S0140: Physician License Number

<table>
<thead>
<tr>
<th>S0140</th>
<th>Physician License Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record the Florida license number of the resident’s physician.</td>
</tr>
</tbody>
</table>

| F | L | M | E | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Item Rationale**

- Allows for identification of the resident’s physician.

**Coding Instructions**

- Record the Florida medical license number of the resident’s physician. Begin writing in the left-hand box. Enter one digit per box. The first two letters are FL and the second two represent the type of doctor— for example, ME for physician or DO for osteopathic physician.

**Coding Tips**

- Physician must have an active medical license number.
- You can search for the physician’s license number on the Florida Department of Health’s License Verification website at [http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP](http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP).
- List the attending physician’s number even though the resident might often be seen by a nurse practitioner (ARNP) or physician’s assistant (PA).

**Example**

F L M E 1 2 3 4 5 6 7
S0141: Physician Last Name

<table>
<thead>
<tr>
<th>S0141</th>
<th>Physician Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record the last name of the resident's physician.</td>
</tr>
</tbody>
</table>

**Item Rationale**

- Allows for identification of the resident’s physician.

**Coding Instructions**

- Enter the active provider’s last name exactly as it appears on his/her medical license.
- Begin writing in the left-hand box. Enter one digit per box. Use as many boxes as needed. If the last name is longer than the space provided, record as many letters of the last name as possible.
- List the attending physician’s name even though the resident might often be seen by an ARNP or PA.

**Example**

*Dr. Anna Rodriguez-de la Sierra*

R O D R I G U E Z - D E L A S I E R

S0165: Specialty Services

<table>
<thead>
<tr>
<th>S0165</th>
<th>Specialty Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check all that apply since the most recent comprehensive or quarterly OBRA assessment:</td>
</tr>
<tr>
<td></td>
<td>□ A - Dementia/Alzheimer’s</td>
</tr>
<tr>
<td></td>
<td>□ B - Behavioral Health</td>
</tr>
<tr>
<td></td>
<td>□ C - Traumatic Brain Injury</td>
</tr>
<tr>
<td></td>
<td>□ D - Ventilator</td>
</tr>
<tr>
<td></td>
<td>□ E - On-Site Dialysis</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- The health issues and specialty services in Item S0165 can have a profound effect on an individual’s self-image, dignity, and quality of life.
• In the event of a disaster, residents receiving these specialty services could potentially require extra planning and care.

Planning for Care

• Re-evaluation of specialty services and procedures the resident received or programs the resident was involved in is important to ensure the continued appropriateness of the treatments, procedures, or programs.

Steps for Assessment

1. Review the medical record to determine if any of the listed specialty services were documented since the most recent comprehensive or quarterly assessment.
2. This item is not to be coded based on diagnosis alone. A review of the resident’s individualized care plan will be necessary to determine if any particular specialized services are identified for the resident.

Coding Instructions

• Check all that apply.

S0509: Pre-Admission Screening and Resident Review (PASRR) Level 1 Completed Prior to Admission

<table>
<thead>
<tr>
<th>S0509</th>
<th>PASRR Level 1 Screening Completed Prior to Admission</th>
<th>if A0310A = 01, then code 0 – No or 1 – Yes; otherwise, code 9 - N/A PASRR not indicated.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Was a PASRR Level 1 screening completed prior to resident’s admission to facility?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ 0 - No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ 1 – Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ 9 - N/A PASRR not indicated</td>
<td></td>
</tr>
</tbody>
</table>

Item Rationale

Health-related Quality of Life

• Individuals who are admitted to a Medicaid Certified nursing facility must have a Level 1 PASRR completed to screen for possible mental illness (MI), Intellectual disability (ID), (“mental retardation” (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident’s method of payment.¹

• Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.

• Obtain this information about a resident to assist with determination of appropriate placement and care of the individual.

• See http://ahca.myflorida.com/Medicaid/PASRR/index.shtml for additional information about PASRR.

• See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html for CMS information on PASRR.

Planning for Care

• PASRR Level 1 results may trigger the need for a Level 2 evaluation.

Steps for Assessment

1. Review medical record to determine if a PASRR Level 1 was completed prior to resident being admitted to your facility.

Coding Instructions

• **Code 0, No:** if A0310A = 01 and a completed PASRR Level 1 is not present as part of the resident’s medical record on admission.

