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 item plays a key part for vulnerable populations. This item 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:

- Coding should not rely solely on the participant’s responses to Section C items but rather reflect the assessor’s overall observations and the full context of the assessment. It is recommended to code Section C at the end of the assessment based on these observations and the information gathered through open-ended questions throughout the entire assessment process.
- 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 items should paint a consistent picture regarding the individual’s cognitive abilities. Be sure to consider the individual’s medical diagnosis prior to evaluating cognitive ability.
- C1 “Cognitive Skills for Daily Decision Making” should be coded based on the individual’s ability to make everyday decisions. Examples of everyday decisions include:
    - Choosing items of clothing
    - Knowing when to eat meals
    - Using a clock or calendar to apply time to organize and plan the day. (Scheduling activities and managing daily routines)
    - Awareness of one’s strengths and limitations (asking for help when necessary, using necessary assistive devices)
- C2 “Memory/recall ability”
    - C2a: When short term memory concerns are observed or reported, you may conduct a structured test of recalling 3 unrelated items (book, watch, table). Or ask the person to describe a recent event that you should both have knowledge of (such as the election of a new political leader, a major holiday) or that you can validate with a family member (for example, what the person had for breakfast)
        - This should only be coded for true memory issues that go beyond “typical”

forgetfulness. 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 might include: Is this a common occurrence for you? Or are you eventually able to recall the reason?

- C2b procedural memory is the cognitive ability to perform an activity that requires multiple steps, such as dressing or preparing a meal. It does not involve the physical skills to complete the steps. To assess this ability, you may ask, describe how to make a grilled cheese sandwich or describe how you got ready this morning.
- C2c situational memory relates to the individual's ability to recognize frequently encountered people AND knows the location of commonly visited places. Determine if the person can recognize all their caregivers or family members. Are they able to locate different parts of the house or facility?

- Section C3 is evaluating the presence of **delirium**. C3c "Mental function varies over the course of the day" should be coded when an individual's cognitive function and behaviors change throughout the day (sometimes better, sometimes worse) due to a delirium process. This is common among sundowners in individuals with dementia.
- If cognitive concerns are identified that may affect the individual's ability to self-direct, then self-direction tools, such as Self Direction Questionnaire and/or SLUMS, should be utilized to ensure the individual 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 individual's ability to self-direct despite section C Coding. Stating "No concerns with pt's ability to Self-Direct" will not suffice if C1, C2b and C2c are coded. 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 diagnoses such as stroke, dementia and developmental delays. Again, these items may go hand in hand with Section C and, combined, should paint a consistent picture. When evaluating the ability to make self understood, it can be in any form (written, communication board, etc.); it does not have to be verbal. These items are not intended to address language barriers.
- D4 "Vision" should be coded based on one's ability to see objects in adequate lighting, using visual aids. If an individual is blind or near blind, please remember to code this item appropriately to ensure accurate LOC scoring. A diagnosis of legally blind does not automatically indicate a specific coding need. It is important to ask follow up questions to discern if the person can read print, see shapes/shadows, etc. before coding.

Section E:

- E4 "Behavior Symptoms" should be closely considered for individuals with a developmental disability, dementia, and mental health diagnosis. Also, remember other diseases, such as Huntington's, may have these symptoms too.
- Ask yourself, has the individual ever had these symptoms, and if it weren't for current interventions (HCBS, DMH services, 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 effects", 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 a complete understanding of how this decision will impact their health, this would be coded for resisting care.

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 "Bedbound" evaluates whether an individual is bedbound. Coding an individual as bedbound automatically triggers 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 who are moved to the chair for the day.

Section G4:

- The IADL section evaluates how much of each task an individual can independently perform. Pay 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 items.
- G4a "Meal Preparation" evaluates an individual's presumed ability to **safely** prepare a **simple** meal, such as microwaving, making a sandwich, toasting bread, or pouring cereal. Refer to the Meal Prep Quick Guide for more specific guidance.
    - When coding meal prep, four key subtasks should be considered: Planning the meal, assembling the ingredients, preparing the meal, and setting out or transferring the meal and utensils to the eating area.
    - Determine how many of these subtasks the individual needs assistance with and whether assistance is consistent or only occasional in the last 3 days. Consider the participant's physical, mental, and cognitive ability to complete all subtasks safely.
    - Ability to use the stove or stand for long periods of time should **not** influence coding for **simple** meal preparation.
    - Participants coded independent may still receive dietary time on their care plan if they prefer more complex meals be prepared for them. (Document thoroughly).
- G4d "Managing Medications": Refer to G4 – Managing Medications Scoring Guidance for information on how to code this item.
- 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 are an earlier loss activity.

