

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 02/04/05 05/01/06
Section: Nursing Facility	Section: 36.12	
Subject: Case Mix Guidelines	Pages: 24-26	Cross Reference:

(Note to the Provider: All federal requirements must be met, and those sections contained herein may be more stringent and will supercede the federal requirements for the Resident Assessment Instrument. It is the responsibility of the provider to be in compliance with both the federal and State requirements.)

One of the primary aims of the Division of Medicaid (DOM) is the utilization of an accurate MDS 2.0+ to form the foundation for an equitable payment system based on consistent data. At the core of this system is the Minimum Data Set 2.0 Plus (MDS 2.0+) resident assessment instrument and its accurate completion.

The RUG-III classification system has seven major classification groups: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. The seven groups are further divided by the intensity of the resident's activities of daily living (ADL) needs and, in the Clinically Complex category, by the presence of depression; and in the Impaired Cognition, Behavioral and Physical Functioning categories, by the provision of restorative nursing services.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the Mississippi RUG-III Classification system for nursing facilities can be found at the end of this section.

SEVEN MAJOR M3PI RUG-III CLASSIFICATION GROUPS	
MAJOR RUG-III GROUP	CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP
Rehabilitation	Residents receiving physical, speech or occupational therapy.
Extensive Services	Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications suctioning, tracheostomy care, ventilator/respirator and comorbidities that make the resident eligible for other RUG categories.
Special Care	Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, ulcers, stage III or IV pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding

Clinically Complex	Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot/wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes.
Impaired Cognition	Residents having cognitive impairment in decision-making, recall and short-term memory. (Score on MDS 2.0 cognitive performance scale >=3.)
Behavior Problems	Residents displaying behavior such as wandering, verbally or physically abusive or socially inappropriate, or who experience hallucinations or delusions.
Reduced Physical Functions	Residents whose needs are primarily for activities of daily living and general supervision.

M3PI MISSISSIPPI (5.12)

Please note that items labeled as S6 or S7 are from Mississippi Section S.

I. M³PI-MS Major Categories (5.12)

Major Categories

MDS+ Item

Extensive Care (One or More) ADL Score >6 (See ADL Index)

Parenteral/IV Feeding	S7a=1
Suctioning	S6i=1
Tracheostomy Care	S6j=1
Ventilator/Respirator	S6l=1
IV Medication	6c=1

Rehabilitation (One or More) ADL Score 4-18

Speech, Occupational and/or Physical	P1baA,P1baB P1bbA,P1bbB
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- A.** Received 150 minutes or more per week
At least 5 days of therapy per week
(Any combination of the three disciplines)
- or**
- B.** Received 45 minutes or more per week
At least 3 days of any combination of the 3 therapies per week
With 2 or more Nursing Rehabilitation/Restorative care practices, each for at least 15 minutes, each for at least 6 days

Special Care (One or More)

Ulcers; 2 or more of ANY type ulcer with Selected Skin Care Treatment (2 or more)	M1a-d=1-9 M5a-e=1 M5g-h=1
or Stage III or IV Pressure Ulcer with Selected Skin Care Treatment (2 or More)	M2a=3-4 M5a-e=1 M5g-h=1
or Feeding Tube and Aphasia and Parenteral/Enteral Intake* (K6a=3,4) or (K6a=2 and K6b=2,3,4,5)	K5b=1 I1r=1 K6a=2,3,4 K6b=2,3,4,5
or Surgical Wound and Surgical Wound Care or Application of Dressings or Application of Ointments	M4g=1 M5f=1 M5g=1 M5h=1
or Open Lesions (other than ulcers rashes cuts) and Surgical Wound Care or Application of Dressings or Application of Ointments	M4c=1 M5f=1 M5g=1 M5h=1
or Respiratory Therapy x 7 days	P1bdA=7
or Cerebral Palsy with ADL >9	1s=1
or Fever and Vomiting or Weight Loss or Pneumonia or Dehydration or Feeding Tube and Parenteral/Enteral Intake* (K6a=3,4) or (K6a=2 and K6b=2,3,4,5)	J1h=1 J1o=1 K3a=1 I2e=1 J1c=1 K5b=1 K6a=2,3,4 K6b=2,3,4,5
or Multiple Sclerosis with ADL >9	llw=1
or Quadriplegia with ADL >9	l1z=1
or Radiation Treatments	S6h=1

***51% + calories or 26%+ calories and 501+cc per day intake**

Clinically Complex (One or More)**Residents who meet the criteria for Extensive or Special Care category
and an ADL score of 6 or less.**

or Dehydration	J1c=1
or Hemiplegia/Hemiparesis and ADL>9	I1v=1
or Internal Bleeding	J1j=1
or Pneumonia	I2e=1
or Chemotherapy	S6a=1
or Dialysis	S6b=1
or Transfusions	S6k=1
or Oxygen	S6g=1
or Physician Order changes on 4 or more days and Physician Visits on 1 or more days	P8=4-14 P7=1-14
or Physician Order changes on 2 or more days and Physician Visits on 2 or more days	P8=2-14 P7=2-14
or Diabetes and Injections on 7 Days and Physician Order changes on 2 or more days	I1a=1 O3=7 P8=2-14
or Feeding Tube and Parenteral/Enteral Intake* (K6a=3,4) or (K6a=2 and K6b=2,3,4,5)	K5b=1 K6a=2,3,4 K6b=2,3,4,5

