Quality Measure	Short Stay or Long Stay	MDS Look Back Assessments	Cause of Trigger and MDS Section	Exclusions and MDS Section	Interventions, Ideas and Approaches
Walk Independently Worsened	Long Stay > 101 days	Latest PPS, Discharge or OBRA assessment completed 46-165 days prior compared to Latest PPS, Discharge or OBRA Completed in last 3 months	A decrease of one or more points on the "Walk 10 feet" item between the target assessment and prior assessment (GG0170I on target assessment – GG0170I on prior assessment ≤ -1).	Comatose at prior assessment Prognosis of less than 6 month life expectancy at prior assessment Resident totally dependent or not attempted for walking on prior assessment Prior assessment is a discharge assessment with or without return anticipated	Assess Root Cause Assess ADL Coding Accuracy Assess Medical Condition or Changes Assess Medication Changes MD Consult PT/OT Referral RNA/FMP Program Education of staff on incorporating Independence into ADL care daily to encourage independence Assess Palliative Care Options and Life Expectancy Recreation Programming with emphasis on mobility skills and physical exercise
Percent of Patients with Pressure Ulcers	Long Stay > 101 days	Latest PPS, Discharge or OBRA Completed in last 3 months	Stage 2-4 pressure ulcers or unstageable pressure ulcers are present as indicated in M0300	Target assessment is an admission assessment, 5 day assessment or readmission/return assessment MDS responses in M0300 dashed (-)	Consistent body audit procedure for early intervention of reddened areas- color, temperature and sensation assessment Assessment of Root Cause MD Consult Assessment of sheering and bony prominence Effective Wound Treatment and timely changes Braden and high risk protocol Mattress, cushion, footwear and Positioning Moisture Barriers Bowel and Bladder Training and Toileting Schedules Frequency of Wet/Soiled Checks Nutrition and Hydration Management PT/OT Referral Modality Treatment- ACP Self repositioning training RNA/FMP programming for Sit to Stand/mobility Turning and Positioning program
Antipsychotic Medication Use	Long Stay > 101 days	Latest PPS, Discharge or OBRA Completed in last 3 months	Received antipsychotic in 7 day look-back (N0415A1 = [1])	1. Schizophrenia (I6000 = [1]). 2. Tourette's syndrome (I5350 = [1]). 3. Huntington's disease (I5250 = [1]).	Root Cause of Behaviors Assessment of need of Antipsych med Assessment of Reduction of low dose Antipsych meds Evaluate Environmental triggers Assess medical condition that may trigger behaviors Assess Pain and Pain Mgt Med Review- may cause behaviors Assess Communication and ability to make needs known Environmental Adaptation to decrease external stimuli Staff education on approach to behaviors OT Referral Recreation Programming Pet/Music Therapy RNA/FMP programming- Walk to Dine
	Short Stay <101 days	Admission or 5 Day compared to Latest PPS, Discharge or OBRA Completed	Newly started on antipsychotic meds after the initial assessment No415A1 = 1		

Quality Measure	Short Stay or Long Stay	MDS Look Back Assessments	Cause of Trigger and MDS Section	Exclusions and MDS Section	Interventions, Ideas and Approaches
Physical Restraint	Long Stay > 101 days	Latest PPS, Discharge or OBRA Completed in last 3 months	-Trunk restraint used in bed (P0100B= 2) OR - Limb restraint used in bed (P0100C= 2) OR - Trunk restraint used in chair or out of bed (P0100E=2) OR - Limb restraint used in chair or out of bed (P0100F=1) OR - Chair prevents rising used in chair or out of bed (P0100G =2 Restraint Defined: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. It is the effect the device has on the resident not the name or the purpose of the device	None	Assess Root Cause Assess Medical Condition or Changes Assess Pain Assess Medication Reactions MD consult PT/OT Referral Restraint Reduction trials to least restrictive device Evaluate Environmental Triggers causing behaviors Environmental Adaptation Pain Management Recreation Programming Behavior Management and Cognitive Training Assess Communication and ability to make needs known Toileting Schedule and Bowel and Bladder Retraining Purposeful activities and Occupation RNA/FMP program Exercise Urban Zen Referral Music/Pet Therapy
Increased Need for ADL Help	Long Stay > 101 days	Latest PPS, Discharge or OBRA assessment completed 46-165 days prior compared to Latest PPS, Discharge or OBRA Completed in last 3 months	Section GG- Sit to Lying, Sit to Stand, Eating, Toilet Transfer Increase in 2 or more coding points, such as supervision or touching assistance to substantial/maximal assistance in one late loss ADL item or One point increase, such as from partial/moderate assistance to substantial/maximal assistance in 2 or more late loss ADL items	All 4 late loss ADL items are dependence or not attempted on prior assessment 3 late loss ADLs indicate dependence or not attempted and 1 indicates substantial/max assistance on prior assessment Comatose (B0100=1) Life Expectancy less than Six months (J1400=1) Hospice Care (Oo100K2=1)	Assess Root Cause Assess ADL Coding Accuracy Assess Medical Condition or Changes Assess Medication Changes MD Consult PT/OT Referral RNA/FMP Program Education of staff on incorporating Independence into ADL care daily to encourage independence Assess Palliative Care Options and Life Expectancy
Catheter Inserted and left in Bladder	Long Stay > 101 days	Latest PPS, Discharge or OBRA Completed in last 3 months	Indwelling Catheter (H0100A=1)	Target assessment is an admission, 5 day, or Readmission Neurogenic bladder (I1550=1 or -) Obstructive Uropathy (I1650 = 1 or -)	Assess need for Catheter Remove as able

