Maintaining independence in ADLs and mobility is very important to most of us. In fact, functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers.

Restorative nursing programs refer to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehab therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehab therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech therapy.

This is more than just normal nursing care!
Restorative Nursing Teleconference
Script

Slide 6  In order to code a restorative nursing program under this item, the technique, training or skill practice must take place at least 15 minutes during the 24 hour period. You should total the minutes for the entire day for each program, but you cannot combine time across item categories. This is the time your staff spends with the resident.

Code each type of restorative care separately. (For instance, the times from a transfer program and a bed mobility program may not be combined.)

This time must be documented somewhere.

Slide 7  To code this item, you cannot have groups with more than four residents per supervising helper or caregiver.

Slide 8  The following criteria for restorative care must be met to code it on the MDS:

• Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the record. If the goal(s) are not measurable, Case Mix will take the item away. The goal should be related to the restorative function you are working on. A goal of “resident will maintain her weight” would not be appropriate for eating. “It addresses the resident’s weight, NOT the ADL function of eating, and could be achieved by totally feeding the resident or even with tube feedings.”

Slide 9  Please note that these goals can be measured. They are objective. They are specific to the program and what you’re trying to achieve. These are not INTERVENTIONS, they are goals.
Restorative Nursing Teleconference
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Slide 10
• What is this a goal for? If it is for eating, remember that restorative nursing addresses the function of eating. You can maintain someone’s weight with tube feedings.
• This is an intervention, not a goal. What are trying to achieve with these arm flexes?
• What? What is the current strength and flexibility? What joints?
• What are you trying to achieve to maintain the resident’s independence and functional status? Staff could keep a resident clean, dry and odor free.

Slide 11
• Evidence of periodic evaluation by the registered nurse must be present in the medical record.
• Assessment of the objectives and interventions of a restorative nursing program should be an ongoing process, not just during the care planning process in order to achieve the best outcomes possible.
• The better your goal is, the easier it will be to evaluate whether or not the resident is meeting the goal. The evaluation should contain information that will help in the decision as to whether or not a program should be DC’d because the goal is met, revised because the resident is not making progress, revised because the resident can achieve more, etc.

• It is not uncommon for the eval to be missing entirely. It just hasn’t been done.

Slide 12
• It is possible that if a resident has met his/her goals that you will still want to continue the program in order for the resident to maintain his/her abilities, however, does this evaluation say that?
• This evaluation addresses the goal, indicates what the resident is capable of doing and indicates why the program is being revised (staff think she has the potential to improve even more).
Slide 13

• Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
• A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program. Sometimes, under nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician’s order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services. The therapist’s time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

Slide 14

In the past, reviewers have found that sometimes aides document that programs are being completed but when observed, the aides are not completing the programs as written. The aides, when interviewed, deny knowledge of the program (even though they have been documenting that they are doing the program.)

This has been noticed with things like eating programs, transfer programs, ROM.

Alert and oriented residents will tell the reviewers that the programs aren’t being implemented as written.

Slide 15

How do your nurses supervise the programs? Do they actually observe from time to time to assure the aides are implementing the programs as written? Do they talk to the residents? Do they interview the aides or do they just look at documentation.

The problems that reviewers have noted (such as aides not aware of the programs, or not really implementing) shouldn’t happen if nurses are supervising the activities.
Prior to coding the MDS, review the resident’s medical record looking carefully at any restorative nursing program notes and flow sheets. Restorative nursing documentation needs to have the minutes of each treatment recorded. Check the record to determine the number of days the technique, training, or skill practice was received and/or practiced and for how long. If the restorative nursing is provided in a group, rather than individualized training, make sure your documentation shows the ratio of residents to caregiver.

The RAI User’s Manual is your reference for coding the MDS. Information related to Restorative Nursing Programs is found on pages O-31 through O-38 in the RAI User’s Manual.

You can purchase the manual through several private vendors, or you can download it for free from the website listed on this slide. CMS periodically updates/revises the RAI User’s Manual. You should check this website on at least a quarterly basis to make sure you have the most up-to-date version.
The following activities are provided by restorative nursing staff.

