ASPEN
MDS
Viewer

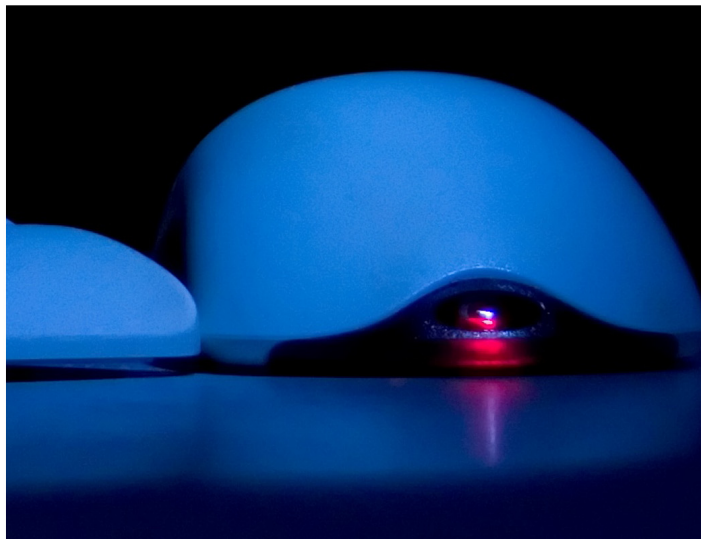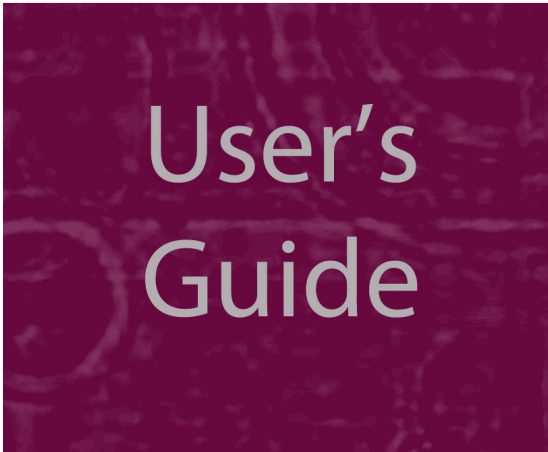## User's Guide

Information in this procedures guide is subject to change without notice.

All brand or product names are trade names, service marks, trademarks, or registered trademarks of their respective companies or organizations.

Systems Environment

Application Development: Microsoft Visual C++ and C# 2008 (9.0), .NET 3.51 SP1

Desktop Database (ASE-Q only): SQL Anywhere 11

CMS-supported operating systems and MS Internet Explorer versions are posted on the QTSO Website
https://www.qtso.com
under the Minimum System Requirements section

Oracle Database 11g/12c

Enterprise Edition Release 11.2.0.3.0

Optional System Environments

MAPI Compliant E-mail client to support e-mail transfer of survey information

Note: This document can be viewed online or printed in a duplex (two-sided) format. Blank pages have been automatically inserted as needed for correct pagination in the printed copy.

Contents

Introduction

The ASPEN Minimum Data Set (MDS) Viewer displays information used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and non-critical access hospitals with Medicare swing bed agreements. Items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies.

MDS assessment data are also used to monitor the quality of care in nursing homes. MDS-based quality measures (QMs) were developed by researchers to assist:

1   State Survey and Certification staff in identifying potential care problems in a nursing home.

2   Nursing home providers with quality improvement activities/efforts.

3   Nursing home consumers in understanding the quality of care provided by a nursing home.

4   CMS with long-term quality monitoring and program planning. CMS continuously evaluates the usefulness of the QMs, which may be modified in the future to enhance their effectiveness.

About this Procedures Guide

The *Minimum Data Set User's Guide* gives you the information you need to:

- Open the ASPEN MDS Viewer
- Select a resident and display assessments
- View item set values for each assessment section
- Sort the section summary view by item set

Note: This guide assumes that you are familiar with basic Windows operations.

This guide consists of this introduction and the following two chapters:

- Using the MDS Viewer

  Provides procedures for viewing the MDS data.

- MDS Viewer Records

  Presents descriptions of the records displayed in the MDS Viewer.

