SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess *the management of pain,* the presence of pain, pain frequency, effect *of pain on sleep, and pain interference with therapy and day-to-day activities*. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.

J0100: Pain Management

J0100. Pain Management - Complete for all residents, regardless of current pain level	
At any time in the last **5** days, has the resident:	
Enter Code ☐	**A. Received scheduled pain medication regimen?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Received PRN pain medications OR was offered and declined?** 0. **No** 1. **Yes**
Enter Code ☐	**C. Received non-medication intervention for pain?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Pain can cause suffering and is associated with inactivity, social withdrawal, depression, and functional decline.
- Pain can interfere with participation in rehabilitation.
- Effective pain management interventions can help to avoid these adverse outcomes.

Planning for Care

- Goals for pain management for most residents should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Identification of pain management interventions facilitates review of the effectiveness of pain management and revision of the plan if goals are not met.
- Residents may have more than one source of pain and will need a comprehensive, individualized management regimen.
- Most residents with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain.
- Some residents with intermittent or mild pain may have orders for PRN dosing only.

DEFINITION

PAIN MEDICATION REGIMEN

Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

Draft

J0100: Pain Management (cont.)

- Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens.
- Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Steps for Assessment

1. Review medical record to determine if a pain regimen exists.
2. Review the medical record and interview staff and direct caregivers to determine what, if any, pain management interventions the resident received *any time* during the *last* 5 days. Include information from all disciplines.

Coding Instructions for J0100A-C

Determine all interventions for pain provided to the resident any time in the last 5 days. Answer these items even if the resident currently denies pain.

Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen

- **Code 0, no:** if the medical record does not contain documentation that a scheduled pain medication was received.
- **Code 1, yes:** if the medical record contains documentation that a scheduled pain medication was received.

Coding Instructions for J0100B, Received PRN Pain Medication

- **Code 0, no:** if the medical record does not contain documentation that a PRN medication was received or offered.
- **Code 1, yes:** if the medical record contains documentation that a PRN medication was either received OR was offered but declined.

DEFINITIONS

SCHEDULED PAIN MEDICATION REGIMEN
Pain medication order that defines dose and specific time interval for pain medication administration. For example, "once a day," "every 12 hours."

PRN PAIN MEDICATIONS
Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as "every 4 hours as needed for pain" or "every 6 hours as needed for pain."

NON-MEDICATION PAIN INTERVENTION
Scheduled and implemented nonpharmacological interventions include, but are not limited to, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal or alternative medicine products are not included in this category.

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J0100: Pain Management (cont.)

Coding Instructions for J0100C, Received Non-medication Intervention for Pain

- **Code 0, no:** if the medical record does not contain documentation that a non-medication pain intervention was received.
- **Code 1, yes:** if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy.

Coding Tips

- Code only pain medication regimens without PRN pain medications in J0100A. Code receipt of PRN pain medications in J0100B.
- For J0100B code only residents with PRN pain medication regimens here. If the resident has a scheduled pain medication J0100A should be coded.

Examples

1. The resident's medical record documents that *they* received the following pain management in the *l*ast 5 days:
   - Hydrocodone/acetaminophen 5/500 1 tab PO every 6 hours. Discontinued on day 1 of *the* look-back period.
   - Acetaminophen 500mg PO every 4 hours. Started on day 2 of *the* look-back period.
   - Cold pack to left shoulder applied by PT BID. PT notes that resident reports significant pain improvement after cold pack applied.

     Coding: J0100A would be **coded 1, yes**.

     Rationale: Medical record indicated that resident received a scheduled pain medication *in* the *last* 5 day*s*.

     Coding: J0100B would be **coded 0, no.**

     Rationale: No documentation was found in the medical record that resident received or was offered and declined any PRN medications *in* the *last* 5 day*s*.

     Coding: J0100C would be **coded 1, yes.**

     Rationale: The medical record indicates that the resident received scheduled non-medication pain intervention (cold pack to the left shoulder) *in* the *last* 5 day*s*.
2. The resident's medical record includes the following pain management documentation:
   - Morphine sulfate controlled-release 15 mg PO Q 12 hours: Resident refused every dose of medication *in* the *last* 5 day*s*. No other pain management interventions were documented.

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J0100: Pain Management (cont.)

Coding: J0100A would be **coded 0, no.**

Rationale: The medical record documented that the resident did not receive scheduled pain medication *in* the *last* 5 day*s*. Residents may refuse scheduled medications; however, medications are not considered "received" if the resident refuses the dose.

Coding: J0100B would be **coded 0, no**.

Rationale: The medical record contained no documentation that the resident received or was offered and declined any PRN medications *in* the *last* 5 day*s*.

Coding: J0100C would be **coded 0, no**.

Rationale: The medical record contains no documentation that the resident received non-medication pain intervention *in* the *last* 5 day*s*.

J0200: Should Pain Assessment Interview Be Conducted?

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code	
☐	0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain 1. **Yes** → Continue to J0300, Pain Presence

Item Rationale

Health-related Quality of Life

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about pain directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying pain.

Planning for Care

- Interview allows the resident's voice to be reflected in the care plan.
- Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning.

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J0200: Should Pain Assessment Interview Be Conducted? (cont.)

Steps for Assessment

1. Interact with the resident using *their* preferred language. Be sure *they* can hear you and/or *have* access to *their* preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item J0800, Indicators of Pain or Possible Pain.
3. Review Language item (A11*I*0) to determine whether or not the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

Attempt to complete the interview with all residents.

- **Code 0, no:** if the resident is rarely/never understood or an interpreter is required but not available. Skip to **Indicators of Pain or Possible Pain** item (J0800).
- **Code 1, yes:** if the resident is at least sometimes understood and an interpreter is present or not required. Continue to **Pain Presence**.

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "—") entered in the *Pain Assessment I*nterview items *(*J0300–J0600*)*. Item J0700, Should the Staff Assessment for Pain be Conducted*?*, is coded 0, No.
- Do not complete the Staff Assessment for Pain items (J0800–J0850) if the *Pain Assessment I*nterview should have been conducted but was not done.
- If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate *the Pain Assessment I*nterview *was* not attempted*, skip the Pain Assessment Interview items (J0300–J0600),* and complete *the* **Staff Assessment of Pain** item (J0800).

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J0300–J0600: Pain Assessment Interview

Pain Assessment Interview	
J0300. Pain Presence	
Enter Code ☐	Ask resident: *"**Have you had pain or hurting at any time** in the last 5 days?"* 0. **No** → Skip to J1100, Shortness of Breath 1. **Yes** → Continue to J0410, Pain Frequency 9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain
J0410. Pain Frequency	
Enter Code ☐	Ask resident: *"**How much of the time have you experienced pain or hurting** over the last 5 days?"* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 9. **Unable to answer**
J0510. Pain Effect on Sleep	
Enter Code ☐	Ask resident: *"Over the past 5 days, **how much of the time has pain made it hard for you to sleep at night?"*** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0520. Pain Interference with Therapy Activities	
Enter Code ☐	Ask resident: *"Over the past 5 days, **how often have you limited your participation in rehabilitation therapy sessions due to pain?"*** 0. **Does not apply - I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0530. Pain Interference with Day-to-Day Activities	
Enter Code ☐	Ask resident: *"Over the past 5 days, **how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"*** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**
J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)	
Enter Rating ☐☐	**A. Numeric Rating Scale (00-10)** Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00 -10 pain scale) **Enter two-digit response. Enter 99 if unable to answer.**
Enter Code ☐	**B. Verbal Descriptor Scale** Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale) 1. **Mild** 2. **Moderate** 3. **Severe** 4. **Very severe, horrible** 9. **Unable to answer**

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J0300–J0600: Pain Assessment Interview (cont.)

