REVISIONS TO THE OCTOBER 2003 SWING BED MDS MANUAL APRIL 2004			
Page	**Item**	**Change**	**Description**
3-10	10a	Clarify first bullet	For example, for an SB MDS item with a 7-day period of observation, assessment information is collected for a 7-day period ending on **and** <u>including</u> the ARD, which is the 7th day of this observation period. For an item with a 14-day observation period, the information is collected for a 14-day period ending on **and** <u>including</u> the ARD.
3-39	23	Clarify Eating scenario	Mr. V is able to feed himself. Staff must set up the tray, cut the meat, open containers and hand him the utensils. Mr. V requires more help during dinner, as he is tired and less interested in completing his meals. In addition to encouraging him to continue eating and frequently handing him his utensils and cups to complete the meal, at these times a staff member also must assist in guiding his hand in order to get the utensil to his mouth. *Self Performance = 2 Support Provided = 2* *Coding rationale: Resident is unable to complete the meal without staff providing non-weight-bearing assistance (3 or more times in the observation period).*
3-43	23	Correct diagram	Add "b" next to '3 or more times' from 'Non-Weight-Bearing Physical Assistance' diamond to 'Limited Assistance' circle
3-51	25f	Add sentence	Do not code quadriparesis here.
3-51	25	Clarify Process	Consult with physician for confirmation. A physician diagnosis is required to code the MDS.
3-53	26	Clarify Process	Consult with physician for confirmation. A physician diagnosis is required to code the MDS.
3-55	29a	Add sentence	Do not include fluids administered solely as flushes.
3-59	31	Delete phrase	"due to any cause" in item title.
3-59	31	Delete first sentence in Coding and phrase in second sentence	Record the number of ulcers/open lesions at each stage on the patient's body in the last 7 days. If necrotic eschar is present, prohibiting accurate staging, code the ulcer/open lesion a Stage "4". If there are no ulcers/open lesions at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers/open lesions at any one stage, enter "9" in the appropriate box.
3-60	31	Clarify second bullet	For the SB-MDS assessment, pressure ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the SB-MDS assessment. Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the SB-MDS.

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Page	**Item**	**Change**	**Description**
3-65	33b	Clarify Definition	Code here any open lesions/sores that are not coded elsewhere in Items 31 and 33. Do NOT code skin tears or cuts here.
3-72	38bd	Add sentence	A trained nurse may perform the assessment.
3-78	39i	Add sentence	Dentures are not considered to be prostheses for coding this item.
4-2	4.3 Table	Delete from Item 10a ARD	13 Admission Date
4-2	4.3 Table	Delete from Item 15	45b Completion Date
4-2	4.3 Table	Delete from Item 16	45b Completion Date