**Section 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements**

a) Activities of Daily Living (ADL)

1) Documentation shall support the ADL coded level as defined in the Resident Assessment Instrument (RAI) Manual.

2) Documentation of ADLs shall support the RAI requirement was met for coding Self Performance and Support during the look-back period. It is the responsibility of the person completing the assessment to consider all episodes of the activity that occurred over a 24-hour period during each day of the 7-day look-back period. There shall be signatures/initials of staff providing the ADL assistance and dates to authenticate the services were provided as coded during the look-back period. If using an ADL grid for supporting documentation, the key for self-performance and support provided shall be equivalent to definitions to the MDS key.

3) The ADL scores for residents lacking documentation shall be reset to zero.

b) Extensive Services. Documentation shall support that the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support tracheostomy care was completed during the look-back period while a resident in the facility.

2) Documentation shall support the use of a ventilator or respirator during the look-back period while a resident in the facility. Documentation shall support the device was an electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration. This does not include BiPAP or CPAP devices or a ventilator or respirator that is used only as a substitute for BiPAP or CPAP.

3) Documentation supports the need for and use of isolation during the look-back period while a resident is in the facility.

4) Documentation shall support the following conditions for "strict isolation" were met during the look-back period:

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

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

C) The resident is in a room alone because of active infection and cannot have a roommate even if the roommate has a similar active infection that requires isolation. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.).

5) Treatment and/or procedures the resident received shall be care planned and reevaluated to ensure continued appropriateness.

6) Extensive services are defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL RUG-IV GROUP |
| Extensive Services − At least one of the following:  Tracheostomy Care while a resident  (O0100E2)  Ventilator or Respirator while a resident  (O0100F2)  Infection Isolation while a resident  O0100M2) | ≥ 2  ≥ 2  ≥ 2  •  • | Tracheostomy care and Ventilator/Respirator  Tracheostomy care OR Ventilator/Respirator  Infection Isolation:  Without trach  Without Ventilator /Respirator | ES3  ES2  ES1 |

c) Rehabilitation. Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) All RAI Manual requirements and definitions shall be met, including the qualifications for therapists.

2) Documentation shall support medically necessary therapies that occurred after admission or readmission to the facility that were:

A) Ordered by a physician based on a qualified therapist's (i.e., one who meets Medicare requirements) assessment and treatment plan;

B) Documented as delivered in the clinical record; and

C) Care planned and periodically evaluated to ensure the resident receives needed therapies and the current treatment plans are effective. Any service provided at the request of the resident or family that is not medically necessary shall not be included, even when performed by a therapist or a therapy assistant. It does not include the services performed when a facility elects to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services that are considered restorative care.

3) Documentation shall support the therapies were provided while the individual was living and being cared for at the long-term care facility. It does not include therapies that occurred while the person was an inpatient at a hospital or recuperative or rehabilitation center or other long-term care facility, or recipient of home care or community based services.

4) Documentation shall support the services were directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with a qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of these services in the facility.

5) Documentation shall support the services were a level of complexity and sophistication, or the condition of the resident shall be of a nature that requires the judgment, knowledge, and skills of a therapist.

6) Documentation shall support the services were provided with expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services shall be necessary for the establishment of a safe and effective maintenance program.

7) Documentation shall support the services are considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition.

8) Documentation shall support that services are medically necessary for the treatment of the resident's condition. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable and they must be furnished by qualified personnel.

9) Documentation shall include the actual minutes of therapy. Minutes shall not be rounded to the nearest 5th minute and conversion of units to minutes or minutes to units is not acceptable.

10) Documentation shall identify the different modes of therapy (i.e., individual, concurrent, group) and the documentation shall support the criteria for the mode identified is met.

11) Documentation shall support that the restorative program include nursing interventions that promote the residents ability to adapt and adjust to living as independently and safely as possible. The program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

12) Documentation shall include the following components for a restorative program is met:

A) There are measurable objectives/interventions established for the performance of the activity;

B) A licensed nurse shall evaluate and document the results of the evaluation related to the program on a quarterly basis.

C) Documentation includes the actual number of minutes the activity were performed and supports at least 15 minutes in a 24-hour period for a minimum of 6 days; and

D) Individuals who implement the program shall be trained in the interventions and supervised by a nurse.

13) Documentation shall support the requirements identified for coding ADL were met.

