their experience in the long-term care setting, and will need to be reminded by the interviewer to focus on their usual routines prior to admission. Ask the resident, "Is this what you did before you came to live here?"

If the resident has difficulty responding to prompts regarding particular items, backtrack by re-explaining that you are asking these questions to help you understand how the resident's usual day was spent and how certain things were done. It may be necessary to ask a number of open-ended questions in order to obtain the necessary information. Prompts should be highly individualized.

Walk the resident through a typical day. Focus on usual habits, involvement with others, and activities. Phrase questions in the past tense. Periodically reiterate to the resident that you are interested in the resident's routine before nursing facility admission, and that you want to know what he or she actually did, not what he or she might like to do.

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