

STATE-DEFINED SECTION S REFERENCE MANUAL

Section S is the State Defined Section of the MDS 3.0. It is to be completed with each MDS and is a requirement for Illinois.

S0161: Resident required the services and resided on a specialized unit during the last 14 days (14-day look back period).

Definitions

Special Care Unit - Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for those residing in that area.

Dementia/Alzheimer's Unit - A unit dedicated to cognitively impaired residents who have a diagnosis of Alzheimer's disease and/or dementia. The unit meets the criteria defined in 77 Ill. Adm. Code Part 300, Subpart U: Alzheimer's Special Care Unit or Center Providing Care to Persons with Alzheimer's Disease or Other Dementia.

Behavioral Health Unit - A unit dedicated to residents with severe, medically based behavior disorder which causes diminished capacity for judgment, retention of information or decision making skills. The unit shall have behavior intervention programs designed to reduce/control behaviors that may be distressing or disruptive to the resident, other facility residents, staff members or the care environment. The unit must have a specialized, documented program that increases staff interventions in an effort to enhance the resident's quality of life, functional and cognitive status. The unit shall meet criteria as defined in the Illinois Department of Public Health's (IDPH) rules and regulations and shall have the required staffing to meet the resident's needs.

Traumatic Brain Injury (TBI) Unit - A unit dedicated to residents diagnosed as TBI and may have behaviors which cause diminished capacity for judgment, retention of information or decision making skills. The unit shall have policies and procedures for caring for the residents. The facility shall have sufficient staff to meet the care for the resident and an environment that is aimed at reducing distractions for the TBI resident.

Ventilator Unit - A unit dedicated to residents requiring ventilator services. The unit shall have respiratory therapy staff available in-house 24 hours a day to meet the needs of the residents and at least one full-time professional nursing staff member who has completed a course in the care of the ventilator-dependent individuals. All criteria relating to ventilator care as identified in 89 Ill. Adm. Code Part 147 shall be met.

Steps for Assessment

1. Review the medical record (e.g., therapy records, treatment records, medication records, recreation therapy notes, physician notes and nursing notes) and consult with each of the qualified care providers to collect information required for these services.
2. Determine if the resident resided on the unit and services were provided to the resident, as required, during the 14 day look back period.
3. Interview staff and direct caregivers to determine what services were actually provided to the resident during the look back period.
4. Observe the resident to determine overall care needs and level of functioning.

Coding Instructions

Check all that apply.

S0161A: Dementia/Alzheimer's unit

S0161B: Behavioral Health unit

S0161C: TBI unit

S0161D: Ventilator Unit

S0161Z: None of the above

S0600: Resident has met the criteria identified and is eligible for enhanced Medicaid reimbursement (7-day look back period).

Definitions

Enhanced Rates - Payments made to nursing facilities for services provided to the resident with exceptional needs. For the purpose of this section, exceptional needs means ventilator care and traumatic brain injury care as identified in the 89 Ill. Adm. Code Part 147.335.

Exceptional Medical Care - This is defined as a level of care with extraordinary cost related to services, which may include physician, nurse, ancillary specialist services, medical equipment, and/or supplies that have been determined to be a medical necessity related to ventilator and traumatic brain injury services.

Traumatic Brain Injury (TBI) - For purposes of this section is defined as a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

Ventilator - For purposes of this section is defined as any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respirations. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

Steps for Assessment

1. Review the medical record (e.g., therapy evaluation, treatment records, respiratory therapy, recreational therapy notes, mental health professional progress notes, social service, behavioral tracking notes, physician notes and nursing notes) and consult with each of the qualified care providers to collect information required for these services.
2. Determine if all the services were provided to the resident, as required, during the 7-day look back period.
3. Interview staff and direct caregivers to determine what services were actually provided to the resident during the 7-day look back period.
4. Observe the resident to determine overall care needs and level of functioning.

Coding Instructions

Check all that apply.

Note: If the resident is on a ventilator continuously, check S0600B.

S0600A: Resident requires the use of a ventilator for a minimum of 10 hours in a 24 hour period.