- 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 a 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 focuses on the level of weight-bearing assistance required to complete the task. It captures both the individual's performance and capacity to complete the task. While performance is considered in this item, only the capacity coding is used in calculating the LOC score. **Capacity** reflects a person's **presumed ability** to complete the task safely.
- G5a "Bathing" should be coded based on whether the individual needs assistance with washing their body. If assistance is **only** needed with washing their back, then G5a should **not** be coded to reflect a need for assistance, as most individuals 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 individuals to wash their hair separately 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 episode 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 coded higher than walking.

- Incontinence points are captured in G5i “Toilet Use”. If an individual 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.
- G5j “Bed Mobility” refers to how the person moves to and from the lying position, turns from side to side, and positions their body while in bed. It does NOT include lifting the legs in/out of the bed.
- G5k “Eating” should be coded for the amount of assistance needed to complete the act of eating or drinking, regardless of method of nutrition (By mouth, tube feeding, TPN). Setup help for eating any type of food may include cutting meat and/or opening containers once the food has been placed on the table or eating area.

Section H:

- Incontinence should be scored no matter the type or cause.
- If an individual 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:

- At least one primary diagnosis should be coded for each individual (coding of 1).
- The primary diagnosis/diagnoses should be the condition(s) that are the main cause of the individual’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 the last 90 days” (if applicable) should be updated at every assessment. If an individual mentions a recent fall, it is important to ask follow-up questions to ensure safety risks are accurately scored.
    - Falls should only be coded when both conditions are met:
        - The individual is unable to regain balance without support and lands on the ground or furniture (e.g., bed, chair)
        - The fall occurs due to a physical limitation (such as weakness, poor coordination, or mobility impairment).
    - Do **NOT** count as a fall:
        - Individual missteps but regains balance without needed support.

        - Isolated stumble over clutter, rugs, cords, animals, etc., with no ongoing underlying balance issues or related medical diagnoses. These brief, random incidents are common for most people and are not classified as falls.

- J4a–d "Balance" items should be coded whenever there are concerns related to balance or gait. Assessors should rely on observation, information gathered throughout the assessment, and documented diagnoses to accurately code these items. Observation is especially important, and it is appropriate to ask the individual to stand, walk, or retrieve an item—such as their medications—to support an accurate assessment.
    - Keep in mind that many individuals may report difficulty standing from a seated position, so follow-up questions are essential to determine the correct coding. For example:
        - Does the participant need to use furniture, a device, or another person for support when standing?
        - Do they need to rock back and forth to gain momentum before standing?
        - Do they require several attempts before they are able to stand successfully?
    - 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.
- J4g "Abnormal thought process" should be coded when an individual **expresses** their thoughts in an unusual way. A diagnosis of depression or anxiety does not typically result in abnormal expression of thoughts except in severe instances. Dementia, schizophrenia, schizoaffective disorder and bipolar mania are common diagnoses that may present with abnormal thought processes. Examples of an abnormal thought process include:
    - Loose associations: Jumps from one topic to another with no clear connection
    - Thought blocking: Suddenly stops talking mid-sentence and cannot recall what they were saying
    - Flight of ideas: Talks very fast; ideas come so quickly you can't keep up.
    - Tangentiality: Goes off-topic and does not return to the main point.
    - Incoherence: Speech is disorganized or illogical, making it hard to understand.
    - Neologism: Creation of new, made-up words that are not meaningful to others.

- Punning: Using wordplays or sound-based jokes that interfere with clear communication.

Section K:

- Code K2e **only** when a physician orders a diet that requires the individual to weigh, measure, or calculate specific nutrient components such as calories, sodium, carbohydrates, potassium, protein, or similar nutrients.
    - Examples may include, but are not limited to:
        - Sodium Restricted Diet: Limits sodium to 2,300 mg/day or less to help manage blood pressure, fluid retention, and cardiovascular disease.
        - Diabetic Diet: Controls blood sugar by regulating carbohydrates, calories, and protein—often specifying 45–60 g of carbohydrates per meal. This may include the physician ordered use of the MyPlate method to measure portions.
        - Renal Diet: Manages chronic kidney disease by reducing sodium, potassium, phosphorus, and often protein. Specific nutrient amounts are adjusted based on disease stage.
        - High Calorie/Protein: Combats malnourishment and muscle wasting and often focuses on additional meals and targets calorie and protein intake ranges.
    - Do NOT code K2e for:
        - Food allergies or intolerances (such as gluten, peanuts, dairy, Alpha gal).
        - General recommendations like “limit” or “watch” a nutrient when no weighing, measuring, or calculating is required.
        - Removal of a type of food, such as "spicy foods”.
        - If measurements are unknown AND the participant reports not following the diet

      Note: While K2e is not coded in these instances, some of the instances may warrant additional care plan time.
- 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 individual has a limitation (e.g., tremors) that affects their physical ability to use utensils to cut food, this should be factored into the coding of G5k “Eating.”

Section L:

- 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 2, “Implemented but not received in last 3 days”.
- 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.