• **Code 1, Yes:** if A0310A=01 and the PASRR Level 1 was completed in its entirety prior to resident’s admission to your facility.

• **Code 9, N/A:** if A0310A≠01.

**S0511 PASRR Level 1 Completion Date**

<table>
<thead>
<tr>
<th>S0511</th>
<th>PASRR Level 1 Completion Date Complete only when A0310A = 01</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record PASRR Level 1 completion date (YYYYMMDD).</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Item Rationale

Health-related Quality of Life

- All individuals who are admitted to a Medicaid Certified nursing facility must have a Level 1 PASRR completed to screen for possible mental illness (MI), Intellectual disability (ID), (“mental retardation” (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident’s method of payment.
- Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- Obtain this information about a resident to assist with determination of appropriate placement and care of the individual.
- See [http://ahca.myflorida.com/Medicaid/PASRR/index.shtml](http://ahca.myflorida.com/Medicaid/PASRR/index.shtml) for additional information about PASRR.
- See [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html) for CMS information on PASRR.

Planning for Care

- PASRR Level 1 results may trigger the need for a Level 2 evaluation.

Steps for Assessment

1. Review medical record to determine if a PASRR Level 1 has been completed.

Coding Instructions

- If a PASRR Level 1 was completed prior to the resident’s admission to your facility, enter that PASRR Level 1 completion date.
- If the PASRR Level 1 was not completed prior to resident entering your facility but has been completed by the date of the MDS Admission assessment, enter the PASRR Level 1 completion date.
- This item will be left blank if a PASRR Level 1 was not completed or if A0310A≠01.
S1002: Local Health Department Reporting

<table>
<thead>
<tr>
<th>S1002</th>
<th>Local Health Department Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has resident had any disease process or condition that has been reported to the local health department since the most recent comprehensive or quarterly OBRA assessment?</td>
</tr>
<tr>
<td></td>
<td>□ 0 – No</td>
</tr>
<tr>
<td></td>
<td>□ 1 - Yes</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Disease processes and conditions can have a significant adverse effect on an individual’s status and quality of life.
- Control of communicable diseases and conditions that may significantly affect public health is of paramount importance.

**Planning for Care**

- Early detection of disease outbreaks is essential for controlling outbreaks in long term care facilities.
- In the event of a disaster, plans for transfer and care of residents with certain disease processes and conditions would likely require special care and coordination.

**Steps for Assessment**

1. Identify reportable disease or condition
   - Review medical record, including treatment records, provider’s progress notes, diagnosis/problems list, nursing notes, and other resources available.

**Coding Instructions**
• **Code 0, No:** If the resident has not had any reportable disease process or condition reported since the most recent comprehensive or quarterly OBRA assessment.

• **Code 1, Yes:** If the resident’s record review revealed reported disease process or conditions since the most recent comprehensive or quarterly OBRA assessment.

### S1003: State Health Department Reporting

<table>
<thead>
<tr>
<th>S1003</th>
<th>State Health Department Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has resident had any disease process or condition that has been reported to the appropriate state health department since the most recent comprehensive or quarterly OBRA assessment?</td>
</tr>
<tr>
<td></td>
<td>□ 0 – No</td>
</tr>
<tr>
<td></td>
<td>□ 1 - Yes</td>
</tr>
</tbody>
</table>

### Item Rationale

**Health-related Quality of Life**

- Disease processes and conditions can have a significant adverse effect on an individual’s status and quality of life.
- Control of communicable diseases and conditions that may significantly affect public health is of paramount importance.

**Planning for Care**

- Early detection of disease outbreaks is essential for controlling outbreaks in long term care facilities.
- In the event of a disaster, plans for transfer and care of residents with certain disease processes and conditions would likely require special care and coordination.

### Steps for Assessment

1. Identify reportable disease or condition
   - Review medical records, including treatment records, provider’s progress notes, diagnosis/problems list, and other resources available.
Coding Instructions

- **Code 0, No**: If the resident has not had any disease process or conditions reported to the state health department since the most recent comprehensive or quarterly OBRA assessment.
- **Code 1, Yes**: If the resident’s record review revealed reported disease process or conditions since the most recent comprehensive or quarterly OBRA assessment.

