Mississippi Division of Medicaid

SUPPORTIVE DOCUMENTATION REQUIREMENTS USER GUIDE

RUG-IV MDS Items
48-Grouper
Version II

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Revised for Assessments with an ARD on or after January 1, 2020

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Introduction

Accuracy of the Minimum Data Set (MDS) item responses is very important for any number of reasons: responses guide the care provided to the resident; Quality Measures assist state survey in identifying potential care problems in a nursing facility; and the Medicare Prospective Payment System rates are set based on MDS responses. Beginning July 1, 2014, the Mississippi Division of Medicaid reimbursement rate calculations for nursing facilities classified MDS assessments into one of 48 Resource Utilization Groups version IV (RUG-IV) and adjusted facility rates based on an average Case Mix Index (CMI) for each facility. See the Mississippi Roster Report User Guide for a more complete description of the RUG-IV system and CMI.

These revised Supportive Documentation Requirements apply to all Medicaid-certified Mississippi nursing facilities for assessments with an Assessment Reference Date (ARD) on or after January1, 2020.

SOURCE OF DOCUMENTATION REQUIREMENTS

Thorough documentation is expected of all professionals providing care. The submitted MDS data for each resident should accurately reflect the resident's condition as documented in the resident's clinical records maintained by the nursing facility. The information in these Requirements has been compiled in conjunction with the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual), instructions that are printed on the MDS 3.0 form itself, and the Data Submission Specifications for MDS 3.0. Nursing facility personnel should review these resources thoroughly to accurately understand MDS coding and meet all requirements. If later guidance is released by the Centers for Medicare & Medicaid Services (CMS) that contradicts or augments guidance provided in this document, this more current information from CMS becomes the minimum acceptable standard.

MDS ITEMS FOR REQUIREMENTS

While thorough documentation and accurate coding of the MDS is essential for all MDS item responses, the RUG-IV classification system uses only a subset of the MDS assessment items; those that may have an impact on your facility's rate. As such, these requirements identify only the MDS items used in the RUG- IV system.

OVERALL DOCUMENTATION INSTRUCTIONS

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, The Mississippi Division of Medicaid requires documentation to substantiate MDS items associated with the RUG classifications applicable to reimbursement as defined in the Supportive Documentation Requirements User Guide.

All conditions or treatments must have been present or occurred within the designated observation or look back period, which includes the full 24 hours of the (ARD) located at MDS Section A2300. The ARD is defined in Section A of the RAI Manual as the specific end point for look back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the ARD. Unless otherwise noted on the MDS form, this look back period, also called the observation period or assessment period, is a 7-day look back period ending on the ARD. Thus, look back periods covering 7 days end on this date, 14 days end on this date, etc. Some assessments may have an observation period less than 7 days (such as a Medicare 5-day assessment) however; the ARD is always the end point for the observation period.

Documentation in the clinical record should consistently support the item response and reflect care related to the symptom/problem. Documentation must apply to the appropriate look back period and reflect the resident's status on all shifts.

Documentation from all disciplines and all portions of the resident's clinical record may be used to verify an MDS item response. Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all clinical records. At a minimum, the signature must include the first initial, last name, and title/credential. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there must also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS). When electronic signatures are used, there must be a policy to identify those who are authorized to sign electronically and safeguards in place to prevent unauthorized use of electronic signatures.

In cases of corrections, obliterations, errors or mistaken entries, at a minimum, the staff must line through the incorrect information and include the staff's initials, the date the correction was made and the correct information.

The Mississippi Division of advises nursing facilities to maintain and have readily available supporting medical records to include timely access to electronic medical records. **No additional original clinical documentation will be accepted after the exit conference.**

Effective November 28, 2017 and after, the facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of care. The baseline care plan must:

1) Be developed within 48 hours of admission; and
2) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
    a) Initial goals based on admission orders;
    b) Physician orders, which includes medications and administration schedules (dosage, route, and frequency), as well as, Cardiopulmonary Resuscitation, Do Not Resuscitate Order, Advanced Directive, and Admitting Diagnosis;
    c) Special Nursing Care (i.e., Oxygen Therapy, Immunizations, Tuberculin Test, Percutaneous Endoscopic Gastrostomy Tube, Ostomy, Tracheostomy, Colostomy, Foley Catheter, etc.)
    d) Dietary orders (Regular, Mechanical Soft, Pureed, Bland, Renal, Thicken Liquid, etc.);
    e) Therapy services (Physical, Occupational, Speech, and Respiratory Therapies);
    f) Social services; and
    g) Pre-Admission Screening and Resident Review (PASRR) recommendations, if applicable.

A person-centered comprehensive care plan must be developed and implemented for each resident, consistent with the resident's rights and measurable objectives , a description of the services to be provided , and timeframes to attain or maintain the resident's medical, nursing, and mental and psychological needs identified in the assessment. The care plan must reflect the resident's needs, strengths, goals, life history and preferences consistent with the resident's rights, and must be reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly review assessment, and the services provided or arranged must be consistent with the resident's written person-centered care plan.

Supportive Documentation Requirements

REQUIREMENTS EXPLANATIONS TABLE

The Supportive Documentation Requirements table contains a header per section as well as three columns described below. Each section header identifies that section's look back period.

MDS 3.0 Item Location and Item Description

This column identifies the MDS 3.0 item location by section letter and item number and the description of the MDS item. A notation of CPS (Cognitive Performance Scale) in this column indicates the MDS item affects the results of the cognitive determination used in some of the RUG classifications. A notation of Brief Interview for Mental Status (BIMS) indicates the MDS item associated with the BIMS severity score. A notation of Restorative Nursing in this column indicates the MDS item is used in the count of Restorative Nursing programs in the RUG-IV system.

RUG-IV Categories Impacted

This column identifies any RUG-IV groups potentially impacted by the MDS item. Additionally, there may be informational data in a particular area denoted by Informational Only.

Minimum Documentation and Review Standards Required Within the Specified Observation Period

This column provides an overview of any requirements for minimum documentation required to support the MDS responses. The column may also contain additional information that may aid the user in correctly providing supporting documentation for the MDS item.