Item Rationale

Health-related Quality of Life

- The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively impaired residents.
- Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

Planning for Care

- Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain.
- Resident self-report is the most reliable means for assessing pain.
- Pain assessment provides a basis for evaluation, treatment need, and response to treatment.
- Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications.
- Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities.
- *The assessment of pain is not associated with any particular approach to pain management. Since the use of opioids is associated with serious complications, an array of successful nonpharmacologic and nonopioid approaches to pain management may be considered. There are a range of pain management strategies that can be used, including but not limited to non-opioid analgesic medications, transcutaneous electrical nerve stimulation (TENS) therapy, supportive devices, acupuncture, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, and ultrasound.*
- Pain assessment prompts discussion about factors that aggravate and alleviate pain.
- Similar pain stimuli can have varying impact on different individuals.
- Consistent use of a standardized pain intensity scale improves the validity and reliability of pain assessment. Using the same scale in different settings may improve continuity of care.
- Pain intensity scales allow providers to evaluate whether pain is responding to pain medication regimen(s) and/or nonpharmacological intervention(s).

J0300–J0600: Pain Assessment Interview (cont.)

Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)

1. Interview any resident not screened out by the **Should Pain Assessment Interview be Conducted?** item (J0200).
2. The Pain Assessment Interview for residents consists of *seven* items: the primary question **Pain Presence** item (J0300) and *six* follow-up questions. If the resident is unable to answer the primary question on **Pain Presence** item J0300, skip to the **Staff Assessment for Pain** beginning with **Indicators of Pain or Possible Pain** item (J0800).
3. Because this item asks the resident to recall pain *in* the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period. This should more accurately capture pain episodes that occur *in* the *last* 5 day*s*.
4. Conduct the interview in a private setting.
5. Be sure the resident can hear you.
   - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
6. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
7. Give an introduction before starting the interview. Suggested language: "I'd like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain."
8. Directly ask the resident each item in *the Pain Assessment Interview* in the order provided.
   - Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant. Some residents avoid use of the term "pain" but may report that they "hurt." Residents may use other terms such as "aching" or "burning" to describe pain.
9. If the resident chooses not to answer a particular item, accept *their* refusal, **code 9**, and move on to the next item.
10. If the resident is unsure about whether pain *or the effects or interference of pain* occurred in the *last* 5 day*s*, prompt the resident to think about the most recent episode of pain and try to determine whether it occurred in the *last 5 days*.

DEFINITION

PAIN
Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever *they* say it does.

J0300: Pain Presence

J0300. Pain Presence	
Enter Code ☐	Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?"* 0. **No** → Skip to J1100, Shortness of Breath 1. **Yes** → Continue to J0410, Pain Frequency 9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

Steps for Assessment

1. Ask the resident: "Have you had pain or hurting at any time in the last 5 days?"

DEFINITION

NONSENSICAL RESPONSE
Any unrelated, incomprehensible, or incoherent response that is not informative with respect to the item being coded.

Coding Instructions for J0300, Pain Presence

Code for the presence or absence of pain regardless of pain management efforts in the last 5 days.

- **Code 0, no:** if the resident responds "no" to *having* any pain *or hurting* in the *last* 5 days. **Code 0, no:** even if the reason for no pain is that the resident received pain management interventions. If coded 0, the pain interview is complete. Skip to **Shortness of Breath** item (J1100).
- **Code 1, yes:** if the resident responds "yes" to *having any* pain *or hurting in* the *last 5 days*. If coded 1, proceed to *the Pain Assessment Interview*.
- **Code 9, unable to answer:** if the resident is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the **Staff Assessment for Pain**.

Coding Tips

- Rates of self-reported pain are higher than observed rates. Although some observers have expressed concern that residents may not complain and may deny pain, the regular and objective use of self-report pain scales enhances residents' willingness to report.

Examples

1. When asked about pain, *Resident* S responds, "No. I have been taking the pain medication regularly, so fortunately I have had no pain."

   Coding: J0300 would be **coded 0, no**.

   Rationale: *Resident* S reports having no pain during the look-back period. Even though *they* received pain management interventions during the look-back period, the item is coded "No," because there was no pain.

2. When asked about pain, *Resident* T responds, "No pain, but I have had a terrible burning sensation all down my leg."

   Coding: J0300 would be **coded 1, yes**.

   Rationale: Although *Resident* T's initial response is "no," the comments indicate that *they have* experienced pain (burning sensation) during the look-back period.

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J0300: Pain Presence (cont.)

3. When asked about pain, *Resident* G responds, "I was on a train in 1905."

   Coding: J0300 would be **coded 9, unable to respond.**

   Rationale: *Resident* G has provided a nonsensical answer to the question. The assessor will complete the **Staff Assessment for Pain**.

J0410: Pain Frequency

J0410. Pain Frequency	
Enter Code ☐	Ask resident: *"**How much of the time have you experienced pain or hurting** over the last 5 days?"* 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 9. **Unable to answer**

Steps for Assessment

1. Ask the resident: "How much of the time have you experienced pain or hurting over the last 5 days?" Staff may present response options on a written sheet or cue card. This can help the resident respond to the items.
2. If the resident provides a related response but does not use the provided response scale, help clarify the best response by echoing (repeating) the resident's own comment and providing related response options. This interview approach frequently helps the resident clarify which response option *they* prefer.
3. If the resident, despite clarifying statement and repeating response options, continues to have difficulty selecting between two of the provided responses, then select the more frequent of the two.

Coding Instructions

Code for pain frequency over the last 5 days.

- **Code 1, *Rarely or not at all*:** if the resident responds "*rarely*" to the question.
- **Code 2, *Occasionally*:** if the resident responds "*occasionally*" to the question.
- **Code 3, *Frequently*:** if the resident responds "*frequently*" to the question.
- **Code 4, *Almost constantly*:** if the resident responds "*almost constantly*" to the question.
- **Code 9, *U*nable to answer:** if the resident is unable to respond, does not respond, or gives a nonsensical response.

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J0410: Pain Frequency (cont.)

Coding Tips

- No predetermined definitions are offered to the resident related to frequency of pain.
  - The response should be based on the resident's interpretation of the frequency options.
  - Facility policy should provide standardized tools to use throughout the facility in assessing pain to ensure consistency in interpretation and documentation of the resident's pain.

Examples

1. When asked about pain, *Resident* C responds, "All the time. It has been a terrible week. I have not been able to get comfortable for more than 10 minutes at a time since I started physical therapy four days ago."

   Coding: J04*1*0 would be **coded 1, almost constantly**.
   Rationale: *Resident* C describes pain that has occurred "all the time."

2. When asked about pain, *Resident* J responds, "I don't know if it is frequent or occasional. My knee starts throbbing every time they move me from the bed or the wheelchair."

   The interviewer says: "Your knee throbs every time they move you. If you had to choose an answer, would you say that you have pain frequently or occasionally?"

   Resident J is still unable to choose between frequently and occasionally.

   Coding: J04*1*0 would be **coded 2, frequently**.
   Rationale: The interviewer appropriately echoed *Resident* J's comment and provided related response options to help *them* clarify which response *they* preferred. *Resident* J. remained unable to decide between frequently and occasionally. The interviewer therefore coded for the higher frequency of pain.

3. When asked about pain, *Resident* K responds: "I can't remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away."

   The interviewer clarifies by echoing what *Resident* K said: "You've had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen. If you had to choose from the answers, would you say you had pain occasionally or rarely?"

   Resident K replies "Occasionally."

   Coding: J04*1*0 would be **coded 3, occasionally**.
   Rationale: After the interviewer clarified the resident's choice using echoing, the resident selected a response option.

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J0410: Pain Frequency (cont.)

4. When asked about pain, *Resident* M responds, "I would say rarely. Since I started using the patch, I don't have much pain at all, but four days ago the pain came back. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day."

   Coding: J0410 would be **coded 4, rarely**.
   Rationale: *Resident* M selected the "rarely" response option.

