Section A:

- A12 “Residential/Living Status” and A13 “Living Arrangement” should align with each other and with the demographics of the electronic case record.
- A12 coding – RCFs and ALFs should be coded as 2 “Assisted Living/Semi-Independent Living/Board and Care.

Section B:

- B5 “Residential History Over Last 5 Years” must be updated at each assessment as this question plays a key part for vulnerable populations. This question should be scored as 1 “Yes” for anyone who is currently living in one of these settings or has lived in one of these settings within the last 5 years, no matter how short the duration of the stay. This includes short-term rehab and psych stays. Please note, per regulation requirements the look back period refers to 5 years preceding the current reassessment date.

Section C:

- Cognition points are only awarded if the individual has a combination of C1 and any of the following: C2, C3, D1, or D2. The coding of these questions should paint a consistent picture regarding the individual’s cognitive abilities.
- C2 “Memory/recall ability” should only be marked for true memory issues that go beyond “typical” forgetfulness. It is important to ask follow up questions for C2 and C3 to truly understand the severity of the issue.
  - For example, the individual states they walk into a room and forget why they went into the room. Follow up questions to determine if this behavior goes beyond “typical” forgetfulness could include: What does that look like for you? How does that effect your daily decision making? Is this a common occurrence for you? Does the issue create safety concerns? Also be sure to consider the individual’s medical diagnoses.
- If after asking these questions it is clear the individual exhibits only “typical” memory issues that everyone experiences at times, it would be appropriate to code C2 and C3 as 0 to indicate no issues. However, if someone has a true procedural or situational memory deficit, it would be expected that C1 would be coded at least a 1.
- If cognitive concerns are identified that may affect the person’s ability to self-direct then self-direction tools, such as Self Direction Questionnaire and/or SLUMS, should be utilized to ensure the person is able to direct their care. **IF** you feel as though the tools are not needed, further clarification should be provided in the case note

explaining why there are no concerns with the person's ability to self-direct despite section C Coding. Stating "No concerns with pt's ability to Self-Direct" will not suffice if C2b and C2c are coded as memory issues. Self-direction is defined in HCBS Policy 3.25.

Section D:

- D1 "Making Self Understood" and D2 "Ability to Understand Others" should be closely evaluated for individuals with dementia and developmental delays. Again these questions may go hand in hand with Section C and combined should paint a consistent picture.
- Significant vision impairments are captured in the algorithm under the coding of D4 "Vision". If an individual is blind or near blind, please remember to code this question appropriately.

Section E:

- E4 "Behavior Symptoms" should be closely considered for individuals with a developmental delay, dementia, and MI diagnosis. Also remember other diseases such as Parkinson's may have these symptoms too.
- Ask yourself has the individual ever had these symptoms and if it weren't for current interventions (HCBS, DMHS, medications, etc.) would they exhibit them. If the answer is yes, at a minimum 1 "Present but not exhibited in the last 3 days" should be coded.
- E4f, Resisting Care- If a participant is cognitively able to make informed decisions regarding accepting/complying with care, this would not be coded here. For example, if a competent participant states, "I understand this medication may help treat this condition, but I'm not taking it because I am worried about the side effect", we would consider this an informed decision and it would not be coded. However, if the participant has dementia or an I/DD diagnosis and is refusing to take medications without complete understanding of how this decision will impact their health, this would be coded for resisting care.

  Review the v.10 interRAI manual for additional examples of E4 coding.

Section F:

- F1g "Neglected, abused, or mistreated" should be coded if the individual has experienced a serious or life-threatening situation that went untreated or appropriately acknowledged. Additional questions may be needed to make this determination. If current abuse or neglect is indicated, this should be coded accordingly, a referral made and documented in case notes.

Section G1:

- G1a "Is the person bedbound", coding an individual as 1 "Bedbound" will award 18 points, triggering LOC eligibility.
- An individual should only be coded as bedbound if they are truly restricted to the bed

and are only moved out of bed on rare instances such as to have the linens changed or in an emergency. This would not include those that are moved to chair for the day.

- Individuals with a true code of G1a=1 should be coded 8 “Did not occur” in both G5f “Walking” and G5g “Locomotion” (If G1a=1, then G5f and G5g = 8).