S0600B: Resident requires the use of a ventilator for a minimum of 16 hours in a 24 hour period.

S0600C: Resident meets the criteria and is receiving services under TBI-Tier I.

S0600D: Resident meets the criteria and is receiving services under TBI-Tier II.

S0600E: Resident meets the criteria and is receiving services under TBI-Tier III.

S0600Z: None of the above

Coding Tips (TBI Facility)

The following criteria shall be met in order for a facility to qualify for TBI reimbursement.

- The facility shall have written policies and procedure for the care of residents with TBI and behaviors that include, but are not limited to, monitoring for behaviors, identified and reduction of agitation, safe and effective interventions for behaviors, and assessment of risk factors for behaviors related to safety of residents and staff. Staff shall be in-services on these policies.
- The facility shall have staff to complete the required physical (PT), occupational (OT) or speech therapy (SP), as needed. Additionally, a facility shall have staffing sufficient to meet the behavior, physical and psychosocial needs of the resident.
- Staff shall receive in-service for the care of a TBI resident and dealing with behavior issues identifying and reducing agitation, and rehabilitation for the TBI resident. In-service training shall be conducted at least annually. In-service documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.
- The facility environment shall be such that it is aimed at reducing distractions for the TBI resident during activities and therapies. This shall include, but not be limited to, avoiding overcrowding, loud noises, and lack of privacy, seclusion and social isolation.
- The care plans on all residents shall address the physical, behavioral and psychosocial needs of the TBI residents. Care plans shall be individualized to meet the resident's needs, and shall be revised as necessary.
- The facility shall use the "Rancho Los Amigos Cognitive Scale" to determine the level of cognitive functioning. The assessment shall be completed quarterly by a trained rehabilitation registered nurse.

Coding Tips (TBI Resident)

- There shall be documentation by a neurologist that the resident has a severe and extensive TBI diagnosis.
- The diagnosis shall meet the diagnosis as defined on Page 2.

- There shall be documentation the diagnosis has resulted in significant deficits and disabilities that required intense rehabilitation therapy. In addition, documentation from the neurologist shall identify the resident has the ability to benefit from rehabilitation and a potential for independent living.
- Diagnostic testing shall support the presence of a severe and extensive TBI as a result of external force.
- Documentation shall support the resident was assessed using the Rancho Los Amigos Cognitive Scale and scored a Level IV through X.
- Documentation shall support the resident is medically stable and has been assessed for potential behaviors and safety risk to self, staff and others.
- The injury shall have occurred within 6 months of the admission date.
- The resident shall meet the criteria in Tier III upon admission.

Coding Tips (TBI Tier III Resident)

This includes residents who had an injury resulting in TBI diagnosis within the prior six months and has high rehabilitation needs. Tier III shall not exceed 9 months. The following requirements shall be met.

- The resident shall have extensive deficits in physical functioning and require intensive rehabilitation needs.
- The resident shall score an IV through VII on the Rancho Los Amigos Cognitive Scale.
- The resident's BIMS is less than 13 or cognitive skills for decision making are moderately to severely impaired.
- There shall be documentation to support the facility is monitoring behaviors and has implemented interventions to identify the risk factors for behaviors and to reduce the occurrence of behaviors.
- The resident shall receive Rehabilitation therapy (PT, OT or ST) at least 500 minutes per week and at least one rehabilitation discipline 5 days per week (O0400). The therapy shall meet the RAI Manual guidelines for coding. The resident shall continue to show the potential for improvement in the therapy programs.
- The resident shall have trained rehabilitation staff on-site working with them on a daily basis. This shall include a trained rehabilitation nurse and rehabilitation aides. Documentation supports the resident requires a minimum of 6 to 8 hours per day of one-to-one support as a result of functional issues.
- Documentation shall support the interdisciplinary team meet weekly to discuss the resident's rehabilitation progress and potential.
- Documentation shall support the resident received psychological therapy at least 2 days per week. Documentation shall include a summary of the sessions, resident's progress and potential goals, and identify any revisions needed.
- There shall be documentation to support monthly oversight of the resident by a neurologist.
- The resident shall have a comprehensive medical and neuro-psychological assessment completed upon admission and quarterly. It shall include, but is not limited to, the following:

physical ability/mobility, motor coordination, hearing/vision/speech, behavior/impulse control, social functionality, cognition, safety needs, medical needs and communication needs.

