201. RESIDENT ASSESSMENT

3. A written comprehensive plan of care has been developed and maintained except for those exempted under Section 204; and

C. ACTIVITIES OF DAILY LIVING (ADL) AND SCORING FOR DEPENDENCIES.

Each ADL shall be addressed individually in the medical record. Blanket statements such as, "Dependent in all ADL's," shall not be acceptable.

ADL's shall be coded using nursing summaries, nurse's notes, checklists, etc. The coding shall reflect the trend of the charting. In cases where both the nursing summary and the daily information are not consistent, the daily shall override.

201. RESIDENT ASSESSMENT

In addition, a dependency in one (1) ADL shall not necessarily indicate a dependency in another area. When a checklist is used to assess individual ADL's and there is more than one (1) area checked under the same ADL, if the information is conflicting, and there is no other clarifying information available, the least dependent status indicated shall be used to score the resident. Reviewers shall not normally research ADL information beyond one (1) month prior to the target date. When the ADL information cannot be found within this one (1) month reference period, the resident shall be scored as "0" (independent) for that ADL.

The following lists the eight (8) Key Activities of Daily Living and a description of what each score represents. Scores have been segregated based upon whether or not they indicate that a dependency exists.

1. DRESSING (Scored from 0 through 4)

   Resident is Not Dependent If Scored As Follows:

   0. Chooses and puts on own clothes

   1. Clothes picked out for resident, minimal supervision required

201. RESIDENT ASSESSMENT

Resident Is Dependent If Scored As Follows:

2. Receives active help of another person

3. Totally dressed by staff (unable to participate)

4. Bed attire Code for bedfast residents only

2. GROOMING (Scored 0 through 3)

Resident Is Not Dependent If Scored As Follows:

0. Keeps self neat and clean

1. Grooms self with supervision

Resident Is Dependent If Scored As Follows:

2. Receives daily assistance of another person

3. Receives total grooming by another person (unable to participate)

3. BATHING (Scored 0 through 5)

Resident Is Not Dependent If Scored As Follows:

0. Self

1. Receives supervision with some prompts and reminders

2. Receives supervision with prompting and reminding for entire bath.

201. RESIDENT ASSESSMENT

3. Receives assistance to get into and out of tub

Resident Is Dependent If Scored As Follows:

4. Receives personal help of assisting with feet, back, perineal care, etc.

5. Completely unable to bath self

4. EATING (Scored 0 through 4)

Resident Is Not Dependent If Scored As Follows:

0. Feeds self (without need of set up assistance)

1. Feeds self but receives prompting or reminding

Resident Is Dependent If Scored As Follows:

2. Receives help to cut meat and arrange food within reach, butter bread, etc., at the time meal is delivered.

3. Fed part of each meal or observed during entire meal due to risk of occasional gagging or choking

4. Fed all food by staff (Include Tube Feeding)

201. RESIDENT ASSESSMENT

5. BED MOBILITY (Scored 0 through 3)

Resident Is Not Dependent If Scored As Follows:

0. Turns and sits up in bed by self
1. Occasional help to turn and sit up

Resident Is Dependent If Scored As Follows:

2. Always receives help to turn and sit up
3. Turned and repositioned by staff

6. TRANSFERRING (Scored 0 through 4)

Resident Is Not Dependent If Scored as Follows:

0. Transfers independently (with or without mechanical device)
1. Requires physical presence of another person during transfer, needs and receives guidance only

Resident Is Dependent If Scored As Follows:

2. Transfers with aid of one (1) person
3. Transfers with aid of two (2) persons or total transfer mechanical device
4. Remains bedfast

201. RESIDENT ASSESSMENT

7. AMBULATION (Scored 0 through 4)

GUIDANCE TO A DESTINATION DOES NOT CONSTITUTE A DEPENDENCY IN WALKING

Resident Is Not Dependent If Scored as Follows:

0. Independent

1. Requires the help of a device (cane, walker, crutch)

Resident is Dependent If Scored As Follows:

2. Personal help of one (1) person

3. Personal help of two (2) persons

4. Unable to walk

8. TOILETING (Scored 0 through 6)

The following scoring is used except when the resident has a catheter and is continent of bowel or has an ostomy and is continent of urine in which case the resident shall receive a code of 0. However, if a continent resident with either a catheter or ostomy or both receives help to toilet, they shall received a code of 1.