Section G4:

- This section looks at the amount of the task the individual is able to complete on their own. Pay particularly close attention to G4a “Meal preparation” and G4d “Managing medications” as these are standalone LOC categories and points are based solely on the coding for these questions.
- When coding assistance is needed with stairs (G4f), determine how much assistance is needed to safely climb a full flight of stairs. Reminder G4 does not look at weight-bearing support, just whether assistance is needed throughout the task. This can be as simple as holding onto an arm to prevent falls or to help carry assistive devices or oxygen. It is okay for stairs and walking/locomotion to not align as stairs is an earlier loss activity.
- Refer to the Meal Prep Quick Guide, paying close attention to the flow chart.
    - Meal prep coding considers all four key steps outlined in the meal prep quick guide as they relate to a **simple meal** (microwaving, making a sandwich, toasting, pouring cereal, etc.)
    - Ability to use the stove should not be a coding factor if the participant can safely prepare simple meals.
    - Consider the participant’s physical, mental, and cognitive ability to complete tasks safely across all 4 steps.
    - Participants coded independent may still receive dietary time on their care plan if they prefer more complex meals be prepared for them. (Document thoroughly).
- Review the G4 – Managing Medications Scoring Guidance for information on how to code this question.
- G4i “Transportation” looks at the overall assistance needed to complete all subtasks associated with being transported. It does not look at the assistance needed with the actual driving task. When determining the correct coding for transportation, first determine whether the individual is transported using private vehicle or utilizes public transportation. Then ask how much assistance the individual needs with the specific subtasks associated with their mode of transportation.
    - Private transportation – How much assistance is needed to get to and from the vehicle? How much assistance is needed to get in and out of the vehicle?
    - Public transportation – How does individual travel by public transportation?

(Public bus, taxi, etc.) Based on the type of public transportation determine which of the following subtasks would be applicable. Are they able to call for their ride? How much assistance is needed to get to and from the vehicle and in/out of the vehicle? Are they able to navigate to the bus stop? Are they able to pay the fare unassisted? Are they able to give directions?

Section G5:

- This section looks at the amount of weight bearing assistance needed to complete the task. Therefore, we should look at the whole task and code **capacity** based on the portion of the task where the most help is needed.
  - **Ex:** The individual may be able to bathe sitting on their shower chair independently however they are unable to step into the bath independently, therefore the transfer into the bath is where the most assistance is needed, and the coding should be based on how much help they need during that small piece of the task where they depend on others.
- To ensure that the InterRAI coding accurately reflects the individual's need for assistance, the individual's ability to safely complete the tasks in G5 should be factored into the coding, as opposed to coding solely based on the individual's performance over the past 3 days.
  - **Ex:** When coding G5a for an individual who has not bathed in the past three days due to the individual's inability to safely bathe without assistance, the coding should be based on the type of assistance needed to complete the task safely. Coding of an 8 "Did not occur" in this situation would not accurately reflect the need for assistance, causing the LOC score to be skewed. (If a person has not bathed in the past three days due to personal choice, but is physically able to do so, it would be appropriate to code G5a as an 8.)
- G5a "Bathing" should be coded based on whether the individual needs assistance with washing their body. If assistance **only** needed with washing their back, then G5a should **not** be coded to reflect a need for assistance as most persons have difficulty with this aspect of bathing.
- G5b "bath transfer" is coded for the assistance needed to get in/out of the bath.
- G5c (Hygiene) should be coded to reflect assistance needed with grooming/hygiene, this includes assistance needed with the washing of hair. Since it is common for persons to wash their hair separate from bathing it is appropriate for assistance with washing hair to be factored into hygiene/grooming tasks.
- G5f "Walking" looks only at how an individual walks between locations on the same floor. G5g "Locomotion" looks at how an individual walks and/or wheels between locations on the same floor.

- **If an individual only walks** – walking and locomotion scores will be identical and based on the individual's ability to walk between locations on the same floor.
- **If an individual only wheels** – walking will be an 8 and locomotion will be based on the individual's self-sufficiency once in the chair.
- **If an individual walks AND wheels** – walking will be based on the individual's ability to walk between locations on the same floor. Locomotion will be based on the 3 most dependent episodes of walking and wheeling over the last 3 days. Most often, walking will be the most dependent episodes of locomotion, and the locomotion score will therefore match the walking score. However, someone with arm weakness might need limited assistance with walking, but total dependence while wheeling. In this case, locomotion would be scored higher than walking.

