For Washington State Nursing Home staff

From Residential Care Services, Aging and Disability Services
Department of Social & Health Services

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our mascot
Cousin IT

"This is I.T." Newsletter

Info and Tips from the MDS-WA Office—***Clinical*** *stuff,* ***Computer*** *stuff,* ***Reports*** *'n stuff, and other STUFF!*

By Marge Ray and Judy Bennett, State of WA, DSHS

Inside this issue:

Marge

Judy

Sandy

Transitions

The birds are singing, the garden is starting to show real progress and we are transitioning from Spring to Summer. The changes begin slowly but the anticipation of increased sunshine, warmer weather and more time outdoors keeps us going. Change…the one thing we can always count on!

As it is with nature, seasons come and go in life also. My season as the Washington State RAI Coordinator is winding down and will be completed June 29 when I enter a new phase of life called "retirement". I have spent the past 25 years working in Residential Care Services, with the last 13 devoted to the MDS and related issues. I want to take this opportunity to thank you for being on the front lines 24/7 for our elders and vulnerable adults and for asking those good questions that have kept my gray cells busy and my hairdresser employed! I plan to enjoy many hours in the sun as my husband and I will journey south to Arizona during the fall and winter months. Down in that part of the country, MDS may mean More Dreaded Scorpions, however. My next task is to learn how to decorate a cactus for the holidays without becoming a pin cushion!

For the next several weeks, MDS clinical coding assistance will be minimally available by telephone only. My successor, Sandy Kerrigan, is currently the program manager for the Nurse Aide Training and Competency and Evaluation Program (NATCEP) and will transition to MDS once her replacement is on board. Sandy has extensive experience in acute care, Hospice and telephone triage. She is excited to move into her new role and looks forward to working with you all. In the interim, the RAI User's manual and the subsequent CMS Errata and Clarification documents provide the information needed to code, transmit and correct MDS assessments.

The RAI manual and CMS Errata documents are available at the following website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

SNF PPS presentations and clarification documents can be obtained at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEdu12.html

Facilities may also contact their Quality Assurance Nurse (QAN) for MDS clinical item coding questions and Judy Bennett, the Washington State Automation Coordinator is available to answer transmission and error correction questions.

MDS Coding—Bits and Pieces

The following issues keep popping up in either provider questions or QAN findings from facility case mix visits, so we thought it would be a great opportunity to address them now.

1. Do CAAs have to be completed if a resident discharges prior to the completion deadline?

No. Per the RAI manual, chapter 2 page 17, if a resident is discharged prior to the completion deadline for the assessment, completion of that assessment is not required. The portions of the RAI that have been completed must be retained in the resident's medical record. In closing the record, the nursing home should note why the RAI was not completed.

Remember that CAAs (Care Area Assessments) are required for OBRA comprehensive assessments. These assessments are completed on admission, annually, when a significant change in status has occurred and when a significant correction to a prior comprehensive assessment is needed. Comprehensive assessments include the MDS, the CAA process and care planning. While you are to retain the incomplete assessment in the resident's record, you **may not transmit** a comprehensive assessment to the CMS data base unless **all** components are completed, including the CAA review.

2. How can I submit a managed care/HMO MDS?

The short answer is, "you can't". CMS has clearly stated in the RAI manual, chapter 5, page 1 that assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted. If you are requested by private insurers, such as managed care/HMO organizations, to complete a PPS assessment for them you may do so but it cannot be submitted to the CMS data base.

3. Can Parkinsonism be coded at I5300-Parkinson's disease?

No, they are not the same. Parkinsonism is the general condition that causes a combination of movement abnormalities seen in Parkinson's disease such as tremor at rest, impaired speech, balance problems, slow movement or muscle stiffness. Although Parkinson's disease is the most common cause of parkinsonism, not everyone with parkinsonism has Parkinson's diseases. Parkinsonism can be caused by stroke, repeated head trauma such as injuries sustained in boxing, medication side effects, Lewy body dementia, and certain neurodegenerative disorders.

4. Is a "scab" on a wound that is pressure related coded as Eschar?

A "scab" is made up of dried blood cells and serum and sits on the top of the skin. It forms over exposed wounds, such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc). A scab is evidence of wound healing. For example, a pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2 and should still be staged as such. This is why it is extremely important to distinguish a scab from eschar. They are differently both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. Eschar characteristics and the level of damage it causes to tissues is what make it easy to distinguish it from a scab.

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Bits and Pieces continued from Page 2

5. If a resident has MRSA in a wound and is in their room, can O0100M-Isolation for active-infectious disease be coded?

The RAI manual states that this item can only be coded when a resident requires transmission-based precautions and strict isolation alone in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.