View this Document Online

You must have Adobe Reader installed to view this document online. You can download the latest version from https://get.adobe.com/reader/.

On any page, you can click the Increase (+) or Decrease (-) button in the toolbar to adjust the page magnification to your comfort level. Use the bookmarks in the left pane of Adobe Reader to locate and go (click the bookmark) to relevant information in this procedures guide.
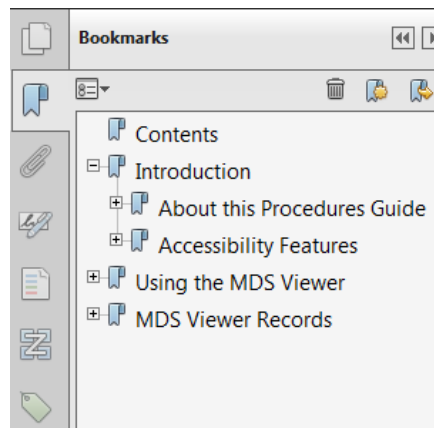
Figure 1: Bookmarks

You can also click the Contents bookmark and then click links in the table of contents to go to relevant topics.

TIP: For best viewing quality in the Adobe Reader, go to Edit | Preferences | Page Display (path may vary somewhat depending on version). Select the applicable Smooth Text option.

If you need more information, links to relevant additional material are included. Click a link to directly access the related information.

In the Using MDS Viewer chapter, there are links (cross-references) to additional material. They are grouped at the end of a procedure or descriptive section.

More ...

➡ Click the link to go to descriptive information about the indicated topic.

View a Printed Copy of this Document

While it is designed to be used easily online, you can print this document if you prefer. If you print this document, use the Table of Contents to locate the information you need. Links (cross-references) to additional material in this document include page numbers; simply go to the indicated page.

Conventions

This guide uses the following conventions:

Bold   In procedures: names of screens, screen sections, windows you open; and buttons, menu options, keys you press.

web   Generic reference to the World Wide Web.

More ...
Introduces a list of "see also" cross-references.

Note: Notes give you important information that may affect how you use a function.

TIP: Tips give you useful hints, suggestions, or alternative approaches.

Accessibility Features

This procedures guide incorporates the following 508-compliant accessibility features:

- Alternate text (alt text), which screen readers can read, is defined for all graphics. In the Screens chapter, there are links (cross-references) to the field/column descriptions for the indicated screen or section of screen.

- All graphics have captions.

- Information is not conveyed by means of color alone.

- Tables are not used for formatting, so all text is accessible to screen readers.

- Windows keyboard shortcuts are included in the Supporting Materials chapter for easy reference.

- Reading order is optimized, so content is read correctly by screen readers.

Using the MDS Viewer

You can open the ASPEN MDS Viewer from ASPEN Central Office (ACO), ASPEN Regional Office (ARO), and ASPEN Survey Explorer-Quality (ASE-Q). The application window, provides quick access to resident assessment information.

Open the MDS Viewer

To open the MDS Viewer:

1 In ACO/ARO or ASE-Q Tree view, expand the facility associated with the resident you want to view.

2 Right-click the **Residents MDS 3.0** node and select **MDS 3.0 Resident Viewer**.

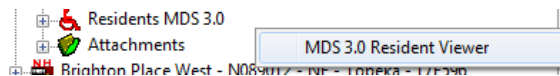*Figure 2: MDS 3.0 Resident Viewer*

The ASPEN MDS Viewer opens for the selected facility and, in ASE-Q, displays all residents whose most recent assessment is assigned to that facility. In ACO/ARO, residents display if any assessment was performed at the facility.

The title bar displays the facility name, CCN and, in ACO/ARO, Exclude discharges days for the selected facility.
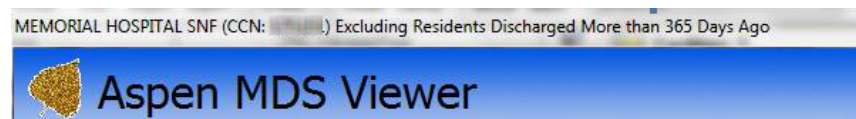

Figure 3: Title bar

ASE-Q Check

When you start ASE-Q, a check is performed on nursing home facilities. If the most recent assessment for a facility is 90 days old, a warning message displays that facilities have privacy information more than 90 days old. Users have the option to proceed and remove the old data, or exit ASE-Q. If the user selects "No, Exit ASE-Q", ASE-Q will shut down, and the assessment data remains. Otherwise, assessment data is removed for those facilities.