201. RESIDENT ASSESSMENT

Resident Is Not Dependent If Scored As Follows:

0. Continent (include resident who manages the problem of dribbling)

Resident Is Dependent If Scored As Follows:

1. Receives help to toilet, no incontinence
2. Occasional incontinence, not more than once a week (Includes resident who receives help because of dribbling). A leaking catheter is not dribbling.
3. Nocturnal incontinence only
4. Incontinent bladder, more than once per week
5. Incontinent bowel, more than once per week (Include resident with ostomy bag that leaks more than once per week)
6. Incontinent of both bowel and bladder.

201. RESIDENT ASSESSMENT

D. CRITERIA FOR BEHAVIOR. For residents with present behavioral problems requiring intervention, the medical records for Behavior shall establish that:

1. The behavior problem(s) have been identified and specifically described. General statements such as "can be combative" shall not meet the criteria. The reviewer shall be able to ascertain from the record what behavior occurred and the surrounding circumstances leading to the need for behavior intervention;

2. The resident's behavior has been assessed by a physician;

3. A written plan of intervention addressing the behavioral problem has been developed;

4. Progress notes indicating the resident's response to treatment have been recorded in descriptive terms by licensed nurses;

The code shall be 0 when criteria 1-4 are not met.

201. RESIDENT ASSESSMENT

E.. RATING BEHAVIOR NEEDS (Scored from 0 through 4). The resident shall be assigned one (1) of the following scores based upon which one best describes the resident's current behavior.

0. Behavior requires no intervention.

1. Requires occasional intervention in the form of cues. Resident responds to cues.

2. Requires regular staff intervention in the form of redirection. Resident is resistive, but responds to redirection as stated in the plan of care.

3. Requires behavioral management and staff intervention. Resident is resistant to redirection as stated in the plan of care.

4. Requires behavioral management and staff intervention because resident is physically abusive to self and others. Resident physically resists redirection.

201. RESIDENT ASSESSMENT

F. CRITERIA FOR SPECIAL TREATMENTS. These are procedures that are special nursing needs rather than routine care needs. In order to establish that a resident is receiving Special Nursing Treatments, the medical record shall establish that:

1. The physician has performed a medical evaluation identifying the high risk or unstable medical condition requiring special nursing treatment, with written orders for the treatment which are signed within fourteen (14) days of the receipt of the order.

2 A registered nurse, following the plan of care, may delegate the medical and nursing functions to other team members and coordinates the care.

3. A registered nurse reassesses quarterly.

201. RESIDENT ASSESSMENT

G. DEFINITION OF SPECIAL NURSING TREATMENTS. Listed below are the Special Nursing Treatments along with their definitions:

1. Tube Feeding. This includes any type of tube current being used to deliver food or nutritional substances directly into the gastrointestinal system.

2. Oxygen and Respiratory Therapy. Special nursing measures to improve respiratory function include postural drainage, nebulizers, IPPB, respirators, suctioning, and oxygen.

3. Ostomy/Catheters. If more extensive than routine ostomy or catheter care. Catheter care is coded only when it is more extensive that the normal care. Normal catheter care include such activities as changing the catheter, emptying the bag, cleaning the outlet and monitoring the intake and output.

4. Wound or Pressure Ulcer of stage two or greater.

   Only includes therapeutic measures; not preventative measures.

201. RESIDENT ASSESSMENT

Wound is defined as more than a simple redness or abrasion.

