MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Supportive Documentation Requirements

Effective May 1, 2023

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WELCOME AND INTRODUCTIONS

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QUESTIONS?

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Answers will be posted to the web portal following training

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SUPPORTIVE DOCUMENTATION REQUIREMENTS

Effective May 1, 2023

Introduction

- ✓ Accuracy of the Minimum Data Set (MDS) item responses is very important:
  - Responses guide the care provided to the resident
  - Quality Measures assist state survey in identifying potential care problems in a nursing facility
  - The Medicare Prospective Payment System rates are set based on MDS responses
- ✓ Beginning July 1, 2022, the Connecticut Department of Social Services 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 Connecticut Roster Report User Guide for a more complete description of the RUG-IV system and CMI)
- ✓ These Supportive Documentation Requirements apply to all Connecticut Medicaid-certified nursing facilities for assessments with an Assessment Reference Date (ARD) on or after May 1, 2023.

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 the Supportive Documentation 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, the more current information from CMS becomes the minimum acceptable standard.

MDS Items for Review

- ✓ 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.**
- ✓ 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, it is a matter of good clinical practice and an expectation of trained and licensed health care professionals to include documentation that:
  - Contributes to the identification and communication of a resident's problems, needs, and strengths
  - Monitors resident's condition on an on-going basis
  - Records treatment and response to treatment
  - Good clinical practice is an expectation of CMS
- ✓ 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.
- ✓ The Connecticut Department of Social Services requires documentation to substantiate MDS items associated with the RUG classifications applicable to reimbursement as defined in the Supportive Documentation Requirements User Guide.

Overall Documentation Instructions, Cont.

- ✓ 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 Assessment Reference Date (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.
  - 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.

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OVERALL DOCUMENTATION INSTRUCTIONS, CONT.

- ✓ Documentation in the clinical record **should**:
  - Consistently support the item response
  - Reflect care related to the symptom/problem
- ✓ Documentation **must**:
  - Apply to the appropriate look-back period
  - Reflect the resident's status on all shifts

Overall Documentation Instructions, Cont.

- ✓ 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 and/or initials.**
- ✓ Signatures are required to authenticate all clinical records.
  - At a minimum, the signature must include:
    - First initial
    - Last name
    - Title/Credential

Overall Documentation Instructions, Cont.

- ✓ 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.

OVERALL DOCUMENTATION INSTRUCTIONS, CONT.

- ✓ In cases of corrections, obliterations, errors or mistaken entries, at a minimum, the staff must:
  - Line through the incorrect information
  - Include the staff's initials
  - Include the date the correction was made
  - Include the correct information

OVERALL DOCUMENTATION INSTRUCTIONS, CONT.

- ✓ The Connecticut Department of Social Services advises nursing facilities to maintain and have readily available supporting medical records to include timely access to electronic medical records.

Overall Documentation Instructions, cont.

- ✓ 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

Overall Documentation Instructions, Cont.

- ✓ A person-centered comprehensive care plan must be developed and implemented for each resident that:
  - Is consistent with the resident's rights and measurable objectives
  - Includes description of the services to be provided
  - Includes 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.

  - Must be reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly review assessment.
  - Services provided or arranged must be consistent with the resident's written person-centered care plan.

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REQUIREMENTS TABLE EXPLANATION

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.

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REQUIREMENTS TABLE EXPLANATION

RUG-IV Categories Impacted

- ✓ This column identifies any RUG-IV groups potentially impacted by the MDS item.
- ✓ 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.

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REQUIREMENTS TABLE EXPLANATION

- ✓ 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.**

RUG-IV 48-GROUP MDS ITEMS

- ✓ The following slides list the various MDS items utilized in the RUG-IV 48-group classification.
- ✓ Keep in mind that many of the items require a second item, specific coding values or a combination of items to actually classify in a RUG category.
- ✓ **ADLs play a role in each category.**

EXTENSIVE SERVICES
MDS ITEMS

- ✓ Tracheostomy care (while a resident)
- ✓ Ventilator/respirator (while a resident)
- ✓ Infection isolation (while a resident)

REHABILITATION
MDS ITEMS

- ✓ Speech-Language Pathology and Audiology Services
- ✓ Occupation Therapy
- ✓ Physical Therapy
- ✓ Distinct Calendar Days of Therapy
- ✓ Restorative Nursing
  - Includes scheduled toileting programs

Restorative Nursing MDS Items

Restorative Nursing MDS Items	
Current toileting program or trial# ↔	Bowel toileting program#
Passive range of motion# ↔	Active range of motion#
Bed mobility# ↔	Walking#
Dressing and/or grooming	Eating and/or swallowing
Splint or brace assistance	Amputation/prosthesis care
Transfer	Communication
#For RUG classification, count as one program even if both provided	