Tree View

The left pane of the MDS Viewer organizes the residents in the conventional Windows tree format. All residents in the tree are listed under the All Roster node and are also listed alphabetically. You can expand and collapse tree branches (nodes) as needed. Expand the resident node in Tree view to view a list of assessments for that resident.

➡ Click the **Plus** to expand the branch/node.
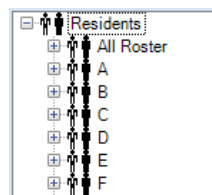
Figure 4: Collapsed nodes
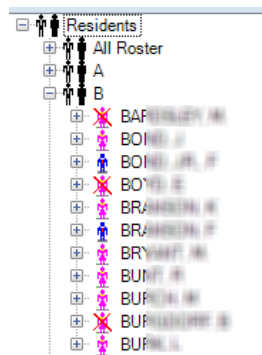
Figure 5: Expanded node

To view resident assessments in Tree view:

➡ Expand the **All Roster** node, and then expand the resident name.

    -or-

➡ Locate the resident in the alpha nodes and expand the resident name.
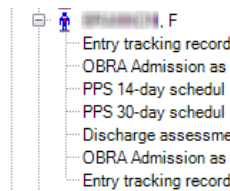
Figure 6: Expanded resident node in Tree view shows assessments

All assessments for the expanded resident are listed below the resident name.

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"Assessment Types and Definitions" on page 20

Section View

To the right of Tree view, in the area labeled Section, assessments are listed for the resident selected in Tree view. The summary view column headers (A-Z) relate to the MDS item labels. Highlight an assessment in summary view to see the details below.
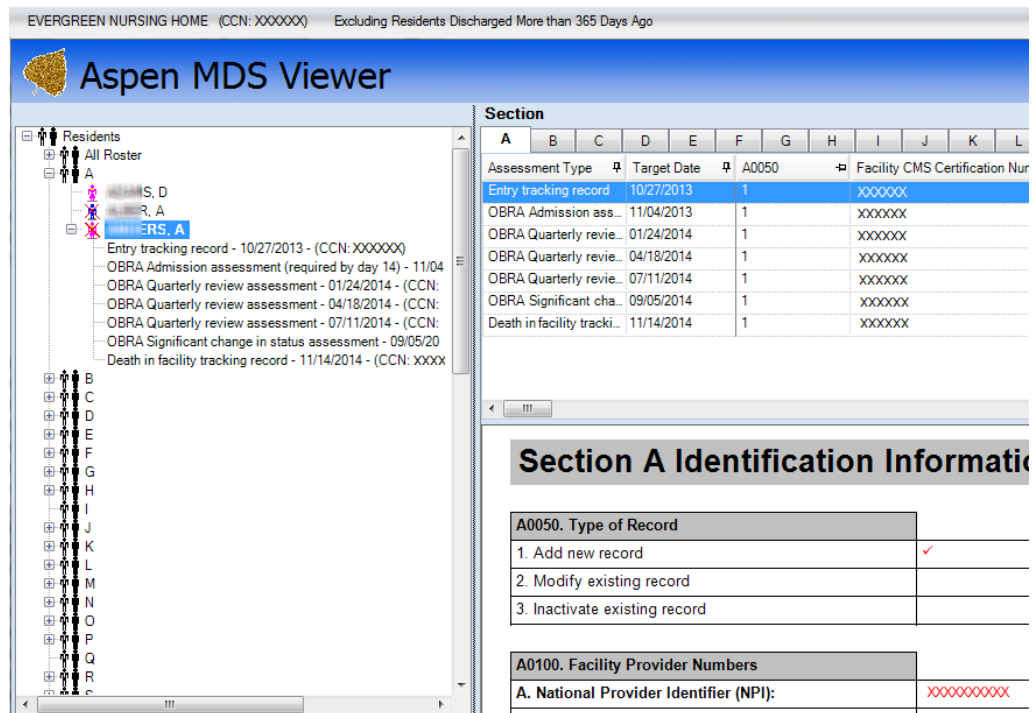
Figure 7: Section view displays details of highlighted assessment