All federal requirements must be met. In addition, state requirements may be more stringent and will supersede the federal requirements for the Resident Assessment Instrument and its components. It is the responsibility of the provider to be in compliance with both the federal and state requirements.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section B: Hearing, Speech, and Vision (7-day look back)		
Section B **B0100** Comatose (CPS)	*~Special Care High* *~Behavioral Symptoms and Cognitive Performance*	**Comatose**: A pathological state in which neither arousal (wakefulness, alertness), nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g. pain). **Persistent Vegetative State**: Sometimes residents who were comatose after an anoxic-ischemic injury (i.e. not enough oxygen to the brain) from cardiac arrest, head trauma, or massive stoke, regain wakefulness but do not show evidence of any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres. ***Does require:*** • Diagnosis of coma or persistent vegetative state by a physician, nurse practitioner, physician assistant or other licensed, authorized staff as permitted by state law that is active within the observation period. • Have a relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should be eliminating or minimizing complications and providing care consistent with resident health care goals. ***Does NOT include:*** • Resident in advanced stages of progressive neurologic disorders (i.e. Alzheimer's). • Resident who is actively dying related to terminal illness.
B0700 Makes Self Understood (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of the resident's ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination of these within the time frame. • Consistency with physician and interdisciplinary notes, interventions and the person-centered care plan. • The focus of the person-centered care plan should be to identify the best methods to facilitate communication for the resident and should identify the underlying cause or causes. ***Does include:*** • Reduced voice volume. • Difficulty in producing sounds. • Difficulty in finding the right word, making sentences, writing, and/or gesturing.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section C: Cognitive Patterns *(7-day look back)*		
Section C Brief Interview for Mental Status (BIMS) **BIMS Items**	*Informational Only*	These items are coded to determine the resident's attention, orientation and ability to register and recall new information.
C0200 Repetition of Three Words (BIMS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** Validation of completion of item C0200 on or before the ARD date. • An exact description of the resident's responses. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should be to optimize remaining function, and promote as much social and functional independence as possible while maintaining health and safety.
C0300 A,B,C **Temporal Orientation (BIMS)**	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Validation of completion of item C0300 A, B, C on or before the ARD date. • An exact description of the resident's responses. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should be to optimize remaining function, and promote as much social and functional independence as possible while maintaining health and safety.
C0400 A,B,C Recall (BIMS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Validation of completion of item C0400 A, B, C on or before the ARD. • An exact description of the resident's responses. • The focus of the person-centered care plan should be to optimize remaining function, and promote as much social and functional independence as possible while maintaining health and safety.
C0500 BIMS Summary Score		Total score reflects cognitive status: • 13-15 Cognitively intact • 8-12 Moderately impaired • 0-07 Severe impairment
C0700 Short-Term Memory (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation to determine functional capacity to remember recent events and assess the mental state of residents who cannot be interviewed. • Documentation in the clinical record with example(s) describing the lack of follow through on a direction given 5 (five) minutes earlier within the observation period. • Example(s) must reference the 5 (five) minute time frame. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should be to assess for additional support needed to optimize remaining function, and promote as much social and functional independence as possible while maintaining health and safety.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
C1000 Cognitive Skills for Daily Decision Making (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation in the clinical record within the observation period of example(s) demonstrating degree of compromised daily decision-making about tasks of everyday living. • The focus of the person-centered care plan should be to assess for additional support needed by resident, optimize remaining function, and promote as much social and functional independence as possible while maintaining health and safety. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan (e.g. clocks, calendars, and assistive devices). • Documentation of seeking information from others to plan the day. • Supervision or assistance required to make decisions. • Cognitive performance must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the person- centered care plan. ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.
Section D: Mood (14-day look back)		
Section D **Resident Mood Items**	*Informational Only*	Items in this section are coded to identify signs and symptoms of mood distress.
D0200 Resident Mood Interview (PHQ-9©) **D0200A-I, Column 2** Resident Mood Interview Symptom Frequency **D0300** PHQ-9© Total Severity Score	*~Special Care High* *~Special Care Low* *~Clinically Complex*	• Documentation in the clinical record within the time frame must have an exact description of the resident's responses to the occurrence and symptom frequency. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and mood/behavior records. • Have a person-centered care plan in place with specific interventions addressing each mood symptom(s) coded. • The focus of the person-centered care plan should be to assess for additional support needed by the resident including focusing on identifying and addressing the underlying cause or causes. ***Does require:*** • Validation of completion of items D0200 A-I on or before the ARD. • Evidence of resident mood interview (PHQ-9©) in the medical record within the observation period. • Items coded to record symptom occurrence and frequency of mood symptoms. Responses to PHQ-9© can indicate possible depression. Scores can be interpreted as follows: A. 1-04 Minimal depression B. 5-09 Mild depression C. 10-14 Moderate depression D. 15-19 Moderately severe depression E. 20-27 Severe depression

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
D0500 Staff Assessment of Resident Mood (PHQ-9-OV©) **D0600** PHQ-9-OV© Total Severity Score	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Example(s) that demonstrates the resident's mood (specific to each D0500A- J item). • Evidence of daily documentation supporting frequency of mood. • An exact description of resident's responses, staff observations and symptom frequency. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and mood/behavior records. • Have a person-centered care plan in place with specific interventions addressing each mood symptom(s) coded. • The focus of the person-centered care plan should be to assess for additional support needed by the resident including focusing on identifying and addressing the underlying cause or causes. Responses to PHQ-9-OV© can indicate possible depression. Scores can be interpreted as follows: A. 1-04 Minimal depression B. 5-09 Mild depression C. 10-14 Moderate depression D. 15-19 Moderately severe depression E. 20-30 Severe depression
Section E: Behavior *(7-day look back)*		
Section E Psychosis & Behavioral Symptoms	*Informational Only*	Items in this section are coded to identify behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents, staff members or the care environment. This section focuses on the resident's actions, not the intent of his or her behavior.
Section E Psychosis & Behavioral Symptoms	*~Behavioral Symptoms and Cognitive Performance*	***Does Require:*** • A specific description, frequency and impact of the behavior experienced by the resident within the observation period. • Follow-up evaluation and care plan interventions developed to improve symptoms and/or reduce their impact. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and mood/behavior records, and person-centered care plan.
E0100A Hallucinations	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation within the observation period with example(s) of a resident's perception of the presence of something that is not actually there. • When the cause is not reversible the person-centered care plan should focus on management strategies to minimize the amount of disability and distress. ***Does include:*** • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.
E0100B Delusions	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation within the observation period with example(s) of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. • The focus of the person-centered care plan should include management strategies to minimize the amount of disability and distress. ***Does NOT include:*** • A resident's expression of a false belief when the resident easily accepts a reasonable alternative explanation. • A belief that cannot be shown to be false or is impossible to determine if it is false.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
E0200A (code 2 or 3) Physical Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation within the observation period with example(s) of physical behavioral symptoms directed toward others. • Daily documentation reflecting a frequency of 4 days to daily occurrence(s) for each applicable physical behavioral symptom. • The focus of the person-centered care plan should address the treatment planning and interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include, but not limited to:*** • Hitting, kicking, pushing, scratching, grabbing, and abusing others sexually.
E0200B (code 2 or 3) Verbal Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation within the observation period with example(s) of verbal behavioral symptoms directed toward others. • Daily documentation reflecting a frequency of 4 days to daily occurrence(s) for each applicable verbal behavioral symptom occurrence. • The focus of the person-centered care plan should address the treatment planning and interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include, but not limited to:*** • Threatening others, screaming at others, cursing at others.
E0200C (code 2 or 3) Other Behavioral Symptoms *not directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation within the observation period with example(s) of other behavioral symptoms NOT directed toward others. • Daily documentation reflecting a frequency of 4 days to daily occurrence(s) for each applicable behavioral symptom occurrence • The focus of the person-centered care plan should address the treatment planning and interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include, but not limited to:*** • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, disruptive sounds.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
E0800 (code 2 or 3) Rejection of Care	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Documentation within the observation period with example(s) of the resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being. • Daily documentation reflecting a frequency of 4 days to daily occurrence(s) for each applicable rejection of care occurrence. • The focus of the person-centered care plan should reflect resident's choices and address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include:*** • Behaviors that interrupt or interfere with the delivery or receipt of care including; verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the resident care. • Hindering the delivery of care by disrupting the usual routine or process by which care is given. • Exceeding the level of resources that is usually present for the provision of care. ***Does NOT include:*** • Behaviors that have already been addressed (e.g. by discussion or care planning with the resident and/or family), and determined to be consistent with resident's values, preferences or goals. • Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as rejecting care.
E0900 (code 2 or 3) Wandering	*~Behavioral Symptoms and Cognitive Performance*	May or may not be driven by confused thoughts or delusional ideas. May be oblivious to his or her physical or safety needs. ***Does require:*** • Documentation within the observation period with example(s) of moving from place to place with or without a specified course or known direction. • Daily documentation reflecting a frequency of 4 days to daily occurrence(s) for each wandering occurrence. • The focus of the person-centered care plan should address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does NOT include:*** • Pacing. • Traveling via a planned course to another specific place (dining room or activity).