Stage two pressure ulcer is defined as a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

5. Skin Care. Skin care is defined as a recognized therapeutic measure in response to an identifed High Risk or Unstable condition which is related to a medical condition. Preventative skin care is not coded.

6. Rehabilitative Procedures. Rehabilitative procedures are to be included if used for RESTORATIVE measures only (do not include maintenance measures). Progress notes shall reflect progress toward the goal, as stated on the plan of care.

   These procedures may also be carried out as follow-up to a specific physical therapy program.

201. RESIDENT ASSESSMENT

In addition, physician-prescribed programs which are not a follow-up to a physical therapy program may also be considered to be rehabilitative procedures. Rehabilitative procedures shall be aimed at restoring a skill which has been functionally lost or compromised to the point of becoming dysfunctional.

7/8. Toileting (Bowel or Bladder Rehabilitation Program). The medical record shall establish that there is potential for bowel or bladder rehabilitation. Progress notes shall reflect progress toward the goal as stated on the plan of care. The approach shall be more comprehensive than scheduled toileting.

9. Hyperalimentation

10. Intravenous fluids

11. Intravenous medications

12. Blood transfusions

201. RESIDENT ASSESSMENT

13. Drainage tubes (tubes which drain secretions other than normal body fluids)

14. Symptom Control for the Terminally Ill. Symptom control for the terminally ill means a program designed by a physician, registered nurse and the resident, for ongoing management of pain, nausea or other disabling symptoms. The medical record shall establish that a terminal illness has been diagnosed by the physician.

15. Isolation Precautions - Isolation may be coded as special nursing treatment when nursing procedures are required and used which are over and above universal precautions as defined by the Center for Disease Control (CDC) for clients who have an identified high risk or unstable condition and meet the other criteria for special treatment. Cohorting without isolation precautions in excess of universal precautions shall not warrant isolation coding.

201. RESIDENT ASSESSMENT

H. CRITERIA FOR CLINICAL MONITORING. In order to receive case mix credit, Special Nursing Treatment Clinical Monitoring shall take place on every shift (with the exception of Tube Feedings.)

Clinical monitoring includes nursing observations emanating from the resident's DIAGNOSIS and Medically Unstable or High Risk Condition(s).

The medical record shall establish that:

1. The physician has identified the unstable condition for which the clinical monitoring is needed. The physician may use a progress note, a doctor's order, or another method as long as the condition has been identified as unstable or high risk. The plan of care shall not be acceptable as a method of identification of the unstable condition. The plan of care shall be developed from the identification of the unstable condition.

2. A registered nurse has assessed the high risk condition. The R.N. assessment of the high risk condition may be a progress note, statement on the checklist, nurse's note, or other written indication.

201. RESIDENT ASSESSMENT

3. A written plan for clinical monitoring has been developed; and is included on the comprehensive plan of care (individually or in conjunction with a special treatment).

4. Systematically recorded measurements of the status of the high risk condition directly related to the special nursing treatment have been made (may be collected by any member of the nursing staff).