J0510: Pain Effect on *Sleep*

J0510. Pain Effect on Sleep	
Enter Code ☐	Ask resident: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"*** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Steps for Assessment

1. *Read the question and response choices exactly as they are written.*
2. *No predetermined definitions are offered to the resident. The resident's response should be based on their interpretation of frequency response options.*
3. *If the resident's response does not lead to a clear answer, repeat the resident's response and then try to narrow the focus of the response. For example, if the resident responded to the question, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" by saying, "I always have trouble sleeping," then the assessor might reply, "You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?" The assessor can then narrow down responses with additional follow-up questions about the frequency.*

Coding Instructions

Code for pain effect on sleep over the last 5 days.

- ***Code 1, Rarely or not at all:*** *if the resident responds that pain has rarely or not at all made it hard to sleep over the past 5 days.*
- ***Code 2, Occasionally:*** *if the resident responds that pain has occasionally made it hard to sleep over the past 5 days.*
- ***Code 3, Frequently:*** *if the resident responds that pain has frequently made it hard to sleep over the past 5 days.*
- ***Code 4, Almost constantly:*** *if the resident responds that pain has almost constantly made it hard to sleep over the past 5 days.*
- ***Code 8, Unable to answer:*** *if the resident is unable to answer the question, does not respond or gives a nonsensical response.*

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J0510: Pain Effect on *Sleep* (cont.)

Coding Tips

- *This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.*
- *If the resident reports they had pain over the past 5 days and the pain does not interfere with their sleep (e.g., because the resident is using pain management strategies successfully)**, code 1, Rarely or not at all**.*

Examples

1. *When asked, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" the resident replied, "I've had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. The pain hasn't kept me from sleeping at all."*

   Coding: *J0510 would be* ***coded 1, Rarely or not at all****.*
   Rationale: *The resident reports pain has been present over the past 5 days but that they have had no sleep problems related to pain.*

2. *When asked, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" the resident responded, "All the time. It's been hard for me to sleep all the time. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."*

   Coding: *J0510 would be* ***coded 4, Almost constantly****.*
   Rationale: *The resident reports pain-related sleep problems "all the time" over the past 5 days, so the most applicable response is "Almost constantly."*

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J0520: Pain Interference with Therapy Activities

J0520. Pain Interference with Therapy Activities	
Enter Code ☐	Ask resident: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"*** 0. **Does not apply - I have not received rehabilitation therapy in the past 5 days** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Steps for Assessment

1. *Read the question and response choices as written.*

Coding Instructions

Code for pain interference with therapy activities over the last 5 days.

- ***Code 0, Does not apply:*** *if the resident responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule) over the past 5 days.*
- ***Code 1, Rarely or not at all:*** *if the resident responds that pain has rarely or not at all limited their participation in rehabilitation therapy sessions over the past 5 days.*
- ***Code 2, Occasionally:*** *if the resident responds that pain has occasionally limited their participation in rehabilitation therapy sessions over the past 5 days.*
- ***Code 3, Frequently:*** *if the resident responds that pain has frequently limited their participation in rehabilitation therapy sessions over the past 5 days.*
- ***Code 4, Almost constantly:*** *if the resident responds that pain has almost constantly limited their participation in rehabilitation therapy sessions over the past 5 days.*
- ***Code 8, Unable to answer:*** *if the resident is unable to answer the question, does not respond, or gives a nonsensical response.*

> ***DEFINITION***
>
> ***REHABILITATION THERAPY***
>
> *Special healthcare services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.*

Coding Tips

- *This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.*

J0520: Pain Interference with Therapy Activities (cont.)

- *Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff or the resident carrying out a prescribed therapy program without staff members present.*

Example

1. *When asked, "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?" the resident responded, "Since the surgery a week ago, the pain has made it hard to even get out of bed. I try to push myself, but the pain frequently limits how much I can do with my therapist."*

   Coding: *J0520 would be* ***coded 3, Frequently****.*
   Rationale: *The resident reports that pain frequently limited participation in therapies over the past 5 days.*

J0530: Pain Interference with Day-to-Day Activities

J0530. Pain Interference with Day-to-Day Activities	
Enter Code ☐	Ask resident: *"Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"*** 1. **Rarely or not at all** 2. **Occasionally** 3. **Frequently** 4. **Almost constantly** 8. **Unable to answer**

Steps for Assessment

1. *Read the question and response choices as written.*

Coding Instructions

Code for pain interference with day-to-day activities over the last 5 days.

- ***Code 1, Rarely or not at all:*** *if the resident responds that pain has rarely or not at all limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.*
- ***Code 2, Occasionally:*** *if the resident responds that pain has occasionally limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.*
- ***Code 3, Frequently:*** *if the resident responds that pain has frequently limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.*
- ***Code 4, Almost constantly:*** *if the resident responds that pain has almost constantly limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.*
- ***Code 8, Unable to answer:*** *if the resident is unable to answer the question, does not respond, or gives a nonsensical response.*

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J0530: Pain Interference with Day-to-Day Activities (cont.)

Coding Tips

- *This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.*

Examples

1. *When asked, "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" the resident responded, "Although I have some pain in my back, I'm still able to read, eat my meals, and take walks like I usually do."*

   Coding: *J0530 would be* ***coded 1, Rarely or not at all****.*
   Rationale: *The resident reports that pain has not limited their participation in day-to-day activities over the past 5 days.*

2. *When asked, "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" the resident responded, "The pain has made it hard to do pretty much anything. Even getting out of bed to brush my teeth has been hard. I haven't been able to talk to my family because the pain is so bad. It's just constant. I'd say it constantly limits what I do."*

   Coding: *J0530 would be* ***coded 4, Almost constantly****.*
   Rationale: *The resident reports that pain has constantly limited their participation in other activities over the past 5 days.*

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J0600: Pain Intensity

J0600. **Pain Intensity** - Administer **ONLY ONE** of the following pain intensity questions (A or B)	
Enter Rating [ ][ ]	**A. Numeric Rating Scale (00-10)** Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale) **Enter two-digit response. Enter 99 if unable to answer.**
Enter Code [ ]	**B. Verbal Descriptor Scale** Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale) 1. **Mild** 2. **Moderate** 3. **Severe** 4. **Very severe, horrible** 9. **Unable to answer**

Steps for Assessment

1. You may use either *the* **Numeric Rating Scale** item (J0600A) or *the* **Verbal Descriptor Scale** item (J0600B) to interview the resident about pain intensity.
   - For each resident, try to use the same scale used on prior assessments.
2. If the resident is unable to answer using one scale, the other scale should be attempted.
3. Record **either** the **Numeric Rating Scale** item **or** the **Verbal Descriptor Scale** item. Leave the response for the unused scale blank.
4. Read the question and item choices slowly. While reading, you may show the resident the response options (the **Numeric Rating Scale** or **Verbal Descriptor Scale**) clearly printed on a piece of paper, such as a cue card. Use large, clear print.
   - For the **Numeric Rating Scale**, say, "Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine."
   - For **Verbal Descriptor Scale**, say, "Please rate the intensity of your worst pain over the last 5 days."
5. The resident may provide a verbal response, point to the written response, or both.

Coding Instructions for J0600A. Numeric Rating Scale (00-10)

Enter the two digit number (00-10) indicated by the resident as corresponding to the intensity of their worst pain over the last 5 days, where zero is no pain, and 10 is the worst pain imaginable.

- Enter 99 if unable to answer.
- If the Numeric Rating Scale is not used, leave the response box blank.

Coding Instructions for J0600B. Verbal Descriptor Scale

- **Code 1, mild:** if resident indicates that *their* pain is "mild."
- **Code 2, moderate:** if resident indicates that *their* pain is "moderate."
- **Code 3, severe:** if resident indicates that *their* pain is "severe."
- **Code 4, very severe, horrible:** if resident indicates that *their* pain is "very severe or horrible."