**O0500A, Range of Motion (Passive)**
Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident’s needs, planned, monitored, evaluated, and documented in the medical record. For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the resident’s available range of motion. The resident provides no assistance.

The use of continuous passive motion (CPM) devices as nursing restorative care is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff have been trained in technique (for example, properly aligning resident’s limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device.

**O0500B, Range of Motion (Active)**
Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the medical record. Include active ROM and active-assisted ROM. For range of motion (active): any participation by the resident in the ROM activity should be coded here.

For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored, evaluated, and documented in the resident’s medical record. Range of motion should be delivered by staff who are trained in the procedures.

**O0500C, Splint or Brace Assistance**
Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record. For splint or brace assistance: assess the resident’s skin and circulation under the device, and reposition the limb in correct alignment.

When you write the goals for these programs, ask yourself what you are trying to achieve.
Slide 20  The following activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.

**O0500D, Bed Mobility**

Code activities provided to improve or maintain the resident’s self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

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Slide 21  The following activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.

**O0500E, Transfer**

Code activities provided to improve or maintain the resident’s self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

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Slide 22  The following activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.

**O0500F, Walking**

Code activities provided to improve or maintain the resident’s self-performance in walking, with or without assistive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.
Restorative Nursing Teleconference
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Slide 23  
**O0500G, Dressing and/or Grooming**  
Code activities provided to improve or maintain the resident’s self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to be individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident's medical record. Remember, this a restorative NURSING program and nursing needs to supervise to assure it is being implemented as written.

Slide 24  
**O0500H, Eating and/or Swallowing**  
Code activities provided to improve or maintain the resident’s self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident’s ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

*Note that the purpose is to improve or maintain the resident’s ability in feeding him or herself and the resident’s ability to ingest nutrition and hydration BY MOUTH. That means your goals and interventions for this program should address that purpose. How are you going to assist the resident to improve or maintain his or her ability to feed themselves? What are you trying to achieve?*

Slide 25  
**O0500I, Amputation/ Prosthesis Care**  
Code activities provided to improve or maintain the resident’s self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.
Restorative Nursing Teleconference
Script

Slide 26  
**O0500J, Communication**  
Code activities provided to improve or maintain the resident’s self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

Slide 27  
This item does not include procedures or techniques carried out by or under the direction of qualified therapists.

- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check **Technique—Range of Motion [Passive]** item O0500A, 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item O0500A, 5 minutes of **Technique—Range of Motion [Active]** item O0500B, and 5 minutes of **Splint or Brace Assistance** item O0500C, over 2 days in the last 7 days.

- Review for each activity throughout the 24-hour period. **Enter 0**, if none.
Mr. V. has lost range of motion in his right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory.

To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist, and hand three times per day.

The nursing assistants and Mr. V.’s wife have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in Mr. V.’s care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). This time is documented in the resident’s record every day for the last 7 days.

The nursing assistants report that there is less resistance in Mr. V.’s affected extremity when bathing and dressing him.

Is this enough information to know whether or not you can code this as restorative nursing on the MDS?

Remember, in order to code a program as Restorative Nursing on the MDS, you must do all of the following:

There must be Measureable objective and interventions documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process and the results of this reassessment should be documented in the resident’s medical record.

Evidence of periodic evaluation by the RN must be present in the resident’s medical record.

Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.

A nurse must supervise the activities in a restorative nursing program.
Slide 30  Now do you have enough information to code Restorative Nursing on the MDS?

Slide 31  Both Passive Range of Motion (O0500A) and Splint or Brace Assistance (O0500C) would be coded 7. This was the number of days these nursing restorative techniques were provided.

Slide 32  Mrs. E. has Amyotrophic Lateral Sclerosis. She no longer has the ability to speak or even to nod her head “yes” or “no.” Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions.

The speech-language pathologist taught both Mrs. E. and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has been in use over the past 2 weeks and has proven very successful. The nursing staff, volunteers, and family members are reminded by a sign over Mrs. E.’s bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E.’s care plan.