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section G: Functional Status (7-day look back)		
Section G Functional Status **ADL Self- performance** **ADL Support**	*Informational*	Items are coded in this section to assess the need for assistance with activities of daily living (ADLs). Measures what the resident actually did, not what he or she might be capable of doing. Measures the most support, provided by staff over the last seven days, even if that level of support only occurred once.
G0110A, Column 1&2 Bed Mobility **G0110B**, Column 1&2 Transfer **G0110I**, Column 1&2 Toilet Use **G0110H**, Column 1&2 Eating	*~Extensive Services* *~Rehabilitation* *~Special Care High* *~Special Care Low* *~Clinically Complex* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation must reflect all episodes over each 24-hour period during the observation period while a resident. • Initials and dates to authenticate the services provided including signatures and titles to authenticate initials per episode. • Staff who actually provided the service and/or person taking responsibility for the service must initial documentation. • The ADL key for self-performance and support provided must include all the MDS key options and be equivalent to the intent and definition of the MDS key (key of "7" self-performance is optional). • ADL self-performance and support provided key definitions must be included in the electronic or hard copy ADL collection tool. • If using narrative notes to support ADLs, each episode must include the specific ADL(s) and degree of self-performance and support provided as well as the exact frequency of the episode. • Wording must be equivalent to MDS key definitions for example "extensive (weight-bearing) assist of one for transfers". • ADL documentation must be maintained as part of the legal medical record and accessible during the on-site review. • Documentation of the self-performance and support and frequency must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan specific to the four late-loss ADLs should address the underlying cause or causes, improving or maintaining function when possible, and preventing additional decline when improvement is not possible. ***Does NOT include:*** • Individuals hired, compensated or not, by individuals outside the facility's management and administration. • Services provided other than by staff in the facility; such as family, hospice staff, nursing/CNA students and other visitors. • ADL self-performance and support provided with key definitions posted outside the ADL collection tool (i.e. taped to computer or kiosk).
Section H: Bladder and Bowel *(7-day look back)*		
Section H **Bladder and Bowel**	*Informational*	Items are coded in this section to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
H0200C Current Urinary Toileting Program or Trial Restorative Nursing	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Evidence of a trial toileting program. • Resident's response to the trial toileting program. • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern. • Evidence that the program was communicated verbally to staff and the resident (as appropriate) and through a person-centered care plan, flow records, and a written report. • Resident's progress towards the program goal(s) by a licensed nurse during the observation period. • **Systematic** toileting program that is being managed 4 days of the 7-day look back period. • The focus of the person-centered care plan should include steps toward ensuring that the resident receives appropriate treatment and have interventions to restore as much bladder function as possible and modify as appropriate. ***Does include:*** • Program if only used by day (when documented that the resident does not want awakened at night). ***Does NOT include:*** • Less than 4 days of a systematic urinary toileting program. • Simply tracking continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.
H0500 Bowel Toileting Program Restorative Nursing	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Implementation of an individualized, resident-specific bowel toileting program that was based on an assessment of the resident's unique bowel pattern. • Evidence that the program was communicated verbally to staff and the resident (as appropriate) and through a care plan, flow records, and a written report within the time frame. • Documentation of resident's progress towards the program goal(s) by a licensed nurse within the observation period. • The focus of the person-centered care plan should include steps toward ensuring that the resident receives appropriate treatment and have interventions to restore as much bowel function as possible and modify as appropriate. ***Does NOT include:*** • Less than 4 days of a systemic bowel toileting program. • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses (7-day and 60-day look back)		

Active Diagnosis Definition:

A physician documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death within the 7-day look back period.

Does require:

- Physician documented diagnosis in the 60-day look back period.
- Documentation supporting active diagnosis in the 7-day look back period.
- Documentation related to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.
- Consistency with radiological reports, laboratory reports, positive study, test or procedures, physician orders, progress notes, interdisciplinary notes, treatment records, mood/behavior records and the current person-centered care plan.
- The focus of the person-centered care plan should identify how the diagnosis has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death and the interventions.

Does include:

- Functional limitations – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.
- Nursing monitoring – nursing monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations; medication management, to include: name, dose, route, and frequency as ordered; etc.).

Does NOT include:

Conditions that have been resolved, that do not affect the resident's current status or do not drive the resident's person-centered care plan within the 7-day look back period; these would be considered inactive diagnoses.