Coding Tips (TBI Tier II Resident)

This includes residents who have reached a plateau in rehabilitation ability, but still require services related to TBI. Tier II shall not exceed 12 months. The resident must have previously been in Tier III. The following requirements must be met:

- The resident scores a Level IV through VII on the Rancho Los Amigos Cognitive Scale.
- The resident's BIMS is less than 13 or cognitive skills for decision making are moderately to severely impaired.
- The resident has behaviors and these behaviors impact or impact others. Behaviors shall be tracked daily and interventions implemented. There shall be documentation of weekly meetings with interdisciplinary staff to discuss behaviors, effectiveness of interventions and to implement revisions as necessary.
- Documentation supports the resident require limited or extensive assistance with 3 or more ADLs.
- The resident is on 2 or more of the following restorative: bed mobility, transfer, walking, dressing/grooming, eating or communication.
- Resident receives either psychological or recreational therapy at least 2 or more days a week. Documentation shall include a summary of the sessions, resident's progress and potential goals, and identify any revisions needed.
- Documentation shall support the resident has one to one meeting with a licensed social worker at least twice a week to discuss potential needs, goals and any behavior issues.
- Documentation of at least quarterly oversight of care plan by a neurologist.
- Documentation the resident has received instruction and training at least twice per week that includes, but is not limited to, behavior modification, anger management, time management goal setting, life skills and social skills.
- Behavioral rehabilitation assessment and evaluations shall be completed quarterly and shall include cognition, behaviors, interventions and outcomes.
- Documentation shall support the resident requires intensive counseling, behavioral management and neuro-cognitive therapy. The resident behaves in such a manner as to indicate an inability, without ongoing supervision and assistance of others; they would be unable to satisfy the need for nourishment, personal care, medical care, shelter, self-protection, and safety.

Coding Tips (TBI Tier I Resident)

This includes residents who have received intensive rehabilitation and are preparing for discharge to the community. The resident shall receive intervention and training focusing on independent living skills, prevocational training and employment support. Tier I should not exceed 6 months. The resident must have previously scored in Tier II or III. The following requirements shall be met.

- The resident scores a Level VIII through X on the Rancho Los Amigos Cognitive Scale (purposeful, appropriate and stand-by assistance to modified independence).

- The resident has no behaviors or behaviors present, but less than 4 days. If behaviors are present, the resident receives behavior management training to address the specific behaviors identified.
- The resident's BIMS is between 13 and 15 or cognitive skills for decision making are intact.
- The resident requires limited or less assistance on all ADL.
- The resident has an assessment shall be completed quarterly to identify the resident's needs and risk factors related to independent living. This assessment shall include, but is not limited to, physical development and mobility, communication skills, cognition level, food preparation and eating behaviors, personal hygiene and grooming, health and safety issues, social and behavioral issues, ADL potential with household chores, transportation, vocational skills and money management.
- The resident has an active discharge plan in place or referral has been made to the local contact agency. There shall be weekly documentation by a licensed social worker related to discharge potential and progress. This shall include working with the resident on community resources and prevocational employment options.
- The resident shall receive interventions and/or training related to their specific discharge needs.

Coding Tips (Ventilator Facility)

The following criteria shall be met in order for the facility to qualify for enhanced ventilator services.