Item sets for the selected assessment section are listed in columns (A-Z) across from the assessment. Data values displayed in red indicate a change in value from the prior assessment. For data value descriptions, hold your mouse over any data value to display Hover Help.
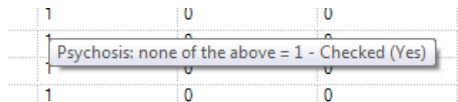
Figure 8: Hover Help

View Assessments in Section view

To view resident assessments in Section view:

➡ Select the resident name in Tree view.

A summary view of the assessments displays at the top of the right pane with the details of the highlighted assessment below.

Figure 9: Tree view and Section view list assessments for selected resident

To view an assessment section:

➡ Click the alpha tab (A-Z) in summary view that corresponds to the assessment you want to view. The right panes will refresh with summary and detail information for that section.

For instance, click the E tab to view summary and detail information about Behavior for the selected resident.

To view the item sets for an assessment:

➡ Use the horizontal scroll bar to view all items sets listed in columns across from the assessment in summary view.

➡ In the detailed view (below), use the vertical scroll bar to view all item sets for the assessment selected in summary view.
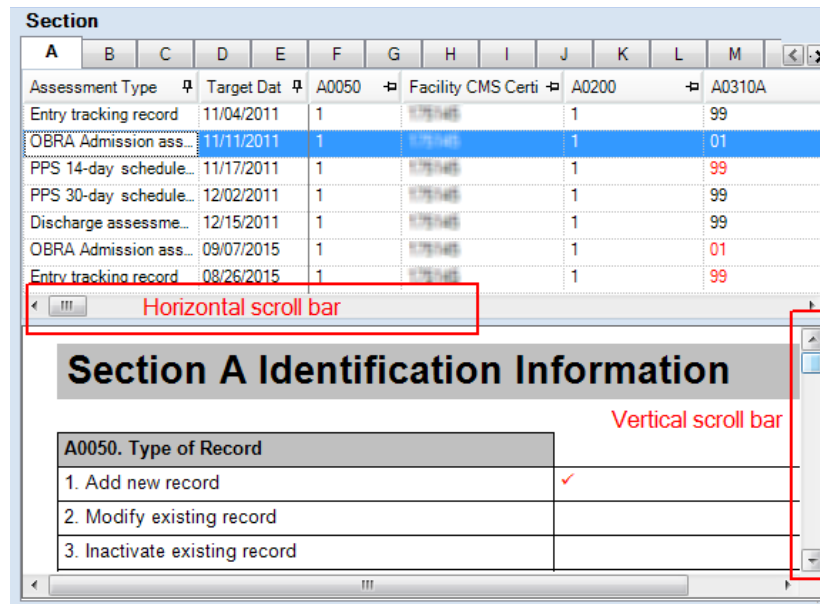
Figure 10: Use scroll bars to view item sets

More ...

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"Assessment Types and Definitions" on page 20
"Assessment Record Item Type/Intent" on page 28

Sort the Section Summary view

The assessment summary view default order is on assessment date, descending (most current assessment first). You can reorder the columns in summary view.

➡ Click the Pin icon on a column heading to move the column to be the left-hand 'frozen' column on the summary grid.
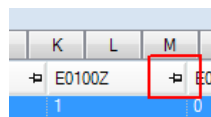
Figure 11: Pin icon

More ...

"Icons" on page 19

Displayed Residents/Assessments

In ACO/ARO the MDS Viewer continues to show assessments for former residents after they have moved to a different facility, and includes information on the facility to which the resident moved. In the case where a resident came from another facility to the current facility, the MDS Viewer also includes the assessments from the resident's prior provider in the assessment information for the resident's current provider.

