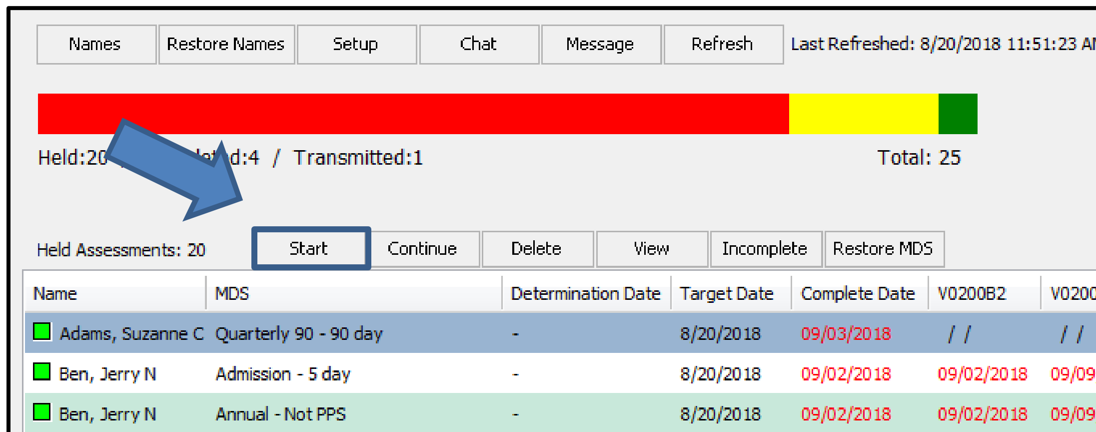
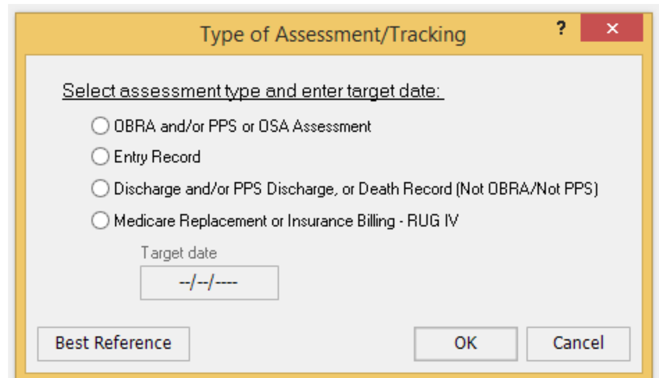
MDS Foundations