- The facility shall have admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.
- The facilities shall be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.
- The facility shall have a method to clinically assess the oxygenation and ventilation of the resident (arterial blood gases or other methods) and they shall be available on-site for the management of residents.
- The facility shall have emergency and life support equipment, including mechanical ventilators, connected to electrical outlets with back-up generator power in the event of a power failure.
- The ventilators utilized shall be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.
- The ventilators used shall have an audible, redundant ventilator alarm system to alert staff of a ventilator malfunction, failure or resident disconnect.
- The facility shall have a back-up ventilator available at all times.
- The facility shall have a minimum of one RN on duty for 8 consecutive hours, 7 days per week, as required by 77 Ill. Adm. Code 300.1240. For facilities licensed under the Hospital Licensing Act, an RN shall be on duty at all times, as required by 77 Ill. Adm. Code 250.910. Additional RN staff may be determined necessary by the Department, based on the Department's review of the ventilator services.
- The facility shall have licensed nursing staff on duty in sufficient numbers to meet the needs of residents as required by 77 Ill. Adm. Code 300.1230. For facilities licensed under the

Nursing Home Care Act, the Department requires that an RN shall be on call, if not on duty, at all times.

- The facility shall have no less than one licensed respiratory care practitioner licensed in Illinois available at the facility or on call 24-hours a day to provide care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing as determined by the needs and number of the residents being served by a facility.
- The facility shall have at least one of the full-time licensed nursing staff member who has successfully completed a course in the care of ventilator dependent individuals and the use of the ventilators. The course shall be conducted and documented by a licensed respiratory care practitioner or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals.
- All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing such care. In-service training shall be conducted at least annually by a licensed respiratory care practitioner or qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals. Training shall include, but is not limited to, status and needs of the resident, infection control techniques, communicating with the ventilator resident, and assisting the resident with activities. In-service training documentation shall include name and title of the in-service director, duration of the presentation, content of presentation and signature and position description of all participants.
- The facility shall be required to implement the written protocols and staff shall be in-services on these policies in the following areas:
 - o Pressure Ulcers - The facility shall have established policies and procedures on assessing, monitoring and prevention of pressure ulcers, including development of a method of monitoring the occurrence of pressure ulcers. Staff shall receive in-service training on those areas.
 - o Pain - The facility shall have established policies and procedures on assessing the occurrence of pain, including development of a method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.
 - o Immobility - The facility shall have established policies and procedures to assess the possible effects of immobility. These shall include, but not be limited to, range of motion techniques, contracture risk. Staff shall receive in-service training on this area.
 - o Risk of infection - The facility shall have established policies and procedures on assessing risk for developing infection and prevention techniques. These shall include, but are not limited to proper hand washing techniques, aseptic technique in delivery care to a resident, and proper care of equipment and supplies. Staff shall receive in-service training on this area.
 - o The facility's policies shall include monitoring expectations of the ventilator resident, routine maintenance of equipment and specific staff training related to ventilator settings and care.
 - o The facility shall have a policy for cleaning and maintaining equipment.
- The facility shall have a method of assessing a resident's risk for social isolation.
- The facility shall have a method of routinely assessing a resident's weaning potential and interventions implemented as needed.

- The facility shall have a method to monitor and track infections.
- The facility shall have a method of tracking ventilator associated pneumonia.
- The facility shall have a method to track hospitalizations, reason for hospitalizations, and interventions aimed at reducing hospitalizations for ventilator residents.

Coding Tips (Ventilator Resident)

The following criteria shall be met for the resident to qualify for enhanced ventilator services.

- The services delivered shall meet the definition of ventilators as defined on Page 2.
- Documentation shall support the resident received clinical monitoring of oxygenation stability at least twice a day.
- Documentation shall support the respiratory therapist evaluated and documented the respiratory status of a ventilator resident on no less than a weekly basis.
- A pulmonologist, or physician experienced in the management of ventilator care, shall direct the care plan for ventilator residents on no less than a twice per week basis.
- Documentation shall support the resident has a health condition that requires medical supervision 24-hours a day of licensed nursing care and specialized services or equipment.
- The medical records shall contain physician's orders for respiratory care that includes, but is not limited to, diagnosis, ventilator settings, tracheostomy care and suctioning (when applicable).
- Documentation shall support the resident receive tracheostomy care at least daily.
- Documentation shall support the resident has been assessed quarterly for their risk for developing pressure ulcers.
- Documentation shall support the resident received interventions for pressure ulcer prevention that included, but are not limited to, turning and repositioning, use of pressuring reducing devices, hydration and nutritional interventions and daily skin checks.
- Documentation shall support the resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.
- Documentation shall support an effective pain management regime is in place for the resident when needed.
- Documentation shall support the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.
- Documentation supports the effects of immobility were monitored and interventions implemented as needed.
- Documentation shall support the resident was given oral care every shift to reduce the risk of infection.
- Interventions shall be in place to involve a resident in activities when possible.
- Documentation shall support the weaning process and the use of mechanical ventilation for a portion of each day for stabilization when applicable.