***51%+ calories or 26%+ calories and 501+ cc per day intake**

or Coma and Awake None of the Day and Totally Dependent in Bed Mobility and Totally Dependent in Transferring and Totally Dependent in Eating and Totally Dependent in Toilet Use	B1=1 N1d=1 G1aA=4,8 G1bA=4,8 G1hA=4,8 G1iA=4,8
or Septicemia	I2g=1
or Burns (Second or Third Degree)	M4b=1
or Infection of Foot and Foot Dressing	M6b=1 M6f=1

or
Open Lesion on Foot
and Foot Dressing

M6c=1
M6f=1

Impaired Cognition (ADL sum of 10 or less)

Combination of the Following Items:

Short Term Memory Problem	B2a
Cognitive Skills for Daily Decision Making	B4
Making Self Understood	C4

Combinations include;

B2a=1 and B4=1 and C4=2
B2a=1 and B4=1 and C4=3
B2a=1 and B4=2
B2a=1 and C4=2
B2a=1 and C4=3
B4=1 and C4=2
B4=1 and C4=3
B4=2 and C4=1
B4=2 and C4=2
B4=2 and C4=3
B4=3

Behavioral Problems (one or more) ADL sum of 10 or less

Wandering on 4 or more days	E4aA>=2
or	
Verbally Abusive on 4 or more days	E4bA>=2
or	
Physically Abusive on 4 or more days	E4cA>=2
or	
Socially Inappropriate/Disruptive Behavior on 4 or more days	E4dA>=2
or	
Hallucinations	J1i=1
or	
Delusions	J1e=1
or	
Resists Care 4 or more days	E4eA>=2

Physical Functioning (reduced function) ADL sum of 4-18

Residents who do not meet the criteria for any of the categories previously described shall be classified in the Physical Functioning categories. Additional splits are established for residents receiving Nursing Rehabilitation/Restorative care practices. ADL scores determine final category.

II. Extensive Category Splits

Once the resident qualifies for Extensive by having S6c or S6i or S6j or S6l or S7a and an ADL score equal to or greater than 7, the following counter is used to determine the splits:

Start the counter at zero	0
If the resident qualifies for Special Care	Add 1
If the resident qualifies for Clinically Complex	Add 1
If the resident qualifies for Impaired Cognition	Add 1
If the resident has Parenteral/IV Feeding (S7a=1)	Add 1
If the resident has IV Medication (S6c=1)	Add 1
The counter can be zero (0) to five (5).	
A count of zero (0) or one (1) puts the resident in SE1.	
A count of two (2) or three (3) puts the resident in SE2.	
A count of four (4) or five (5) puts the resident in SE3.	

Please note that S6i, S6j and S6l will qualify the resident for Extensive but none of these items add to the counter for the splits. Also, if the ADL score is 4-6, then resident falls to Special Care. (This is the only case where a resident with an ADL of 4-6 will qualify for the Special Care category.)

Depression Criteria

III. Depression and Nursing Rehabilitation/Restorative Care Criteria

Mood and Behavior Patterns (**3 or more** indicators)

Negative Statements	E1a>=1
Repetitive Questions	E1b>=1
Repetitive Verbalizations	E1c>=1
Persistent Anger	E1d>=1
Self Deprecation	E1e>=1
Expression of Unrealistic Fears	E1f>=1
Recurrent Statements	E1g>=1
Repetitive Health Complaints	E1h>=1
Repetitive non-Health Complaints	E1i>=1
Unpleasant Mood in Morning	E1j>=1
Insomnia/Change in Sleep Pattern	E1k>=1
Sad Worried Facial Expressions	E1l>=1
Crying, Tearfulness	E1m>=1
Repetitive Physical Movements	E1n>=1
Withdrawal From Activities	E1o>=1
Reduced Social Interaction	E1p>=1

IV. Rehabilitation/Restorative Nursing Criteria

Techniques/Practices (**2 or more** provided)

Range of Motion - Passive*	P3a=>6
or Range of Motion - Active*	P3b=>6
or	
Training/Skill Practice in Bed Mobility*	P3d=>6
or Training/Skill Practice in Walking*	P3f=>6
or	
Splint or Brace Assistance*	P3c=>6

or	
Training/Skill Practice in Transfers*	P3e=>6
or	
Training/Skill Practice in Dressing/Grooming*	P3g=>6
or	
Training/Skill Practice in Eating/Swallowing*	P3h=>6
or	
Amputation/Prosthesis Care*	P3i=>6
or	
Communication*	P3j=>6
or	
Toileting Program	H3a=1
or Bladder Retraining	H3b=1

***Each provided for at least 15 minutes, at least 6 of the past 7 days.**

V. ADL Dependency Index

Determining ADL Scores

Bed Mobility Coding	ADL Score
G1aA=-,0,1	1
G1aA=2	3
G1aA=3,4,8 AND G1aB=-,0,1,2	4
G1aA=3,4,8 AND G1aB=3,8	5
Transfer Coding	ADL Score
G1bA=-,0,1	1
G1bA=2	3
G1bA=3,4,8 AND G1bB=-,0,1,2	4
G1bA=3,4,8 AND G1bB=3,8	5
Toileting Coding	ADL Score
G1iA=-,0,1	1
G1iA=2	3
G1iA=3,4,8 AND G1iB=-,0,1,2	4
G1iA=3,4,8 AND G1iB=3,8	5
Eating Coding	ADL Score
G1hA=-,0,1	1
G1hA=2	2
G1hA=3,4,8	3
S7a=1	3
K5b=1 and (K6a=3,4)	3
K5b=1 and (K6a=2 and K6b=2,3,4,5)	3