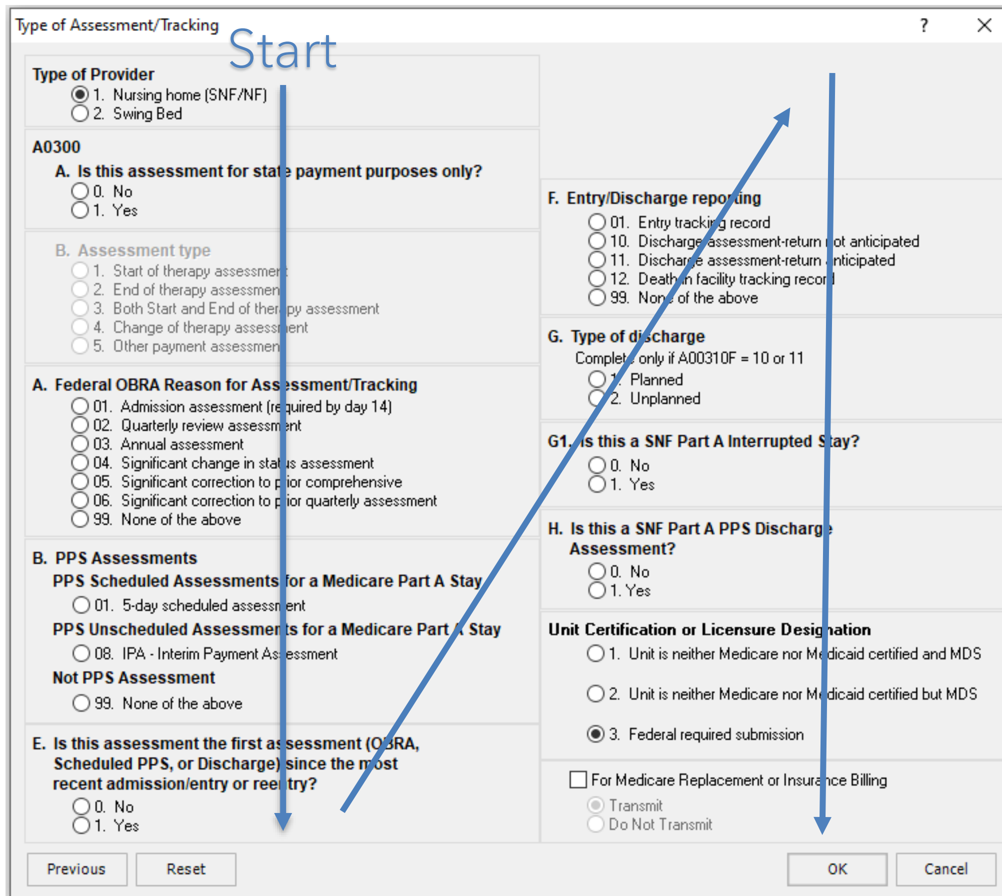
Starting an MDS

(MDS Manager is used here, however, this option is also available in the 'American Data – ECS' dropdown menu)



1) From within the *MDS Manager*, click onto the **Start** button.
2) Select the client name. Click **OK**.
3) The first *Type of Assessment/Tracking Form* screen will appear.
    a) Select whether the assessment is OBRA/PPS, and Entry Record, a Discharge/PPS Discharge/Death Record, or a RUG IV assessment for insurance purposes.
    b) Enter the target date (Assessment Reference Date, ARD) for the assessment and click **OK**.
        i) This will automatically populate into A2300 on your assessment.

