Select Admission Assessment Data Elements

Section A: Identification Information

A1005. Ethnicity

- **Coding:** A. No, not of Hispanic, Latino/a, or Spanish origin, and X. Resident unable to respond.
- **Rationale:** Both code A and code X should be selected. When asked about her ethnicity, Mrs. Z. was unable to respond. She stated that the choices were confusing and she was not sure. Her daughter Lily was present during the Admission assessment and identified that Mrs. Z.'s ethnicity was not Hispanic, Latino/a, or Spanish. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative for the information to code this item.

A1010. Race

- **Coding:** E. Chinese and F. Filipino.
- **Rationale:** Mrs. Z. reported that she identifies as both Chinese and Filipino. Although Lily confirmed the accuracy of this response, Mrs. Z. was able to recall this information and respond on her own.

A1110. Language

- **Coding:** A. English, and B. 0. No.
- **Rationale:** Mrs. Z. stated that her preferred language is English and declined the need for an interpreter.

A1250. Transportation

- **Coding:** C. No.
- **Rationale:** Mrs. Z. uses the local Dial-A-Ride program to attend activities and lunch weekly at the Senior Center. Her daughter takes her grocery shopping, to church, and to medical appointments. Mrs. Z. stated that she does not have any trouble getting to medical appointments or the things she needs based on the combined support of her daughter, neighbor, and local transportation services.

Section B: Hearing, Speech, and Vision

B1300. Health Literacy

- **Coding:** 8. Resident unable to respond.

  Rationale: When asked how often she needs to have someone help her read instructions, pamphlets, or other written material from her doctor or pharmacy, Mrs. Z. stated that she could not remember. Although Lily provided additional information about Mrs. Z.'s health literacy, it cannot be used for coding. This item is a resident self-report item, and no other source should be used to identify the response.

Section D. Mood

D0700. Social Isolation

- **Coding:** 2. Sometimes.
- **Rationale:** Mrs. Z. stated that she sometimes feels a bit lonely on days when her daughter does not visit, or on rainy days when she lacks the motivation to go out.

Section GG. Functional Abilities and Goals

GG0115. Functional Limitation in Range of Motion

- **Coding:** A. Upper extremity and B. Lower extremity are both coded as response option 1. Impairment on one side.
- **Rationale:** On admission, Mrs. Z. presented with a right lower arm contusion and right hip fracture, both interfering with daily functions.

GG0120. Mobility Devices

- **Coding:** B. Walker and C. Wheelchair (manual or electric).
- **Rationale:** Mrs. Z. is currently using a walker and wheelchair and also used these devices while hospitalized in acute care prior to admission in the last 7 days.

Section J: Health Conditions

J0200. Should Pain Assessment Interview be Conducted?

- **Coding:** 1. Yes.
- **Rationale:** Mrs. Z. was alert and communicative and able to respond to the pain interview questions.

J0300. Pain Presence

- **Coding:** 1. Yes.
- **Rationale:** Mrs. Z. indicated that she has been experiencing pain since her admission to the acute care hospital on April 10, 2023. This period of time includes the last 5 days.

J0410. Pain Frequency

- **Coding:** 4. Almost constantly.
- **Rationale:** Mrs. Z. stated that since being admitted to the acute care hospital on April 10, 2023, which includes the last 5 days, her pain has been present almost constantly at varying levels.

J0510. Pain Effect on Sleep

- **Coding:** 2. Occasionally.
- **Rationale:** Mrs. Z. noted that over the last 5 days (since being in the hospital), she occasionally wakes up at night due to hip pain and requests her PRN (as needed) pain medication so that she can fall back to sleep.

J0520. Pain Interference with Therapy Activities

- **Coding:** 2. Occasionally.
- **Rationale:** Mrs. Z. reported that her engagement with rehabilitation therapy sessions has continued to be inconsistent due to experiencing pain. Although taking pain medication before the therapy session is helpful, she occasionally refuses or requests to shorten the session due to pain.

J0530. Pain Interference with Day-to-Day Activities

- **Coding:** 2. Occasionally.

  Rationale: Mrs. Z. stated that her ability to complete day-to-day activities is occasionally limited by pain that is relieved by acetaminophen.