S1004: Resident had a disease process or condition that has been reported to the appropriate local/state health department since the last assessment.

Steps for Assessment

Review the clinical record to determine if the resident had a condition that was considered to be a reportable communicable disease and to determine if it was reported to the local/state health department when required.

Coding Instructions

Code 0, No: The resident did not have a condition that required reporting to the local/state health Department or the condition was present, but not reported.

Code 1, Yes: The resident did have a condition that required reporting and it has been reported to the local/state health Department.

S1150: Resident has active diagnosis of TBI and meets the care and service requirements as defined in 89 Ill. Adm. Code 147.335(b) and is eligible for the TBI add-on (7-day look back).

Definitions

Active Diagnosis - An illness or condition that is currently causing or contributing to a resident's complications and/or functional, cognitive, medical and psychiatric symptoms or impairments.

Steps for Assessment

Review the clinical record to determine if the resident has an active TBI diagnosis and meets the care and services needs defined in 89 Ill. Adm. Code 147.335(b) during the 7-day look back.

Coding Instructions

Code 0, No: The resident does not have a TBI diagnosis or the diagnosis did not meet the care and service requirements identified in 89 Ill. Adm. Code 147.335(b).

Code 1, Yes: The resident does have a TBI diagnosis and did meet the care and service requirements identified in 89 Ill. Adm. Code 147.335(b).

Coding Tips

Facilities licensed by the Department of Public Health under the Nursing Home Care Act and meeting all the care and services requirements of 89 Ill. Adm. Code 147.335(b) will receive a per diem add-on of \$5.00 for each resident scoring as TBI on the MDS 3.0, but not otherwise qualifying for Tier 1, 2 or 3. While the care and services defined in this section must be met, the criteria related to diagnosis and timeframes in this section does not apply. See pages 3-6 for a description of care and services.

S1200: Resident has a primary and/or secondary SMI Diagnosis (7-day look back period).

Definitions

Active Diagnoses - Physician documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look back period.

Primary Diagnosis - Defined as the main diagnosis or the condition that motivates admission or is the most serious condition upon admission.

SMI Diagnosis - Defined as the presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DMS IV) American Psychiatric Association, excluding alcohol and substance abuse, Alzheimer's disease, and other forms of dementia based upon organic or physical disorders.

Steps for Assessment

1. Review the medical record (progress notes, most recent history and physical, transfer documents, discharge summaries, diagnosis list, PASRR, and other resources as available) to determine if is a Serious Mental Illness (SMI) diagnosis in the last 60 days.
2. Determine whether the diagnoses are active within the last 7 days.

Coding Instructions

Enter Code 1, 2, or 3 for each diagnosis listed.

Code 1: The diagnosis identified meets the definition for a primary diagnosis.

Code 2: The diagnosis identified meets the definition for a secondary diagnosis.

Code 3: There was no diagnosis or it did not meet the definitions above.

S1200A: Schizophrenia

S1200B: Delusional Disorder

S1200C: Schizoaffective Disorder

S1200D: Psychotic Disorder

S1200E: Bipolar Disorder I

S1200F: Bipolar Disorder II

S1200G: Cyclothymic Disorder

S1200H: Bipolar Disorder-not otherwise specified

S1200I: Major Depression, Recurrent

S3310: Resident received therapy services (i.e., PT, OT, ST) during the 7-day look back and these services were billed to the following:

Steps for Assessment

1. Review the medical record, including therapy documentation to determine if the resident received therapy (as identified in the RAI manual) during the 7-day look back.
2. Determine the payor source for those therapy services.

Coding Instructions

Check all that apply.