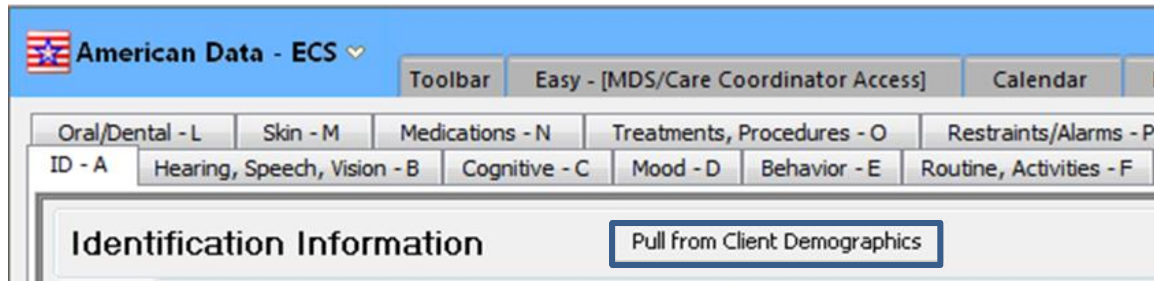




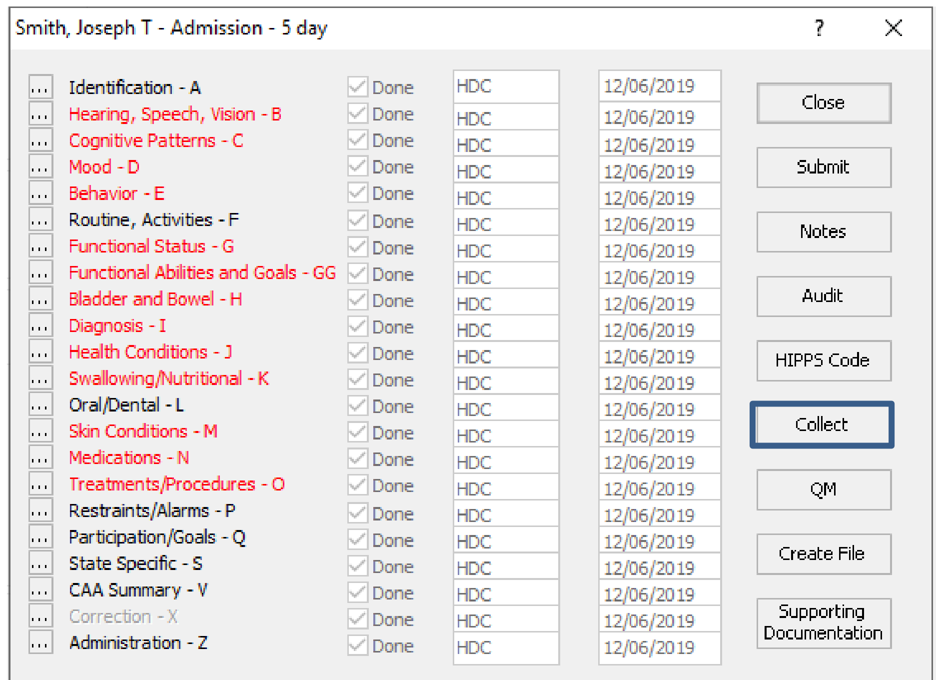
Code the MDS

1) The *Assessment Type* screen will appear.
2) This screen will narrow down what item set should be used for this assessment.
3) Complete items in order – You will see that some items effect those that follow. This will be true throughout the assessment.
    a) Example: If you code A0300A as yes, you will see many of the following items become inactive. This is because those items are not valid choices for assessments that are for state purposes only (OSA, Optional State Assessments).
4) Use the "Reset" button in the lower left if you need to start over.
5) The "Previous" button will allow you to go back to the prior screen to select a different option.
6) Once you are finished, click OK. Your assessment will now open.
    a) The information from the *Assessment Type* screen will be filled in for you on the assessment.
    b) The Assessment will open with the Status screen open for you. You will also notice tabs across the top of the screen for each section. You may navigate either by using the tabs or by using the picklist boxes next to the section names in the status screen.

Gathering Information from Charting



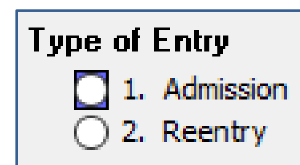
If it is a resident's first assessment



1) You will notice that section 'A' is mostly blank.
2) Select **Pull from Client Demographics** from the top of section 'A.'
3) This will fill in demographic information such as name and identifying numbers for both the resident and your facility.

Use the "Collect" feature to gather additional information

1) Select **Status** from the bottom right corner of your screen.
2) Select the **Collect** button on the *Status* screen.
3) Verify your ARD in the box that pops up and click **Ok**.
4) The system will search entries from within the lookback period for information relevant to this assessment.
5) To add this information to your assessment:
    a) Check Boxes and Radio Buttons: You will see a blue highlight behind answers that are indicated in charting.
    b) Fill in the blank items:
        i) Information will appear next to the response field, in a box that is highlighted blue.
        ii) Double click this information to copy it into the response field.