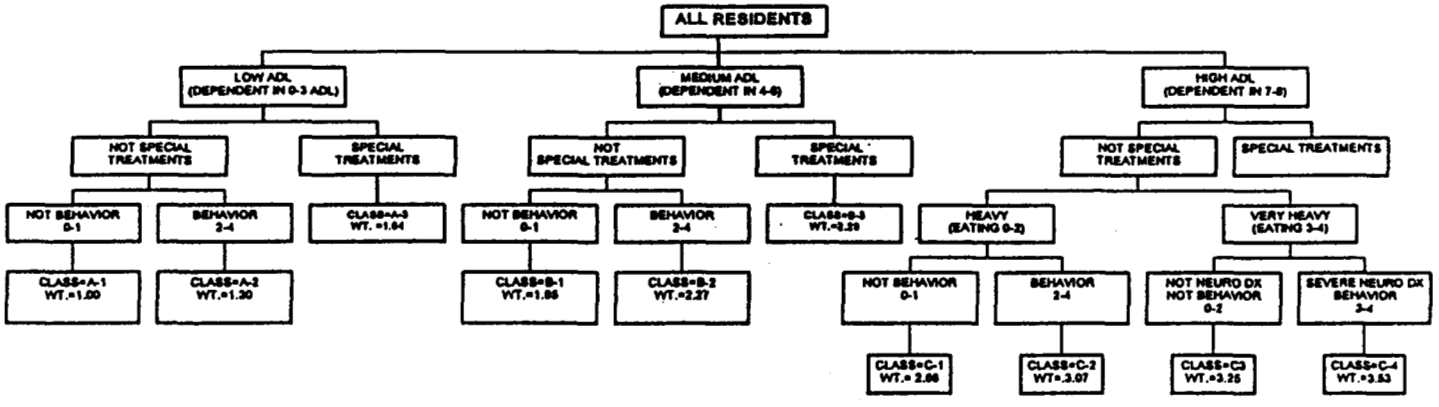
5. Scoring of Clinical Monitoring

   0. Less than once a day

   1. Less than all shifts each day

   2. Monitoring on every shift

RESIDENT CLASSIFICATION SYSTEM DECISION TREE



KEY ACTIVITIES OF DAILY LIVING (ADLs)

	Not Dependent	Dependent
Dressing	0-1	2-4
Grooming	0-1	2-3
Bathing	0-3	4-5
Eating	0-1	2-4
Bed Mobility	0-1	2-3
Transferring	0-1	2-4
Ambulation	0-1	2-4
Toileting	0	1-6

202. RESIDENT NURSING ASSESSMENT CLASSIFICATION

A. ADL Categories. Review scores on the eight (8) Key Activities of Daily Living (ADL) determine the total number of ADL in which the resident is considered dependent. ADL and dependency scores are as follows:

ADL	Not Dependent	Dependent
Dressing	0-1	2-4
Grooming	0-1	2-3
Bathing	0-3	4-5
Eating	0-1	2-4
Bed Mobility	0-1	2-3
Transferring	0-1	2-4
Ambulation	0-1	2-4
Toileting	0	1-6

Based on the number of Key Activities of Daily Living (ADL) in which the resident is considered dependent, the resident is categorized as follows:

	Dependent In	ADL Category
LOW ADL	0-3 ADL	A
MEDIUM ADL	4-6 ADL	B
HIGH ADL	7-8 ADL	C

202. RESIDENT NURSING ASSESSMENT CLASSIFICATION

B. CASE MIX CLASSIFICATION AND WEIGHTS. The following describes how each of the eleven (11) case mix classifications and corresponding weights are determined.

1. If the resident receives Special Nursing Treatment and Clinical Monitoring is scored as a "2" (Clinical Monitoring is not necessary for tube feeding), then the Case Mix Classification and weight shall be as follows:

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
A	A-3	1.64
B	B-3	2.29
C	C-5	4.12

202. RESIDENT NURSING ASSESSMENT CLASSIFICATION

2. If the resident is ADL Category "A" or "B", does not receive Special Nursing Treatment along with Clinical Monitoring on all three shifts, is not receiving tube feeding, and behavior has a score of 2 or more; then the Case Mix Classification and Weight shall be as follows:

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
A	A-2	1.30
B	B-2	2.27

3. If the resident is ADL Category "A" or "B", does not receive Special Nursing Treatment along with Clinical Monitoring on all three shifts, is not receiving tube feeding, and behavior has a score of less than 2; then the Case Mix Classification and Weight shall be as follows:

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
A	A-1	1.00
B	B-1	1.95

202. RESIDENT NURSING ASSESSMENT CLASSIFICATION

4. If the resident is ADL Category "C", does not receive Special Nursing Treatment along with Clinical Monitoring on all three shifts, is not receiving tube feeding, has a score of less than 3 in eating, and does not have a behavior score of 2 or more; then the Case Mix Classification and Weight shall be as follows:

