

RAI Spotlight



DEPARTMENT OF
HEALTH



MDS Observation Periods

Observation periods are defined for every item on the MDS. The most common is the 7-day observation period which includes the full 24 hours of the Assessment Reference Date and the prior six days. The facility is responsible for selecting an MDS item response based on events of the full observation period even if the resident was not in the facility on those days. The following quotations from the RAI Manual detail this very clearly:

“If desired by the facility, the MDS could be completed in entirety on the day of admission. However, this requires the staff to rely on resident and family reporting of information and transfer documentation to a large degree as a source of information on the resident’s status during the time periods used to code each MDS item, as opposed to allowing a period for facility observation.” (Page 2-4).
“The ARD is not altered if the

beneficiary is out of the facility for a temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary’s temporary absence (when permitted under MDS coding guidelines – see Chapter 3) but may not extend the observation period.” (Page 2-38/PPS)
“The observation period may not be extended simply because a resident was out of the facility during a portion of the observation period; e.g., a home visit or therapeutic leave. For example, if the ARD is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. When collecting assessment information, you may use data from the time period of the LOA as long as the particular MDS
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Questions about the RAI? Suggestions about Teleconference Topics?

Please submit them to qa-mds@state.pa.us

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Section J2/3 Pain Teleconference

Date: January 8, 2009
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: J2/3 Pain Symptoms/Site
Handouts: Power Point slides will be available about January 5 on the DOH Message Board at
<http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp>
Call in number: 1-888-694-4728 or 1-973-582-2745
Conference ID Number: 73532827

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for accessing this will be posted on the DOH Message Board.

Additional questions: qa-mds@state.pa.us





Section P4 Restraints Q & A

On October 9, 2008, a training teleconference was provided on Section P4 Devices and Restraints. For all the situations presented, the facility should be care planning and documenting very well. The following questions were received:

Q: We are using half siderails on both sides of the bed for a resident who cannot get out of bed independently. She uses the rails to reposition herself in bed but cannot put the rails down. Are they restraints?

A: *No; they are not preventing her from doing something she could do otherwise.*

Q: A non-ambulatory resident sits in a wheelchair and the resident wears a seat belt across their lap to keep their hips positioned correctly. The resident cannot open the belt and it does not stop the resident from doing anything they normally could do. Is this a restraint?

A: *Since she is non-ambulatory, we assume that she is unable to get out of any chair. The seat belt is being used as a positioning device, and is not preventing the resident from doing anything she can do otherwise. It would not be considered a restraint.*

Q: An ambulatory resident has one side rail on the bed. The siderail does not hinder the resident's ability to get out of bed. The resident uses the rail to hold onto when getting out of bed or doing a self transfer. The resident cannot lower the rail. Is this a restraint?

A: *No. The siderail is not preventing her from doing anything she wants to do even though she cannot lower the siderail. If she could not get out of bed without lowering the siderail and was unable to do that, then it would be a restraint.*

Q: You quoted from a CMS Survey and Certification Letter during the presentation. Where can it be found? What does it say?

A: *S&C-07-22 titled Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities was released June 22, 2007 at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf. The definition of physical restraints found in the SOM is "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." This letter attempted to clarify some of the terms used in this definition.*

"Freedom of Movement" means any change in place or position for the body or any part of the body that the person is physically able to control.

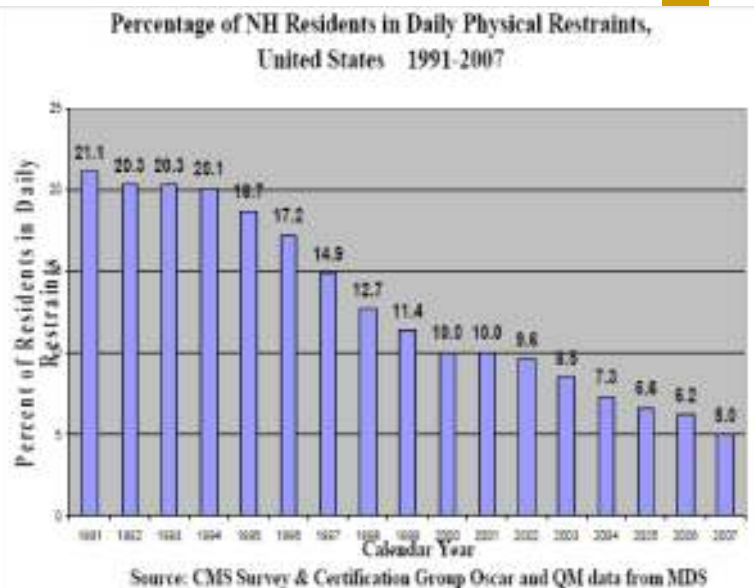
"Remove Easily" means that the manual method, device, material or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the resident's physical condition and ability to accomplish the objective, (e.g., transfer to a chair, get to the bathroom on time).