**Scores from each of the four areas are summed for the total ADL score.
Lowest score = 4 (1+1+1+1), Highest score = 18 (5+5+5+3)**

Mississippi Case Mix Index for M3PI vers 5.12 - 7/1/98 Revised 9/17/98			
Group	Description	Regular Index	Access Incentive Index
SE3	Extensive Special Care 3 / ADL>6	2.839	2.896
SE2	Extensive Special Care 2 / ADL>6	2.316	2.362
SE1	Extensive Special Care 1 / ADL>6	1.943	1.982
RAD	Rehab. All Levels / ADL 17-18	2.284	2.330
RAC	Rehab. All Levels / ADL 14-16	1.936	1.975
RAB	Rehab. All Levels / ADL 10-13	1.772	1.807
RAA	Rehab. All Levels / ADL 4-9	1.472	1.501
SSC	Special Care / ADL 17-18	1.877	1.915
SSB	Special Care / ADL 15-16	1.736	1.771
SSA	Special Care / ADL 7-14 (Extensive 4-6)	1.709	1.743
CC2	Clin. Complex w/Depression / ADL 17-18	1.425	1.454
CC1	Clin. Complex / ADL 17-18	1.311	1.337
CB2	Clin. Complex w/Depression / ADL 12-16	1.247	1.272
CB1	Clin. Complex / ADL 12-16	1.154	1.177
CA2	Clin. Complex w/Depression / ADL 4-11	1.043	1.064
CA1	Clin. Complex / ADL 4-11	0.934	0.953
IB2	Cog. Impaired w/ Nurs. Rehab. / ADL 6-10	1.061	1.082
IB1	Cog. Impaired / ADL 6-10	0.938	0.957
IA2	Cog. Impaired w/ Nurs. Rehab. / ADL 4-5	0.777	0.777
IA1	Cog. Impaired / ADL 4-5	0.703	0.703
BB2	Behav. Prob. w/ Nurs. Rehab. / ADL 6-10	1.021	1.041
BB1	Behav. Prob. / ADL 6-10	0.866	0.883
BA2	Behav. Prob. w/ Nurs. Rehab. / ADL 4-5	0.750	0.750
BA1	Behav. Prob. / ADL 4-5	0.612	0.612
PE2	Phys. Func. w/ Nurs. Rehab. / ADL 16-18	1.188	1.212
PE1	Phys. Func. / ADL 16-18	1.077	1.077
PD2	Phys. Func. w/ Nurs. Rehab. / ADL 11-15	1.095	1.117
PD1	Phys. Func. / ADL 11-15	0.990	0.990
PC2	Phys. Func. w/ Nurs. Rehab. / ADL 9-10	0.937	0.956
PC1	Phys. Func. / ADL 9-10	0.865	0.865
PB2	Phys. Func. w/ Nurs. Rehab. / ADL 6-8	0.824	0.841
PB1	Phys. Func. / ADL 6-8	0.749	0.749
PA2	Phys. Func. w/ Nurs. Rehab. / ADL 4-5	0.637	0.637
PA1	Phys. Func. / ADL 4-5	0.575	0.575
BC1	RUG3/M3PI not calculated due to errors	0.575	0.575

Case Mix Documentation Guide

DOM developed the documentation requirements for use in the reimbursement system. While designed to provide nursing facility staff with some leadership concerning documentation needs, these requirements reflect the minimum documentation that must be present to support or validate the facility's coding of the MDS 2.0+ payment items. Appropriately applied, the guidelines in this document should improve consistency in a resident's clinical record but may not be sufficient for licensure and certification surveys, acute situations, etc. The facility staff is responsible for documenting as needed, according to standards of professional practice.

DOM will not prescribe methods of charting or documenting. Facilities remain responsible for assuring that documentation is reflective of and consistent with the MDS 2.0+ item definitions and time frames, as well as any subsequent revised or updated State or federal guidelines. All pertinent, interdisciplinary information in the resident record will be utilized for the review process.

Since the MDS 2.0+ is to be an accurate reflection of the resident, observable differences between the resident and the coding of the MDS 2.0+ shall be thoroughly explained, and the changes should be trackable in the clinical record. Any documentation removed from the record shall be made readily available upon request by the Case Mix Program Nurses. They may also copy any or all of the clinical record if deemed necessary.

If treatments, procedures, therapies, etc., occurred outside the facility, documentation from the institution providing the services must be available in the clinical record.

Appeal Process

If a facility disagrees with any of the classification adjustments, an appeal may be filed to the Division of Medicaid, Division of Institutional Long Term Care. The appeal must be made in writing within thirty (30) calendar days of the notification and must contain the reason for the appeal. Any available documentation supporting the facility's statement should be attached to the written appeal.

If the facility is dissatisfied with the results of this appeal, it should request an administrative hearing in writing within thirty (30) calendar days to the Executive Director of DOM.