Section K: Swallowing/Nutritional Status

K0520. Nutritional Approaches

- **Coding: K0520 Column 1. On Admission:**
  - A. Parenteral/IV feeding.
  - D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol).
- **Rationale:** On admission to the Skilled Nursing Facility (SNF), Mrs. Z. was receiving peripheral intravenous (IV) hydration due to nutritional risk associated with reduced oral intake related to anorexia. She was also ordered a heart-healthy diet (which is considered a therapeutic diet). The nutritional supplements with meals are considered part of that therapeutic diet).

- **Coding: K0520 Column 2. While Not a Resident:**
  - A. Parenteral/IV feeding.
- **Rationale:** In the acute care hospital prior to this SNF admission (while not a resident and within the last 7 days), Mrs. Z. was receiving a heart-healthy diet, nutritional supplements with meals, and peripheral IV hydration due to nutritional risk associated with reduced oral intake related to anorexia. Please note that when coding this item on admission, only response option A. Parenteral/IV feeding would be selected. Option D. Therapeutic diet is not one of the available response options in Column 2.

- **Coding: K0520 Column 3. While a Resident:**
    - A. Parenteral/IV feeding.
    - D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol).
- **Rationale:** While a resident of the SNF and within the last 7 days, Mrs. Z. was receiving peripheral IV hydration due to nutritional risk associated with reduced oral intake related to anorexia. She was also receiving a heart-healthy diet (which is considered a therapeutic diet). The nutritional supplements with meals are considered part of that therapeutic diet.

Section N: Medications

N0415. High-Risk Drug Classes: Use and Indication

- **Coding: N0415 Column 1. Is taking:**
    - E. Anticoagulant.
    - F. Antibiotic.
    - H. Opioid.
- **Coding: N0415 Column 2. Indication noted:**
    - E. Anticoagulant.
    - F. Antibiotic.
    - H. Opioid.
- **Rationale:** On admission to the SNF, Mrs. Z. was taking apixaban, which is classified as an anticoagulant; levofloxacin, which is classified as an antibiotic; and tramadol, which is classified as an opioid. Per the medication list, all three drugs had indications noted.

Section O: Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

- **Coding: O0110 Column A. On Admission:**
    - C1. Oxygen Therapy.
    - C2. Continuous.
    - G1. Non-Invasive Mechanical Ventilator.
    - G3. CPAP.
    - H1. IV Medications.
    - H3. Antibiotics.
    - O1. IV Access.
    - O2. Peripheral.

- **Rationale:** On admission to the SNF, Mrs. Z. was using oxygen continuously at 2 liters per minute to maintain her oxygen saturation at greater than 92 percent. Mrs. Z. also used a continuous positive airway pressure (CPAP) machine (with oxygen) at night and when napping for treatment of obstructive sleep apnea. She had a peripheral IV access site and was receiving IV fluids and IV antibiotics.

- **Coding: O0110 Column B. While a Resident:**
  - C1. Oxygen Therapy.
  - G1. Non-Invasive Mechanical Ventilator.
  - H1. IV Medications.
  - I1. Transfusions.
  - O1. IV Access.
- **Rationale:** While a resident of the SNF and within the last 14 days, Mrs. Z. was using oxygen continuously at 2 liters per minute to maintain her oxygen saturation at greater than 92 percent. Mrs. Z. also used a CPAP machine, which is classified as a non-invasive mechanical ventilator. She received a blood transfusion on April 23 at the infusion center while a SNF resident. She also had a peripheral IV access site during this time for IV fluids and antibiotics.

Select Discharge Assessment Data Elements

Section A: Identification Information

A2105. Discharge Status

- **Coding:** 12. Home under care of organized home health service organization.
- **Rationale:** On May 10, 2023, Mrs. Z was discharged home from the SNF. She will reside with her daughter and will be receiving home health services.

A1005. Ethnicity

- **Coding:** A. No, not of Hispanic, Latino/a, or Spanish origin.
- **Rationale:** During the discharge assessment, Mrs. Z. was able to respond without assistance as her mental fogginess had cleared. She stated that her ethnicity was not Hispanic, Latino/a, or Spanish.

A1010. Race

- **Coding:** E. Chinese and F. Filipino.
- **Rationale:** Mrs. Z. reported that she identifies as both Chinese and Filipino. Mrs. Z. was able to respond on her own without issue.