If the most recent assessment for a resident at the facility being viewed is one of the discharge types, the resident displays in the tree with an "X" over the icon, indicating they are discharged. A discharged resident continues to display as discharged in this facility's viewer until one of the following occurs:

• The resident is re-admitted to the same facility and the re-admission assessment becomes the most current (Resident continues to display but the X icon is removed).

• The target date of the resident's discharge record exceeds the date threshold for displaying discharged residents. This is set under State Customization and allows the state to control how far back discharged residents continue to display. If a state sets Exclude discharge days to 365, then residents whose most current assessment is a discharge type with a target date greater than 365 days in the past no longer displays (default display period for discharged resident is two years).

To set Exclude discharge days:

1 From the **System** menu, select **State Customization**.
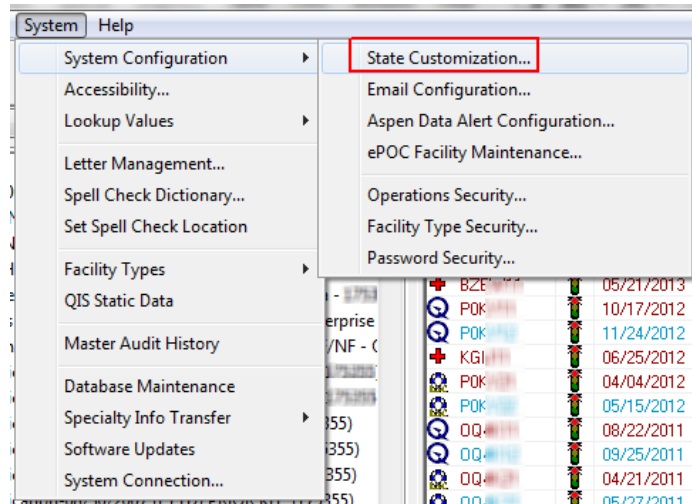
Figure 12: State Customization menu option

Note: You may be required to enter a password to set Exclude discharge days.

2 To exclude recent discharges from resident assessments, enter the number of days in **Exclude discharges [ ] days**. The maximum and default values are two years, but the value can be changed to any number of days less than two years.
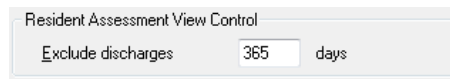
Figure 13: Resident Assessment View Control

When users view resident assessment information, they will not see discharges with a target date earlier than today minus the exclude discharges days.

The Exclude discharge period is included in the MDS Viewer title bar.
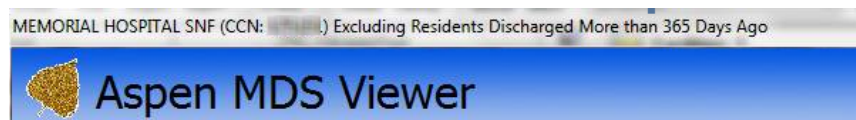
Figure 14: Exclude Discharge Days setting in title bar

Residents that Move Between Providers

The resident name branch of Tree view shows resident is "Currently at: ABC Nursing (CCN:XXXXXX)" when ASPEN verifies a more recent assessment at a different provider than the most recent assessment at the provider being viewed. If multiple providers have more recent assessments, then only the provider with the most recent assessment is shown.
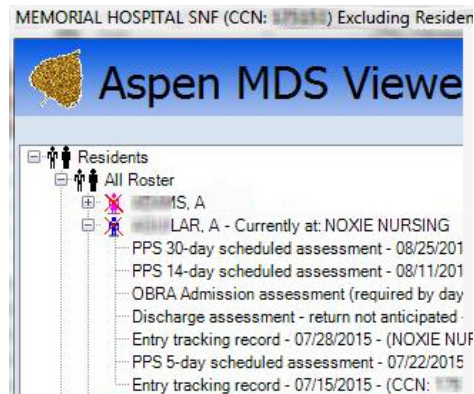
Figure 15: Example of "Currently at:" notation

Updated MDS Data

As part of the survey process for Nursing Home facilities Surveyors, Central Office, and Regional Office staff members can view updated MDS Data from the Resident node.

MDS Transfer to ASE-Q

When you transfer survey shells to ASE-Q, only assessments performed at the current facility within the last 180 days transfer. Therefore, there is no Exclude Discharge Days setting in ASE-Q, as in ACO/ARO.