14) Rehabilitation is defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL Rug-IV Group |
| At least 5 distinct calendar days (15 min per day minimum) in any combination of Speech, Occupational or Physical Therapy in the last 7 days. (O0400A4, O0400B4, O0400C4) AND 150 minutes or greater of any combination of Speech, Occupational or Physical Therapy in the last 7 days (O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3)  OR  At least 3 distinct calendar days (15 min per day minimum) in any combination of Speech, Occupational, or Physical Therapy in the last 7 days (O0400A4, O0400B4, O0400C4) AND 45 minutes or greater in any combination of Speech, Occupational or Physical Therapy in the last 7 days (O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3) AND at least 2 nursing rehabilitation services.  See description of Restorative in subsection (h) | 15-16  11-14  6-10  2-5  0-1 | None  None  None  None  None | RAE  RAD  RAC  RAB  RAA |

d) Special Care High-Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support the requirements and criteria for coding an active disease diagnosis were met.

2) Documentation shall support the ADL scores met the requirements and criteria for coding.

3) Documentation shall include the date completed and the staff member completing the Mood interview when indicated. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, a brief description of the symptoms, staff observing, and any interventions.

4) Documentation shall support a diagnosis of coma or persistent vegetative state.

5) Documentation shall support an active diagnosis of Septicemia. Interventions and/or treatments for the diagnosis shall be documented upon delivery.

6) Documentation shall support an active diagnosis of diabetes, and shall support insulin injections were given the entire 7 days of the look-back period and there were orders for insulin changes on 2 or more days during the look-back period.

7) Documentation shall support the active diagnosis of Quadriplegia.

8) Documentation shall support the active diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and/or asthma with shortness of breath while lying flat. Interventions and/or treatments for the condition shall be documented upon delivery.

9) Documentation to support fever shall include a recorded temperature of at least 2.4 degrees higher than the previous recorded baseline temperature and documentation shall support one of the following: pneumonia, vomiting, weight loss, and/or feeding tube with at least 51% of total calories or if 26-50% of the calories there is also fluid intake of 501cc or more per day. Interventions and/or treatments for the condition shall be documented upon delivery.

10) Documentation shall support the intervention of parenteral or IV feedings. Documentation shall support the intervention was administered for nutrition or hydration purposes.

11) Documentation of respiratory therapy shall include the following:

A) Physician orders that include a statement of frequency, duration, and scope of treatment;

B) The actual minutes the therapy was provided while a resident is in the facility;

C) Evidence that the services are provided by a qualified professional; and

D) Evidence that the services are directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel.

12) Special Care High is defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL RUG-IV Group |
| Special Care High (ADL Score of ≥ 2 or more and at least one of the following:  Comatose (B0100) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0110I1 all = 4 or 8)  Septicemia (I2100)  Diabetes (I2900) with both of the following:  • Insulin injections for all 7 days (N0350A = 7)  • Insulin order changes on 2 or more days (N0350B ≥ 2)  Quadriplegia (I5100) with ADL score ≥ 5(ADLs as above)  Asthma or COPD (I6200) AND shortness of breath while lying flat (J1100C)  Fever (J1550A) and one of the following:  • Pneumonia (I2000)  • Vomiting (J1550B)  • Weight Loss (K0300 = 1 or 2)  • Feeding Tube (K0510B1 or K0510B2) with at least 51% of total calories (K0710A3 = 3) OR 26% to 50% through parenteral/enteral intake (K0710A3 = 2) and fluid intake is 501cc or more per day (K0710B3 = 2)  Parenteral/IV Feeding (K0510A1 or K0510A2)  Respiratory Therapy for all 7 days (O0400D2 = 7)  If a resident qualifies for Special Care High but the ADL score is a 1 or less, then the resident classifies as Clinically Complex | 15-16  15-16  11-14  11-14  6-10  6-10  2-5  2-5 | Depression  No Depression  Depression  No Depression  Depression  No Depression  Depression  No Depression  (Note: See description of depression indicators in subsection (k)) | HE2  HE1  HD2  HD1  HC2  HC1  HB2  HB1 |

e) Special Care Low – Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support the requirements and criteria for coding disease diagnosis were met. This includes an active diagnosis of Cerebral Palsy, Multiple Sclerosis, or Parkinson's.

2) Documentation shall support an active diagnosis of respiratory failure and the administration of oxygen therapy while a resident. Documentation shall include the date and method of delivery. Documentation shall support a need for the use of oxygen.

3) Documentation shall support the requirements and criteria for coding ADLs were met.

4) Documentation shall include the date, and staff completing the Mood interview. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, a brief description of the symptom, any interventions implemented and identification of staff observing.