Section I Diagnosis		
I2000 Pneumonia	*~Special Care High* *~Clinically Complex*	A disease of the lungs characterized by inflammation and consolidation followed by resolution and caused by infection or irritants. ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization.
I2100 Septicemia	*~Special Care High*	Invasion of the bloodstream by virulent microorganisms from a focus of infection that is accompanied by chills, fever, and prostration and often by the formation of secondary abscesses in various organs. ***Does require:*** • Positive blood cultures ***Does NOT include:*** • A hospital discharge note referencing septicemia during hospitalization. • Does not include a diagnosis of urosepsis.
I2900 Diabetes Mellitus (DM)	*~Special Care High*	A variable disorder of carbohydrate metabolism caused by a combination of hereditary and environmental factors and usually characterized by inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
I4400 Cerebral Palsy	*~Special Care Low*	A disability resulting from damage to the brain before, during or shortly after birth and outwardly manifested by muscular incoordination and speech disturbances.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
I4900 Hemiplegia/ Hemiparesis	*~Clinically Complex*	Total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain.
I5100 Quadriplegia	*~Special Care High*	An abnormal condition characterized by paralysis of both arms, legs and the trunk of the body below the level of the associated injury to the spinal cord. This disorder is usually caused by a spinal cord injury in the area of the fifth to seventh cervical vertebrae. Automobile accidents and sporting mishaps are common causes. ***Does require:*** • Physician documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs) and is not the result of another condition. ***Does NOT include:*** • Functional quadriplegia, quadriparesis. • Complete immobility due to severe physical disability or frailty that extends to all limbs.
I5200 Multiple Sclerosis (MS)	*~Special Care Low*	A demyelinating disease marked by patches of hardened tissue in the brain or the spinal cord and associated especially with partial or complete paralysis and jerking muscle tremor.
I5300 Parkinson's Disease	*~Special Care Low*	A chronic progressive neurological disease chiefly of later life that is linked to decreased dopamine production in the substantia nigra and is marked especially by tremor of resting muscles, rigidity, slowness of movement, impaired balance, shuffling gait - called also paralysis agitans, and Parkinson's. ***Does include:*** • Paralysis agitans • Shaking palsy ***Does NOT include:*** • Parkinsonism and Parkinson′s Syndrome
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	*~Special Care High*	**Asthma**: A physical condition that makes it difficult for someone to breathe. A chronic lung disorder that is marked by recurring episodes of airway obstruction (as from bronchospasm) manifested by labored breathing accompanied especially by wheezing and coughing and by a sense of constriction in the chest, and that is triggered by hyperactivity to various stimuli (as allergens or rapid change in air temperature). **Chronic Obstructive Pulmonary Disease and/or Chronic Lung Disease**: Pulmonary disease (as emphysema or chronic bronchitis) that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation-abbreviation COPD.
I6300 Respiratory Failure	*~Special Care Low*	**Respiratory Failure**: A condition in which not enough oxygen passes from the lungs into the blood. Respiratory failure also can occur if the lungs can′t properly remove carbon dioxide from the blood. ***Does require:*** • Documentation of an acute respiratory event with interventions. ***Does not include:*** • Chronic compensated respiratory failure.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section J J1100C Shortness of Breath (dyspnea) when lying flat	~*Special Care High*	**Shortness of Breath**: Difficulty in drawing sufficient breath; labored breathing. **Dyspnea**: Difficult or labored respiration. ***Does require:*** • Documentation of the presence of or observation of shortness of breath or trouble breathing when lying flat during the observation period. Documentation of signs and symptoms such as, but not limited to: 1) increased respiratory rate; 2) pursed lip breathing; 3) a prolonged expiratory phase; 4) audible respirations and gasping for air at rest; 5) interrupted speech pattern (only able to say a few words before taking a breath); and 6) use of shoulder and other accessory muscles to breath, as applicable. OR • Interventions to avoid an actual reoccurrence of shortness of breath while lying flat that are applied at all times or on an as needed basis must include detailed documentation of the intervention(s) daily. The medical record must reflect the initial occurrence within the facility. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The resident should not be placed in distress to assess this condition. • The focus of the person-centered care plan should address underlying cause(s) that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible. ***Does not include:*** Potential for Shortness of Breath while lying flat without evidence of an actual occurrence documented.
J1550A Fever	~*Special Care High*	This item is coded to record a fever which is defined as a temperature of 2.4 degrees F higher than the baseline. ***Does require:*** • Consistent route (rectal, oral, etc.) of temperature measurement between the baseline and the elevated temperature. • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established and documented prior to the ARD. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan.
J1550B Vomiting	~*Special Care High*	This item is coded to record the regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic). ***Does require:*** • Description of vomitus (regurgitation of stomach contents). • Frequency of episodes and accompanying symptoms must be documented. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)		
Section K Swallowing/ Nutritional **K0300** (code 1 or 2) Weight Loss	*Informational* *~Special Care High*	Items in this section are coded to assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration. ***Does require:*** • Weight loss should be monitored and recorded at least monthly. • Evidence of the resident's weight loss of 5% or more in last month OR 10% or more in last 6 months. • Percentage based on the actual weight. • Supporting the expressed goal for the physician prescribed weight loss regimen in the medical record. • Assess weight loss and care plan at the time of detection and not delayed until the next MDS assessment. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should focus on measures to address the underlying causes(s), including any reversible issues and conditions that led to weight loss. ***Does include:*** • Mathematical rounding. • Planned or unplanned. • Weight loss via physician-prescribed weight loss regimen.