MDS Viewer Records

Icons

Icons located beside the resident name in Tree view indicate a male or female resident and if the most recent assessment is a discharge-type assessment. The Pin icon in Section view is used for sorting.

Icon	Description
	Female resident
	Male resident
	Female icon with X on top indicates most recent assessment type is discharge
	Male icon with X on top indicates most recent assessment type is discharge
	Click icon to move column to the left-hand 'frozen' column on the summary grid

Assessment Types and Definitions

In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Detailed instructions are provided throughout the rest of this chapter.

Admission

Refers to the date a person enters the facility and is admitted as a resident. A day begins at midnight and ends at 11:59 p.m. Regardless of whether admission occurs at midnight or 11:59 p.m., this date is considered the 1st day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:

- when the resident has never been admitted to this facility before; OR

- when the resident has been in this facility previously and was discharged return not anticipated; OR

- when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

Assessment Combination

Refers to the use of one assessment to satisfy both OBRA and Medicare PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. Sections 2.11 and 2.12 provide more detailed information on combining Medicare and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA assessment requirements, such as Admission and Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA.

Assessment Completion

Refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (Item Z0500) and CAA(s) (Item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.

- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.

Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for Medicare assessments.

Assessment Reference Date (ARD)

Refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at midnight and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 a.m. on June 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding.

Assessment Scheduling

Refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and the observation periods required to complete the MDS items.

Assessment Submission

Refers to electronic MDS data being in record and file formats that conform to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. Chapter 5, CFR 483.20(f)(2), and the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site provide more detailed information.

Assessment Timing

Refers to when and how often assessments must be conducted, based upon the resident's length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the Medicare-required PPS assessment timing schedule is provided in Section 2.8.

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary team (IDT).

- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.

- This cycle (Comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – Comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a Significant Change in Status Assessment (SCSA) has not occurred, 2) an uncorrected significant error in prior comprehensive or Quarterly assessment was not determined, and 3) was not discharged with return not anticipated.

- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.

- When a resident does have a SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.

- Early Medicare-required assessments completed with an ARD prior to the beginning of the prescribed ARD window will have a payment penalty applied (see Section 2.13).

Assessment Transmission

Refers to the electronic transmission of submission files to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system using the Medicare Data Communication Network (MDCN). Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

Comprehensive

MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process and care planning. Comprehensive MDSs include Admission, Annual, Significant Change in Status Assessment (SCSA), and Significant Correction to Prior Comprehensive Assessment (SCPA).

Death In Facility

Refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. A Discharge assessment is not required.

Discharge

Refers to the date a resident leaves the facility. A day begins at midnight and ends at 11:59 p.m. Regardless of whether discharge occurs at midnight or 11:59 p.m., this date is considered the actual date of discharge. There are two types of discharges – return anticipated and return not anticipated. A Discharge assessment is required with both types of discharges. Section 2.6 provides detailed instructions regarding both discharge types. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

• Resident is discharged from the facility to a private residence (as opposed to going on an LOA);

• Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);

• Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.

• Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed.

Discharge Assessment

Refers to an assessment required on resident discharge. This assessment includes clinical items for quality monitoring as well as discharge tracking information.

Entry

Term is used for both an admission and a reentry, and requires completion of an Entry tracking record.

Entry and Discharge Reporting

MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter or leave a nursing home. Entry/Discharge reporting includes Entry tracking record, Discharge assessments, and Death in Facility tracking record.

Interdisciplinary Team (IDT1)

A group of clinicians from several medical fields that combines knowledge, skills, and resources to provide care to the resident.

1 42 CFR 483.20(k)(2) A comprehensive care plan must be Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative;"

2 The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

Item Set

Refers to the MDS items that are active on a particular assessment type or tracking form. There are 10 different item subsets for nursing homes and 8 for swing bed providers as follows:

• Nursing Home

Comprehensive (NC2) Item Set. This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone or combined with any other assessment (PPS assessment and/or Discharge assessment).

Quarterly (NQ) Item Set. This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly Assessment). This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.

PPS (NP) Item Set. This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day). This item set is used for a standalone scheduled PPS assessment or a scheduled PPS assessment combined with a PPS OMRA assessment and/or a Discharge assessment.