J0600: Pain Intensity (cont.)

- **Code 9, unable to answer:** if resident is unable to answer, chooses not to respond, does not respond or gives a nonsensical response.
- If the **Verbal Descriptor Scale** is not used, leave the response box blank.

Examples for J0600A. Numeric Rating Scale (00-10)

1. The nurse asks *Resident* T to rate *their* pain on a scale of 0 to 10. *Resident* T states that *they are* not sure, because *they have* shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK. The nurse reminds *Resident* T to think about all the pain *they* had *over* the last 5 days and select the number that describes *their* worst pain. *They* report that *their* pain is a "6."

   Coding: J0600A would be **coded 06**.
   Rationale: The resident said *their* pain was 6 on the 0 to 10 scale. Because a 2-digit number is required, it is entered as 06.

2. The nurse asks *Resident* S to rate *their* pain, reviews use of the scale, and provides the 0 to 10 visual aid. *Resident* S says, "My pain doesn't have any numbers." The nurse explains that the numbers help the staff understand how severe *their* pain is and repeats that the "0" end is no pain and the "10" end is the worst pain imaginable. *Resident* S replies, "I don't know where it would fall."

   Coding: Item J0600A would be **coded 99, unable to answer.** The interviewer would go on to ask about pain intensity using the **Verbal Descriptor Scale** item (J0600B).
   Rationale: The resident was unable to select a number or point to a location on the 0-10 scale that represented *their* level of pain intensity.

Examples for J0600B. Verbal Descriptor Scale

1. The nurse asks *Resident* R to rate *their* pain using the verbal descriptor scale. *They* look at the response options presented using a cue card and say *their* pain is "severe" sometimes, but most of the time it is "mild."

   Coding: J0600B would be **coded 3, severe.**
   Rationale: The resident said *their* worst pain was "Severe."

2. The nurse asks *Resident* U to rate *their* pain, reviews use of the verbal descriptor scale, and provides a cue card as a visual aid. *Resident* U says, "I'm not sure whether it's mild or moderate." The nurse reminds *Resident* U to think about *their* worst pain *over* the last 5 days. *Resident* U says, "At its worst, it was moderate."

   Coding: Item J0600B would be **coded 2, moderate.**
   Rationale: The resident indicated that *their* worst pain was "Moderate."

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J0700: Should the Staff Assessment for Pain be Conducted?

J0700. Should the Staff Assessment for Pain be Conducted?	
Enter Code ☐	0. **No** (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea) 1. **Yes** (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Item Rationale

Item J0700 closes the pain interview and determines if the resident interview was complete or incomplete and based on this determination, whether a staff assessment *should* be completed.

Health-related Quality of Life

- Resident interview for pain is preferred because it improves the detection of pain. However, a small percentage of residents are unable or unwilling to complete the pain interview.
- Persons unable to complete the pain interview may still have pain.

Planning for Care

- Resident self-report is the most reliable means of assessing pain. However, when a resident is unable to provide the information, staff assessment is necessary.
- Even though the resident was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors and observing the resident's affect during the interview.

DEFINITION

COMPLETED *PAIN ASSESSMENT* INTERVIEW

The *P*ain *Assessment* *I*nterview is successfully completed if the resident reported no pain (J0300 = *0. No*), or if the resident reported pain (J0300 = *1. Y*es) and the follow-up question J04*1*0 is answered.

Steps for Assessment

1. The **Staff Assessment for Pain** should only be completed if the **Pain Assessment Interview** (J0*3*00–J0600) was not completed.

Coding Instructions for J0700. Should the Staff Assessment for Pain be Conducted?

- **Code 0, no:** if the resident completed the **Pain Assessment Interview** item (J04*1*0 = 1, 2, 3, or 4*)*. Skip to **Shortness of Breath (dyspnea)** item (J1100).
- **Code 1, yes:** if the resident was unable to complete the **Pain Assessment Interview** (J04*1*0 = 9). Continue to **Indicators of Pain or Possible Pain** item (J0800).

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J0800: Indicators of Pain

Staff Assessment for Pain	
J0800. Indicators of Pain or Possible Pain in the last 5 days	
↓ Check all that apply	
☐	**A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
☐	**B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
☐	**C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐	**D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
☐	**Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

Item Rationale

Health-related Quality of Life

- Residents who cannot verbally communicate about their pain are at particularly high risk for under-detection and undertreatment of pain.
- Severe cognitive impairment may affect the ability of residents to verbally communicate, thus limiting the availability of self-reported information about pain. In this population, fewer complaints may not mean less pain.
- Individuals who are unable to verbally communicate may be more likely to use alternative methods of expression to communicate their pain.
- Even in this population some verbal complaints of pain may be made and should be taken seriously.

Planning for Care

- Consistent approach to observation improves the accuracy of pain assessment for residents who are unable to verbally communicate their pain.
- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (e.g., bathing, transferring, dressing, walking and potentially during eating).
- Staff must carefully monitor, track, and document any possible signs and symptoms of pain.
- Identification of these pain indicators can:
  - — provide a basis for more comprehensive pain assessment,
  - — provide a basis for determining appropriate treatment, and
  - — provide a basis for ongoing monitoring of pain presence and treatment response.
- If pain indicators are present, assessment should identify aggravating/alleviating factors related to pain.

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J0800: Indicators of Pain (cont.)

Steps for Assessment

1. **Review the medical record** for documentation of each indicator of pain listed in J0800 that occurred *in* the *last* 5 days. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with the direct care staff on all shifts who work most closely with the resident during activities of daily living (ADL).
2. **Interview staff** because the medical record may fail to note all observable pain behaviors. For any indicators that were not noted as present in medical record review, interview direct care staff on all shifts who work with the resident during ADL. Ask directly about the presence of each indicator that was not noted as being present in the record.
3. **Observe resident** during care activities. If you observe additional indicators of pain *in* the *last* 5 days code the corresponding items.
   - Observations for pain indicators may be more sensitive if the resident is observed during ADL, or wound care.

DEFINITIONS

NON VERBAL SOUNDS
e.g., crying, whining, gasping, moaning, groaning or other audible indications associated with pain.

VOCAL COMPLAINTS OF PAIN
e.g., "That hurts," "ouch," "stop," etc.

FACIAL EXPRESSIONS THAT MAY BE INDICATORS OF PAIN
e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.

PROTECTIVE BODY MOVEMENTS OR POSTURES
e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, etc.

Coding Instructions

Check all that apply in the last 5 days based on staff observation of pain indicators.

- If the medical record review and the interview with direct care providers and observation on all shifts provide no evidence of pain indicators, Check J0800Z, None of these **signs observed or documented**, and proceed to *the* **Shortness of Breath** item (J1100).
- **Check J0800A, nonverbal sounds:** included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported *in* the *last 5 days*.
- **Check J0800B, vocal complaints of pain:** included but not limited to if the resident was observed *to or reported* to *have* made vocal complaints of pain (e.g. "that hurts," "ouch," or "stop") *in the last 5 days*.
- **Check J0800C, facial expressions:** included but not limited to if grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported *in* the *last 5 days*.
- **Check J0800D, protective body movements or postures:** included but not limited to if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported *in* the *last 5 days*.

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J0800: Indicators of Pain (cont.)

- **Check J0800Z, none of these signs observed or documented:** if none of these signs were observed or reported *in* the *last 5 days*.

Coding Tips

- Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain. These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the contribution of pain should be considered when following up on those symptoms and behaviors.

Examples

1. *Resident* P has advanced dementia and is unable to verbally communicate. A note in *their* medical record documents that *they have* been awake during the last night crying and rubbing *their* elbow. When you go to *their* room to interview the certified nurse aide (CNA) caring for *them*, you observe *Resident* P grimacing and clenching *their* teeth. The CNA reports that *they have* been moaning and said "ouch" when *the CNA* tried to move *their* arm.