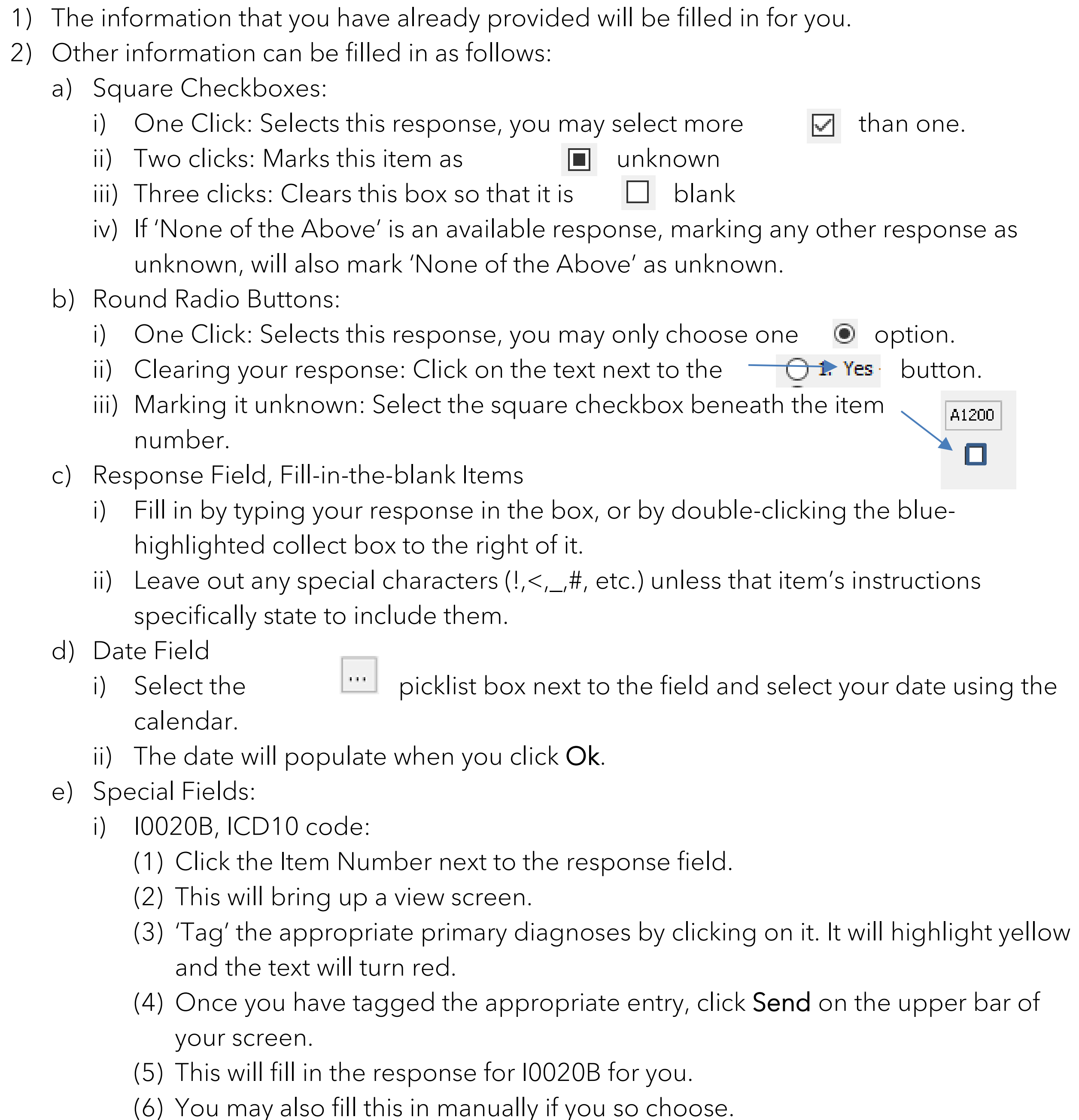


6) Information gathered by using *Collect* will not appear on your assessment unless you select it. You may choose to

either utilize or disregard any information provided.

7) To see the entries explaining any information suggested by the *Collect* feature, click on the Item Number next to the question.

Filling in Responses



1) The information that you have already provided will be filled in for you.
2) Other information can be filled in as follows:
   a) Square Checkboxes:
      i) One Click: Selects this response, you may select more than one.
      ii) Two clicks: Marks this item as unknown
      iii) Three clicks: Clears this box so that it is blank
      iv) If 'None of the Above' is an available response, marking any other response as unknown, will also mark 'None of the Above' as unknown.
   b) Round Radio Buttons:
      i) One Click: Selects this response, you may only choose one option.
      ii) Clearing your response: Click on the text next to the button.
      iii) Marking it unknown: Select the square checkbox beneath the item number.
   c) Response Field, Fill-in-the-blank Items
      i) Fill in by typing your response in the box, or by double-clicking the blue-highlighted collect box to the right of it.
      ii) Leave out any special characters (!,<,_,#, etc.) unless that item's instructions specifically state to include them.
   d) Date Field
      i) Select the ... picklist box next to the field and select your date using the calendar.
      ii) The date will populate when you click **Ok**.
   e) Special Fields:
      i) I0020B, ICD10 code:
         (1) Click the Item Number next to the response field.
         (2) This will bring up a view screen.
         (3) 'Tag' the appropriate primary diagnoses by clicking on it. It will highlight yellow and the text will turn red.
         (4) Once you have tagged the appropriate entry, click **Send** on the upper bar of your screen.
         (5) This will fill in the response for I0020B for you.
         (6) You may also fill this in manually if you so choose.

i) I8000, Additional Active Diagnoses
   (1) First, choose **Populate**, to pull in all this resident's diagnoses.
      (a) This will also show the ICD10 code, the clinical category, any associated NTA points, and if it qualifies as a SLP comorbidity.
   (2) Select appropriate diagnoses, and then select **<<Add** to add them to the list of active diagnoses on the left.
      (a) The ICD10 code will populate as well.
      (b) You may add up to 10 diagnoses in this way.
      (c) The order does not matter.
      (d) Click the **X** next to a diagnosis to remove it from the list.

Signing a section and Checking for Errors

1) Once you have completed a section, select **Sign Section** from the lower right corner of your screen.
   a) This will save your responses and check the section for errors.
   b) If you have partially completed a section, but need to leave the screen and return later, you may select Sign Section, and then Skip Errors on the following screen to save your work. It is not necessary to complete the entire section or address all errors to save the section.