OMRA - Start of Therapy (NS) Item Set. This is the set of items active on a standalone start of therapy OMRA assessment.

OMRA - Start of Therapy and Discharge (NSD) Item Set. This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).

OMRA (NO) Item Set. This is the set of items active on a standalone end of therapy OMRA and a change of therapy OMRA assessment. The code used is "NO" since this was the only type of OMRA when the code was initially assigned.

OMRA - Discharge (NOD) Item Subset. This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).

Discharge (ND) Item Set. This is the set of items active on a standalone Discharge assessment (either return anticipated or not anticipated).

Tracking (NT) Item Set. This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

Inactivation Request (XX) Item Set. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

- Swing Beds

PPS (SP) Item Set. This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day) or a Swing Bed Clinical Change assessment. This item set is used for a scheduled PPS assessment that is standalone or in any combination with other swing bed assessments (Swing Bed Clinical Change assessment, OMRA assessment, and/or Discharge assessment). This item set is also used for a Swing Bed Clinical Change assessment that is standalone or in any combination with other swing bed assessments (scheduled PPS assessment, OMRA assessment, and/or Discharge assessment).

OMRA – Start of Therapy (SS) Item Set. This is the set of items active on a standalone start of therapy OMRA assessment.

OMRA – Start of Therapy and Discharge Assessment (SSD) Item Set. This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).

OMRA (SO) Item Set. This is the set of items active on a standalone end of therapy OMRA and change of therapy OMRA assessment.

OMRA - Discharge Assessment (SOD) Item Set. This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).

Discharge (SD) Item Set. This is the set of items active on a standalone Discharge assessment (either return anticipated or not anticipated).

Tracking (ST) Item Set. This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

Inactivation (XX) Item Set. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

Printed layouts for the item sets are available in Appendix H of this manual.

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, and A0310F). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2.15 of this chapter provides manual lookup tables for determining the item set, when automated software is unavailable.

Leave of Absence (LOA)

Does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the patient.

Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record.

MDS Assessment Codes

Those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, and A0310F of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

Medicare-Required PPS Assessment

Provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment) and A0310C (PPS Other Medicare Required Assessment – OMRA). They include:

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)

- Start of Therapy (SOT) Other Medicare Required (OMRA)

- End of Therapy (EOT) OMRA

- Both Start and End of Therapy OMRA

- Change of Therapy (COT) OMRA

Non-Comprehensive

MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly and Significant Correction to Prior Quarterly (SCQA) assessments.

Observation (Look Back) Period

The time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at midnight and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS.

OBRA-Required Tracking Records and Assessments

Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:

Tracking records:

- Entry

- Death in facility

Assessments:

- Admission (comprehensive)

- Quarterly

- Annual (comprehensive)

- SCSA (comprehensive)

- SCPA (comprehensive)

- SCQA
- Discharge (return not anticipated or return anticipated)

Reentry

Refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

Respite

Refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.

Assessment Record Item Type/Intent

A: Identification Information

Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.

B: Hearing, Speech, and Vision

Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.

C: Cognitive Patterns

Determine the resident's attention, orientation, and ability to register and recall information.

D: Mood

Identify signs and symptoms of mood distress.

E: Behavior

Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.

F: Preferences for Customary Routine and Activities

Obtain information regarding the resident's preferences for his or her daily routine and activities.

G: Functional Status

Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.

H: Bladder and Bowel

Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

I: Active Diagnoses

Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.

J: Health Conditions

Document health conditions that impact the resident's functional status and quality of life.

K: Swallowing/Nutritional Status

Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.

L: Oral/Dental Status

Record any oral or dental problems present.

M: Skin Conditions

Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.

N: Medications

Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.

O: Special Treatments, Procedures and Programs

Identify any special treatments, procedures, and programs that the resident received during the specified time periods.

P: Restraints

Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.

Q: Participation in Assessment and Goal Setting

Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.

V: Care Area Assessment (CAA) Summary

Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.

X: Correction Request

Request to modify or inactivate a record already present in the QIES ASAP database.

Z: Assessment Administration

Provide billing information and signatures of persons completing the assessment.

