

Section O Activity Sheet

Instructions

1. Read the scenario below.
2. Calculate the number of minutes of therapy for each service provided.
3. Code O0400 in your MDS 3.0 instrument according to the results of your calculation and using the information provided in the scenario.
4. You may work individually or in pairs/ groups.

Scenario

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/10 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law.

Her initial SLP evaluation was performed on 10/06/10, the PT initial evaluation on 10/07/10, and the OT initial evaluation on 10/09/10. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/17/08 was an appropriate ARD for her Medicare-required 14-day MDS.

During the look-back period, she received the following:

1. Speech-language pathology services
 - Individual dysphagia treatments
 - Monday - Friday for 30-minute sessions each day
 - Cognitive training
 - Monday and Thursday for 35-minute concurrent therapy sessions
 - Tuesday, Wednesday and Friday 25-minute group sessions
 - Individual speech techniques
 - Tuesday and Thursday for 20-minute sessions each day.
2. Occupational therapy services
 - Individual sitting balance activities
 - Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT split the sessions, with OT recording 20 minutes each session and PT recording 10 minutes each session.)
 - Individual wheelchair seating and positioning
 - Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.

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- Balance/coordination activities
 - Tuesday-Friday for 20 minutes each day in group sessions.
- 3. Physical therapy services
 - Individual wound debridement followed by application of routine wound dressing
 - Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing
 - Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing
 - For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
 - Individual sitting balance activities
 - Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT split the sessions, with OT recording 20 minutes each session and PT recording 10 minutes each session.)
 - Individual bed positioning and bed mobility training
 - Monday-Friday for 35 minutes each day
 - Concurrent therapeutic exercises
 - Monday-Friday for 20 minutes each day.
- 4. Respiratory therapy services
 - Sunday-Thursday for 10 minutes each day.
- 5. Psychological therapy services were not provided.
- 6. Recreational therapy services
 - Tuesday, Wednesday, and Friday for 30-minute sessions each day.

Section M Activity Sheet #1

Instructions

1. Read the scenario below.
2. Code Section M in your item set as appropriate for each assessment.
3. You may work individually or in pairs/ groups.

Scenario

- Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer.
- The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home.
- On Mr. S' first quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved.
- On the second quarterly assessment, the Stage 2 pressure ulcer was noted to have worsened to a Stage 3.
- The dimensions of the Stage 3 pressure ulcer at the 2nd quarterly assessment are:
 - L 3.0cm
 - W 2.4cm
 - D 0.2cm with 100% granulation tissue noted in the wound bed

Section M Activity Sheet #2

Instructions

1. Read the scenario below.
2. Code Section M in your item set as appropriate for each assessment.
3. You may work individually or in pairs/ groups.

Scenario

- Mrs. P is admitted to the nursing home on 10/23/2010 for a Medicare stay.
- In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin break down.
- On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010.
 - This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed.
 - Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth.
- Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems.
- She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer.
- Mrs. P. also has pressure redistribution devices on both her bed and chair, and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance.
- On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/10.
- Upon reentry the 5-day PPS ARD was set at 11/19/2010.
- In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx; however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth.
- It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.