B1	Comatose/ Persistent Vegetative State	<p>This item is coded to record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.</p> <p>Coma is a pathological state in which neither arousal (wakefulness, alertness) nor awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move extremities upon command or in response to noxious stimuli (e.g., pain). Sometimes residents who were comatose for a period of time after an anoxic-ischemic injury (e.g., not enough oxygen to the brain), from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but have no evidence of any purposeful behavior or cognition. Their eyes are open and they seem to be awake. They may grunt, yawn, pick with their fingers and have random movements of their heads and extremities. A neurological exam shows that they may have extensive damage to both cerebral hemispheres. This state is different from coma and if it continues is called a persistent vegetative state.</p> <ul style="list-style-type: none"> • Must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death • Does not include a diagnosis of semi-comatose • Documentation must support "no discernable consciousness" • Documentation must include physical functioning abilities
B2a	Short Term Memory Problem	<p>This item is coded to determine the resident's functional capacity to remember recent events. If the test to determine short term memory problems cannot be conducted (resident will not cooperate, is non-responsive, etc.) and the staff was unable to make a determination based on observation of the resident, use the "-" response to indicate that the information is not available because it could not be assessed.</p> <ul style="list-style-type: none"> • An exact description of the short term memory problem must be documented. • The method of assessing /determining the short term memory problem must be documented. • <u>The condition must be consistent with physician and interdisciplinary notes and interventions.</u>
B4	Cognitive Skills for Daily Decision Making	<p>This item is coded to record the resident's actual performance in making everyday decisions about tasks or activities of daily living .</p> <ul style="list-style-type: none"> • A description of the resident's ability to make everyday decisions about the tasks or activities of daily living must be documented. • The supervision or assistance required to make decisions must be documented. • The frequency of the impaired decision making process must be documented. • <u>The resident's performance must be consistent with physician and interdisciplinary notes and interventions.</u>

C4	Making Self Understood	<p>This item is coded to document the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.</p> <ul style="list-style-type: none"> • A description of the resident's ability to make self understood must be documented. • <u>The resident's ability must be consistent with physician and interdisciplinary notes and interventions.</u>
E1	Indicators of Depression, Anxiety, Sad Mood	<p>This item is coded to record the frequency of indicators observed in the last thirty days, irrespective of the assumed cause of the indicator (behavior).</p> <ul style="list-style-type: none"> • A specific description and frequency of any of the indicators must be documented • <u>This indicator</u> may be expressed non-verbally and identified through observation of the resident during usual daily routine • <u>This indicator must be consistent with physician and interdisciplinary notes and interventions.</u>
E1a	Negative Statements	e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."
E1b	Repetitive Questions	e.g., "Where do I go; What do I do?"
E1c	Repetitive Verbalizations	e.g., Calling out for help, ("God help me.")
E1d	Persistent Anger With Self or Others	e.g., Easily annoyed, anger at placement in nursing home; anger at care received
E1e	Self Deprecation	e.g., "I am nothing; I am of no use to anyone."
E1f	Expressions of Unrealistic Fears	e.g., fear of being abandoned, left alone, being with others
E1g	Recurrent Statements That Something Terrible is About to Happen	e.g., believes he or she is about to die, have a heart attack
E1h	Repetitive Health Complaints/ Concerns	e.g., persistently seeks medical attention, obsessive concern with body functions
E1i	Repetitive Anxious Complaints/ Concerns (Non-Health Related)	e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

E1j	Unpleasant Mood in Morning	e.g., may be angry, irritable
E1k	Insomnia/ Change in Usual Sleep Pattern	e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep
E1l	Sad, Pained, Worried, Facial Expression	e.g., furrowed brows
E1m	Crying, tearfulness	Self-explanatory
E1n	Repetitive Physical Movements	e.g., pacing, hand wringing, restlessness, fidgeting, picking
E1o	Withdrawal from Activities of Interest	e.g., no interest in long standing activities or being with family/friends
E1p	Reduced Social Interaction	e.g., less talkative, more isolated
E4	Behavioral Symptoms	<p>These items are coded to identify the frequency of behavioral symptoms in the past seven days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them.</p> <ul style="list-style-type: none"> • <u>A description of the exact or specific behavior exhibited must be documented.</u> • <u>The symptoms must be consistent with physician and interdisciplinary notes and interventions.</u>
E4aA	Wandering	<p>This is locomotion with no discernable rational purpose. The resident may appear oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair. Do not include pacing.</p> <ul style="list-style-type: none"> • A description of the exact or specific behavior exhibited must be documented.
E4bA	Verbally Abusive	<p>This includes, but is not limited to other residents or staff being threatened, screamed at, or cursed at.</p> <ul style="list-style-type: none"> • A description of the exact or specific behavior exhibited must be documented.
E4cA	Physically Abusive	<p>This includes, but is not limited to other residents or staff being hit, shoved, scratched, or sexually abused.</p> <ul style="list-style-type: none"> • A description of the exact or specific behavior exhibited must be documented.
E4dA	Socially Inappropriate/ Disruptive Behavior	<p>This includes, but is not limited to making disruptive sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smear/threw food/feces, hoarding, rummaging through others' belongings.</p> <ul style="list-style-type: none"> • A description of the exact or specific behavior exhibited must be documented.