   Coding: Nonverbal Sounds item (J0800A); Vocal Complaints of Pain item (J0800B); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be **checked**.

   Rationale: *Resident* P has demonstrated vocal complaints of pain (ouch), nonverbal sounds (crying and moaning), facial expression of pain (grimacing and clenched teeth), and protective body movements (rubbing *their* elbow).

2. *Resident* M has end-stage Parkinson's disease and is unable to verbally communicate. There is no documentation of pain in *their* medical record *in* the *last* 5 day*s*. The CNAs caring for *them* report that on some mornings *they* moan and wince when *their* arms and legs are moved during morning care. During direct observation, you note that *Resident* M cries and attempts to pull *their* hand away when the CNA tries to open the contracted hand to wash it.

   Coding: **Nonverbal Sounds** items (J0800A); **Facial Expressions** item (J0800C); and **Protective Body Movements or Postures** item (J0800D), would be **checked**.

   Rationale: *Resident* M has demonstrated nonverbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).

3. *Resident* E has been unable to verbally communicate following a massive cerebrovascular accident (CVA) several months ago and has a Stage 3 pressure ulcer. There is no documentation of pain in *their* medical record. The CNA who cares for *them* reports that *they* do not seem to have any pain. You observe the resident during *their* pressure ulcer dressing change. During the treatment, you observe groaning, facial grimaces, and a wrinkled forehead.

   Coding: **Nonverbal Sounds** item (J0800A), and **Facial Expressions** item (J0800C), would be **checked**.

   Rationale: The resident has demonstrated nonverbal sounds (groaning) and facial expression of pain (wrinkled forehead and grimacing).

J0800: Indicators of Pain (cont.)

Examples (cont.)

4. *Resident* S is in a persistent vegetative state following a traumatic brain injury. *They are* unable to verbally communicate. There is no documentation of pain in *their* medical record *in* the *last* 5 day*s*. The CNA reports that *they* appear comfortable whenever *the CNA* cares for *them*. You observe the CNA providing morning care and transferring *them* from bed to chair. No pain indicators are observed at any time.

   Coding: None of These Signs Observed or Documented item (J0800Z), would be **checked**.
   Rationale: All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.

J0850: Frequency of Indicator of Pain or Possible Pain

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days	
Enter Code ☐	Frequency with which resident complains or shows evidence of pain or possible pain 1. **Indicators of pain** or possible pain observed **1 to 2 days** 2. **Indicators of pain** or possible pain observed **3 to 4 days** 3. **Indicators of pain** or possible pain observed **daily**

Item Rationale

Health-related Quality of Life

- Unrelieved pain adversely affects function and mobility contributing to dependence, skin breakdown, contractures, and weight loss.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as to an increase in behavior problems, particularly for cognitively impaired residents.

Planning for Care

- Assessment of pain frequency provides:
  - A basis for evaluating treatment need and response to treatment.
  - Information to aide in identifying optimum timing of treatment.

Steps for Assessment

1. Review medical record and interview staff and direct caregivers to determine the number of days the resident either complained of pain or showed evidence of pain as described in J0800 *in* the *l*ast 5 days.

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J0850: Frequency of Indicator of Pain or Possible Pain (cont.)

Coding Instructions

Code for pain frequency in the last 5 days.

- **Code 1:** if based on staff observation, the resident complained or showed evidence of pain 1 to 2 days.
- **Code 2:** if based on staff observation, the resident complained or showed evidence of pain 3 to 4 days.
- **Code 3:** if based on staff observation, the resident complained or showed evidence of pain on a daily basis.

Examples

1. *Resident* M is an 80-year-old *individual* with advanced dementia. During the *last* 5 days, *Resident* M was noted to be grimacing and verbalizing "ouch" over the past 2 days when *their* right shoulder was moved.

   Coding: Item J0850 would be **coded 1, indicators of pain observed 1 to 2 days.**
   Rationale: *They have* demonstrated vocal complaints of pain ("ouch"), facial expression of pain (grimacing) on 2 of the last 5 days.

2. *Resident* C is a 78-year-old individual with a history of CVA with expressive aphasia and dementia. *In* the *last* 5 days, the resident was noted on a daily basis to be rubbing *their* right knee and grimacing.

   Coding: Item J0850 would be **coded 3, indicators of pain observed daily.**
   Rationale: The resident was observed with a facial expression of pain (grimacing) and protective body movements (rubbing *their* knee) every day *in* the *last 5 days*.

J1100: Shortness of Breath (dyspnea)

J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
☐	A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
☐	B. **Shortness of breath** or trouble breathing **when sitting at rest**
☐	C. **Shortness of breath** or trouble breathing **when lying flat**
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

- Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.
- Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.

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J1100: Shortness of Breath (dyspnea) (cont.)

Planning for Care

- Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.
- The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

Steps for Assessment

Interview the resident about shortness of breath. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.

1. If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when *they* engage in certain activities.
2. Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing. Interview staff on all shifts, and family/significant other regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.
3. Observe the resident for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.
4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

Coding Instructions

Check all that apply during the 7-day look-back period.

Any evidence of the presence of a symptom of shortness of breath should be captured in this item. A resident may have any combination of these symptoms.

- **Check J1100A:** if shortness of breath or trouble breathing is present when the resident is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- **Check J1100B:** if shortness of breath or trouble breathing is present when the resident is sitting at rest.
- **Check J1100C:** if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath.
- **Check J1100Z:** if the resident reports no shortness of breath or trouble breathing and the medical record and staff interviews indicate that shortness of breath appears to be absent or well controlled with current medication.

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J1100: Shortness of Breath (dyspnea) (cont.)

Examples

1. *Resident* W has diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure. *They are* on 2 liters of oxygen and daily respiratory treatments. With oxygen *they are* able to ambulate and participate in most group activities. *They* report feeling "winded" when going on outings that require walking one or more blocks and *have* been observed having to stop to rest several times under such circumstances. Recently, *they* describe feeling "out of breath" when *they* try to lie down.

   Coding: J1100A and J1100C would be **checked.**

   Rationale: *Resident* W reported being short of breath when lying down as well as during outings that required ambulating longer distances.

2. *Resident* T has used an inhaler for years. *They are* not typically noted to be short of breath. Three days ago, during a respiratory illness, *they* had mild trouble with *their* breathing, even when sitting in bed. *Their* shortness of breath also caused *them* to limit group activities.

   Coding: J1100A and J1100B would be **checked.**

   Rationale: *Resident* T was short of breath at rest and was noted to avoid activities because of shortness of breath.

J1300: Current Tobacco Use

J1300. Current Tobacco Use	
Enter Code ☐	Tobacco use 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life.

Planning for Care

- This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.
- If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.

Steps for Assessment

1. Ask the resident if *they* used tobacco in any form during the 7-day look-back period.
2. If the resident states that *they* used tobacco in some form during the 7-day look-back period, **code 1, yes**.

DEFINITION

TOBACCO USE
Includes tobacco used in any form.

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J1300: Current Tobacco Use (cont.)

3. If the resident is unable to answer or indicates that *they* did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period.

Coding Instructions

- **Code 0, no:** if there are no indications that the resident used any form of tobacco.
- **Code 1, yes:** if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

J1400: Prognosis

J1400. Prognosis	
Enter Code ☐	Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation) 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Residents with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services in the nursing home.

Planning for Care

- If life expectancy is less than 6 months, interdisciplinary team care planning should be based on the resident's preferences for goals and interventions of care whenever possible.

Steps for Assessment

1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If the physician states that the resident's life expectancy may be less than 6 months, request that *they* document this in the medical record. Do not code until there is documentation in the medical record.
3. Review the medical record to determine whether the resident is receiving hospice services.