K0510A (code 1 or 2) Parenteral / IV Feeding	*~Special Care High*	***Does require:*** • Nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital as an outpatient or as an inpatient, administered for nutrition or hydration. • Alternative nutritional approaches are monitored to validate their effectiveness. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should be to prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance, and to address the underlying cause or causes of any current dehydration. • A periodic reevaluation of the appropriateness of the care plan approach. ***Does include:*** • Fluids received by the nursing home resident. • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • Consistency in the clinical record of the physician's order, time, type, amount, and rate of administration. • IV at KVO (keep vein open) rate. • IV fluids contained in IV piggyback. • Hypodermoclysis and sub-Q ports in hydration therapy. • IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition or hydration. ***Does NOT include:*** • Additives, such as electrolytes & insulin that are added to TPN and/ or IV fluids. • IV medications. • IV fluids used to reconstitute and/or dilute medications. • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • IV fluids administered in conjunction with chemotherapy or dialysis.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
K0510B (code 1 or 2) Feeding Tube	*~Special Care High* *~Special Care Low*	***Does require:*** • Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system in the last 7 (seven) days. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should include a reevaluation during the quarter of the appropriateness of the feeding tube approach for nutrition and/or hydration. ***Does include, but not limited to:*** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes. • Evidence in the clinical record to include time, type, amount and rate of administration. • Alternative nutritional approaches are monitored to validate their effectiveness. • Periodic reevaluation of the appropriateness of the care plan approach.
K0710A3 Proportion of Total Calories the Resident Received Through Parenteral or Tube Feeding During Entire 7 days	*~Special Care High* *~Special Care Low*	***Does require:*** • Evidence to support the proportion of calories actually received (not just what is ordered), for nutrition or hydration through the parenteral or tube feeding during the entire 7-day observation period. • Evidence of intake records to determine actual caloric intake through the parenteral or tube feeding routes. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should include monitoring the proportion of calories to ensure adequate nutrition and/or hydration. • Oral intake must be documented. • Proportion of calories received through artificial routes to be monitored with periodic reassessment to ensure adequate nutrition and hydration. *For residents receiving both oral nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* • Calorie count of the tube feeding provided within observation period. • Calorie count of the oral feeding provided within observation period. Percent of total calories provided by tube feeding.
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding During Entire 7 days	*~Special Care High* *~Special Care Low*	***Does require:*** • Evidence to support average fluid intake per shift totaled daily by IV and/or tube feeding during the entire 7-day observation period. Formula and water flushes should be totaled every shift; each should have a total and then a grand total for all fluids given each day. • Evidence in the clinical record to include intake records to determine actual fluid intake through parenteral or tube feeding routes. • Fluid intake received through artificial routes to be monitored with periodic reassessment to ensure adequate nutrition and/or hydration. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should include monitoring the average fluid intake to ensure adequate hydration. *How the facility calculated the average fluid intake through the tube feeding provided and must include:* • Adding the total amount of fluid received each day by IV or tube feedings only. • Divide the week's total fluid intake by 7 (or look back period if less than seven days) to calculate the average of fluid intake per day. Divide by 7 (or look back period if less than seven days) even if the resident did not receive IV fluids or tube feeding on each of the 7 days.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
Section M M0300 Unhealed Pressure Ulcers	*Informational Only*	A pressure ulcer is defined as a lesion(s) caused by unrelieved pressure that result(s) in damage to the underlying tissues. Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface.
M0300B1 Stage 2 **M0300C1** Stage 3 **M0300D1** Stage 4	*~Special Care Low*	**Stage 2**: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or opened/ruptured blister. When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do **not** code as a Stage 2. **Stage 3**: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Stage 4**: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may present on some parts of the wound bed. Often includes undermining and tunneling.
M0300F1 Unstageable Due to Slough/Eschar	*~Special Care Low*	**Unstageable due to slough or eschar**: Pressure ulcers that are not stageable due to coverage of the wound bed by slough and/or eschar. Staging should be determined once enough slough and/or eschar are removed to expose the base of the wound and the true depth/stage. **These documentation requirements apply to items M0300A1 – M0300F1.** ***Does require:*** • A detailed description of the current stage of pressure ulcer(s) within the 7-day observation period that includes, but is not limited to, the size (length, width, and depth), location, dimensions, stage, tissue color observed, drainage, etc. • If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage. • Documentation must include a complete historical description (length, width, depth, & stage) of pressure ulcer(s) when the reported stage is numerically higher than the current description. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the pressure ulcer. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. ***Does NOT require:*** • Staging of current pressure ulcer(s) if highest reported stage and history of ulcer(s) are documented. ***Does NOT include:*** • Facility wound reports that are not part of the resident's clinical record are not acceptable for reimbursement. • Pressure ulcers that are healed before the look-back period. • A pressure ulcer surgically repaired with a flap or graft. • If pressure is NOT the primary cause. • Oral mucosal ulcers caused by pressure (reported at L0200C).

