RAI Manual

Pages J-27 to J-35

Coding for MDS Items J1700 to J1900

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 he or she takes 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.

J1700: Fall History on Admission (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, Mrs. J. is asked about falls and says she has "not really fallen." However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.

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

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

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

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.

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 Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

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

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.)

4. A resident fell, lacerated his 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. Mr. R. fell on his right hip in the facility on the ARD of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to QIES ASAP. Three days later, Mr. 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: Mr. R. had a fall-related injury that caused him 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 QIES ASAP 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.