DEFINITION

CONDITION OR CHRONIC DISEASE THAT MAY RESULT IN A LIFE EXPECTANCY OF LESS THAN 6 MONTHS

In the physician's judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average resident with that level of illness would not be expected to survive more than 6 months.

This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on typical or average life expectancy of residents with similar level of disease burden as this resident.

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J1400: Prognosis (cont.)

Coding Instructions

- **Code 0, no:** if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
- **Code 1, yes:** if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services.

Examples

1. *Resident* T has a diagnosis of heart failure. During the past few months, *they have* had three hospital admissions for acute heart failure. *Their* heart has become significantly weaker despite maximum treatment with medications and oxygen. *Their* physician has discussed *their* deteriorating condition with *them* and *their* family and has documented that *their* prognosis for survival beyond the next couple of months is poor.

   Coding: J1400 would be **coded 1, yes**.
   Rationale: The physician documented that *their* life expectancy is likely to be less than 6 months.

2. *Resident* J was diagnosed with non-small cell lung cancer that is metastatic to *their* bone. *They are* not a candidate for surgical or curative treatment. With *their* consent, *Resident* J has been referred to hospice by *their* physician, who documented that *their* life expectancy was less than 6 months.

   Coding: J1400 would be **coded 1, yes**.
   Rationale: The physician referred the resident to hospice and documented that *their* life expectancy is likely to be less than 6 months.

DEFINITIONS

HOSPICE SERVICES
A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.

TERMINALLY ILL
"Terminally ill" means that the individual has a medical prognosis that *their* life expectancy is 6 months or less if the illness runs its normal course.

J1550: Problem Conditions

J1550. Problem Conditions	
↓ Check all that apply	
☐	A. Fever
☐	B. Vomiting
☐	C. Dehydrated
☐	D. Internal bleeding
☐	Z. None of the above

Draft

J1550: Problem Conditions (cont.)

Intent: This item provides an opportunity for screening in the areas of fever, vomiting, fluid deficits, and internal bleeding. Clinical screenings provide indications for further evaluation, diagnosis and clinical care planning.

Item Rationale

Health-related Quality of Life

- Timely assessment is needed to identify underlying causes and risk for complications.

Planning for Care

- Implementation of care plans to treat underlying causes and avoid complications is critical.

Steps for Assessment

1. Review the medical record, interview staff on all shifts and observe the resident for any indication that the resident had vomiting, fever, potential signs of dehydration, or internal bleeding during the 7-day look-back period.

Coding Instructions

Check all that apply (blue box)

- **J1550A**, fever
- **J1550B**, vomiting
- **J1550C**, dehydrated
- **J1550D**, internal bleeding
- **J1550Z**, none of the above

Coding Tips

- **Fever:** Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date.
- **Fever assessment prior to establishing base line temperature:** A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.
- **Vomiting:** Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).

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J1550: Problem Conditions (cont.)

- **Dehydrated:** Check this item if the resident presents with two or more of the following potential indicators for dehydration:
  1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
  2. Resident has one or more potential clinical signs (indicators) of dehydration, **including but not limited to** dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).
  3. Resident's fluid loss exceeds the amount of fluids *they* take in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
- **Internal Bleeding:** Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding.

J1700: Fall History on Admission/Entry or Reentry

J1700. Fall History on Admission/Entry or Reentry Complete only if A0310A = 01 or A0310E = 1	
Enter Code ☐	**A.** Did the resident have a fall any time in the **last month** prior to admission/entry or reentry? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**B.** Did the resident have a fall any time in the **last 2-6 months** prior to admission/entry or reentry? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**C.** Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry? 0. **No** 1. **Yes** 9. **Unable to determine**

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of injury, morbidity, and mortality in older adults.
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.

Draft

J1700: Fall History on Admission/Entry or Reentry (cont.)

Planning for Care

- Determine the potential need for further assessment and intervention, including evaluation of the resident's need for rehabilitation or assistive devices.
- Evaluate the physical environment as well as staffing needs for residents who are at risk for falls.

Steps for Assessment

The period of review is 180 days (6 months) prior to admission, looking back from the resident's entry date (A1600).

1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred.
2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls.
3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls.

Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident's entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred.

DEFINITION

FALL
Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, 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 a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if *they* had not caught *them*self or had not been intercepted by another person – this is still considered a fall.

CMS understands that challenging a resident's balance and training *them* to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

J1700: Fall History on Admission/Entry or Reentry (cont.)

Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no falls and transfer records and medical records do not document a fall in the 2-6 months prior to the resident's entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident's entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information, **or** if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

Coding Instructions for J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information, **or** if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

DEFINITION

FRACTURE RELATED TO A FALL
Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.

Examples

1. On admission interview, *Resident* J is asked about falls and says *they have* "not really fallen." However, *they* go on to say that when *they* went shopping with *their child* about 2 weeks ago, *their* walker got tangled with the shopping cart and *they* slipped down to the floor.

   Coding: J1700A would be **coded 1, yes**.

   Rationale: Falls caused by slipping meet the definition of falls.

J1700: Fall History on Admission/Entry or Reentry (cont.)

2. On admission interview a resident denies a history of falling. However, *their child* says that *they* found *their parent* on the floor near *their* toilet twice about 3–4 months ago.

   Coding: J1700B would be **coded 1, yes**.

   Rationale: If the individual is found on the floor, a fall is assumed to have occurred.

3. On admission interview, *Resident* M and *their* family deny any history of falling. However, nursing notes in the transferring hospital record document that *Resident* M repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at *their* bedside to prevent injury the week prior to nursing home transfer.

   Coding: J1700A would be **coded 1, yes**.

   Rationale: Medical records from an outside facility document that *Resident* M was found on a mat on the floor. This is defined as a fall.

4. Medical records note that *Resident* K had hip surgery 5 months prior to admission to the nursing home. *Resident* K's *child* says the surgery was needed to fix a broken hip due to a fall.

   Coding: Both J1700B and J1700C would be **coded 1, yes**.

   Rationale: *Resident* K had a fall related fracture 1–6 months prior to nursing home entry.

5. *Resident* O's hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and *Resident* O denies any history of falling.

   Coding: J1700C would be **coded 0, no**.

   Rationale: The fractures were not related to a fall.

6. *Resident* P has a history of a "Colles' fracture" of *their* left wrist about 3 weeks before nursing home admission. *Their child* recalls that the fracture occurred when *Resident* P tripped on a rug and fell forward on *their* outstretched hands.

   Coding: Both J1700A and J1700C would be **coded 1, yes.**

   Rationale: *Resident* P had a fall-related fracture less than 1 month prior to entry.

Draft

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent	
Enter Code ☐	Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent? 0. **No** → Skip to J2000, Prior Surgery 1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

Item Rationale

DEFINITION

PRIOR ASSESSMENT
Most recent MDS assessment that reported on falls.

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Fear of falling can limit an individual's activity and negatively impact quality of life.

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
- Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

Steps for Assessment

1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.
4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

Draft

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Coding Instructions

- **Code 0, no:** if the resident has not had any fall since the last assessment. Skip to **Swallowing Disorder** item (K0100) if the assessment being completed is an OBRA assessment. If the assessment being completed is a Scheduled PPS assessment, skip to **Prior Surgery** item (J2000).
- **Code 1, yes:** if the resident has fallen since the last assessment. Continue to **Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)** item (J1900), whichever is more recent.

Example

1. An incident report describes an event in which *Resident* S was walking down the hall and appeared to slip on a wet spot on the floor. *They* lost *their* balance and bumped into the wall, but *were* able to grab onto the hand rail and steady *them*self.

   Coding: J1800 would be **coded 1, yes**.
   Rationale: An intercepted fall is considered a fall.

Draft

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent		
Coding: 0. **None** 1. **One** 2. **Two or more**	↓ **Enter Codes in Boxes**	
	☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.
- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.