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SPECIAL CARE HIGH MDS ITEMS

- ✓ Comatose with ADL self-performance of 4 or 8
- ✓ Septicemia
- ✓ Diabetes Mellitus
  - Insulin injections for all 7 days and
  - Insulin order changes on 2 or more days
- ✓ Quadriplegia with ADL score >= 5
- ✓ COPD with shortness of breath while lying flat
- ✓ Fever with one of the following:
  - Pneumonia
  - Vomiting
  - Weight loss
  - Feeding Tube with requirements*

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SPECIAL CARE HIGH MDS ITEMS

- ✓ *Tube feeding requirements:
  1) Proportion of total calories received through parenteral or tube feeding (K0710A3) is 51% or more of total calories during entire period.

  OR

  2) Proportion of total calories received through parenteral or tube feeding (K0710A3) is 26% to 50% of total calories and average fluid intake per day (K0710B3) is 501 cc or more during entire period.

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SPECIAL CARE HIGH MDS ITEMS (CONTINUED)

- ✓ Parenteral/IV feeding
- ✓ Respiratory therapy for all 7 days
- ✓ Resident mood interview or staff assessment (depression splits)

Special Care Low MDS Items

- Cerebral Palsy with ADL score >=5
- Multiple Sclerosis with ADL score >=5
- Parkinson's Disease with ADL score >=5
- Respiratory Failure
  - with oxygen therapy (while a resident)
- Feeding tube
  - With requirements*
- Two or more Stage 2 pressure ulcers*
- Stage 3 pressure ulcer*
- Stage 4 pressure ulcer*
- Unstageable/slough and/or eschar*
- Two or more venous/arterial ulcers*
- Infection of the foot*
- Diabetic foot ulcer*
- Other open lesion on the foot*
- Radiation while a resident
- Dialysis while a resident
- Resident mood interview or staff assessment

*Stage **2, 3, 4, unstageable, venous ulcers, and arterial ulcers** all require 2 or more selected skin treatments.
***Infection of the foot, diabetic foot ulcer, and other open lesion on the foot** all require application of dressing to the feet.

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CLINICALLY COMPLEX MDS ITEMS

- ✓ Pneumonia
- ✓ Hemiplegia or Hemiparesis with ADL score of >=5
- ✓ Open lesions other than ulcers, rashes cuts*
  - **(with any selected skin treatment)**
- ✓ Surgical wound*
  - **(with any selected skin treatment)**
- ✓ Burns
- ✓ Chemotherapy (while a resident)
- ✓ Oxygen therapy (while a resident)
- ✓ IV medications (while a resident)
- ✓ Transfusions (while a resident)
- ✓ Resident mood interview or staff assessment (depression splits)

Special Care Low and/or Clinically Complex Selected Skin Treatment MDS Items*

- ✓ Pressure reducing device for chair#
- ✓ Pressure reducing device for bed#
- ✓ Turning/repositioning program
- ✓ Nutrition or hydration intervention to manage skin problems
- ✓ Pressure ulcer care
- ✓ Application of non-surgical dressings (other than to feet)
- ✓ Application of ointments/medications (other than to feet)
- ✓ Application of dressings to feet
- ✓ Surgical wound care

#For RUG classification, count as one treatment even if both are provided

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BEHAVIORAL AND IMPAIRED COGNITION ITEMS

- ✓ Impaired Cognition Items
  - BIMS
  - Comatose with ADL self-performance of 4 or 8
  - Making self understood
  - Short term memory problem
  - Severely impaired decision making skills
- ✓ Behavioral Symptom Items
  - Hallucinations
  - Delusions
  - Physical, Verbal behavioral symptoms directed toward others
  - Other Behavioral symptoms not directed toward others
  - Rejection of care
  - Wandering

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REDUCED PHYSICAL FUNCTION MDS ITEMS

- ✓ ADLs
- ✓ Restorative nursing programs

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SECTION B: HEARING, SPEECH, AND VISION

Section B: Hearing, Speech and Vision (7-day look back)

MDS 3.0 Item Location and Item Description	RUG IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
B0100 Comatose **(CPS)**	~Special Care High ~Behavioral Symptoms and Cognitive Performance	**Does require:** • Active diagnosis of coma or persistent vegetative state documented by physician, physician assistant, nurse practitioner or clinical nurse specialist. **Does NOT include:** • Resident in advanced stages of progressive neurologic disorders (i.e., Alzheimer's)

Section B: Hearing, Speech and Vision (7-day look back)

MDS 3.0 Item Location and Item Description	RUG IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
B0700 Makes Self Understood **(CPS)** 	~Behavioral Symptoms and Cognitive Performance	**Does require:** • Example(s) and date(s) of the resident's verbal and/or non-verbal 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, gestures or a combination of these. **Does include:** • Reduced voice volume • Difficulty in producing sounds • Difficulty in finding the right word, making sentences, writing, and/or gesturing.