Using "Audit" and "Notes"

Audit

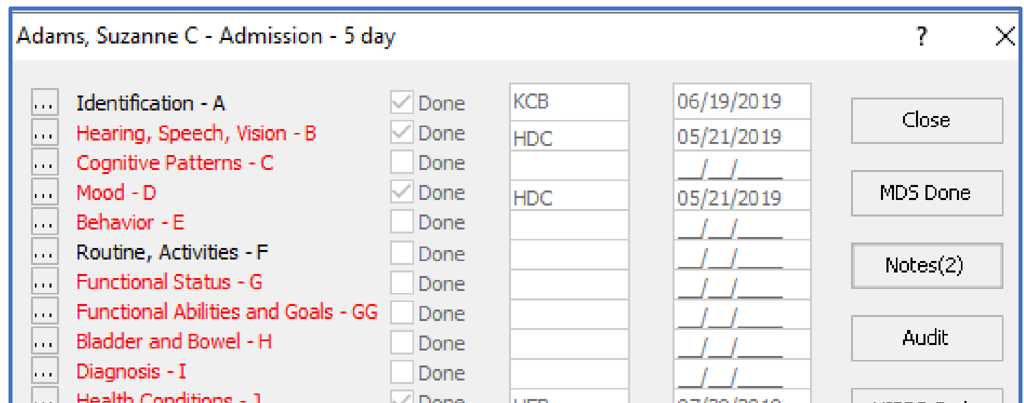
1) Complete the assessment and sign all sections.
2) Open the *Status* box by clicking **Status** in the lower right portion of your screen.
3) Select **Audit** from the options on the right of the box.
4) The system will check your assessment for errors.
   a) Fatal errors will cause CMS to reject the assessment when transmitted

i) These errors will pop up on a screen and list what item number caused the error and why the error occurred.
ii) They often feature several if/then statements. Follow these through from beginning to end to see where the error has occurred.

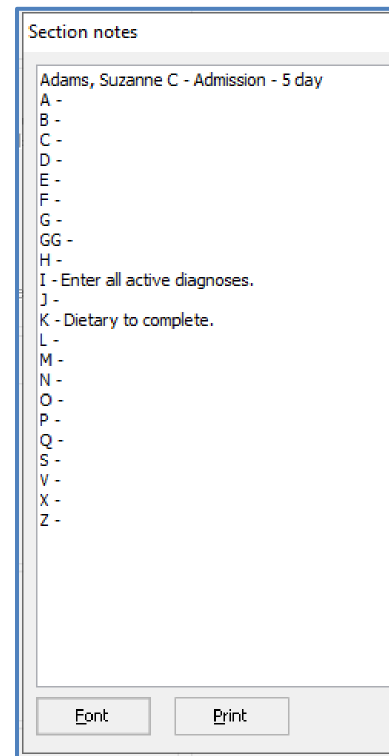
b) Scrubber errors are notifications of conflicting information. For example, if a recent surgery is documented, but not a surgical wound. These warnings are controlled by your facility.

Notes

1) If several staff members are working on an assessment, or if you would like a reminder for yourself about a section, *notes* are a good way to facilitate that communication.
2) To write a note:
   a) When you are working on the section that a note pertains to, select Notes from the bottom right portion of the screen.