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
M1030 Venous/Arterial Ulcers	*~Special Care Low*	**Venous ulcers** are caused by peripheral venous disease, which most often commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg. **Arterial ulcers** are caused by peripheral arterial disease, which commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of these ulcers. Lower extremity and foot pulses may be diminished or absent. ***Does require:*** • Detailed current description of the ulcer within the 7-day observation period that includes but not limited to, location, dimensions, size (length, width & depth), drainage, tissue color, etc. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the venous and/or arterial ulcer. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. ***Does NOT include:*** • Facility wound reports that are not part of the resident's clinical record are not acceptable for reimbursement.
M1040 Other Ulcers, Wounds and Skin Problems	*Informational Only*	These items are coded to record other ulcers, wounds and skin problems present during the last 7 (seven) days. **These documentation requirements apply to items M1040A-M.** ***Does require:*** • A detailed description of the skin impairment (infection, ulcer, surgical wound, lesion or burn) that includes, but is not limited to, the type, location, size, depth, appearance, etc. • A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. ***Does NOT include:*** • Facility wound reports that are not part of the resident's clinical record are not acceptable for reimbursement.
M1040A Infection of the Foot	*~Special Care Low*	***Does require:*** • Signs and symptoms of infection to the foot. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal the infection. • A detailed description of the infected foot that includes, but not limited to: the location, size, depth if applicable, and appearance, etc. ***Does include, but not limited to:*** • Cellulitis. • Purulent drainage. ***Does NOT include:*** • Ankle problems. (Ankle is not part of the foot.) • Pressure ulcers coded in M0300.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
M1040B Diabetic Foot Ulcer	*~Special Care Low*	***Does require:*** • Detailed current description of diabetic foot ulcer including: location, size, depth, appearance, etc. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the diabetic foot ulcer. ***Does NOT include:*** • Pressure ulcers coded in M0300. • Pressure ulcers that occur on residents with diabetes mellitus. • Ulcers located on the ankle. (Ankle is not part of the foot.)
M1040C Other Open Lesion on the Foot, (e.g. cuts, ulcers, fissures)	*~Special Care Low*	Includes but not limited to cuts, ulcers and/or fissures. ***Does require:*** • Detailed current description of open lesion including: location, size, depth, appearance, etc. to foot. • Documentation that the wound is open during the observation period. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the open lesion on the foot. ***Does NOT include:*** • Pressure ulcers coded in M0300. • Open lesions to ankle. (Ankle is not part of the foot.)
M1040D Open Lesion Other Than Ulcers, Rashes, Cuts	*~Clinically Complex*	***Does require:*** • Detailed current description of the open lesion including: location, size, depth, appearance, etc. • Documentation that the wound is open during the observation period. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the open lesion. ***Does include:*** • Skin lesions that develop as a result of diseases and conditions such as syphilis, cancer, wounds, boils, cysts, and vesicles (e.g., bullous pemphigoid). ***Does NOT include:*** • Pressure ulcers coded in M0300. • Skin tears, cuts, rashes. • Diabetic foot ulcers, venous/arterial ulcers.
M1040E Surgical Wound	*~Clinically Complex*	***Does require:*** • Detailed current description of the surgical wound including: location, size, depth, appearance, etc. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the surgical wound. ***Does include:*** • Any healing or non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. • Pressure ulcers that are surgically repaired with grafts and flap procedures. ***Does NOT include:*** • Healed surgical sites and healed stomas. • Lacerations that require suturing or butterfly closure. • PICC sites, central line sites, peripheral IV sites. • Pressure ulcers that have been surgically debrided.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
M1040F Burn	*~Clinically Complex*	***Does require:*** • Detailed current description of the second or third degree burn including degree, location, appearance, size, and drainage, etc. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal the burn. ***Does include:*** • May be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. • The type, cause, and tissue involvement in the clinical record within the observation period. ***Does NOT include:*** • First-degree burns (changes in skin color only).
M1200 Skin and Ulcer Treatments	*Informational Only*	These items are coded to record general skin treatment, basic pressure ulcer prevention and skin interventions that were provided during the last seven days. ***Does Require:*** • Consistency with physician orders, progress notes, interdisciplinary notes, treatment/medication administration records and the person-centered care plan.
M1200A Pressure Reducing Device/*chair* **M1200B** Pressure Reducing Device/*bed*	*~Special Care Low*	***Does require:*** • The use of equipment aimed at reducing pressure away from areas of high risk during the observation period. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan. • The focus of the person-centered care plan should include intervention(s) including frequency and effectiveness of the pressure reducing device related to skin problems. ***Does include:*** • Foam, air, water, gel, or other cushioning placed on chair, wheelchair or bed. • Pressure relieving, reducing, redistributing devices. ***Does NOT include:*** • Egg crate cushions of any type. • Doughnut or ring device in chairs or wheelchairs. • A physician order for a pressure relieving device alone does not validate the device.
M1200C Turning/ Repositioning Program	*~Special Care Low*	A consistent program for changing the resident's position and realigning the body. ***Does include:*** • A "Program," defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the resident's needs. • The focus of the person-centered care plan should include specific, individualized program intervention(s) including frequency and effectiveness of the turning and repositioning program related to skin problems. • Specific interventions (e.g. reposition of side, pillows between knees) and frequency (e.g., every 2 hours) of the program. • Monitoring and reassessing the program to determine the effectiveness of the interventions. • A licensed nurse describing an evaluation of the resident's response to the program within the observation period.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
M1200D Nutrition or Hydration Intervention to Manage and/or prevent Skin Problems	*~Special Care Low*	Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions e.g., wheat free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. ***Does require:*** • Confirmation or suspicion of nutritional deficiencies through a nutritional assessment. • A description of the specific skin condition. • Nutrition or hydration factors that are influencing the skin problem and or wound healing. • Interventions that are specifically tailored to the resident's needs, condition and prognosis. • The focus of the person-centered care plan should include interventions tailored to resident's needs, condition and prognosis related to skin problems. ***Does include:*** • Vitamins and/or supplements (protein, etc.).
M1200E Pressure Ulcer Care	*~Special Care Low*	***Does require:*** • Intervention for treating pressure ulcers coded at M0300. • The focus of the person-centered care plan should include interventions tailored to heal or close the pressure ulcer. ***Does include:*** • Use of topical dressings. • Application of antimicrobial ointments. • Chemical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy.
M1200F Surgical Wound Care	*~Clinically Complex*	***Does require:*** • The focus of the person-centered care plan should include interventions tailored to heal or close the surgical wound. ***Does include:*** • Topical cleansing. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. ***Does NOT include:*** • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer.
M1200G Application of Non-surgical Dressings(with or without medications) Other than to feet	*~Special Care Low* • *~Clinically* Complex	Application of non-surgical dressing (with or without topical medications) to the body other than to the feet at least once during the last 7 days. The focus of the person-centered care plan should include interventions tailored to resident's needs related to non-surgical dressings other than to feet. ***Does include:*** • Compression bandages. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydroactive particles. • Dressing application to the ankle. ***Does NOT include:*** • Non-surgical dressings for pressure ulcers other than to foot; use ulcer care (M1200E). • Band-Aids.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
M1200H Application of Ointments/Medications Other Than to Feet	*~Special Care Low* *~Clinically Complex*	Application of ointments/medications (used to treat a skin condition) other than to feet. The focus of the person-centered care plan should include interventions tailored to resident's needs related to ointments/medications other than to feet. ***Does include:*** • Topical creams. • Powders. • Liquid sealants. • Cortisone. • Antifungal preparation. • Chemotherapeutic agents. ***Does NOT include:*** • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers. Use pressure ulcer care, item M1200E. • Ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).