5) Documentation shall support the presence of a feeding tube and the proportion of calories received through the tube feeding.

6) Documentation shall support the presence of 2 or more Stage 2 pressure ulcers or any Stage 3 or 4 pressure ulcer as defined in the RAI Manual. Documentation shall include observation date, location, and measurement and description of the ulcer. Other factors related to the ulcer shall be noted including: condition of the tissue surrounding the area (color, temperature, etc.), exudates and drainage present, fever, presence of pain, absence or diminished pulses, and origin of the wound (such as pressure, injury or contributing factors) if known. Interventions and/or treatments for the ulcer shall be documented as delivered.

7) Documentation shall support the presence of 2 or more venous or arterial ulcers as defined in the RAI Manual. Documentation shall include observation date, location, and measurement and description of the ulcer. Interventions and/or treatment for the ulcer shall be documented as delivered.

8) Documentation shall support the presence of a Stage 2 pressure ulcer and a venous or arterial ulcer. Documentation shall include observation date, location, and measurement and description of the ulcer. Interventions and/or treatments for the ulcer shall be documented as delivered.

9) Documentation shall support 2 or more of the following interventions when ulcers are noted: pressure relieving devices, turning and repositioning, nutrition and/or hydration, ulcer care, application of dressing and/or application of ointments. Documentation shall support the interventions identified were implemented during the look-back period.

10) Documentation and/or observation shall support the use of pressure relieving devices for the resident. This does not include egg crate cushions, doughnuts or rings.

11) Documentation for a turning and repositioning program shall include specific approaches for changing the resident's position and realigning the body and the frequency it is to be implemented. Documentation shall support the program was implemented and is monitored and reassessed to determine the effectiveness of the intervention.

12) Documentation shall support the nutrition and/or hydration interventions were delivered. These shall be based on an individual assessment of the resident's nutritional deficiencies and needs. Vitamins and mineral supplements shall only be coded on the MDS when noted through a thorough nutritional assessment.

13) Documentation for ulcer care shall support the care was delivered. Documentation shall include the date delivered, type of care delivered, and identification of the staff delivering the care.

14) Documentation shall support the application of non-surgical dressing and shall include date applied and identification of the staff delivering the care. This does not include application of a band-aid.

15) Documentation shall support the application of ointments or medications were actually applied to somewhere other than the feet. This includes only ointments or medications used to treat and/or prevent skin conditions. Documentation shall include name and description of the ointment used, date applied, and identification of the staff delivering the care.

16) Documentation of infections of the foot and/or presence of diabetic foot ulcers or open lesions to the foot shall include a description of the area.

17) Documentation shall support interventions and/or treatments for the problems noted were implemented. Documentation shall define the intervention and treatment, the date delivered and the identification of the staff delivering the care.

18) Documentation shall support the application of dressing to the feet was actually delivered. Documentation shall include the date applied and identification of the staff delivering the care.

19) Documentation shall support the reason for and the administration of radiation while a resident. Documentation shall include the date of administration and identification of the staff delivering the care.

20) Documentation shall support dialysis was administered while a resident. Documentation shall include type of dialysis, date delivered, and identification of the staff delivering the care.

21) Special Care Low is defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL RUG- IV Group |
| Special Care Low-ADL score of 2 or more and at least one of the following:  Cerebral Palsy (I4400) with ADL score ≥ 5  Multiple Sclerosis (I5200) with ADL score ≥ 5  Parkinson's disease (I5300) with ADL score ≥ 5  Respiratory Failure (I6300) and oxygen therapy while a resident (O0100C2)  Feeding Tube (K0510B1 or K0510B2) with at least 51% of total calories (K0710A3 = 3) OR 26% to 50% through parenteral/enteral intake (K0710A3 = 2) and fluid intake is 501cc or more per day (K0710B3 = 2)  2 or more Stage 2 pressure ulcers (M0300B1) with 2 or more skin treatments  • Pressure relieving device for chair (M1200A) and/or bed (M1200B)  • Turning/Repositioning (M1200C)  • Nutrition or hydration intervention (M1200D)  • Ulcer care (M1200E)  • Application of dressing (M1200G)  • Application of ointments (M1200H)  Any Stage 3 or 4 pressure ulcer (M0300C1, D1, F1) with 2 or more skin treatments-See above list  2 or more venous/arterial ulcers (M1030) with 2 or more skin treatments-See above list  One Stage 2 pressure ulcer (M0300B1) and one venous/arterial ulcer (M1030) with 2 or more skin treatments-See above list  Foot infection (M1040A), Diabetic foot ulcer (M1040B) or other open lesion of foot (M1040C) with application of dressing to feet (M1200I)  Radiation treatment while a resident (O0100B2)  Dialysis treatment while a resident (O0100J2)  If a resident qualifies for Special Care Low but the ADL score is 1 or less-then the resident classifies as Clinically Complex | 15-16  15-16  11-14  11-14  6-10  6-10  2-5  2-5 | Depression  No Depression  Depression  No Depression  Depression  No Depression  Depression  No Depression  Note: See description of depression indicators | LE2  LE1  LD2  LD1  LC2  LC1  LB2  LB1 |