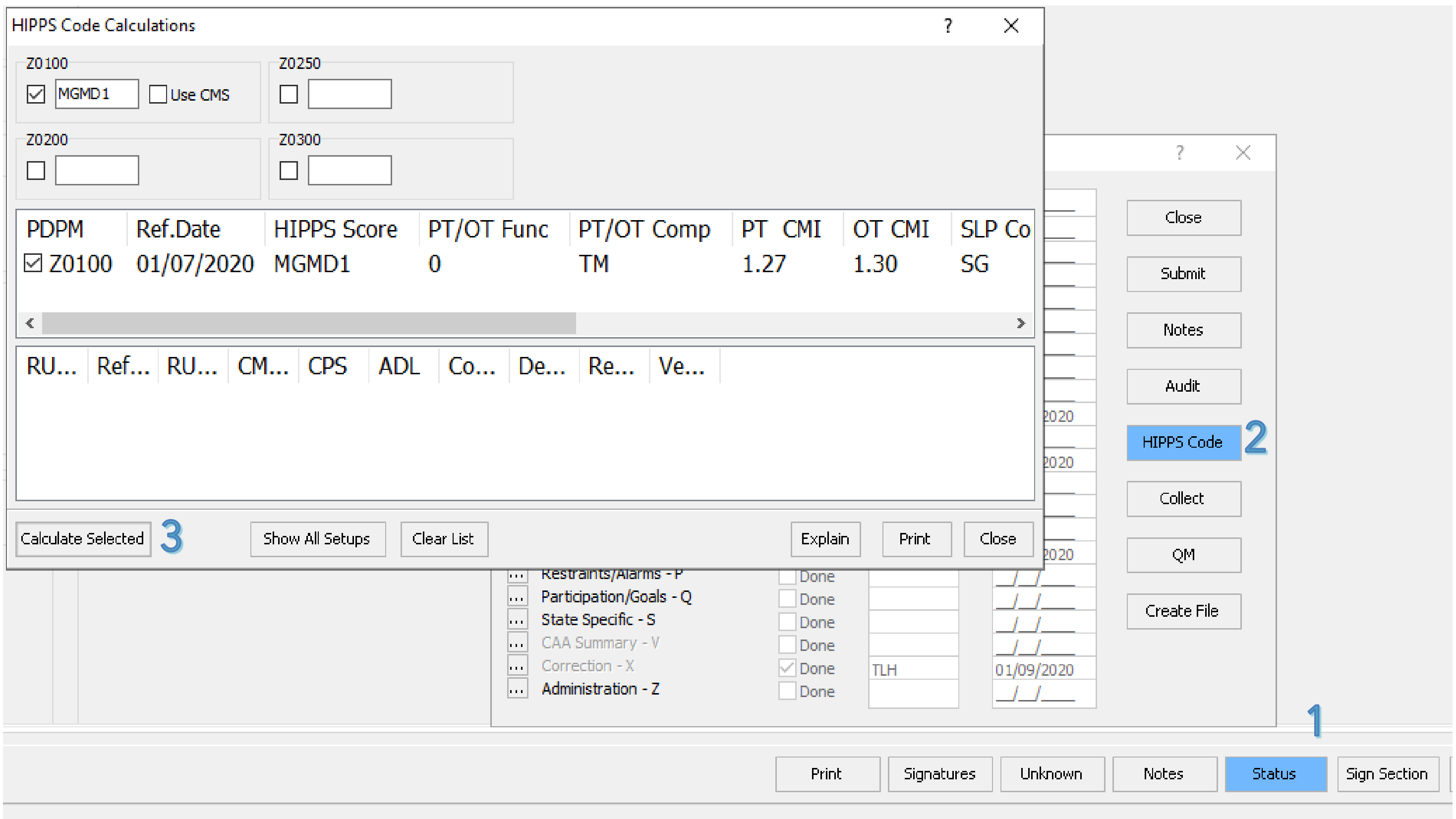
   b) This will open a box where you can type in any pertinent information.
   c) Click Close when you are done, to save your note.
3) To view notes:
   a) Select Status to open the *Status* screen.
   b) Select Notes from the options on the right side of the *Status* screen.
   c) This will open the *Section Notes* box, which will display all notes written on the assessment, and list which sections they pertain to.
   d) If a note has been left on the assessment, this will be indicated in two ways:
      i) On the section where the note was left, there will be a (1) on the *Notes* button.
      ii) On the *Status* screen, the total number of notes on the assessment will be listed in parentheses on the *Notes* button.



Calculating a HIPPS Code

1) Open the *Status* screen.
2) Select HIPPS Code, from the list on the right side of the *Status* screen.

3) On the *HIPPS Code Calculation Screen*, the boxes next to the appropriate items should already be checked for you. If you need different codes than those checked, you may check or uncheck the boxes by the item numbers, as necessary.
4) Click on Calculate Selected to calculate your scores. HIPPS codes will appear in the top box, and any RUG IV scores will appear below. They will be given on the left and scrolling to the right will display them broken down by component.
5) Should you require further details about a score, or how it was calculated, click on the Explain button to display a breakdown of the information used to calculate that score.



Submitting your assessment

1) Open the *Status* screen
2) Select Submit from the options on the right side of the screen (all applicable sections must be signed prior to submitting).
3) Select Yes to confirm that you would like to submit the assessment and check for errors.
4) Select Yes on the *HIPPS Code Writeback* pop-up to continue submitting.
5) Once the assessment is submitted successfully, it will close and return you to the MDS manager.