There are 4 requirements that must be met:

A. The resident has active infection with highly transmissible or epidemiologically significant pathogens acquired by physical contact or airborne, or droplet transmission.

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

C. The resident is in a room alone because of active infection and cannot have a roommate.

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

It goes on to say, "examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections." (page O-4)

Thus, the answer to the question is No, it would not be coded.

6. Restorative Nursing

The inability to validate nursing restorative programs on the MDS continues to be one of the most frequent causes of inaccuracies on case mix accuracy review visits. The criteria that are listed in the RAI manual are very specific and must be present before restorative programs can be coded on the MDS (chapter 3, Section O pages O-32 through 35). The most frequent error relates to the lack of a licensed nurse evaluation of the program. Even when an evaluation is present, very often it does not address the effectiveness of the program in achieving the stated goals. Simply stating that a program was provided for 15 minutes daily for "x" number of days is not sufficient. The nurse needs to document whether or not the interventions identified for that program are accomplishing what was hoped for. If not, what are you going to do about it? What changes need to be made in order to help the resident reach the goal? Does the goal need to be modified and if so, what is the new goal? How do the programs help residents become more independent or reach/maintain their highest functional level?

In other words, provide an analysis of the information and come to a conclusion.

Another criterion that is not consistently met relates to goals not being measureable or objective. Quite often the goals look like "carry overs" from Therapy such as "increase strength and endurance" but there is no mention of why or what the purpose would be for this increase in strength and endurance. Is the program going to help them walk further so they can get to activities or the dining room? Is increased strength needed so that the resident can dress themselves without assistance?

Programs cannot be combined together in order to meet the minimum 15 minutes per day. For example AROM given for 10 minutes a day and PROM given for 10 minutes a day means that neither program qualifies for a day of restorative programming because the criteria is that each program must occur for at least 15 minutes a day to be recorded on the MDS. It is expected that restorative programs will be documented after they occur by the individual that provided those services.

Nursing Assistants who provide the restorative programs must be trained for the specific techniques required to conduct the program, including resident involvement. This training should be provided by individuals who have the knowledge, skills and abilities to adequately train and evaluate whether or not the NA understands and can demonstrate those techniques. One nursing assistant showing another nursing assistant how to do these techniques would not be sufficient to meet this criteria.

Restorative nursing care is based on each resident's assessed need. In other words, can this individual do what they need and want to do? If not, why not? Then determine if a restorative nursing program could help the individual achieve those desired outcomes. Identify "why" the specific programs were chosen for this resident; what is the need that is being addressed with the programs and document this information.

7. Section Q: Local Contact Authority

An important addition to MDS 3.0 requires facilities to refer residents who wish to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community (a "yes" answer to Q0500B) to the Local Contact Agency (LCA). In Washington, the LCA is the Home and Community Services field office for your area. To help facility staff locate the specific office for their nursing home, a new link has been added to our internet site:

Section Q: Referral to Local Contact Agency. You can access this information at:

http://www.aasa.dshs.wa.gov/professional/MDS/MDS3.0/

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Restorative Nursing Word Find

L A I T N E T O P I D C M G N
I N D E P E N D E N C E A N O
N O I T N E V E R P U A I I I
M A X I M I Z E E I E T N K T
F U N C T I O N A L I I T L N
E V R E S E R P O S N N A A E
C E V A L U A T E S G G I W V
D E Z I L A U D I V I D N I R
C F B T N E M E V O R P M I E
N E H T G N E R T S L A O G T
S Y S T E M A T I C M F R U N
M O N I T O R I N G V Z P M I

CUEING
EATING
EVALUATE
FUNCTIONAL
GOALS
IMPROVEMENT
INDEPENDENCE
INDIVIDUALIZED
INTERVENTION
MAINTAIN
MAXIMIZE
MONITORING
POTENTIAL
PRESERVE
PREVENTION
PROM
STRENGTHEN
SYSTEMATIC
WALKING

NH web sites in WA

NH Rates web page
http://www.adsa.dshs.wa.gov/professional/rates/

NH Rates and Reports
http://www.adsa.dshs.wa.gov/professional/rates/reports/

Case Mix web page
http://www.adsa.dshs.wa.gov/professional/CaseMix/

MDS Automation web page
http://www.adsa.dshs.wa.gov/Professional/MDS/

Info for NH Professionals
http://www.aasa.dshs.wa.gov/professional/nh.htm

MDS Clinical web page
http://www.adsa.dshs.wa.gov/Professional/MDS/Clinical/