Codify
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MDS Alert

Compliance: MDS-Focused Surveys: Brace Yourself For Scrutiny Of 7 Key Areas

Make sure MDS records match up to documentation, especially for these issues.

MDS-Focused Surveys are underway, and you could face real deficiency citations. Take these actions to tidy up your MDS coding, documentation, and other processes to minimize your exposure to a negative survey outcome.

The MDS-Focused Survey centers on specific care areas: restraints, pressure ulcers, indwelling catheters, urinary tract infections (UTIs), activities of daily living (ADLs), falls with major injuries, and antipsychotic medications.

1. Double-Check Your Documentation of Restraints

One important issue regarding restraints is surveyors are finding that facilities aren't coding restraints correctly, warns **Kay Hashagen, PT, MBA, RAC-CT**, Senior Consultant with **LW Consulting Inc.** in Harrisburg, Penn. "Watch those Geri-chairs!" Residents who could normally get up from a Geri-chair but can't when it is reclined and locked in position could be considered a restraint.

You need to consider the effect the item has on the resident, not the item's purpose, especially when you're considering a restraint versus an enabler, noted **Mary Ann Leonard, RHIA, RAC-CT of Health Information Professionals** in a recent training for the **Pennsylvania Association of Nurse Assessment Coordinators**. Beware that an enabler may also meet the definition of a restraint.

Remember: The definition of a restraint, according to both the RAI Manual and the State Operations Manual (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."

Also, Leonard advised you should be prepared to address the following questions:

- How did you determine that the item was or was not a restraint?
- Did staff educate the family and/or resident on the risks and benefits of using the item?
- Do you have the necessary documentation required for restraint use?
- Do you have documentation showing restraint reduction attempts, including what has worked and what has failed?
- Did staff use the Care Area Assessment (CAA) to evaluate the appropriateness of the restraint use?

2. Train Staff on ADLs

The MDS-Focused Surveys also address ADLs, mainly because your coding of ADLs directly impacts RUG assignment (which affects reimbursement) and your facility's quality measure (QM) ratings. But also, the pilot surveys found discrepancies in the coding of the late loss ADLs between the MDS and the clinical record, Leonard notes.

Action points: Make sure all involved staff have a clear understanding of the ADL definitions, and that your documentation is timely and accurate, Leonard advised. Make sure staff are using the Rule of 3 properly, and look for contradictions between direct care staff and licensed staff.

3. Understand Falls with Injury Vs. Major Injury

Surveyors have also found that facilities aren't coding falls when a fall has occurred, Hashagen says. Make sure you're adhering to the definition of a fall according to the RAI Manual, which includes the following:

- An unintentional change in position coming to rest on the ground, floor, or next lower surface (such as onto a chair, bed, or bedside mat).
- A fall witnessed or reported by the resident or an observer, or identified when a resident is found on the floor or ground.
- Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital, or in a nursing home.
- Falls are not a result of an overwhelming external force (such as a resident pushes another resident).
- An intercepted fall occurs when the resident would've fallen if she had not caught herself or had not been intercepted by another person this is still considered a fall.

When you code a fall in J1800 Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent, you must record the number of falls at each injury level in J1900, according to Hashagen. These levels include:

- J1900A No injury;
- J1900B Injury (except major); and
- J1900C Major injury.

Make sure you understand the difference between injury and major injury, Leonard stresses. Injury includes skin tears, abrasions, lacerations, hematomas, superficial bruises, sprains, and pain.

Major injury includes bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma, Hashagen notes. You should monitor the resident for any injury that is displayed on the body that could be caused by a fall, from a few hours to a few days afterward. And you should document this on the MDS.

"Don't forget that pain, even though not visible, is considered injury (except major) if the pain is related to the fall," Hashagen reminds. "Remember, you are coding the highest level of injury per fall."

4. Code Antipsychotics the Right Way

Not surprisingly, antipsychotic use remains on the radar for the MDS-Focused Surveys. One key aspect of coding antipsychotics is to make sure you're coding the medication according to its therapeutic category and/or pharmacological classification, not how it is used, Hashagen points out.

Also ensure that you're including all medications given in the last seven days by any route, Leonard said. Document what non-pharmacologic interventions staff have attempted and care planned, as well as physician documentation of gradual dose reduction (GDR) attempts.

5. Focus on UTIs & Catheters

For UTIs, surveyors are looking for incorrect coding based on the required criteria in the RAI Manual, Hashagen states.

Always keep in mind that the look-back period on the MDS for UTIs is different than others 30 days. The chart must include all components to mark UTI on the MDS, and you must have appropriate documentation of the diagnosis, Leonard reminded. Also make sure you have documentation of the signs and symptoms, the significant lab findings, and the current treatment.

What's more: For continence and indwelling catheters, make sure your coding is consistent and that there's a diagnosis to support catheter use, Hashagen says.

Indwelling catheters include all types of catheters that drain urine from the body, including urethral, suprapubic, and nephrostomy, Leonard noted. But this excludes neurogenic bladder and obstructive uropathy. Also included are intermittent catheterizations if done more than one time only.

You must show there's proper care provided and appropriate care planning for indwelling catheters, Leonard added. Make sure the medical diagnosis supports the need for the catheter. Appropriate indications for continuing indwelling catheter use beyond 14 days may include:

- Urinary retention that cannot be treated or corrected medically or surgically;
- Contamination of a Stage 3 or 4 pressure ulcer with urine, which has impeded healing, despite appropriate personal care for the incontinence; and
- Terminal illness or severe impairment which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain.

6. Compare MDS with Wound Reports

Surveyors will look for inconsistent coding regarding pressure ulcers, as well as incorrect staging, according to Hashagen. Make sure you're not coding a pressure ulcer as "healed" when it's not really healed, and be sure to code the correct number of pressure ulcers.

Know what you should code as a pressure ulcer and as present on the prior assessment, and make sure the wound report matches the MDS, Leonard stressed. Make sure the MDS accurately reflects tissue injury, pressure ulcers that have worsened, and debrided ulcers versus surgical closing.

7. Spot Inappropriately Used Dashes

Surveyors are also looking for assessments that aren't completed in a timely manner or not at all, Hashagen notes. But another issue is using dashes ("-") inappropriately "this has been seen throughout the MDS, but particularly with the interviews at Sections C, D, and J."

"All interviews are to be attempted unless the resident is rarely/never understood verbally or in writing," or when you code B0700 Makes Self Understood as 3 Rarely/never understood, Hashagen says. "The RAI Manual has specific guidelines on how and when to code a dash for interviews," so make sure you're following them.

5 Tips for MDS-Focused Survey Prep

Finally, when you're facing an MDS-Focused Survey, be sure to heed the following tips from Hashagen for a best-practice foundation:

1. Print and review the Entrance Conference document that is available from the survey agency (see below).

2. Implement a system to ensure you complete and submit MDS assessments in a timely manner for regularly scheduled assessments and for those requiring significant change of condition assessments.

3. Know the scope of practice for an LPN/LVN in your state, and make sure that proper supervision is provided and reflected in the documentation. Make sure that LPNs/LVNs are not performing "assessments" on patients without

clear documentation under the direction of an RN.

4. Put into place a system that allows a team of caregivers to contribute to the MDS. Information comes from different places, including the ADL records, care plan, interdisciplinary notes, therapy documentation, assessments, and physician orders and progress notes. An accurate MDS will reflect information from all sources.

5. Ensure that staff members use the CAA process effectively. This provides a link between the MDS and care planning. The process should involve and reflect documentation of involvement of the resident, family, and other representatives as appropriate, in addition to the interdisciplinary team.