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
C	C-1	2.56

5. If the resident is ADL Category "C", does not receive Special Nursing Treatment along with Clinical Monitoring on all three shifts, is not receiving tube feeding, has a score of less than 3 in eating, and does have a behavior score of less than 2 or more; then the Case Mix Classification and Weight shall be as follows:

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
C	C-2	3.07

202. RESIDENT NURSING ASSESSMENT CLASSIFICATION

6. If the resident is ADL Category "C", does not receive Special Nursing Treatment along with Clinical Monitoring on all three shifts, is not receiving tube feeding, has a score of 3 or more in eating, and does not have a behavior score greater than 2 or one of the following neuromuscular diagnoses taken from the Publication "International Classification of Diseases," 9th revision, Clinical Modification, (ICD-9-CM):

Diseases of nervous system excluding sense organs
(Codes 320-359 excluding 331.0)

Cerebrovascular Diseases (Code 430-438 excluding 437)

Fracture of skull (Codes 800-804) excluding cases without intracranial injury

Intracranial injury, excluding those with skull fractures (Codes 850-854)

Fracture of vertebral column with spinal cord injury (Code 806)

Spinal cord injury without evidence of spinal bone injury (Code 952)

Injury to nerve roots and spinal plexus (Code 953)

Neoplasms of the brain and spine (Codes 170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6)

Then the Case Mix Classification and Weight shall be as follows"

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
C	C-3	3.25

202. RESIDENT NURSING ASSESSMENT CLASSIFICATION

7. If the resident is ADL Category "C", does not receive Special Nursing Treatment along with Clinical Monitoring on all three shifts, is not receiving tube feeding, has a score of 3 or more in eating, and has either a behavior score of more than 2 or else has one of the neuromuscular diagnoses previously listed; then the Case Mix Classification and Weight shall be as follows:

ADL CATEGORY	CASE MIX CLASSIFICATION	CASE MIX WEIGHT
C	C-4	3.53

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

Data is collected in the following areas for statistical and informational purposes only, and with the exception of Diagnosis does not affect classification and reimbursement:

A. Facility Name.

B. Vendor Number. The eight (8)-digit facility number provided by the Department for Medicaid Services.

C. Recipient's Name. Names shall not be abbreviated. Letters shall be filled in the blocks consecutively.

D. Sex. Enter M for male and F for female.

E. Primary Payor. This is a deleted field and is not being used.

F. Resident Number. Enter the resident's Medicaid number. For residents in pending Medicaid status, enter the letter P and the Social Security Number.

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

G. Primary, First Secondary and Second Secondary Diagnosis.

This information is taken from the resident records; however, to facilitate accurate recording on the assessment document, the facility shall clearly list on the face sheet or the Minimum Data Set in each resident's chart the three (3) most current diagnoses. This shall include any neurodiagnoses. It shall be each facility's responsibility to insure that information relating to diagnoses can easily be found by the PRO reviewer. Reviewers shall use conversion codes to code diagnoses.

H. Date of Birth.

I. Date of Admission. Enter the date of the current admission to the nursing facility. A readmission after a hospital stay shall not constitute a new admission unless the hospital stay covers three or more midnight censuses.

J. Admitted From. Indicate the admission source using the following codes:

1. Home (personal residence) or personal care home

2. Hospital

3. Another Long Term Care Facility
4. Facility for Mentally Retarded
5. Psychiatric Facility

K. Physician's Statement of General Condition. The resident's condition shall be indicated using the following coding system:

1.` Stable at present
2. Unstable at present
3` Improving condition
4. Deteriorating condition
5. Terminally ill

L. Wheeling. This ADL (which is not used to determine classification) shall be scored as follows:

0. Receives no personal help with wheeling, or does not use a wheelchair
1. Requires help negotiating doorways, elevators, ramps, locking or unlocking brakes.
2. Requires total help with wheeling.

Geri chairs, with wheels, shall be considered wheelchairs.