Quality Measure	Short Stay or Long Stay	MDS Look Back Assessments	Cause of Trigger and MDS Section	Exclusions and MDS Section	Interventions, Ideas and Approaches
Falls w/major injury	Long Stay > 101 days	Scan of all submitted MDS that have target dates no more than 275 days prior to to the target assessment	One or more look-back assessments that indicate the occurrence of a fall (J1900c = [1,2]).	The occurrence of falls was not assessed (J1900c = [-]).	Assessment of Root Cause Assessment of Medical Condition/ and vitals Pain Management Behavior/Cognitive Management Sensation/Vision/Hearing treatment Toileting and Incontinence Management Proper Environmental Adaptation- Modification of Room to allow resident to be independent and set up with the safest solution Assessment of interventions added for multiple falls PT/OT Referral Recreation Programming RNA / FMP Programming- Walk to Dine
Urinary Tract Infection	Long Stay > 101 days	Latest PPS, Discharge or OBRA Completed in last 3 months	All the following MUST be present - Determined that resident had a UTI using evidence-based criteria e.g. McGreer, NHSN, LOEB in last 30 days - A physician documented diagnosis in the last 30 days I2300 = checked	Target assessment is an admission assessment, 5 day assessment or readmission/return assessment	Assess Root Cause Medical Review and Treatment Utilize Advanced Nursing protocols Catheter removal if applicable Utilization of gloves with bodily fluids Hand washing Hydration management Toileting Schedules Bowel and Bladder Training Frequent Wet/Soiled Checks
New or Worsened bowel or bladder incont.	Long Stay > 101 days	Latest PPS, Discharge or OBRA assessment completed 46-165 days prior compared to Latest PPS, Discharge or OBRA Completed in last 3 months	Bowel or Bladder incontinence is new or worsened from prior assessment H0300 (bladder) H0400 (bowel)	Target assessment is admission or 5D Resident is comatose Resident has an indwelling catheter (target or prior assessment) Resident has an ostomy (target or prior assessment)	Assess Root Cause Review and educate on Incontinent Documentation Review Cognitive Assessment Coding Assess Type of Incontinence Stress VS Urge VS Overflow VS Functional Bowel or Bladder Retraining Trials Voiding Diary Q2 hour toileting Review of fluids Medication Review of Stool softeners, Diuretics, Antidepressants, Antihypertensive, Muscle relaxants, Hypnotics, Narcotics, Sedatives, Anti-Parkinsonian Lab or Renal Consults PT/OT for Room assessment and adaptation, toilet training, toilet transfer training, walk to bathroom training, at bedside set up of toileting ie commodes/urinals Estim/Tens Incontinence Training Pelvic Floor Training and exercise Briefs vs Pull ups assessment Dietary review of foods that may cause bowel or bladder incontinence SLP assessment to ensure able to communicate needs for toileting

Quality Measure	Short Stay or Long Stay	MDS Look Back Assessments	Cause of Trigger and MDS Section	Exclusions and MDS Section	Interventions, Ideas and Approaches
Changes in Skin Integrity: Pressure Ulcer/Injury (Part A stays only)	Short Stay 100 days or less	End of PPS compared to PPS 5 Day	Discharge Assessment indicates 1 or more new or worsened Stage 2-4 Pressure ulcers, or unstageable pressure ulcers M0300B1 through M0300G2) Ex. M0300B1 – M0300B2 > 0 would trigger	Resident Died during the SNF stay (5D with matched DIF)	Consistent body audit procedure for early intervention of reddened areas- color, temperature and sensation assessment Assessment of Root Cause MD Consult Assessment of sheering and bony prominence Effective Wound Treatment and timely changes Braden and high risk protocol Mattress, cushion, footwear and Positioning Moisture Barriers Bowel and Bladder Training and Toileting Schedules Frequency of Wet/Soiled Checks Nutrition and Hydration Management Modality Treatment- ACP Self repositioning training Turning and Positioning program
Discharge Function Score	Short Stay 100 days or less	Stays that meet or exceed expected discharge function score	GG0130A3. Eating GG0130B3. Oral hygiene GG0130C3. Toileting hygiene GG0170A3. Roll left and right GG0170C3. Lying to sitting on side of bed GG0170D3. Sit to stand GG0170E3. Chair/bed-to-chair transfer GG0170F3. Toilet transfer GG0170I3: Walk 10 Feet GG0170J3: Walk 50 Feet with 2 Turns GG0170R3. Wheel 50 feet with 2 Turns	Unplanned Discharge SNF stay less than 3 days Died during SNF Part A stay Dx: coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, severe anoxic brain damage, cerebral edema, or compression of the brain Discharged to hospice or received hospice while a resident No PT/OT on the 5D PPS	PT/OT/SLP services Additional RNA/FMP Programming Care giver training Home Exercise Program Training to complete in Room Education of staff to encourage independence with ADLs and mobility with self-care and mobility Recreation Programming with emphasis on return to home skills and physical exercise Review of Section GG Utilization Review discussions Review of clinical factors e.g. pain, depression