"Medical Symptom" is defined as an indication or characteristic of a physical or psychological condition...Before a resident is restrained, the facility must determine that the resident has a specific medical symptom that cannot be addressed by another, less restrictive intervention and a restraint is

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Restraint Reduction Success!

On November 7, 2008, CMS released a report "Freedom from Unnecessary Physical Restraints: Two Decades of National Progress in Nursing Home Care." (www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-11.pdf) This report traces the initiatives that have been put in place since OBRA '87 giving "credit for critical advances in reduction of daily restraints...to the dedicated consumer advocates, professionals, and nursing home staff who carefully cultivated a better understanding of methods to work with NH residents to attain... the highest practicable physical, mental and psychosocial well-being of each resident... We owe our thanks and respect to such individuals." The graph details what has been accomplished!





UMR Baseline Reviews

The UMR teams have completed their annual Baseline reviews based on the certified CMI Reports for February 1, 2008. In each facility participating in the Medical Assistance program, 20 records were selected from that report and all positive RUG items (those with a response that might affect RUG classification) were reviewed to assure that "...the Federally approved PA specific MDS data for each resident accurately describes the resident's condition, as documented in the resident's clinical record maintained by the nursing facility." (PA Title 55 Chapter 1187.33 (2)). Of the 227,231 positive RUG items reviewed, 14,517 were found to be unsupported by the clinical record. The overall state RUG Element Error Rate is 6.39%; this is slightly increased from the 2007 rate of 6.36%.

What RUG items were most often found to be unsupported? The following table lists the elements that were reviewed at least 1,000 times and have an error rate greater than 10%.

MDS Item	Description	Times Reviewed	Times Unsupported	Error Percentage
H3a	Toileting Program (14)	2,615	637	24.36
P3b	ROM Active	2,085	420	20.14
P3a	ROM Passive	1,277	247	19.34
P3f	Walking	1,860	315	16.94
N1c	Awake all/most of evening	2,501	407	16.27
P8	Physicians Orders (14)	10,364	1,665	16.07
N1b	Awake all/most of afternoon	2,653	383	14.44
P3g	Dressing/Grooming	1,466	202	13.78
N1a	Awake all/most of morning	1,859	248	13.34
I2j	UTI (30)	1,625	202	12.43

For further guidance beyond the RAI Manual, CMS has posted Tip Sheets on several of these items which are available at www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage



MDS Observation Period

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item allows you. For example, Section P7, if the family takes the resident to the physician, the visit may be counted. For information on coding minutes of therapy while the resident is out of the SNF, see pages 3-185 and 3-186. This procedure applies to all assessments, regardless of whether or not they are being completed for clinical or payment purposes." (Page 3-31)

The only time it is acceptable to use a shortened observation period occurs when the resident dies or is discharged prior

to the end of the observation period. The ARD must be adjusted to equal the discharge date. The facility may choose to "Change the ARD to the date of discharge, but complete the MDS using less than a full observation period. In this case, the Assessment Reference Date had been set at Day 5, and the resident was discharged after 4 days of the observation period. For items with a 7-day observation period, the MDS would be completed using the data collected for the 4-day period in the nursing facility and the 2-day period prior to admission." (Page 3-30) In any other circumstances, the facility is responsible for selecting a response to an MDS item that reflects the resident's status throughout the defined observation period.

Teleconference Q & As



(Continued from page 2)

required to treat the medical symptom, protect the resident's safety, and help the resident attain or maintain his or her highest level of physical or psychological well-being... Falls do not constitute self-injurious behavior or a medical symptom that

warrants the use of a physical restraint... There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent or reduce falls.