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

M. Communication. This ADL (which is not used to determine classification) shall be scored as follows:

0. Communicates needs and can be understood.
1. Communicates needs with difficulty but can be understood.
2. Communicates with sign/body language, written messages, gestures or other means. Resident understood but communication is very limited.
3. Communicates inappropriate content/garbled sounds/echolia. Cannot be understood.
4. Unable or does not communicate.

N. Hearing (with hearing aid if used). This area (which is not used to determine classification) shall be scored as follows:

0. Adequate
1. Hearing difficulty at level of conversation
2. Hears only very loud sounds
3. No useful hearing
4. Not determined.

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

O. Vision (with glasses if used). This item (which is not used to determine classification) shall be scored as follows:

0. Adequate
1. Difficulty seeing printed material
2. Difficulty seeing objects in environment
3. Has no useful vision
4. Not determined.

P. Orientation. Orientation is defined as awareness of individuals to their present environment as it relates to time, place and persons. This item (which is not used to determine classification) shall be scored as follows:

0. Oriented
1. Minor forgetfulness
2. Partial or intermittent periods of disorientation
3. Totally disoriented; does not know time, place or person
4. Comatose; not conscious, persistent vegetative state
5. Not determined

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

Q. Self-Preservation Skills

This item is included to determine whether the individual has the mental judgment and physical ability necessary to cope with a changing environment or a potentially harmful situation. This item (which is not used to determine classification) shall be scored as follows:

0. Independent
1. Minimal Supervision
2. Mentally unable
3. Physically unable
4. Both mentally and physically unable

R. Special Programs. These items shall not be used to determine classification.

A special program is a service provided by a qualified professional. There is a written treatment program designed specifically for the individual, including goals and specific time limitations. Progress notes are written by the professional providing the service.

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

Enter the number one (1) under No Program if the resident is not on a Special Program. If the resident is on a Special Program at the time of the review, enter a 1 in the appropriate box.

0. No program ordered

1. Speech Therapy

   Evaluation or treatment by a speech therapist or speech pathologist of a specific communication disorder.

2. Physical Therapy

   Specialized treatment by a licensed physical therapist to restore function, relieve pain and prevent disability following disease, injury or loss of body part. "Maintenance" programs are included.

3. Occupational Therapy

   Specialized restorative treatment by a registered occupational therapist involving use of sensory integration exercises, perceptual-motor techniques, skill practice and training for independence in activities of daily living and in social skills.

203. IDENTIFYING INFORMATION AND MISCELLANEOUS STANDARDS

4. Psychological/Behavioral Services

   Program directed by a licensed psychologist or behavior analyst designed to change behavior or explore feelings and attitudes.

5. Psychotherapy

   Face-to-face encounter with psychiatrist for evaluation, treatment or monitoring. (Do not code if service is limited to medication review.)

6. Respiratory Therapy

   Care provided by licensed staff to improve respiratory function. May include mini-nebulizers, IPPB, incentive spirometry, postural drainage, respirator, suctioning and oxygen.

S. Psychotherapeutic Drug Use. These items shall not be used to determine classification.

   Enter the appropriate code indicating drug orders.

Anti-Psychotic Tranquilizers (Major/minor)

0. None ordered

1. Ordered on a provide as needed (PRN) basis

2. Order on a regular, daily basis

Anti-Anxiety Tranquilizers

0. None ordered.

1. Ordered on a provide as needed (PRN) basis.

2. Ordered on a regular, daily basis

Anti-Depressant

0. None ordered.

1. Ordered on a provide as needed (PRN) basis.

2. Ordered on a regular, daily basis

Sedatives/Hypnotics

0. None ordered.

1. Ordered on a provide as needed (PRN) basis.

2. Ordered on a regular, daily basis

T. Medication Information: These items have no bearing on Resident Classification.

Medications: Enter the number of times administered on the target date; enter zero (0) if none. Example: If Micro K is given qid = 4 doses