DEFINITION

INJURY RELATED TO A FALL
Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

DEFINITIONS

INJURY (EXCEPT MAJOR)
Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

MAJOR INJURY
Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Draft

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Steps for Assessment

1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls.
4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury.
5. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record.
6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.

Coding Instructions for J1900

Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. **If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.**

Coding Instructions for J1900A, No Injury

- **Code 0, none:** if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900B, Injury (Except Major)

- **Code 0, none:** if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

- **Code 2, two or more:** if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Tip

- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the *Internet* Quality Improvement and Evaluation System (*i*QIES), the assessment must be modified to update the level of injury that occurred with that fall.

Examples

1. A nursing note states that *Resident* K slipped out of *their* wheelchair onto the floor while at the dining room table. Before being assisted back into *their* chair, a range of motion assessment was completed that indicated no injury. A skin assessment conducted shortly after the fall also revealed no injury.

   Coding: J1900A would be **coded 1, one**.

   Rationale: Slipping to the floor is a fall. No injury was noted.

2. Nurse's notes describe a situation in which *Resident* Z went out with *their* family for dinner. When they returned, *their child* stated that while at the restaurant, *Resident Z* fell in the bathroom. No injury was noted when *they* returned from dinner.

   Coding: J1900A would be **coded 1, one**.

   Rationale: Falls during the nursing home stay, even if on outings, are captured here.

3. A nurse's note describes a resident who, while being treated for pneumonia, climbed over *their* bedrails and fell to the floor. *They* had a cut over *their* left eye and some swelling on *their* arm. *They were* sent to the emergency room, where X-rays revealed no injury and neurological checks revealed no changes in mental status.

   Coding: J1900B would be **coded 1, one**.

   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

4. A resident fell, lacerated *their* head, and head CT scan indicated a subdural hematoma.

   Coding: J1900C would be **coded 1, one**.

   Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

5. *Resident* R fell on *their* right hip in the facility on the ARD of *their* Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed *Resident* R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to *i*QIES. Three days later, *Resident* R complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment.

   Original Coding: J1900B, Injury (except major) is **coded 1, one** and J1900C, Major Injury is **coded 0, none**.

   Rationale: *Resident* R had a fall-related injury that caused *them* to complain of pain.

   Modification of Quarterly assessment: J1900B, Injury (except major) is **coded 0, none** and J1900C, Major Injury, is **coded 1, one**.

   Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to *i*QIES and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.

J2000: Prior Surgery

J2000. Prior Surgery - Complete only if A0310B = 01	
Enter Code ☐	Did the resident have major surgery during the **100 days prior to admission**? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the 100 days prior to admission can affect a resident's recovery.

J2000: Prior Surgery (cont.)

Planning for Care

- This item identifies whether the resident has had major surgery during the 100 days prior to the start of the Medicare Part A stay. A recent history of major surgery can affect a resident's recovery.

Steps for Assessment

1. Ask the resident and *their* family or significant other about any surgical procedures in the 100 days prior to admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the 100 days prior to admission.

   Medical record sources include medical records received from facilities where the resident received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

DEFINITION

MAJOR SURGERY

Refers to a procedure that meets the following criteria:

1. *The resident was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the skilled nursing facility (SNF),* ***and***
2. *The surgery carried some degree of risk to the resident's life or the potential for severe disability.*

Coding Instructions

- **Code 0, No:** if the resident did not have major surgery during the 100 days prior to admission.
- **Code 1, Yes:** if the resident had major surgery during the 100 days prior to admission.
- **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission.

Examples

1. *Resident* T reports that *they* required surgical removal of a skin tag from *their* neck a month and a half ago. *They* had the procedure as an outpatient. *Resident* T report no other surgeries in the last 100 days.

   Coding: J2000 would be coded **0, No.**

   Rationale: *Resident* T's skin tag removal surgery did not require an acute care inpatient stay; therefore, the skin tag removal does not meet the required criteria to be coded as major surgery. *Resident* T did not have any other surgeries in the last 100 days.

Draft

J2000: Prior Surgery (cont.)

2. *Resident* A's *spouse* informs *their* nurse that six months ago *Resident A* was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. *Resident* A's *spouse* reports *Resident* A has had no other surgeries since the time of *their* bowel resection.

   Coding: J2000 would be coded **0, No.**

   Rationale: Bowel resection is a major surgery that has some degree of risk for death or severe disability, and *Resident* A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and *Resident* A has not undergone any surgery since that time.

3. *Resident* G was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in *their* medical record. *They were* transferred to the facility immediately following a four-day acute care hospital stay.

   Coding: J2000 would be coded **1, Yes.**

   Rationale: In the last 100 days, *Resident* G underwent a complicated cholecystectomy, which required a four-day hospitalization. *They* additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability.

J2100: Recent Surgery Requiring Active SNF Care

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or if state requires completion with an OBRA assessment	
Enter Code ☐	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.

Planning for Care

- This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

Draft

J2100: Recent Surgery Requiring Active SNF Care (cont.)

Steps for Assessment

1. Ask the resident and *their* family or significant other about any surgical procedures that occurred during the inpatient hospital stay that immediately preceded the resident's Part A admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

   Medical record sources include medical records received from facilities where the resident received health care during the inpatient hospital stay that immediately preceded the resident's Part A admission, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

- **Code 0, No:** if the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 1, Yes:** if the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

Coding Tips

- Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:
  1. the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), **and**
  2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Draft

J2300–J5000: Recent Surgeries Requiring Active SNF Care

Surgical Procedures - Complete only if J2100 = 1	
↓	**Check all that apply**
	Major Joint Replacement
☐	**J2300. Knee Replacement** - partial or total
☐	**J2310. Hip Replacement** - partial or total
☐	**J2320. Ankle Replacement** - partial or total
☐	**J2330. Shoulder Replacement** - partial or total
	Spinal Surgery
☐	**J2400. Involving the spinal cord or major spinal nerves**
☐	**J2410. Involving fusion of spinal bones**
☐	**J2420. Involving lamina, discs, or facets**
☐	**J2499. Other major spinal surgery**
	Other Orthopedic Surgery
☐	**J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
☐	**J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐	**J2520. Repair but not replace joints**
☐	**J2530. Repair other bones** (such as hand, foot, jaw)
☐	**J2599. Other major orthopedic surgery**
	Neurological Surgery
☐	**J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐	**J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
☐	**J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**
	Cardiopulmonary Surgery
☐	**J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
☐	**J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐	**J2799. Other major cardiopulmonary surgery**
	Genitourinary Surgery
☐	**J2800. Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
☐	**J2899. Other major genitourinary surgery**
	Other Major Surgery
☐	**J2900. Involving tendons, ligaments, or muscles**
☐	**J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
☐	**J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
☐	**J2930. Involving the breast**
☐	**J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
☐	**J5000. Other major surgery not listed above**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.

Planning for Care

- This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

Draft

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

Steps for Assessment

1. **Identify recent surgeries:** The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission.
   - Medical record sources for recent surgeries include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available.
   - Although open communication regarding resident information between the physician and other members of the interdisciplinary team is important, it is also essential that resident information communicated verbally be documented in the medical record by the physician to ensure follow-up.
   - Surgery information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.
2. **Determine whether the surgeries require active care during the SNF stay:** Once a recent surgery is identified, it must be determined if the surgery requires **active** care during the SNF stay**.** Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship** to the resident's primary SNF diagnosis, as coded in I0020B.
   - Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered surgeries that do not require active care during the SNF stay.
   - Check the following information sources in the medical record for the last 30 days to identify "active" surgeries: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Coding Instructions

Code surgeries that are documented to have occurred in the last 30 days, and during the inpatient stay that immediately preceded the resident's Part A admission, that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.

- Check off each surgery requiring active SNF care as defined above, as follows:
  - Surgeries are listed by major surgical category: Major Joint Replacement, Spinal Surgery, Orthopedic Surgery, Neurologic Surgery, Cardiopulmonary Surgery, Genitourinary Surgery, Other Major Surgery.