A1110. Language

- **Coding:** A. English and B. 0. No.
- **Rationale:** Mrs. Z. stated that her preferred language is English and declined the need for an interpreter.

A1250. Transportation

- **Coding:** C. No.
- **Rationale:** Mrs. Z. stated that this has not been a problem in the past and since she will be living with her daughter while recuperating after discharge, she does not anticipate any transportation problems. This item is coded based on the past 6 months to a year. Mrs. Z. stated that before admission, she rarely had trouble getting to medical appointments or the things she needs based on the combined support of her daughter, neighbor, and local transportation services.

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

- **Coding:** 1. Yes – Current reconciled medication list provided to subsequent provider.
- **Rationale:** The home health agency was provided with a copy of Mrs. Z.'s reconciled medication list at discharge.

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

- **Coding:** D. Paper-based (e.g., fax, copies, printouts).
- **Rationale:** The home health agency was provided with the reconciled medication list via electronic fax. Electronic fax is considered a paper-based route**.**

Section B: Hearing, Speech, and Vision

B1300. Health Literacy

- **Coding:** 2. Sometimes.
- **Rationale:** The mental fogginess associated with the concussion had cleared and Mrs. Z. reported that she sometimes has difficulty understanding the discharge instructions provided to her by her physician or pharmacy and requires additional help to understand this material.

Section D. Mood

D0700. Social Isolation

- **Coding:** 0. Never.
- **Rationale:** When asked how often she feels lonely or isolated from those around her, Mrs. Z. stated, "never." She indicated that the nursing staff and other patients were great company. She also remarked how happy she was to be going to live with her daughter and being able to see her every day.

Section J: Health Conditions

J0200. Should Pain Assessment Interview be Conducted?

- **Coding:** 1. Yes.
- **Rationale:** Mrs. Z. was alert and communicative and able to respond to the pain interview questions.

J0300. Pain Presence

- **Coding:** 1. Yes.
- **Rationale:** Mrs. Z. indicated that although improved, she has still experienced pain in the last 5 days.

J0410. Pain Frequency

- **Coding:** 2. Occasionally.
- **Rationale:** Mrs. Z. stated that over the last 5 days, her pain has been present occasionally.

J0510. Pain Effect on Sleep

- **Coding:** 1. Rarely or not at all.
- **Rationale:** Mrs. Z. reports that pain no longer affects her sleep.

J0520. Pain Interference with Therapy Activities

- **Coding:** 2. Occasionally.
- **Rationale:** Mrs. Z. reported that she does occasionally experience pain with rehabilitation therapy sessions, which is relieved by acetaminophen.

J0530. Pain Interference with Day-to-Day Activities

- **Coding:** 2. Occasionally.
- **Rationale:** Mrs. Z. reported that she occasionally experiences pain with some day-to-day activities, which is relieved by acetaminophen.

Section K: Swallowing/Nutritional Status

K0520. Nutritional Approaches

- **Coding: K0520 Column 3. While a Resident:**
  - D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol).
- **Rationale:** Within the last 7 days of the SNF stay, Mrs. Z. remained on a heart-healthy diet and she continued to take one nutritional supplement with dinner until May 5, 2023, when the supplements were discontinued. IV fluids were discontinued on April 24, 2023, and the peripheral IV site was removed on April 28, 2023, after the last dose of antibiotics.

- **Coding: K0520 Column 4. At Discharge:**
  - D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol).
- **Rationale:** At discharge, Mrs. Z. was ordered a heart-healthy diet.

Section N: Medications

N0415. High-Risk Drug Classes: Use and Indication

- **Coding: N0415 Column 1. Is taking:**
  - E. Anticoagulant.
- **Coding: N0415 Column 2. Indication noted:**
  - E. Anticoagulant.
- **Rationale:** At discharge, Mrs. Z. will continue apixaban, part of her routine medication regimen, which is classified as an anticoagulant. This drug had an indication noted on the medication list.

Section O: Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

- **Coding: O0110 Column C. At Discharge:**
  - G1. Non-Invasive Mechanical Ventilator.
  - G3. CPAP.
- **Rationale:** At discharge, Mrs. Z. was using a CPAP machine on room air at night and when napping for treatment of obstructive sleep apnea.