SOC/ROC OASIS Assessment

M1028. Active Diagnoses

- **Response: 2** – Diabetes Mellitus (DM) would be checked.
- **Rationale:** This is an active diagnosis, as noted on the hospital discharge summary and confirmed by the physician, and there is ongoing medication and dietary management.

M1060. Height & Weight

- **Response:**
  M1060a. Height: 70 inches
  M1060b. Weight: 220 lbs.
- **Rationale:** The patient's height was measured to the nearest whole inch. Mathematical rounding was used for documenting both the height and weight.

M1311. Current Number of Unhealed Pressure Ulcers at Each Stage

- A1. Stage 2: **Code as 1**
- B1. Stage 3**: Code as 0**
- C1. Stage 4: **Code as 0**
- D1. Unstageable: Non-removable dressing: **Code as 0**
- E1. Unstageable: Slough and/or eschar: **Code as 0**
- F1. Unstageable: Deep tissue injury: **Code as 0**

A2, B2, C2, D2, E2, and F2 are omitted on SOC/ROC.

Rationale: The admission skin assessment completed by the nurse revealed that Mr. W had a 2 cm × 1 cm × 0.1 mm reddened area over his coccyx, with a 0.5 cm serum-filled blister in the center of the reddened area. This was assessed as a Stage 2 pressure ulcer.

M1620. Bowel Incontinence

- **Response: 2,** One to three times weekly.
- **Rationale:** Due to recent hospitalization and medical problems, Mr. W is deconditioned and has difficulty reaching the bathroom in time. These incontinent episodes have occurred two times over the last week.

GG0170C. Lying to Sitting on Side of Bed

GG0170C1: SOC/ROC Performance

- **Response: 02,** Substantial/maximal assistance.
- **Rationale:** The helper, Mr. W's wife, performs more than half of the effort required to complete the activity of lying to sitting on the side of the bed. She supports his trunk and lifts his legs over the edge of the bed to assist him to the sitting position.

GG0170C2: Discharge Goal

- **Response: 06,** Independent.
- **Rationale:** The nurse expects Mr. W to perform the activity of lying to sitting on the side of the bed independently by discharge.

M2001. Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

- **Response: 1,** Yes – Issues found during review.
- **Rationale:** Mr. W's list of medications from the acute care discharge instructions did not match the medications that the patient showed the clinician. Metoprolol was in the home, but not on the discharge orders and the patient stated that he took the medication twice a day. The assessing clinician considered this a potential clinically significant medication issue.

M2003. Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

- **Response: 1,** Yes.
- **Rationale:** The nurse telephoned the physician to discuss and resolve the identified medication issues on the same day they were identified. The physician followed-up via fax within 1 calendar day. The nurse initiated these orders the same day she received the fax. The order for Metoprolol was resumed and the need for Metformin was confirmed and continued.

Discharge OASIS Assessment

M1311. Current Number of Unhealed Pressure Ulcers at Each Stage

- A1. Stage 2: **Code as 0**
- A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC: **Skip**

- B1. Stage 3: **Code as 0**
- B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC: **Skip**

- C1. Stage 4: **Code as 0**
- C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC: **Skip**

- D1. Unstageable: Non-removable dressing: **Code as 0**
- D2. Number of unstageable pressure ulcers that were present at most recent SOC/ROC: **Skip**

- E1. Unstageable: Slough and/or eschar: **Code as 1**
- E2. Number of unstageable pressure ulcers that were present at most recent SOC/ROC: **Code as 0**

- F1. Unstageable: Deep tissue injury: **Code as 0**
- F2. Number of unstageable pressure ulcers that were present at most recent SOC/ROC: **Skip**

Rationale: Upon discharge, the pressure ulcer on the coccyx was unstageable due to coverage of the wound bed by slough. This was not present at SOC/ROC.

M1313. Worsening in Pressure Ulcer Status Since SOC/ROC

a. Stage 2: **Code as 0**
b. Stage 3: **Code as 0**
c. Stage 4: **Code as 0**
d. Unstageable Non-Removable Dressing: **Code as 0**
e. Unstageable Slough and/or Eschar: **Code as 1**
f. Unstageable Deep Tissue Injury: **Code as 0**

Rationale: Upon discharge, the patient was assessed to have an unstageable pressure ulcer due to slough that was new or worsened since the SOC/ROC. The patient had a Stage 2 at SOC/ROC, and the wound deteriorated to unstageable at discharge.

M1620. Bowel Incontinence

- **Response: 0,** Very rarely or never.
- **Rationale:** Upon discharge, Mr. W was continent of bowel and independent in toileting.

M2005. Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

- **Response: 1,** Yes.
- **Rationale:** There was one clinically significant medication issue identified by the RN at SOC. It was resolved in a timely manner using the required two-way communication. No additional medication issues were identified during the episode of care.