S3310A: Medicare Part A

S3310B: Medicare Part B

S3310C: Managed Care Entity

S3310D: Medicaid

S3310Y: Other (i.e., private pay, private insurance, etc.)

S3310Z: None of the above

S3315: Resident has an active diagnosis of COPD and received one or more of the following during the 7 day look back.

Definitions

Active Diagnosis - An illness or condition that is currently causing or contributing to a resident's complications and/or functional, cognitive, medical and psychiatric symptoms or impairments. A physician documented diagnoses that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death.

Chronic obstructive pulmonary disease (COPD) - A chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing. It's caused by long-term exposure to irritating gases or particulate matter, most often from cigarette smoke. People with COPD are at increased risk of developing heart disease, lung cancer and a variety of other conditions. Emphysema and chronic bronchitis are the two most common conditions that contribute to COPD. Chronic bronchitis is inflammation of the lining of the bronchial tubes, which carry air to and from the air sacs (alveoli) of the lungs. It is characterized by daily cough and sputum production. Emphysema is a condition in which the air sacs (alveoli) at the end of the smallest air passages (bronchioles) of the lungs are destroyed as a result of damaging exposure.

Acute Monitoring - Nursing monitoring includes the clinical monitoring by a licensed nurse for a condition/diagnosis that is generally of sudden or rapid onset and of a short course.

Steps for Assessment

Review the medical record to determine what services were documented and delivered during the 7-day look back.

Coding Instructions

Check all that apply.

S3315A: Oxygen

S3315B: Inhaler/Nebulizer

S3315C: Acute Monitoring of Respiratory Status

S3315D: Medications for the treatment of COPD or related respiratory symptoms

S3315Y: Other (i.e., hospital/ER visit related to COPD symptoms, CXR, other medical interventions)

S3315Z: None of the above

S6052: Resident required isolation procedures and was assigned a private room and did not leave the room except for medical treatments/procedures.

Definitions

Isolation or quarantine for active infectious disease - Check only when the resident requires single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmissions. The resident must be in room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.). If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g., dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease.

Steps for Assessment

1. Review the medical record to determine the diagnosis was active and highly transmissible.
2. Review the record and interview staff to determine if the resident was in a room alone during this timeframe.
3. Review the record and interview staff to determine if the resident remained in their room and all services were delivered to them during this timeframe.
4. Review the record to determine if staff was implementing isolation precautions during this timeframe across all shifts.

Coding Instructions

Note: If yes, answer S6053A and S6053B

Code 0, No: The resident was not in a room alone, or the resident left the room for any reason other than transport to another healthcare setting or isolation was not started.

Code 1, Yes: The resident was on isolation, in a room alone, and did not leave the room for any reason other than transport to another healthcare setting.

S6053A: Resident met the isolation requirements-Start Date of isolation-enter date isolation started

S6055B: Resident met the isolation requirements-End Date of isolation-enter date isolation discontinued.

S6232: Is the resident currently receiving an antipsychotic medication?

Steps for Assessment

Review the medical record to determine if the resident is currently receiving an antipsychotic medication.

Coding Instructions

Code 0, No: The resident is currently not receiving an antipsychotic medication

Code 1, Yes: The resident is currently receiving an antipsychotic medication.

S6234: Has an attempt been made to reduce the total amount of antipsychotic medication the resident receives since the ARD of the last OBRA assessment, or, if this is an admission assessment, since the entry date?

Steps for Assessment

Review the medical record to determine if attempts have been made to reduce the amount of antipsychotic medication since the last OBRA or since admission (if an admission assessment).

Coding Instructions

Code 0, No: If there have been no attempts to reduce the total amount of antipsychotic medication the resident receives.

Code 1, Yes: If the resident is currently receiving an antipsychotic medication.

S6236: Was the reduction in the total amount of antipsychotic medication that the resident receives maintained?

Steps for Assessment

Review the medical record to determine if attempts have been made to reduce the amount of antipsychotic medication and if the reduction has been maintained.

Coding Instructions

Code 0, No: If there was a reduction, but the reduction was not maintained

Code 1, Yes: If there was a reduction and that reduction has been maintained.