Because the teaching and practice using the communication board had been completed 2 weeks ago and Mrs. E. is able to use the board to communicate successfully, she no longer receives skill and practice training in communication.

Slide 33  Because Mrs. E has mastered the skill of communication, nursing skill and practice training for communication was no longer needed or provided over the last 7 days. Code Communication (O0500J) as a zero.
Slide 34  A resident is capable of walking independently, however, has experienced several falls due to poor balance. Physical Therapy worked with the resident, teaching her multiple balance exercises which she can do independently but she needs reminders to do the exercises. Sometimes the nursing assistants are in the room completing other tasks such as making the resident’s bed, but they don’t cue the resident or assist her with the exercises. A reminder to complete the balance exercises has been added to her care plan with a goal, “Resident will maintain her ability to walk independently. Resident will not experience falls related to poor balance when she is walking.” The Care Plan interventions indicate the resident is to be reminded and encouraged two times a day to complete her balance exercises. NA’s are documenting these reminders. At the time of the quarterly review, the RN notes that the resident is walking independently with no evidence of balance problems. The RN indicates the staff will continue to remind the resident to complete her balance exercises two times a day.

Slide 35  The staff are only reminding the resident to complete the exercises. The exercises are important and should continue, however, this is not coded on the MDS as the resident completes the exercises independently without participation or cueing from staff. Reminding a resident to complete exercises is not the same as working with the resident for 15 minutes a day.

Slide 36  A resident is capable of walking independently, however, has experienced several falls due to poor balance. Physical Therapy worked with the resident, teaching her multiple balance and strengthening exercises. Due to the resident’s poor cognitive status, she cannot remember how to do the exercises, but is cooperative and willing to do them when cued by staff. Staff need to stay with her throughout the exercises to give her step-by-step verbal cues and occasionally demonstrate the exercises for her. Therapy taught both day and evening shift aides and the nurse manager how to cue the resident through the exercise routine. It takes 10 minutes of staff time in the morning and again in the afternoon to complete the exercises with the resident. NA’s are documenting this time 5 days a week.
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Script

Slide 37  The resident’s Care Plan contains the following goals. “Resident will continue to ambulate independently throughout the day.” “Resident will be free of falls related to poor balance when walking for the next three months.” The BID exercises are also in the care plan.

The RN supervises the program weekly by watching the aides complete the program and documents this supervision.

The RN evaluates the program at the time of the resident’s quarterly assessment. “The resident has been free of falls for the past three months and continues to ambulate independently without assistive devices in her room and on the unit. The resident completes balance exercises two times a day. When asked to complete the balance exercises independently, she becomes confused and sits down after one or two repetitions of the first exercise. She continues to need constant cueing by staff in order to complete the exercises. Due to her history of falls and poor balance and the effectiveness of the exercise program, we will continue with the balance exercises 5 days a week in order to maintain the resident’s ability to walk independently in a safe manner.”

Slide 38  This program does meet all of the criteria for a restorative nursing program. It is being used to maintain the resident’s ability to walk independently. It is requiring staff time to stay with the resident and cue her in order to complete the program.
Scenarios 3 and 4 were included here to demonstrate how similar programs may or may not meet the criteria to be considered a Restorative Nursing Program. The exercises for the resident in Scenario #3 might have been the exact same exercises as the ones used in Scenario #4. The big difference was that staff interventions to complete the exercises were not necessary for the resident in Scenario #3. The resident, once taught, could complete the exercises independently. Just because staff reminded the resident to do the exercises, this didn’t qualify as verbal or physical cueing. The resident in Scenario #4 required the exercises in order to maintain her ability to walk safely independently. She could not do the exercises independently, staff needed to stay with her in order to assure that she completed them correctly.

The exercise programs were important for both residents and the facilities determined the programs should be continued in order for the residents to maintain their ability to walk independently. The difference was in the resident’s individualized needs related to the exercise program. The needs were clearly expressed in the evaluations.

When considering whether or not a program should be coded on the MDS as Restorative Nursing, remember that you need to consider the needs of the individual resident. The goals need to be measurable and need to reflect what functional task you are working on. Remember also, that all criteria, as outlined in the RAI manual, need to be met