- Incontinence points are captured in G5i "Toilet Use". If someone is identified in Section H as having incontinence, ask yourself if they need assistance cleaning themselves up due to the incontinent episodes. If so, G5i should reflect that need.
- G5k "Eating" should be coded for the amount of assistance needed to complete the act of eating or drinking, such as cutting food, and/or opening containers. K3 "Mode of Nutritional Intake" should be coded if the person requires modifications due to issues with swallowing/intake of food.

Section H:

- Incontinence should be scored no matter the type or cause.
- If anyone has an ostomy or catheter, this should be indicated here for the individual to receive points in treatments. If an individual has a catheter or ostomy, H2 and/or H4 should be coded, regardless of leaks or spills.

Section I:

- Each individual should be coded as having at least one primary diagnosis (coding of 1).
- The primary diagnosis/diagnoses should be the condition(s) that are the main cause of the person's need for services.
- Every single diagnosis does not have to be added to the assessment if the individual reports a long list of conditions. Just be sure to include those that most impact the need for services.

Section J:

- J1 "Falls" and J2 "Any fall with major consequences within last 90 days" (if applicable) should be updated at every assessment. If an individual mentions a recent fall, it is

important these questions are updated accordingly to ensure safety risks are accurately scored.

- J4 “Balance Frequency” should also be updated at each assessment to capture safety concerns associated with balance and gait.
- If an individual is unable to walk coding should reflect the following:
    - J4a – Difficult or unable to move to a standing position unassisted
        - Code as 4 – exhibited daily in the last 4 days
    - J4b – Difficult or unable to turn self around and face the opposite direction when standing
        - Code as 4 – exhibited daily in the last 4 days
    - J4d – Unsteady gait
        - Code as 0 – not present
- J4g,h,&i “Psychiatric” should be coded much like the behaviors in section E. Remember to ask yourself if the individual has ever exhibited the behaviors, if so, determine if they would return if it weren’t for the services and/or medications they receive. If the answer is yes, at a minimum “present but not exhibited in the last 3 days” should be coded.

Section K:

- K2e “Physician ordered diet” should only be scored when a specific diet has been ordered and involves weighing, measuring, calculating, and/or restricting selected nutrient components such as calories, sodium, sugar, etc. A doctor recommending someone “watch their sugar” does not count as the restriction does not require nutrients to be counted, weighed, or measured.
- K3 “Mode of nutritional intake” should be scored for the individuals requiring modification to consume food/ingest nutrients. This section can really paint a picture for care plan needs such as increased time under dietary to cut up/puree meals. It is especially important to capture those with tube or TPN feedings in this section as it impacts treatment points. Coding of K3 is about nutritional intake, if the person has a limitation (e.g. tremors) that effects their physical ability to use utensils to cut food this should be factored into the coding of G5k “Eating.”

Section L:

- L1 “Most severe pressure ulcer” should be scored based on the most severe ulcer regardless of type of ulcer.
- If the individual has a skin defect it must be captured in L1-L5. If the individual’s skin condition is due to broken skin that is being treated determine if N2j “Wound care”

should be coded.

Section N:

- N2 “Treatments” should be coded for any treatments the individual is **currently** ordered to receive. If a treatment is ongoing but has not occurred within the past three days, such as chemotherapy, code as 1 “Ordered but not yet implemented.”
- N2j “Wound care” should be coded only if the individual has broken skin and there are medical orders to treat the skin on a routine basis.
    - If N2j is coded for wound care, then section L should be coded for a skin condition.
    - Broken skin refers to any condition where the skin is not intact causing increased risk of infection; even if a scab has developed the skin would be broken.
- N3 “Formal Care” should be coded for any formal care service the individual is **currently** ordered to receive. If a service is ongoing but has not occurred within the past three days, such as physical therapy, code a “1” in the “Days” column.
- N3a- Formal Care Services should only reflect services provided outside of the HCBS program. This section should inform current unmet needs and support coordination with external services. (Note: This guidance does vary from the InterRAI manual)
- N8 “Monitoring” should only be coded for a mental health condition if the individual is seeing a licensed mental health provider at least monthly.

Section S:

- Refer to the InterRAI Section S: Back-up Plan Quick Guide for guidance.

Section T:

- The signature line of the interRAI should include the full first and last name of the assessor completing the assessment.