E4eA	Resists Care	<p>This includes, but is not limited to residents taking medications/injections, ADL assistance, or help with eating.</p> <ul style="list-style-type: none"> • A description of the exact or specific behavior exhibited must be documented. • Signs of resistance may be verbal and/or physical. • This does not include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute the treatment).
G1A	ADL Self Performance	<p>These items are coded to record the resident's self-care performance for bed mobility, transfers, eating, and toileting activities of daily living during the last seven days. This measures what the resident actually did, not what he or she might be capable of.</p> <ul style="list-style-type: none"> • Code for resident's performance over all shifts. • A description of each ADL/ADL subtask, as applicable to the individual resident, must be documented. • The resident's participation in any ADL/ADL subtask, as applicable to the individual resident, must be documented. • <u>The number of times supervision and/or physical assistance (non-weight bearing and/or weight bearing) was provided for each ADL/ADL subtask, as applicable to the individual resident, must be documented.</u>
G1B	ADL Support Provided	<p>These items are coded to record the type and highest level of support the resident received for bed mobility, transfers, eating, and toileting activities of daily living during the last seven days.</p> <ul style="list-style-type: none"> • Code for the most support provided over all shifts. • The number of times supervision and /or physical assistance (non-weight bearing and/or weight bearing) was provided for each ADL/ADL subtask, as applicable to the individual resident, must be documented. • A description of the support provided (no help, set-up help, one person physical assist, two+ persons physical assist) for each ADL/ADL subtask, as applicable to the individual resident, must be documented.
H3a	Scheduled Toileting Plan	<p>This is a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a bedpan/urinal, or remind the resident to go to the toilet.</p> <ul style="list-style-type: none"> • The exact description of the plan must be documented including frequency, reason, and response. • The plan must be periodically evaluated and revised as necessary, which would include documentation of the resident's response to the plan. • This includes, but is not limited to, habit training and/or prompted voiding. • This does not include routine changing of resident's incontinent briefs, pads, or linens when wet, where there is no participation in the plan by the resident.

H3b	Bladder Retraining Program	<p>This is a retraining program where the resident is taught to consciously delay urinating (voiding) or to resist the urgency to void. Residents are encouraged to void on a schedule, rather than according to their urge to void.</p> <ul style="list-style-type: none"> • The exact description of the intervention or plan must be documented including frequency, reason, and response. • The plan must be periodically evaluated and revised as necessary, which would include documentation of the resident's response to the program.
I1a	Diabetes	<ul style="list-style-type: none"> • This must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. • Includes insulin dependent diabetes mellitus and diet controlled diabetes mellitus
I1r	Aphasia	<p>This is a speech or language disorder caused by disease or injury to the brain resulting in difficulty <u>expressing thoughts (i.e. speaking, writing)</u> or understanding spoken or written language.</p> <ul style="list-style-type: none"> • <u>This</u> must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death • Does not include the diagnosis of dysphasia.
I1s	Cerebral Palsy	<p>This is paralysis related to developmental brain defects or birth trauma. This includes spastic quadriplegia secondary to cerebral palsy.</p> <ul style="list-style-type: none"> • Must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death
I1v	Hemiplegia/ Hemiparesis	<p>This is the paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body.</p> <ul style="list-style-type: none"> • Must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death • There must be documentation that addresses the loss of function or sensation.
I1w	Multiple Sclerosis	<p>This is a chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesia, speech disturbances, and visual disturbances.</p> <ul style="list-style-type: none"> • Must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death

I1z	Quadriplegia	<p>This is the paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. This includes hands, fingers, feet, and toes.</p> <ul style="list-style-type: none"> • An active diagnosis by a physician that has a <u>current</u> relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death <u>must be documented in the clinical record.</u> • <u>This</u> does not include the diagnosis of quadriparesis • <u>This</u> does not include the diagnosis of spastic quadriplegia (e.g., secondary to Cerebral Palsy)
I2e	Pneumonia	<p>This is the inflammation of the lungs caused primarily by bacteria, viruses, and chemical irritants.</p> <ul style="list-style-type: none"> • Must be an An active diagnosis by a physician that has a <u>current</u> relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death <u>must be documented in the clinical record</u> • Signs and symptoms of illness must be documented (e.g., chest congestion, breath sounds, coughing, etc.) • Treatment and interventions must be documented (e.g., antibiotic therapy)
I2g	Septicemia	<p>This is a morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted provided the physician has documented the septicemia diagnosis in the resident's clinical record.</p> <ul style="list-style-type: none"> • Must be an active diagnosis by a physician that has a relationship to the current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death • Signs and symptoms of illness should be documented • Treatment and interventions must be documented.
J1c	Dehydration	<p>This is a condition that occurs when fluid output exceeds fluid intake. Code this item if the resident has two or more of the following indicators.</p> <p>Resident usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages, and water in high fluid content foods such as gelatin and soups).</p> <p>Resident has <u>one or more</u> clinical signs of dehydration, <u>included but not limited to</u>, such as dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).</p> <p>Resident's fluid loss exceeds the amount of fluids taken in (e.g., loss from vomiting, fever, diarrhea, that exceeds fluid replacement).</p> <ul style="list-style-type: none"> • Signs and symptoms of illness must be documented • Interventions and treatments must be documented