M1200I Applications of Dressings to Feet	*~Clinically Complex*	Interventions to treat any foot wound or ulcer other than a pressure ulcer. ***Does include:*** • Dressing changes to the feet (with or without topical medication). • The focus of the person-centered care plan should include interventions tailored to resident's needs related to dressings to the feet. • Treatments and monitoring to the foot only for this section. ***Does NOT include:*** • Dressing application to the ankle. (Ankle is not part of the foot.)
Section N: Medications *(7-day look back)*		
Section N N0350A Days of Insulin Injections	*~Special Care High*	Documentation to include the number of days that insulin injections were received for the last 7 (seven) days. ***Does require:*** • Consistency with physician orders, treatment/medication administration records and the person-centered care plan. ***Does include:*** • Subcutaneous insulin pumps, and the number of days the resident actually required a subcutaneous injection to restart the pump.
N0350B Days of Orders for Insulin	*~Special Care High*	Documentation to include the number of days that the insulin orders changed for the last 7 (seven) days. ***Does include:*** • Sliding scale order that is new, discontinued or is the first sliding scale order. ***Does NOT include:*** • A day simply because a different dose of insulin is administered based on an existing sliding scale order.
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
Section O O0100 Special Treatments, Procedures and Programs (Column 2 only)	*Informational Only*	• Includes special treatments, programs and procedures that the resident received after admission/entry or re-entry to the facility and within 14-days observation period. • A description that includes the name of the drug, amount given, route and time must be documented in the clinical record within the observation period. • Consistency with physician orders, progress notes, interdisciplinary notes, treatment/medication administration records and the person-centered care plan. • The focus of the person-centered care plan should center on the specific interventions and the impact to ensure the continued appropriateness of the treatment, procedure, or program. • Does NOT include services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
O0100A, 2 Chemotherapy	*~Clinically Complex*	Administration of any type of chemotherapy agent (anticancer drug) given by any route for the sole purpose of cancer treatment. ***Does require:*** • A description that includes the name of the drug, amount given, route and time must be documented in the clinical record within the observation period. • Monitoring each shift of the specific side effects associated with the chemotherapy and the person-centered care plan. ***Does NOT include:*** • Chemotherapy agent given for reasons other than treatment of cancer (e.g. Megace for appetite stimulation). • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer.
O0100B, 2 Radiation	*~Special Care Low*	Administration of intermittent radiation therapy, as well as radiation administered via radiation implants in the last 14 days inside or outside of facility. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant. • A description that includes the type, route and/or method of administration and time must be documented in the clinical record within the observation period and the person-centered care plan. • Monitoring each shift of the specific side effects associated with the specific radiation therapy and person-centered care plan.
O0100C, 2 Oxygen Therapy	*~Special Care Low* *~Clinically Complex*	Administration of oxygen continuously or intermittently via mask, cannula, etc., delivered to relieve hypoxia in last 14 days. ***Does require***: • Active physician order • Documentation of precipitating event for PRN usage and activating standing orders. • The focus of the person-centered care plan should monitor for the effectiveness to relieve hypoxia and ensure the continued appropriateness of oxygen therapy. ***Does include:*** • Resident places or removes his/her own oxygen mask, cannula. • Oxygen when used in BiPAP/CPAP. • Must include the method of administration, time and amount of oxygen administered within the observation period. ***Does NOT include:*** • Hyperbaric oxygen for wound therapy.
O0100E, 2 Tracheostomy Care	*~Extensive Services*	Administration of cleansing the tracheostomy site, cannula and/or dressings to the site in last 14 days. ***Does require:*** • A physician order with specific type and description of the tracheostomy care to include but not limited to, cleansing solution, inner cannula, strap and/or tie change procedure. • The focus of the person-centered care plan should monitor for effectiveness and continued appropriateness of the tracheostomy care. ***Does include:*** • Changing a disposable cannula. • Resident performing his/her own tracheostomy care.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
O0100F, 2 Ventilator or Respirator	*~Extensive Services*	Administration of any type of electrically or pneumatically powered closed system mechanical ventilator support device that ensures adequate ventilation in the resident who is unable to support his/her own respiration. ***Does require:*** • The type of ventilator device and frequency used during the observation period. • The focus of the person-centered care plan should monitor for effectiveness and ensure the continued appropriateness of the ventilator/respirator. ***Does include:*** • Any resident, who in the last 14 days, was in the process of being weaned off the ventilator or respirator. ***Does NOT include:*** • Times when used as a substitute for BiPAP or CPAP.
O0100H, 2 IV Medications	*~Clinically Complex*	Administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port during the last 14 days. The focus of the person-centered care plan should monitor for effectiveness and reevaluate the appropriateness of the IV medications. ***Does include:*** • Epidural, intrathecal, and baclofen pumps. • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids. ***Does NOT include:*** • Flushes to keep an IV/heparin lock or port patent. • IV fluids without medication. • Subcutaneous pumps. • IV medications administered during dialysis or chemotherapy. • Dextrose 50% and/or Lactated Ringers.
O0100I, 2 Transfusions	*~Clinically Complex*	Administration of blood or any blood products (e.g., platelets, synthetic blood products etc.) administered directly into the bloodstream during the last 14 days. ***Does require:*** • The time, type, amount and the monitoring of side effects as per the person-centered care plan. • The focus of the person-centered care plan should monitor for effectiveness and ensure the continued appropriateness of the transfusion while monitoring for side effects. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.
O0100J, 2 Dialysis	*~Special Care Low*	Administration of peritoneal or renal dialysis that occurred at the facility or another facility during the last 14 days. ***Does require:*** • The focus of the person-centered care plan should be monitoring of side effects as well as the time and type of dialysis (e.g. hemodialysis, peritoneal, etc.) administered. • A post dialysis assessment that includes: vital signs, shunt/dressing, etc. on each re-entry to the facility. ***Does include:*** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). • Resident performing his/her own dialysis. • Communication records between the facility and dialysis center monitoring weight changes, vital signs, medications and other communications pre- and post-dialysis administration and assessment of shunts, etc. • Signatures of nurses at facility. ***Does NOT include:*** • IV, IV medication and blood transfusion administered during dialysis.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
O0100M, 2 Isolation or Quarantine for Active Infectious Disease	*Informational Only*	***Code for "Single Room Isolation" only when all the following conditions are met:*** 1. Resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. **Standard Precautions Include**: • Hand hygiene compliance • Glove use • Masks • Eye protection • Gowns 3. Resident is in a room alone because of active infection and cannot have or cohort with a roommate or other residents. 4. Must remain in room. All services must be brought to the resident. 5. Documentation per each discipline related to in room status by all members of the IDT.
O0100M, 2 Isolation or Quarantine for Active Infectious Disease	*~Extensive Services*	***Does require:*** • Active physician order to include: diagnosis, type of isolation, and need for a private room. • Evidence supporting an active infectious disease, i.e., symptomatic and/or have a positive test and are in the contagious stage. • The need for transmission-based precautions and strict isolation alone in separate room. (See definition for "single room isolation" criteria.) • Highly transmissible or epidemiologically significant pathogens acquired by physical contact, airborne or droplet transmission. • Documentation must include rationale describing why the infection must be contained in a single room isolation (cannot have a roommate) and why precautions must be over and above standard precautions. • The focus of the person-centered care plan should define the necessity for isolation, interventions for the health and safety of the resident and staff, and address the resident's functional status, cognition, physical, and social abilities and improve quality of life. ***Does NOT include:*** • Standard precautions • Contact precautions. • History of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with a roommate.