Coding Tips

- Resident may have a “Reportable Disease or Condition” that was reported to the local health department but not to the state health department.

S1100: Diseases

<table>
<thead>
<tr>
<th>S1100</th>
<th>Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check all diseases that apply since the most recent comprehensive or quarterly OBRA assessment:</td>
</tr>
<tr>
<td>□ A</td>
<td>Clostridium Difficile</td>
</tr>
<tr>
<td>□ B</td>
<td>MRSA (Methicillin-Resistant Staphylococcus Aureus)</td>
</tr>
<tr>
<td>□ C</td>
<td>VRE (Vancomycin-Resistant Enterococci)</td>
</tr>
<tr>
<td>□ D</td>
<td>VISA (Vancomycin-Intermediate Staphylococcus Aureus)</td>
</tr>
<tr>
<td>□ E</td>
<td>VRSA (Vancomycin-Resistant Staphylococcus Aureus)</td>
</tr>
<tr>
<td>□ F</td>
<td>Other MDRO (Multi-Drug Resistant Organism)</td>
</tr>
<tr>
<td></td>
<td>F1 - Enter name of first MDRO</td>
</tr>
<tr>
<td></td>
<td>F2 - Enter name of second MDRO</td>
</tr>
<tr>
<td>□ G</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>□ H</td>
<td>Herpes Zoster</td>
</tr>
<tr>
<td>□ I</td>
<td>Scabies</td>
</tr>
<tr>
<td>□ J</td>
<td>CRE (Carbapenem-Resistant Enterobacteriaceae)</td>
</tr>
<tr>
<td>□ Z</td>
<td>None of the Above</td>
</tr>
</tbody>
</table>

Item Rationale

**Health-related Quality of Life**

- Disease processes can have a significant adverse effect on an individual’s health status and quality of life.
Planning for Care

- This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

1. Identify presence of condition: The disease conditions in this section require documentation by a physician, nurse practitioner, or physician assistant.

   - Review medical records such as progress notes, physician orders, history and physical, laboratory reports, transfer documents, discharge summaries, diagnosis/problems list. If a diagnosis/problem list is used, only conditions confirmed by a physician, ARNP, or PA should be coded.

Coding Instructions

- Check each disease that applies.
- If S1100 F is checked, enter the first MDRO in S1100F1 and the second MDRO in S1100F2.
- If the resident’s record review doesn’t identify any of the above diseases, select ‘Z – None of the above’.

Coding Tips

- Specific documentation by a physician, nurse practitioner, or physician’s assistant may be found in physician notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
- Additional resources for MDROs can be found on [http://www.cdc.gov/hicpac/mdro/mdro_1.html](http://www.cdc.gov/hicpac/mdro/mdro_1.html).
S6050: Isolation Precautions Needed

<table>
<thead>
<tr>
<th>S6050</th>
<th>Isolation Precautions Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has resident required any type of isolation precautions since admission or the most recent comprehensive or quarterly OBRA assessment other than standard/universal precautions?</td>
</tr>
<tr>
<td></td>
<td>☐ 0 – No</td>
</tr>
<tr>
<td></td>
<td>☐ 1 - Yes</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Disease processes can have a significant adverse effect on an individual’s health status and quality of life.

**Planning for Care**

- This section identifies isolation precautions that drive the current plan of care.

**Steps for Assessment**

1. Identify resident condition
   - Review medical record, including treatment records and provider’s progress notes, diagnosis/problems list, laboratory reports, and other resources available.

**Coding Instructions**

- **Code 0, No**: if the resident did not require any isolation precautions
- **Code 1, Yes**: if the resident’s record review revealed isolation precautions being used.

**DEFINITIONS**

**ISOLATION PRECAUTIONS**

Isolation precautions refer to the measures that are taken in a health care setting to restrict transfer of organisms from an infected or colonized patient to susceptible persons.
**S6051: Isolation Precautions Employed**

<table>
<thead>
<tr>
<th>S6051</th>
<th>Isolation Precautions Needed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check all that apply (If S6050 is ‘No’, then all S6051 items should be unchecked)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes to item S6050, type of isolation precautions employed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ A - Airborne</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ B - Contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ C - Droplet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ D - Protective</td>
<td></td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Disease processes can have a profound effect on an individual’s health status, self-image, dignity, and quality of life.