J1e	Delusions	This is fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary. <ul style="list-style-type: none"> • A specific description of the delusion experienced by the resident must be documented.
J1h	Fever	A fever is present when the resident's temperature (Fahrenheit) is 2.4 degrees greater than the baseline temperature. The baseline temperature may have been established prior to the Assessment Reference Date. <ul style="list-style-type: none"> • There must be documentation of temperatures to establish a baseline.
J1i	Hallucinations	This is false perceptions that occur in the absence of any real stimuli. The resident behaves as if he/she sees, hears, smells, feels, or tastes things others do not; or the resident has conversations when others are not present/ or reports having conversations with persons known to deceased, or hearing voices, or seeing things. <ul style="list-style-type: none"> • A specific description of the hallucination experienced by the resident must be documented. • A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).
J1j	Internal Bleeding	<ul style="list-style-type: none"> • Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). • Clinical indicators may be black, tarry stools; vomiting "coffee ground emesis", hematuria, hemoptysis, severe epistaxis(nose bleed that requires packing) • Does not include nose bleeds that are easily controlled • The source, characteristics, and descriptions of the bleeding must be documented
J1o	Vomiting	This is the regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity, influenza; psychogenic) <ul style="list-style-type: none"> • The frequency of the episodes and accompanying symptoms must be documented. • A description of the vomitus must be documented
K3a	Weight Loss	This includes a 5% or more weight loss in the past 30 days, or a 10% or more weight loss in the past 180 days. <ul style="list-style-type: none"> • Weights must be recorded at least monthly. • The percentage of weight loss during the past 30 and past 180 days must be documented.
K5b	Feeding Tube	This is any tube that can deliver food/nutritional substances/fluids/ medications directly into the gastrointestinal system. <ul style="list-style-type: none"> • This includes, but is not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy tubes.
K6	Parenteral/ Enteral Intake	This is to record the proportion of calories actually received (not ordered), and the average fluid intake, through parenteral or tube feedings in the last seven days. <ul style="list-style-type: none"> • The intake record and calorie count received from parenteral or tube feedings must be documented. • The oral intake must be documented. • Must have received > 50% of total calories through the parenteral or enteral tube during the past 7 days or 26-50% of the total calories and > 500cc daily.

M1	Ulcers	<p>A skin ulcer/open lesion can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are Skin ulcers that may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis.</p> <ul style="list-style-type: none"> • All skin ulcers/open lesions should be coded here <u>Skin ulcers that may develop because of circulatory problems or pressure are coded here.</u> • Rashes without open areas, burns, desensitized skin, <u>ulcers related to disease such as syphilis and cancer</u> and surgical wounds are <u>NOT</u> coded here, but in M4. • <u>A skin ulcer repaired with a flap graft should be coded in M4g as a surgical wound and not as a skin ulcer.</u> • <u>Skin tears/shears should be coded in item M4, unless pressure was a contributing factor.</u> • A detailed description that includes, but is not limited to, the stage of the ulcer, the size (length, width, and depth), and the location must be documented. • Treatment and interventions must be documented <p style="text-align: center;">Staging Ulcers</p> <p>Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.</p> <p>Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.</p> <p>Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.</p> <p>Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.</p>
M2a	Pressure Ulcer	<p>Any lesion <u>skin ulcer</u> caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition are bed sores and decubitus sores.</p> <ul style="list-style-type: none"> • A detailed description that includes, but is not limited to, the stage of the ulcer, the size (length, width, and depth), and the location must be documented. • Treatment and interventions must be documented.
M2b	Stasis Ulcer	<p>An open lesion A <u>skin ulcer</u>, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease.</p> <ul style="list-style-type: none"> • A detailed description that includes, but is not limited to, the stage of the ulcer, the size (length, width, and depth), and the location must be documented. • Treatment and interventions must be documented

M4b	Burns	<ul style="list-style-type: none"> • Includes only second or third degree burns • Includes burns from any cause (e.g., heat, chemicals) • A detailed description that includes, but is not limited to, the location, degree, extent, etc. must be documented. • Treatment and interventions must be documented.
M4c	Open Lesions	<p>This is a local loss of epidermis and variable levels of dermis and subcutaneous tissue. This includes any open skin lesion that is not coded elsewhere in section M. <u>This open sore includes skin ulcers that may develop because of injury or in association with other as a result of diseases and conditions such as syphilis and cancer.</u></p> <ul style="list-style-type: none"> • <u>This does not include pressure or stasis ulcers, rashes, cuts, or skin tears</u> • A detailed description that includes, but is not limited to, the location, size, depth, drainage present, etc. must be documented. • Treatment and interventions must be documented.
M4g	Surgical Wounds	<ul style="list-style-type: none"> • Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body • Does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds. • A detailed description that includes, but is not limited to, the type, location, size, depth, etc., must be documented. • Treatment and interventions must be documented.
M5a	Pressure Relieving Device for Chair	<ul style="list-style-type: none"> • Includes, but not limited to, gel, air, or other cushioning placed on a chair or wheelchair • Does not include egg crate cushions. • A description of the treatment/intervention must be documented.
M5b	Pressure Relieving Device for Bed	<ul style="list-style-type: none"> • Includes, but not limited to, air fluidized, low air loss therapy beds, flotation, water, or bubble mattress/pad placed on bed. • Does not include egg crate mattresses. • A description of the treatment/intervention must be documented.
M5c	Turning/ Repositioning Program	<ul style="list-style-type: none"> • Includes, but not limited to, a continuous, consistent program for changing the resident's position and realigning the body • <u>"Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."</u> • A description of the treatment/intervention must be documented.
M5d	Nutrition/ Hydration Interventions	<p>These are dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.</p> <ul style="list-style-type: none"> • A description of the treatment/intervention must be documented.
M5e	Ulcer Care	<ul style="list-style-type: none"> • Includes any intervention for treating an ulcer at any ulcer stage (e.g., the use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy) • A description of the treatment/intervention must be documented.

