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MDS Alert

Quality Assurance: Tap The MDS To Ensure Rehab Outcomes, Documentation Are On Track

Detect unexpected decline, inconsistencies, missed care opportunities.

If the fiscal intermediary or surveyor took a hard look at a rehab therapy resident's MDSs, would the assessments tell a story that earns the facility kudos -- or one that ends in F tags and payment woes?

Take a look at these specific sections to see how well the facility is promoting optimal rehab outcomes and has documented the reason for resident decline and inconsistencies between rehab therapists' and nursing observations.

Section G1: This one has an "obvious relationship to therapy" because it relates to ADLs and mobility, says **Shehla Rooney, PT**, principal of **Premier Therapy Solutions** in Cookeville, TN.

If the Part A-stay rehab resident has suffered an ADL decline from one Medicare assessment to the next, the team needs to figure out why.

Key point: "It is important to explain in the resident's medical record (progress notes, care plan, weekly assessment, validation reports, etc.) the reason for a decline," advises **Nemcy Cavite Duran, RN, BSN, CRNAC,** director of MDS for **Dr. William O. Benenson Rehabilitation Pavilion** in Flushing, NY.

Duran and **Pauline Franko, PT**, highlight several clinical reasons that can explain a decline in therapy:

• Worsening of foot ulcers or decubiti, which affects ambulation and transfer status;
• **Unstable cardiovascular functioning;**
• **Pneumonia or other acute infections;**
• **Pain or delirium;**
• **Reactions to a new medication;**
• **Cancer.** The person with cancer may do well in therapy for a few days, but weakness and fatigue may prevent the person from performing at her maximum potential, Duran says.
• **Abnormal labs.** For example, a resident may have received a blood transfusion for anemia, or his electrolytes were off, Franko notes.

Bottom line: "In all cases, nursing and therapy documentation should show how the medical condition or other issue impacted the person's participation in therapy," Franko advises. The care plan should also show how the care team addressed the issues that affected the resident's therapy.

Also look at the timeframe covered by assessments showing a decline or lack of progress.

For example, suppose three assessments in a row -- the 5-day, 14-day and 30-day -- show that a resident on very high rehab hasn't improved, suggests Franko. That sounds like a long time.

But "if you look more closely, you may see the overlap in assessment reference dates can result in those assessments really only covering a three-week window." So you need supportive documentation of what's going on with the resident in terms of his response to therapy during that period.

Section B (cognitive patterns): If speech-language pathology or occupational therapy is working with the resident on memory, problem solving and cognitive deficits, look for improvements on subsequent assessments, advises Rooney.

Section E (mood and behavior patterns). If PT is helping the resident improve his mobility and gait, you may see an improvement in the patient's mood as he becomes more independent, Rooney notes.

On the other hand, worsening depression or anxiety could explain a resident's lack of progress in rehab therapy.

Section H (continence). If OT is working on toileting and transfers with a resident, you might expect to see the person's continence status improving if the incontinence was due to a toilet transfer issue, Rooney says.

Section J2 (pain). Persistent pain in spite of treatment may be interfering with therapy. Or, if rehab therapy is addressing pain issues, you may see a decrease in pain symptoms coded in Section J2, Rooney says.

Section K (oral/nutritional status). If speech-language pathology is addressing a resident's dysphagia, "then 'swallowing problem' should be coded in Section K1b," Rooney counsels. You may also see a decrease in weight loss (Section K3) as the speech language pathologist addresses diet modifications, positioning issues, and safe swallowing strategies, she adds.

Section P3 (restorative nursing). When reviewing a rehab resident's MDS assessments over time, do you see restorative nursing coded as he winds down in therapy?

If not, why not?

"There's underuse of rehab low or rehab low plus extensive services, which includes restorative nursing," says **Cheryl Boldt, RN**, a consultant with **Maun Lemke** in Omaha.

"Using that RUG category, the person has time to practice skills so they maintain them and don't end up entering the system again."

Also, people are more open to education toward the end of a stay, Boldt adds. "You can't cram education into the front end so rehab low is a perfect setting for ... providing needed education at a time the family and patient/resident are receptive to learning," Boldt says.