**Planning for Care**

- Transmission based precautions beyond Standard precautions may be necessary for the safety of residents, staff, and visitors.

**Steps for Assessment**

1. Review the medical record to determine if any of the listed isolation precautions were documented since admission or the most recent comprehensive or quarterly OBRA assessment.

**Coding Instructions**

If yes was checked in section S6050, identify the type of isolation precautions being employed. Check each isolation precaution that applies.

- **Code A, Airborne**: if the facility was employing airborne isolation precautions for this resident.
- **Code B, Contact**: if the facility was employing contact isolation precautions for this resident.

**DEFINITIONS**

**Airborne Precautions**

Airborne precautions prevent transmissions of infectious agents that remain infectious over long distances when suspended in the air.

**Contact Isolation**

Contact isolation is used to prevent the spread of diseases that can be spread through contact with open wounds.

**Droplet Precautions**

Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.

**Protective Isolation**

Protective isolation involves the practice of placing a highly susceptible person, such as an immunodeficient patient, in a separate area where the risk of contact with pathogenic microorganisms can be controlled.
• **Code C, Droplet**: if the facility was employing droplet isolation precautions for this resident.

• **Code D, Protective**: if the facility was employing protective isolation for this resident.

**Coding Tips**

• More than one type of isolation may be employed for the resident.

**S6201: Number of Unreported Hospital Stays**

<table>
<thead>
<tr>
<th>S6201</th>
<th>Number of Unreported Hospital Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record previously unreported number of times resident was admitted to hospital with an overnight stay in the last 92 days. Enter ‘0’ if no hospital admissions.</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

• Frequent need for hospitalizations may be an indicator of the resident’s changing health status.

**Planning for Care**

• Hospital records and a review of readmission orders may indicate a need for change in care of the resident.

**Steps for Assessment**

1. Review medical record for documentation of hospitalization.

**Coding Instructions**

• Enter the number of previously unreported times the resident was admitted to the hospital with an overnight stay in the last 92 days.

• If an admission assessment is being done for a resident who is new to the facility and coming directly from a hospital, that hospital stay would not be counted for this item.

• Enter ‘0’ if no hospital admissions.
Coding Tips

- A resident in Observation Status who stayed overnight in the hospital would be coded as “1”.
- Hospital stays for a resident prior to his/her admission to the facility are not counted in this section.
- If a hospital stay was captured in this section on a previous MDS assessment, it would not be coded here.

S6211: Number of Unreported ER Visits

<table>
<thead>
<tr>
<th>S6211</th>
<th>Number of Unreported ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record previously unreported number of times resident visited ER without an overnight stay in the last 92 days. Enter ‘0’ if no ER visits.</td>
</tr>
</tbody>
</table>

Item Rationale

**Health-related Quality of Life**

- Frequent need for ER visits may be an indicator of the resident’s changing health status.

**Planning for Care**

- ER records and a review of physician orders may indicate a need for change in care of the resident.

Steps for Assessment

1. Review medical record for documentation of Emergency Room visits.

Coding Instructions

- Enter the number of previously unreported ER visits without an overnight stay in the last 92 days.
- Enter ‘0’ if no Emergency Room Visits.
Coding Tips

- Emergency Room visits for a resident prior to his/her admission to the facility are not counted in this section.
- If an ER visit was captured in this section on a previous MDS assessment, it would not be counted again in this section.

S9020: Facility FRAES Number

<table>
<thead>
<tr>
<th>S9020</th>
<th>Facility FRAES Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record the facility’s unique FRAES number.</td>
</tr>
</tbody>
</table>

Item Rationale

- Allows for matching the state licensure database to the MDS database.

Coding Instructions

- Enter the FRAES number as an 8-digit number.
- Begin writing in the left-hand box. Enter one digit per box. There must be a FRAES number entered. This number was provided by the Florida MDS Help Desk upon initial certification of the facility.

Coding Tips

- You can obtain the facility’s FRAES number from the Florida QIES Help Desk at 850-412-4501. Once you have this number, it applies to all residents of the facility.

DEFINITIONS

The Florida Regulatory and Enforcement System (FRAES) is a computerized system that assigns a unique identifier to each licensed and/or certified health facility. Each facility will have its own FRAES file number.