M5f	Surgical Wound Care	<ul style="list-style-type: none"> • Includes any interventions for treating or protecting any type of surgical wound (e.g., topical cleansing, wound irrigation, application of antimicrobial ointments, dressings of any type, suture removal, warm soaks, or heat application) • A description and the frequency of the specific care/treatment must be documented.
M5g	Dressings (other than to feet)	<ul style="list-style-type: none"> • Includes, but not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles • A description and the frequency of the specific care/treatment must be documented
M5h	Ointments/ Medications (other than to feet)	<ul style="list-style-type: none"> • Includes, but not limited to, ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.) • This does not include ointments used to treat non-skin conditions (e.g., Nitropaste for chest pain. • A description and the frequency of the specific care/treatment must be documented.
M6b	Infection of Foot	<ul style="list-style-type: none"> • Includes, but not limited to, cellulitis and purulent drainage • Does not include infection of the ankle • A description of the infection must be documented.
M6c	Open Lesion Foot	<ul style="list-style-type: none"> • Includes, but not limited to, cuts, ulcers, fissures • Does not include an open lesion on the ankle • A description of the lesion must be documented.
M6f	Foot Dressing	<ul style="list-style-type: none"> • <u>This includes</u>, but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings and dressings with hydrocolloid or hydroactive particles • <u>This does not include a dressing applied to the ankle</u> • A description and the frequency of the specific care/treatment must be documented.
O3	Injections	<ul style="list-style-type: none"> • This includes any type of medication, antigen, vaccine, by subcutaneous, intramuscular, or intradermal injection • A description that includes the name of the drug, amount given, route, and time must be documented.

P1b	Therapies	<ul style="list-style-type: none"> • Must be performed by a qualified therapist (i.e., one who meets State credentialing requirements or, in some instances, under such a person's supervision). • Nursing administration, in conjunction with the physician and licensed therapist, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents. • Includes only medically necessary therapies furnished after admission to the nursing facility. • Includes only therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. • The therapy may occur either inside or outside the facility. • Transdermal Wound Stimulation (TEWS) treatment for wounds can be coded when complex wound care procedures, requiring the specialized skills of a licensed therapist, are ordered by a physician. However, routine wound care, such as applying/changing dressings, should not be coded as therapy, even when performed by therapists. • Code only actual minutes the resident spent receiving therapy. Do not code therapist evaluation time, preparation or equipment adjusting, or set up time. • Does not include groups of more than four residents per supervising therapist. • Historically, units of therapy time have been used for billing and have been derived from the actual therapy minutes. For MDS reporting purposes, conversion from units to minutes is not appropriate and the actual minutes are the only appropriate measures that can be counted for completion of Item P1b. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
P1ba	Speech Therapy	Services that are provided by a licensed speech-language pathologist.
P1bb	Occupational Therapy	Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others giving therapy. Include services provided by a qualified OT assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direct supervision of a licensed occupational therapist.
P1bc	Physical Therapy	Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapist assistant may provide therapy but not supervise others giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direct supervision of a licensed physical therapist.

P1bd	Respiratory Therapy	<p>Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). A trained nurse refers to a nurse that has been specifically trained on the administration of respiratory treatments and procedures.</p> <ul style="list-style-type: none"> • Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional. • Does not include hand held nebulizers. • Count only the time that the qualified professional spends with the resident. • <u>Respiratory therapy must meet all of the requirements of other specialized therapies.</u>
P3	Nursing Rehabilitation/ Restorative Care	<ul style="list-style-type: none"> • A nursing rehabilitative or restorative care program refers to nursing interventions that assist or promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial function. (<u>"Program" is defined as " a specific approach that is organized, planned, documented, monitored, and evaluated."</u>) • There must be an individualized structured program with measurable objectives, goals, and interventions that is documented in the care plan and the clinical record. • These activities are carried out or supervised by members of the nursing staff. • The staff providing this program must be trained in techniques that promote resident involvement. • A periodic evaluation by a licensed nurse specifically trained in these procedures must be present in the clinical record. • This does not include exercise groups with more than four residents per supervising helper or care giver. • For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The time provided for Items P1a-k must be coded separately, in time blocks of 15 minutes or more. For example, to check Item P3a, 15 or more minutes of PROM must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift); however, 15-minute time increments cannot be obtained by combining P3a, P3b, and P3c. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero ("0") if none.
P3a	Passive Range of Motion	<ul style="list-style-type: none"> • Exercises performed by staff that are planned, scheduled, and documented in the clinical record • The resident provides no assistance. • Does not include passive movement by a resident that is incidental to dressing, bathing, etc.