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

— Examples of surgeries are included for each surgical category. For example, **J2810, Genitourinary surgery - the kidneys, ureter, adrenals, and bladder—open, laparoscopic,** includes open or laparoscopic surgeries on the kidneys, ureter, adrenals, and bladder, but not other components of the genitourinary system.

- Check all that apply.

Major Joint Replacement

- **J2300,** Knee Replacement - partial or total
- **J2310,** Hip Replacement - partial or total
- **J2320,** Ankle Replacement - partial or total
- **J2330,** Shoulder Replacement - partial or total

Spinal Surgery

- **J2400,** Spinal surgery - spinal cord or major spinal nerves
- **J2410,** Spinal surgery - fusion of spinal bones
- **J2420,** Spinal surgery - lamina, discs, or facets
- **J2499,** Spinal surgery - other

Orthopedic Surgery

- **J2500,** Ortho surgery - repair fractures of shoulder or arm
- **J2510,** Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle
- **J2520,** Ortho surgery - repair but not replace joints
- **J2530,** Ortho surgery - repair other bones
- **J2599,** Ortho surgery - other

Neurologic Surgery

- **J2600,** Neuro surgery - brain, surrounding tissue or blood vessels
- **J2610,** Neuro surgery - peripheral and autonomic nervous system - open and percutaneous
- **J2620,** Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices
- **J2699,** Neuro surgery - other

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J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

Cardiopulmonary Surgery

- **J2700,** Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures
- **J2710,** Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open and endoscopic
- **J2799,** Cardiopulmonary surgery - other

Genitourinary Surgery

- **J2800,** Genitourinary surgery - male or female organs
- **J2810,** Genitourinary surgery - the kidneys, ureter, adrenals, and bladder - open, laparoscopic
- **J2899,** Genitourinary surgery - other

Other Major Surgery

- **J2900,** Major surgery - tendons, ligament, or muscles
- **J2910,** Major surgery - the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen - open or laparoscopic
- **J2920,** Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open
- **J2930,** Major surgery - the breast
- **J2940,** Major surgery - repair of deep ulcers, internal brachytherapy, bone marrow, or stem cell harvest or transplant
- **J5000,** Major surgery - not listed above

Coding Tips

The following information may assist assessors in determining whether a surgery should be coded as requiring active care during the SNF stay.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.**
  - The physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) may specifically indicate that the SNF stay is for treatment related to the surgical intervention. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.

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J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

- **In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:**

  The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:

  — The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage).

  — Daily skilled therapy to restore functional loss after surgical procedures.

  — Administration of medication and monitoring that requires skilled nursing.

Examples of surgeries requiring active SNF care and related to the primary SNF diagnosis

1. *Resident* V was hospitalized for gram-negative pneumonia. Since this was *their* second episode of pneumonia in the past six months, a diagnostic bronchoscopy was performed while in the hospital. *They* also *have* Parkinson's disease and rheumatoid arthritis. *They were* discharged to a SNF for continued antibiotic treatment for *their* pneumonia and require daily skilled care.

   Coding: I0020 is coded as 13, Medically Complex Conditions, and the **I0020B** SNF ICD-10 code is J15.6, Pneumonia due to other aerobic Gram-negative bacteria. There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.

   Rationale: *Resident* V did not receive any major surgery during the prior inpatient stay, and *they were* admitted to the SNF for continued care due to pneumonia.

2. *Resident* O, a diabetic, was hospitalized for sepsis from an infection due to Methicillin susceptible Staphylococcus aureus that developed after outpatient bunion surgery. A central line was placed to administer antibiotics. *They were* discharged to a SNF for continued antibiotic treatment and monitoring.

   Coding: I0020 is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is A41.01 (Sepsis due to Methicillin susceptible Staphylococcus aureus). There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.

   Rationale: Neither the placement of a central line nor the outpatient bunion surgery is considered to be a major surgery, but the resident was admitted to the SNF for continued antibiotic treatment and monitoring.

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J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

3. *Resident* H was hospitalized for severe back pain from a compression fracture of a lumbar vertebral body, which was caused by *their* age-related osteoporosis. *They were* treated with a kyphoplasty that relieved *their* pain. *They were* transferred to a SNF after discharge because of *their* mild dementia and need to regulate *their* anticoagulant treatment for atrial fibrillation.

   Coding: I0020 is coded 10, Fractures and Other Multiple Trauma. The **I0020B** SNF ICD-10 code is M80.08XD (Age-related osteoporosis with current pathological fracture, vertebra(e), subsequent encounter for fracture with routine healing). There was no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.

   Rationale: *Resident* H was treated with a kyphoplasty during the inpatient stay prior to SNF admission. Although kyphoplasty is a minor surgery and does not require SNF care in and of itself, the resident has other conditions requiring skilled care that are unrelated to the kyphoplasty surgery.

4. *Resident* J had a craniotomy to drain a subdural hematoma after suffering a fall at home. *They have* COPD and use oxygen at night. In addition, *they have* moderate congestive heart failure, *are* moderately overweight, and *have* hypothyroidism. After a six-day hospital stay, *they were* discharged to a SNF for continuing care. The hospital discharge summary indicated that the patient had a loss of consciousness of 45 minutes.

   Coding: I0020 is coded 07, Other Neurological Conditions. The **I0020B** SNF ICD-10 code is S06.5X2D (Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter). **J2100** would be coded 1, Yes. **J2600**, Neuro surgery - brain, surrounding tissue or blood vessels, would be checked.

   Rationale: The craniotomy surgery during the inpatient stay immediately preceding the SNF stay requires continued skilled care and skilled monitoring for wound care, as well as therapies to address any deficits that led to *their* fall or any functional deficits resulting from *their* fall.

5. *Resident* D was admitted to an acute care hospital for cytoreductive surgery for metastatic renal cell carcinoma. *They were* admitted to the SNF for further treatment of the metastatic renal cell carcinoma and post-surgical care.

   Coding: I0020 is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is C79.01 (Secondary malignant neoplasm of the right kidney and renal pelvis). **J2100** would be coded 1, Yes. **J2810**, Genitourinary surgery – the kidneys, ureter, adrenals, and bladder – open, laparoscopic, would be checked.

   Rationale: *Resident* D was treated with a surgical procedure, genitourinary surgery of the kidney, and admitted to the SNF for further treatment of the metastatic kidney cancer and post-surgical care.

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

6. *Resident* G was admitted to an acute care hospital for severe abdominal pain. *They were* found to have diverticulitis of the small intestine with perforation and abscess without bleeding. *They* had surgery to repair the perforation. *They were* admitted to the SNF for continued antibiotics and post-surgical care.

   Coding: I0020 is coded 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is K57.00 (Diverticulitis of small intestine with perforation and abscess without bleeding), and **J2100** would be coded 1, Yes. **J2910**, Major surgery – the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen – open or laparoscopic, would be checked.

   Rationale: *Resident* G was treated with a surgical procedure, repair of the small intestine perforation, which is a major surgical procedure. *They were* admitted to the SNF for continued antibiotics and post-surgical care.

7. *Resident* W underwent surgical repair for a left fractured hip (i.e., subtrochanteric fracture) during an inpatient hospitalization. *They were* admitted to the SNF for post-surgical care.

   Coding: I0020 is coded as Code 10, Fractures and Other Multiple Trauma. The **I0020B** SNF ICD-10 code is S72.22XD (Displaced subtrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing) and **J2100** is coded as 1, Yes. **J2510**, Ortho surgery – repair fractures of pelvis, hip, leg, knee, or ankle, would be checked.

   Rationale: This is major surgery requiring skilled nursing care to provide wound care and to monitor for early signs of infection or blood clots, for which *Resident* W was admitted to the SNF.

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