MDS Alert

In The Spotlight: Catch MDS Inconsistencies Before They Slip Through The Cracks

An audit system is just the ticket to prevent compliance, care plan shortfalls.

MDS items that don't jibe raise a red flag for coding and care plan woes - or quality indicators/measures that will be off the mark.

Isabella Geriatric Center in New York City has implemented a proactive QA strategy to identify and head off such problems at the get-go.

The facility uses LTCQs Q-Metrics Data Integrity Audit, a proprietary web based program designed to detect inconsistencies among MDS items that could require further investigation. Five nurses complete the nursing sections of the MDS assessments for 705 residents, which is most of the MDS except for rehab, dietary, social services and recreation, says **Mary Mondero**, MDS coordinator for the facility. "And we've learned to slow down and look at every point and also to focus on areas that the LTCQ program has identified as [ones] where we are making mistakes," she says.

As a result, Isabella has developed double-checks and systems to self-correct the MDS before submitting it to the state. For instance, a staff member may code a resident as having a pressure ulcer but then forget to check off nutrition and hydration services provided by the facility. "We would detect that omission before submitting the MDS to the state," says **Yaffa Ungar**, director of clinical compliance for the facility.

Check These Related MDS Items

Based on feedback from the software program, the staff review identified areas of concern that may or may not reflect an actual problem. For example, the interdisciplinary team hones in on these MDS items to look for inconsistencies or missed care plan interventions, as follows:

1. **Late-loss ADLs.** The ADL section turned out to be one where the facility was losing the most reimbursement due to undercoding - especially in transfer and eating where staff might not capture that one instance of extensive assistance, says **Carole Stoll,** director of patient accounts at Isabella. The facility has since provided inservices and coaching to help staff understand the definitions and coding for ADL support and examples of what counts as supervision, limited assistance, extensive assistance and total dependence. They've also coached staff on the importance of using the facility's documentation formats to record all of their ADL care.

2. **The relationship between deficits in range of motion and loss of voluntary movement coded at G4 and the restorative nursing programs coded at P3**. The staff makes sure that the person's deficits coded at G4 match the restorative activities provided, says Ungar. For example, the resident who shows a decline in range of motion may require an active or passive range of motion program as part of the restorative plan of care, she says.

3. **Psychiatric diagnoses, behavioral symptoms and psychoactive medication**. If a person has a psychiatric diagnosis but displays no behavioral symptoms - and receives no psychiatric meds - the LTCQ program prompts staff to revisit that psychiatric diagnosis. "Social services is also now aware that when you code behaviors and mood issues in Section E, you need to look at Section F (psychosocial well-being), as those two sections are related," says Mondero. Section F looks at the resident's sense of initiative and involvement in the facility and "unsettled relationships" with people in the facility or family and friends.

4. **Impaired vision at D1 and lack of a visual appliance at D3**. The program prompts staff to rethink whether a resident requires visual aids to perform his desired activities.

5. **Depression and behaviors in Section E.** If a resident has a diagnosis of depression, the MDS team makes sure to assess, document and code the mood indicators if the person displayed them during the 30-day lookback, says Ungar. Rather than relying only on their own psychosocial resident assessments in coding Section E, the social service and activities staff check with the resident's caregivers to see if they observed him display any sad mood/anxiety indicators or behaviors.

6. **Persistent anger coded in E1 and F1 (sense of initiative/involvement) and F2 (unsettled relationships).** Looking at Section F may help staff identify potential causes of a resident's persistent anger, Ungar notes. For example, the resident may have suffered a recent loss - or his daughter can't visit any more because she moved across the country. The resident may also have unsettled relationships or conflict with a roommate or another person in the facility that's causing him distress. Once the team identifies the underlying cause of the person's anger, then the social worker can help devise psychosocial care plan interventions to address the issue.

7. **Diagnoses of painful conditions coded in Section I and pain coding in Section J.** If the patient has a diagnosis of arthritis or cancer in Section I, for example, the care team would check closely to see how they scored pain on the pain screening and assessment tools, says Stoll. They then correlate the pain assessment to coding in Section J2a and b and J3. The team also scours Section I to look for potentially painful conditions.

8. **A resident coded as occasionally incontinent at H1b who isn't on a toileting plan or bladder/bowel training program**. The staff looks to see if the person would benefit from a toileting program. Editor's note: LTCQ Inc. is based in Lexington, MA. For more information, go to www.ltcq.com or call 781.457.5900.