P3b	Active Range of Motion	<ul style="list-style-type: none"> Exercises performed by a resident, with cuing or supervision by staff, that are planned, scheduled, and documented in the clinical record. Does not include active movement by a resident that is incidental to dressing, bathing, etc.
P3c	Splint or Brace Assistance	<ul style="list-style-type: none"> Assistance can be of two types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assessing the resident's skin and circulation under the device, and repositioning the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record
P3d	Bed Mobility Training and Skill Practice	<ul style="list-style-type: none"> Activities used to improve or maintain the resident's self performance in moving to and from a lying position, turning side to side, and positioning self in bed These sessions are planned, scheduled, and documented in the clinical record
P3e	Transfer Training and Skill Practice	<ul style="list-style-type: none"> Activities used to improve or maintain the resident's self performance in moving between surfaces or planes either with or without assistance These sessions are planned, scheduled, and documented in the clinical record.
P3f	Walking Training and Skill Practice	<ul style="list-style-type: none"> Activities used to improve or maintain the resident's self performance in walking, with or without assistive devices. These sessions are planned, scheduled, and documented in the clinical record.
P3g	Dressing/ Grooming Training and Skill Practice	<ul style="list-style-type: none"> Activities used to improve or maintain the resident's self performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks These sessions are planned, scheduled, and documented in the clinical record.
P3h	Eating/ Swallowing Training and Skill Practice	<ul style="list-style-type: none"> Activities used to improve or maintain the resident's self performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth These sessions are planned, scheduled, and documented in the clinical record
P3i	Amputation / Prosthesis Care Training and Skill Practice	<ul style="list-style-type: none"> Activities used to improve or maintain the resident's self performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body These sessions are planned, scheduled, and documented in the clinical record.

P3j	Communication Training and Skill Practice	<ul style="list-style-type: none"> • Activities used to improve or maintain the resident's self performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices • These sessions are planned, scheduled, and documented in the clinical record.
P7	Physician Visits	<p>To record the number of days during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago).</p> <ul style="list-style-type: none"> • Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity. • Documentation of the physician's evaluation should be included in the clinical record. • Physicians include a M.D., Osteopath, Podiatrist, or Dentist who is either a primary physician or consultant. • Include visits made by an authorized physician's assistant or nurse practitioner (who is not employed by the facility) working in collaboration with the physician • Do not include Medicine Men or Psychologists (PhD) • Visits must be documented in the clinical record. • Does not include exams conducted in the Emergency Room as part of an unscheduled emergency room visit. • <u>Do not count days of a physician examination prior to the date of admission or re-entry.</u>
P8	Physician Orders	<p>To record the number of days during the last 14-day period a physician has changed the resident's orders (or since admission if less than 14 days ago).</p> <ul style="list-style-type: none"> • Physicians include a M.D., Osteopath, Podiatrist, or Dentist who is either a primary physician or consultant. • Include orders written by an authorized physician assistant or nurse practitioner (who is not employed by the facility) working in collaboration with the physician. • Includes written, telephone, fax, or consultation orders for new or altered treatment • Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without change • Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. • <u>Do not count days with orders prior to the date of admission or re-entry.</u>

S6a	Chemotherapy	<ul style="list-style-type: none"> • Includes any type of chemotherapy medication given by any route • The chemotherapy must be given for the treatment of cancer. • Does not include chemotherapy that is given for reasons other than the treatment of cancer (e.g., Megace for appetite stimulation) • Documentation must include the monitoring of the side effects associated with the chemotherapy. • <u>The medication administration must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>
S6b	Dialysis	<ul style="list-style-type: none"> • Includes, but is not limited to peritoneal or renal dialysis • Documentation must include the monitoring of side effects as well as the time and type of dialysis
S6c	IV Medications	<ul style="list-style-type: none"> • Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port • Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medications • Documentation must include the time, type, frequency, and method of administration • <u>Epidurals, intrathecal, and baclofen pumps may be coded here.</u> • <u>Medication administration must be consistent with physician and interdisciplinary notes, and the resident's plan of care.</u> • <u>Do not include IV medications that were administered during dialysis or chemotherapy.</u>
S6g	Oxygen	<ul style="list-style-type: none"> • Includes continuous or intermittent oxygen via mask, cannula, etc. • Does not include hyperbaric oxygen for wound therapy • Documentation must include the method of administration, time, and amount • <u>The oxygen administration must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>
S6h	Radiation Treatments	<ul style="list-style-type: none"> • Includes receiving radiation therapy or having a radiation implant • Documentation must include the type, method of administration, time, and amount • <u>The radiation treatment must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>
S6i	Suctioning	<ul style="list-style-type: none"> • Includes <u>nasal, pharyngeal, nasopharyngeal</u> and tracheal suctioning • Does not include suctioning of the oral cavity • Type, frequency, and results of suctioning must be documented • <u>The treatment must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>
S6j	Tracheostomy Care	<ul style="list-style-type: none"> • Includes the cleansing of the tracheostomy site, cleansing of the tracheostomy cannula, and dressings to the site • Documentation must include the specific type or description of the tracheostomy care • <u>The treatment must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>

S6k	Transfusions	<ul style="list-style-type: none"> • Includes transfusions of blood or any blood products (e.g., platelets) • Documentation must include time, type, amount, and the monitoring of side effects • <u>The treatment must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>
S6l	Ventilator/ Respirator	<ul style="list-style-type: none"> • Includes any type of electrically or pneumatically powered closed system mechanical life support devices • Does not include CPAP or BIPAP • Documentation must include the type of ventilatory device used and the frequency of use • <u>The treatment must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>
S7a	Parenteral/IV	<ul style="list-style-type: none"> • Includes intravenous fluids or hyperalimentation given continuously or intermittently • Includes IV fluids given at a keep open rate (KVO) • <u>Include only fluids administered for nutrition or hydration</u> • Fluids must have been given for a nutritional purpose • Documentation must include type, time, amount, and rate of administration • <u>Do not include fluids administered solely as flushes or for the reconstitution of medications for IV administration.</u> • <u>Do not include parenteral/IV fluids administered during chemotherapy or dialysis.</u> • <u>The treatment must be consistent with physician and interdisciplinary notes and the resident's plan of care.</u>