MDS Alert

What Do You Think?

Question 1: I'm an MDS nurse and was debating the issue of IV meds with another MDS nurse. The RAI manual states that you can NOT use IV fluids as a med, but the nurse I was speaking with said that you could use IV fluids (normal saline) if you had a diagnosis of dehydration and the lab results to prove it. Is she right?

Answer 1: You can include IV fluids if they are given as part of a hydration or nutritional program, answers **Marilyn Mines**, MDS Alert consulting editor and senior manager of clinical services for **FR&R Healthcare Consulting, Inc**. in Deerfield, IL. You must have documentation in the clinical record that clearly reflects the dietary need for the fluids.

Mines points to Section K of the MDS 3.0, pages 11 and 12 (emphasis added):

Check all that apply. If none apply, check K0510Z, None of the above

- **K0510A,** parenteral/IV feeding
- **K0510B,** feeding tube nasogastric or abdominal (PEG)
- **K0510C,** mechanically altered diet require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- **K0510D,** therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- **K0510Z,** none of the above

Coding Tips for K0510A

K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, **provided they were administered for nutrition or hydration.**

- Parenteral/IV feeding The following fluids may be included **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy:**

 IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently

 IV fluids running at KVO (Keep Vein Open)

 IV fluids contained in IV Piggybacks

 Hypodermoclysis and subcutaneous ports in hydration therapy

Question 2: How can I correct an MDS record that has a correct reason for assessment combined with an incorrect reason for assessment? Specifically, our facility submitted a combined Admission/14-day assessment, and then we realized that the resident was discharged from Medicare before the Assessment Reference Date (ARD).

Answer 2: First, you must inactivate the Admission/14-day assessment, according to the **Texas Department of Aging and Disability Services** (DADS). Then you would need to redo the Admission assessment with a new ARD, per the inactivation policy.

If the resident is no longer in the facility due to death or discharge, you could not submit a new Admission assessment for that resident, DADS states. Instead, your facility would have to accept a missed assessment status for the Admission

assessment.

Remember: "Be mindful of the difference between MDS with incorrect reasons for assessment that are invalid and MDS that are done early or late but are valid," DADS stresses. For instance, a valid Change of Therapy (COT) with an ARD set one day early is not optimal, but you should not inactivate it. "Conversely, a COT with an ARD set after a resident was discharged from therapy is invalid and must be inactivated."

Question 3: What dates must I change when correcting an MDS record?

Answer 3: Except for item Z0400 – Signatures of Persons Completing the Assessment or Entry/Death Reporting, the "dates do not change unless a data entry error caused them to not match the information in the clinical record," DADS stated. "Do not update (or change) the ARD from the original date set when the RN Assessment Coordinator signed the MDS as complete, unless the original date entered into the MDS record was incorrect."

Make sure that you update the signatures and dates in Z0400 to reflect the most recent corrections, DADS instructed. But do not modify the date the RN Assessment Coordinator signed the MDS at Z0500B, unless the date listed is not the original date that the RN signed the MDS as complete.

Question 4: I am confused about when it is appropriate to code O0100M. What constitutes "isolation or quarantine?"

Answer 4: To code for O0100M – Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions), you must meet very specific criteria, according to **Carol Siem, MSN, RN, GNP-BC, RAC-CT**, in a recent article for the **Quality Improvement Program for Missouri** (QIPMO) newsletter.

To code O0100M, the resident requires isolation or quarantine (alone in a separate room) due to active infection – symptomatic and/or has a positive test result and is in the contagious stage, Siem explained. You should code O0100M only if the resident's situation has met all of the following conditions:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission;

2. Precautions are over and above standard precautions; that is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect;

3. The resident is in a 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;

4. The resident must remain in his/her room. This requires that all service be brought to the resident (e.g., rehabilitation, activities, dining, etc.).