Supporting Materials

Keyboard Shortcuts

Windows keyboard shortcuts are combinations of two or more keys that, when pressed, can perform the same task as using a mouse or other pointing device.

Ease of Access keyboard shortcuts

Press this	To do this
Right Shift for eight seconds	Turn Filter Keys on and off
Left Alt+Left Shift+PrtScn (or PrtScn)	Turn High Contrast on or off
Left Alt+Left Shift+Num Lock	Turn Mouse Keys on or off
Shift five times	Turn Sticky Keys on or off
Num Lock for five seconds	Turn Toggle Keys on or off
Windows logo key + u	Open the Ease of Access Center

General keyboard shortcuts

Press this	To do this
F1	Display Help
Ctrl+ c (or Ctrl+Insert)	Copy the selected item
Ctrl+ x	Cut the selected item
Ctrl+ v (or Shift+Insert)	Paste the selected item
Ctrl+ z	Undo an action
Ctrl+ y	Redo an action
Delete (or Ctrl+ d)	Delete the selected item and move it to the Recycle Bin
Shift+Delete	Delete the selected item without moving it to the Recycle Bin first

Press this	To do this (Continued)
F2	Rename the selected item
Ctrl+Right Arrow	Move the cursor to the beginning of the next word
Ctrl+Left Arrow	Move the cursor to the beginning of the previous word
Ctrl+Down Arrow	Move the cursor to the beginning of the next paragraph
Ctrl+Up Arrow	Move the cursor to the beginning of the previous paragraph
Ctrl+Shift with an arrow key	Select a block of text
Shift with any arrow key	Select more than one item in a window or on the desktop, or select text within a document
Ctrl with any arrow key+Spacebar	Select multiple individual items in a window or on the desktop
Ctrl+A	Select all items in a document or window
F3	Search for a file or folder
Alt+Enter	Display properties for the selected item
Alt+F4	Close the active item, or exit the active program
Alt+Spacebar	Open the shortcut menu for the active window
Ctrl+F4	Close the active document (in programs that allow you to have multiple documents open simultaneously)
Alt+Tab	Switch between open items
Ctrl+Alt+Tab	Use the arrow keys to switch between open items
Ctrl+Mouse scroll wheel	Change the size of icons on the desktop
Windows logo key+Tab	Cycle through programs on the taskbar by using Aero Flip 3-D
Ctrl+Windows logo key+Tab	Use the arrow keys to cycle through programs on the taskbar by using Aero Flip 3-D
Alt+Esc	Cycle through items in the order in which they were opened
F6	Cycle through screen elements in a window

Press this	To do this (Continued)
F4	Display the address bar list in Windows Explorer
Shift+F10	Display the shortcut menu for the selected item
Ctrl+Esc	Open the Start menu
Alt+underlined letter	Display the corresponding menu
Underlined letter	Perform the menu command (or other underlined command)
F10	Activate the menu bar in the active program
Right Arrow	Open the next menu to the right, or open a submenu
Left Arrow	Open the next menu to the left, or close a submenu
F5 (or Ctrl + r)	Refresh the active window
Alt+Up Arrow	View the folder one level up in Windows Explorer
Esc	Cancel the current task
Ctrl+Shift+Esc	Open Task Manager
Shift	When CD is inserted, prevent it from automatically playing
Left Alt+Shift	Switch the input language when multiple input languages are enabled
Ctrl+Shift	Switch the keyboard layout when multiple keyboard layouts are enabled
Right or Left Ctrl+Shift	Change the reading direction of text in right-to-left reading languages

Dialog Box keyboard shortcuts

Press this	To do this
Ctrl+Tab	Move forward through tabs
Ctrl+Shift+Tab	Move back through tabs
Tab	Move forward through options
Shift+Tab	Move back through options
Alt+underlined letter	Perform the command (or select the option) that goes with that letter
Enter	Replaces clicking the mouse for many selected commands
Spacebar	Select or clear the checkbox if the active option is a checkbox
Arrow keys	Select a button if the active option is a group of option buttons
F1	Display Help
F4	Display the items in the active list
Backspace	Open a folder one level up if a folder is selected in the Save As or Open dialog box