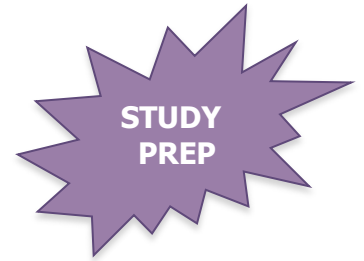




Application Scenarios for Quarterly OASIS Update – April 2026



COS-C Exam Candidates - Simulate exam conditions by:

- answering the following 5 questions in 7 ½ minutes,
- accessing any paper resource you choose for references, &
- recording your response in the corresponding lettered bubble.

Scenario 1: A SOC comprehensive assessment was completed by the RN on Monday. The RN finalized her documentation on Tuesday after a follow-up call with the patient's physician and "synced" the completed visit note. On Thursday, the PT and OT completed their discipline specific evaluations. The quality reviewer completed a chart review late in the day on Thursday and noted that there were some differences in the SOC OASIS responses for functional tasks compared to the PT/OT evaluation findings that demonstrated a change in the patient's status.

Q1: Which statement below is TRUE?

- A. The quality reviewer must update the SOC OASIS responses to reflect the changes in the patient's condition identified within the assessment timeframe.
- B. The RN's completed SOC OASIS can remain as submitted regardless of changes identified in the patient's condition during the assessment timeframe.
- C. Collaboration is required if other agency staff have had direct contact with the patient or had some other means of gathering information to contribute to OASIS data collection.
- D. The PT and OT can collaborate with the quality reviewer to update the SOC OASIS responses without consulting the RN.

1. ☐ A ☐ B ☐ C ☐ D

Scenario 2: A patient has been admitted to home health care following a stroke. This patient was independent with all functional activities prior to the stroke and is eager to continue the work to regain mobility. During the PT evaluation, the PT attempts to ambulate with the patient, providing maximal assistance as well as asking the spouse to assist by following close behind with the wheelchair. The PT requests that the patient sit and rest, but the patient demonstrates impulsive behaviors and continues to take several more stumbling steps, completing the distance of 10 feet. The PT determines that even with the assistance provided, this walking activity was unsafe for the patient.

Q2: Based on this scenario, how would GG0170I - Walk 10 feet be coded?

- A. Code 02 - Substantial/maximal assistance
- B. Code 01 - Dependent
- C. Code 09 - Not applicable

D. Code 88 - Not attempted due to medical condition or safety concerns

2. ☐ A ☐ B ☐ C ☐ D

Scenario 3: During a ROC comprehensive assessment, the RN discovered that the patient's known stage 3 pressure ulcer had been treated with a skin graft during the inpatient facility stay. When reviewing the medical record documentation, the RN identified that the pressure ulcer was treated with a non-surgical skin grafting approach. There were no other wounds identified when completing the full skin assessment.

Q3: How is M1306 - Unhealed Pressure Ulcer/Injury at Stage 2 or Higher and M1340 - Does this patient have a Surgical Wound coded for this scenario?

- A. M1306 - Unhealed Pressure Ulcer/Injury at Stage 2 or Higher = 0. No
M1340 - Does this patient have a Surgical Wound? = 0. No
- B. M1306 - Unhealed Pressure Ulcer/Injury at Stage 2 or Higher = 1. Yes
M1340 - Does this patient have a Surgical Wound? = 1. Yes
- C. M1306 - Unhealed Pressure Ulcer/Injury at Stage 2 or Higher = 1. Yes
M1340 - Does this patient have a Surgical Wound? = 0. No
- D. M1306 - Unhealed Pressure Ulcer/Injury at Stage 2 or Higher = 0. No
M1340 - Y Does this patient have a Surgical Wound? = 1. Yes

3. ☐ A ☐ B ☐ C ☐ D

Scenario 4: An RN is completing a SOC OASIS on a patient and sees in the medical record that 5 days ago the patient was ordered to use a catheter for urinary drainage. Based on the patient report and clinical observations during the comprehensive assessment, the patient is incontinent and would benefit from the use of the catheter. When questioned regarding the status of the catheter order and supplies, the patient states that she does not want the catheter and refused to have the equipment delivered.

Q4: Based on this scenario, how should M1610 - Urinary Incontinence or Urinary Catheter Presence be coded?

- A. 0 - No incontinence or catheter (include anuria or ostomy for urinary drainage)
- B. 1 - Patient is incontinent
- C. 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent or suprapubic)
- D. (-) Dash as the item was not assessed because the catheter was not yet in the home

4. ☐ A ☐ B ☐ C ☐ D

Scenario 5: During the discharge comprehensive assessment, the OT assessed if the patient was able to set up their automated medication reminder device that they began using 2 weeks ago. The patient reports that the device has been so helpful and they have been able to take the right medications at the right times since they have begun using this device. During the assessment, the OT determines that the patient is unable to set up the device on their own and that the patient's son must come over to adjust the medication reminder device when needed.

Q5: Based on this scenario, how would M2020 - Management of Oral Medications be coded at discharge?

- A. 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times
- B. 1 - Able to take medication(s) at the correct times if:
 - a. Individual dosages are prepared in advance by another person OR
 - b. Another person develops a drug diary or chart
- C. 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- D. 3 - Unable to take medication unless administered by another person

5. ☐ A ☐ B ☐ C ☐ D