**O0400 – Therapies (*7-day look back)*
(A) Speech-Language Pathology Services (SLP) (B) Occupational therapy (OT)
(C) Physical therapy (PT)**

General Therapy Requirements

Does require:
- Only skilled therapy provided while a resident in the facility.
- Services be directly and specifically related to an active, medically necessary, written treatment plan signed by the physician.
- Services be preceded by an evaluation prior to the start of therapy.
- Services be of a level of complexity and sophistication, or condition requiring the judgment, knowledge and skills of a therapist.
- Services be reasonable and necessary for condition.
- The focus of the person-centered care plan should define the necessity for, and the frequency and duration of each therapy modality and their respective services.

Does NOT include:
- Services at the request of the family that are not medically necessary.
- Non-skilled services (facility election, maintenance treatments, supervision of CNAs).
- Restorative service time.
- Therapy provided prior to an admission.
- Therapy less than 15 minutes a day.
- Therapy ordered 3 times per week but done five times a week during the ARD.

Minutes of Therapy Requirements

Does require:
- Only skilled therapy minutes be reported or on the MDS.
- Only skilled services after the initial minutes evaluation reported on the MDS.
- Reimbursable (actual) therapy minutes (RTM) ONLY.
- Documentation of RTM for each specific mode of therapy.
- Documentation be differentiated between RTM minutes and billable minutes/units.

Does include:
- Therapist time spent on subsequent reevaluations conducted as part of the treatment process.
- Time required to adjust equipment or otherwise prepare for individualized therapy.
- Family education when the resident is present and documented.

Does NOT include:
- Therapist time spent on documentation or initial evaluation.
- Conversion of units to minutes or minutes to units.
- Rounding to the nearest 5th minute.
- Non-therapeutic rest periods.
- Treatment or portion of treatment that not skilled.
- SLP assistant time.
- Initial evaluation minutes.
- Unattended e-stim minutes.

MDS 3.0 Item Location and Item Description	***RUG-IV Categories Impacted***	***Minimum Documentation and Review Standards Required Within the Specified Observation Period***
Therapy Minutes **O0400A1,2,3** Speech-Language Pathology and Audiology Services **O0400B1,2,3** Occupational Therapy **O0400C1,2,3** Physical Therapy	*~Rehabilitation*	***Does require:*** • RTM minutes with associated initials/signature(s) on a daily basis to support the total number of RTM minutes of actual therapy provided. • Physician order, treatment plan and assessment.
Therapy Days O0400A4 Speech-Language Pathology and Audiology Services **O0400B4** Occupational Therapy **O0400C4** Physical Therapy	*~Rehabilitation*	***Does require:*** • Associated initials/signature(s) on a daily basis to support the total number of days therapy provided. • Treatment for 15 minutes or more per day.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
O0400D2 Respiratory Therapy Days	*~Special Care High*	***Does require:*** • Respiratory therapy services provided by a qualified professional (respiratory therapist, respiratory trained nurse) for the assessment, treatment and monitoring of patients with deficiencies or abnormalities of pulmonary function. • Physician order that includes a statement of medication frequency, duration and scope of treatment. • Actual minutes on a daily/shift/occurrence. • Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided. • The services are reasonable and necessary for treatment of the resident's condition. • Evidence of a licensed nurse's training. • A trained respiratory nurse proficient in the modalities provided and one who has received specific training on the administration of respiratory treatments and procedures when permitted by the state Nurse Practice Act. Training may have been received at a hospital or nursing facility as part of work experience or of an academic program. Respiratory training is not necessarily part of formal nurse programs. • Count only time that a qualified professional spends with the resident. • Respiratory therapy must meet all of the requirements of other specialized therapies. • A respiratory assessment pre and post treatment that includes but is not limited to the following: heart rate, respiratory rates, breath sounds, the presence and description of sputum, direct care minutes, toleration and person-centered care plan. • The focus of the person-centered care plan should include the necessity for, and the frequency and duration of the appropriateness of respiratory therapy. ***Does include:*** • Respiratory services include coughing, deep breathing, heated nebulizers, medications delivered by aerosol treatments, assessing breath sounds and mechanical ventilation, etc. ***Does NOT include:*** • Treatment for less than 15 minutes per day. • Hand-held medication dispensers.
O0420 Distinct Calendar Days of Therapy	*~Rehabilitation*	***Does require:*** • The number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes per day in the past 7 days. ***Does NOT include:*** • The count of more than one day when multiple therapy disciplines provide services on the same calendar day.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
O0500A-J Restorative Nursing Program Days	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	Restorative nursing program refers 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. ***Does require:*** • Evidence of actual minutes on a daily/shift/occurrence for each activity provided within a 24-hour period. • Initials/signature(s) on a daily/shift/occurrence to support the total minutes of restorative nursing activity/activities provided. • The six criteria to meet the definition of a restorative nursing program: 1. Person-centered care plan for each restorative activity with measurable functional goals and interventions. 2. Restorative Nursing modalities must have baseline assessments which must include documentation of actual functional deficits and/or problems identified. 3. Evidence of a periodic evaluation, to include the above, by a licensed nurse. No evaluation note will be accepted after the ARD. The rationale of unmet goals must be documented with a plan to address. 4. Staff must be trained in the techniques that promote resident involvement in the activity. 5. The program is supervised by nursing. 6. There may be no more than 4 residents in a group per supervising staff. • Training and skill practice are activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse. • These activities must be planned, scheduled and documented in the clinical record. • Each restorative modality requires a care plan with the problem, specific interventions and measureable goals. ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • Movement by a resident that is incidental to care. • Treatment of any modality for less than 15 minutes per day. • Restorative Nursing program done 6-7 days per week only during the ARD time frame. • Functional Maintenance Programs.
O0500A Range of Motion Passive	*Informational*	Passive movements per staff in order to maintain flexibility and useful motion in joints of the body to avoid contractures. • Resident provides no assistance. • Does not include passive movement by the resident that is incidental to dressing, bathing, etc.
O0500B Range of Motion Active	*Informational*	Exercises performed by the resident, with cueing, supervision or physical assist by staff. • Includes active ROM and active-assisted ROM. • Does not include active movement by the resident that is incidental to dressing, bathing, etc.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
O0500C Splint / Brace Assist	*Informational*	Verbal and/or physical guidance and direction that teaches the resident how to apply, manipulate and care for brace or splint; or a scheduled program of applying and removing a splint or brace. ***Does require:*** • Splint (type) or brace (type) assistance must include an assessment of the skin and circulation/sensation, redness, and/or swelling under the device timely (every 1-2 hours) daily and reposition the limb in correct alignment periodically and document in the clinical record within the observation period. • Documentation must include the time the splint is placed on the resident and the time the splint is removed off the resident.
O0500D Bed Mobility	*Informational*	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.
O0500E Transfers	*Informational*	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. Examples include: transferring with a slide board or other transfer appliance or the stand, turn and pivot method, etc.
O0500F Walking	*Informational*	Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. Requires the number of feet walked daily documented in the clinical record.
O0500G Dressing/Grooming	*Informational*	Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing personal hygiene tasks.
O0500H Eating/Swallowing	*Informational*	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.
O0500I Amputation/ Prosthesis Care	*Informational*	Activities provided to improve or maintain the resident's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis is attached to the body (e.g., leg stump or eye socket etc.).
O0500J Communication	*Informational*	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.