f) Clinically Complex – Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support the requirements and criteria for coding disease diagnosis were met. This shall include documentation of an active diagnosis of pneumonia that includes current symptoms and any interventions.

2) Documentation shall also support an active diagnosis of hemiplegia or hemiparesis.

3) Documentation shall support the requirements and criteria for coding ADLs were met.

4) Documentation shall include the date completed, and staff completing the Mood interview when indicated. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, brief description of the symptom, any interventions, and identification of staff observing.

5) Documentation shall support the presence of open lesions other than ulcers. The documentation shall include, but is not limited to, an entry noting the observation date, location, measurement and description of the lesion and any interventions. Documentation of interventions shall include at least one of the following: surgical wound care, application of non-surgical dressing to an area other than the feet and/or application of ointments to an area other than the feet. Documentation shall include all the types of interventions, dates delivered, and the staff delivering the interventions.

6) Documentation shall support the presence of a surgical wound. The documentation shall include an entry noting the observation date, origin of the wound, location, measurement and description, and any interventions. Documentation of interventions shall include at least one of the following: surgical wound care, application of non-surgical dressing to an area other than the feet and/or application of ointments to an area other than the feet. Documentation shall include the type of intervention, dates delivered, and the staff delivering the interventions.

7) Documentation shall support the presence of a burn. Documentation shall include an entry noting the observation date, location, measurement and description, and any interventions.

8) Documentation shall support the administration of a chemotherapy agent while a resident in the facility. Documentation shall include the name of the agent, date delivered and the staff delivering.

9) Documentation shall support the administration of oxygen while a resident in the facility. This shall include the date and method of delivery. Additionally, documentation shall support a need for the use of oxygen.

10) Documentation shall support the administration of an IV medication while a resident in the facility. The documentation shall include the name of the medication, date delivered, method of delivery, and identification of staff delivering.

11) Documentation shall support the resident received a transfusion while a resident was at the facility. Documentation shall include the date received, reason and identification of staff delivering the care.

12) Clinically Complex is defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL RUG -IV Group |
| Clinically Complex-At least one of the following:  Pneumonia (I2000)  Hemiplegia/hemiparesis (I4900) with ADL score ≥ 5  Surgical wounds (M1040E) or open lesion (M1040D) with any of the following selected skin treatments:  • Surgical wound care (M1200F)  • Application of non-surgical dressing (M1200G) not to feet  • Application of ointment (M1200H) not to feet  Burns (M1040F)  Chemotherapy while a resident (O0100A2)  Oxygen therapy while a resident (O0100C2)  IV Medication while a resident (O0100H2)  Transfusions while a resident (O0100I2)  If a resident qualifies for Special Care High or Special Care Low, but the ADL score of 1 or 0, then the resident classifies in Clinically Complex CA1 or CA2 | 15-16  15-16  11-14  11-14  6-10  6-10  2-5  2-5  0-1  0-1 | Depression  No Depression  Depression  No Depression  Depression  No Depression  Depression  No Depression  Depression  No Depression | CE2  CE1  CD2  CD1  CC2  CC1  CB2  CB1  CA2  CA1 |

g) Behavioral Symptoms and Cognitive Performance – Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall include the date completed, and staff completing the Mood interview. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, brief description of the symptom, any interventions and identification of staff observing.

2) Documentation shall include the date and staff completing the Brief Interview for Mental Status (BIMS).

3) Documentation shall support the occurrence of a hallucination and/or delusion that include the date observed, description, and name of staff observing.

4) Documentation shall include the date observed, staff observing, frequency, and description of resident's specific physical, verbal or other behavioral symptom. Documentation shall include any interventions and the resident's response.

5) Documentation shall include the date observed, staff observing, frequency and description of the behavior of rejection of care. Rejection of care shall meet all of the coding requirements. Residents, who have made an informed choice about not wanting a particular treatment, procedure, etc., shall not be identified as "rejecting care". Documentation shall include any interventions and the resident's response.

6) Documentation shall include the date observed, staff observing, frequency and description of any wandering behavior. Documentation shall support a determination for the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety and the resident's response to any interventions. Care plans shall address the impact of wandering on resident safety and disruption to others and shall focus on minimizing these issues.

7) Documentation shall identify how the coded behavior affected the resident, staff and/or others. Care plan interventions shall address the safety of the resident and others and be aimed at reducing distressing symptoms.

8) Documentation supports presence of a restorative program. This shall include, but is not limited to, the following: Documentation of the actual number of minutes the program was provided that equals 15 minutes, in a 24-hour period, a restorative care plan that contains measurable objectives, and goals that are specific, realistic and measurable. In addition, documentation shall support the programs are delivered 6-7 days a week, supervised by a licensed nurse, a quarterly evaluation is completed by a licensed nurse, and staff are trained in skilled techniques to promote the resident's involvement in the activity.

9) Behavioral Symptoms and Cognitive Performance is defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL RUG- IV GROUP |
| Behavioral Symptoms and Cognitive Performance  BIMS score of 9 or less AND an ADL score of 5 or less  OR  Defined as Impaired Cognition by Cognitive Performance Scale AND an ADL score of 5 or less  Hallucinations (E0100A)  Delusions (E0100B)  Physical Behavioral symptom directed toward others (E0200A = 2 or 3)  Verbal behavioral symptom directed towards others (E0200B = 2 or 3)  Other behavioral symptom not directed towards others (E0200C = 2 or 3)  Rejection of care (E08002 or 3)  Wandering (E0900 = 2 or 3) | 2-5  2-5  0-1  0-1 | 2 or more Restorative Nursing Programs  0-1 Restorative Nursing Programs  2 or more Restorative Nursing Programs  0-1 Restorative Nursing Programs | BB2  BB1  BA2  BA1 |

h) Reduced Physical Function

1) Documentation shall support the ADL coded level.

2) Documentation shall support presence of a restorative program. This shall include, but is not limited to, documentation of the actual number of minutes the program was provided that equals 15 minutes, in a 24-hour period, 6-7 days a week, a restorative care plan that contains measureable objectives, and goals that are specific, realistic and measurable, documentation that supports the programs are supervised by a licensed nurse, a quarterly evaluation is completed by a licensed nurse and staff are trained in skilled techniques to promote the resident's involvement in the activity.

3) Reduced Physical Function is defined as indicated in the following chart.

|  |  |  |  |
| --- | --- | --- | --- |
| Category (Description) | ADL Score | End Splits or Special Requirements | IL RUG- IV Group |
| Reduced Physical Function  List of Restorative Programs  Passive (O0500A = 6 or 7) or Active (O0500B = 6 or 7) ROM  Splint or brace assistance  (O0500C = 6 or 7)  Bed Mobility (O0500D = 6 or 7)  and/or walking training (O0500F = 6 or 7)  Transfer training (O0500E = 6 or 7)  Dressing and/or grooming training  (O0500G = 6 or 7)  Eating and/or swallowing training  (O0500H = 6 or 7)  Amputation/prostheses care  (O0500I = 6 or 7)  Communication training  (O0500J = 6 or 7)  Urinary (H0200C) and/or bowel training (H0500)  No Clinical Conditions  These programs count as one service even if both are provided | 15-16  15-16  11-14  11-14  6-10  6-10  2-5  2-5  0-1  0-1 | 2 or more Restorative   * 1. Restorative   2 or more Restorative   * 1. Restorative   2 or more Restorative   * 1. Restorative   2 or more Restorative   * 1. Restorative   2 or more Restorative  0-1 Restorative | PE2  PE1  PD2  PD1  PC2  PC1  PB2  PB1  PA2  PA1 |

i) Illinois Specific Classification – This is assigned to a resident for whom RUGs resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter. In addition, a resident for whom an assessment is necessary to determine group classification is incomplete or has not been submitted within 14 calendar days of the time requirements in Section 147.315 shall be assigned the default group.

|  |  |  |  |
| --- | --- | --- | --- |
| An assessment that is missing and/or submitted more than 14 days late from the due date | N/A |  | AA1 |

j) Additional Scoring Indicators

|  |  |  |  |
| --- | --- | --- | --- |
| ADL | Self-Performance | Support | ADL Score |
| Bed Mobility (G0110A)  Transfer (G0110B)  Toilet Use (G0110I) | Coded -, 0, 1, 7, or 8  Coded 2  Coded 3  Coded 4  Coded 3 or 4 | Any Number  Any Number  -,0, 1, or 2  -,0,1 , or 2  3 | 0  1  2  3  4 |
| Eating (G0110H) | Coded -, 0, 1, 2, 7 or 8  Coded -, 0, 1, 2, 7 or 8  Coded 3 or 4  Coded 3  Coded 4 | -, 0, 1 or 8  2 or 3  -, 0 or 1  2 or 3  2 or 3 | 0  2  2  3  4 |

k) Depression – Additional Scoring Indicator − The depression end split is determined by either the total severity score from the resident interview in Section D0200 (PHQ-9) or from the total severity score from the caregiver assessment of Mood D0500 (PHQ9-OV).

|  |  |  |
| --- | --- | --- |
| Resident | Staff | Description |
| D0200A | D0500A | Little interest or pleasure in doing things |
| D0200B | D0500B | Feeling down, depressed or hopeless |
| D0200C | D0500C | Trouble falling or staying asleep, sleeping too much |
| D0200D | D0500D | Feeling tired or having little energy |
| D0200E | D0500E | Poor appetite or overeating |
| D0200F | D0500F | Feeling bad or failure or let self or others down |
| D0200G | D0500G | Trouble concentrating on things |
| D0200H | D0500H | Moving or speaking slowly or being fidgety or restless |
| D0200I | D0500I | Thoughts of better off dead or hurting self |
|  | D0500J | Short tempered, easily annoyed |
| Residents that were interviewed D0300 (Total Severity Score) ≥ 10 but not 99 | | |
| Staff Assessment-Interview not conducted D0600 (Total Severity Score ) ≥ 10 | | |

l) Restorative Nursing – Additional Scoring Indicators

Activities that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's clinical record. These are nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The program shall be performed for a total of at least 15 minutes during a 24 hour-period. Measurable objective and interventions shall be documented in the care plan. There shall be evidence of periodic evaluation by the licensed nurse. A registered nurse or licensed practical nurse shall supervise the activities. This does not include groups with more than 4 residents per supervising staff.

Restorative Nursing Programs-2 or more required to be provided 6 or more days a week

Passive Range of Motion (O0500A) and/or Active Range of Motion (O0500B)\*

These are exercises performed by the resident or staff that are individualized to the resident's needs, planned, monitored, and evaluated. Movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative program. Staff must be trained in the procedures.

Splint or Brace Assistance (O0500C) − This includes verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or there is a scheduled program of applying and removing a splint or brace. The resident's skin and circulation under the device should be assessed and the limb repositioned in correct alignment.

The following activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

Bed Mobility Training (O0500D) and/or walking training (O0500F)\* − Bed Mobility − Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and position self in bed. Walking − Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.

Transfer Training (O0500E) − Activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

Dressing and/or grooming training (O0500G) − Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

Eating and/or swallowing training (O0500H) − Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Amputation/Prosthesis (O0500I) − Activities provided to improve or maintain the resident's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prostheses attaches to the body.

Communication training (O0500J) − Activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

No count days required for current toileting program or trial (H0200C) and/or bowel training program (H0500)\* − This is a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing facility's policies and procedures and current standards of practice. The program is based on an assessment of the resident's unique voiding pattern. The individualized program requires notations of the resident's response to the program and subsequent evaluations as needed. It does not include simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene.

\*Count as one service even if both are provided.

m) Cognitive Impairment – Additional Scoring Indicators

Cognitive impairment is determined by either the summary score from the resident interview in Section C0200-C0400 (BIMS) or from the calculation of Cognitive Performance Scale if the BIMS is not conducted.

Brief Interview for Mental Status (BIMS)

BIMS summary score (C0500 ≥ 9)

n) Cognitive Performance Scale – Additional Scoring Indicators

Cognitive Performance Scale is based off staff assessment. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment.

The resident is cognitively impaired if one of the three following conditions exists.

B0100 Coma (B0100 = 1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0110I1 all = 4 or 8)

C1000 Severely impaired cognitive skills (C1000 = 3)

B0700, C0700, C1000 Two or more of the following impairment indicators are present:

B0700 > 0 Problem being understood

C0700 = 1 Short term memory problem

C1000 > 0 Cognitive skills problem

And

One or more of the following severe impairment indicators are present:

B0700 ≥ 2 Severe problem being understood

C1000 ≥ 2 Severe cognitive skills problem

(Source: Old Section 147.330 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.330 added at 38 Ill. Reg. 12173, effective May 30, 2014)