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SECTION C:
COGNITIVE PATTERNS

Section C: Cognitive Patterns (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
C0200 Repetition of Three Words (BIMS) _____ C0300 A, B, C Temporal Orientation (BIMS) _____ C0400 A, B, C Recall (BIMS)	~Behavioral Symptoms and Cognitive Performance	**Does require:** Validation of completion of interview items C0200, C0300A,B,C, C0400A, B, and C, at Z0400 dated on or before the ARD and within the 7-day observation period.

Section C: Cognitive Patterns (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period

C0700
Short-Term Memory **(CPS)**
 
	~Behavioral Symptoms and Cognitive Performance	**Does require:**
		• Example(s) and date(s) documenting the resident's ability to:
		  ○ Describe an event 5 minutes after it occurred if the resident's response can be validated, or
		  ○ Follow through on a direction given 5 minutes earlier.

Section C: Cognitive Patterns (7-day look back)

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:** • Example(s) and date(s) of the resident's actual performance documenting the degree of compromised daily decision-making about everyday decisions for tasks or daily activities. **Does include:** • Choosing clothing • Knowing when to go to meals • Using environmental cues to organize and plan (e.g., clocks, calendars) • Seeking information from others to plan the day • Acknowledging need to use appropriate assistive equipment (i.e. walker) **Does not include:** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.

SECTION D: MOOD

Section D: Mood (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
D0200A-I, Column 2 Resident Mood Interview (Symptom Frequency)	~Special Care High ~Special Care Low ~Clinically Complex	**Does require:** • Validation of completion of interview items D0200A – I at Z0400 dated on or before the ARD and within the 14-day observation period.

Section D: Mood (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
D0500 A-J, Column 2 Staff Assessment of Resident Mood (Symptom Frequency)	~Special Care High ~Special Care Low ~Clinically Complex 	**Does require:** • Documentation of the date(s), staff member(s) interviewed across all shifts, staff observations and the frequency reported for each applicable item D0500 A-J. • If family member(s) or significant other(s) were interviewed the date the interview was conducted and the frequency reported for each applicable item at D0500 A-J.

SECTION E: BEHAVIOR

Section E: Behavior (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
E0100A Hallucinations 	~Behavioral Symptoms and Cognitive Performance	**Does require:** • Example(s) and date(s) of the resident's perception of the presence of something that is not actually there; OR • Documentation of the date(s) the staff interview was conducted and the date(s), including a description of the hallucination(s), per occurrence(s). **Does include:** • Auditory, visual, or involving smells, tastes or touch.

Section E: Behavior (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
E0100B Delusions	~Behavioral Symptoms and Cognitive Performance	**Does require:** • Example(s) and date(s) of a fixed, false belief not shared by others that the resident holds even if the face of evidence to the contrary; OR • Documentation of the date(s) the staff interview was conducted and the date(s), including a description of the delusion(s), per occurrence(s). **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.

Section E: Behavior (7-day look back)

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:** • Example(s) and date(s) of resident's physical behavioral symptoms directed toward others; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited physical behavioral symptoms directed toward others, including a description of the physical behavioral symptoms directed toward others, per occurrence(s). **Does include:** • Hitting, kicking, pushing, scratching, grabbing, and abusing others sexually **Does not include:** • An interpretation of the behavior's meaning, cause or the assessor's judgement that the behavior can be explained or should be tolerated.

Section E: Behavior (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
E0200B (code 2 or 3) Verbal Behavioral Symptoms directed toward others 	~Behavioral Symptoms and Cognitive Performance	**Does require:** • Example(s) and date(s) of resident's verbal behavioral symptoms directed toward others; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited verbal behavior symptoms toward others, including a description of the verbal behavioral symptoms directed toward others, per occurrence(s). **Does include:** • Threatening others, screaming at others, cursing at others **Does not include:** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.

Section E: Behavior (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
E0200C (code 2 or 3) Other Behavioral Symptoms NOT directed toward others 	~Behavioral Symptoms and Cognitive Performance	**Does require:** • Example(s) and date(s) of resident's other behavioral symptoms NOT directed toward others; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited other behavior symptoms not directed toward others, including a description of the other behavioral symptoms not directed toward others, per occurrence(s). **Does include:** • 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. **Does not include:** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals.

Section E: Behavior (7-day look back)

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:** • Example(s) and date(s) of resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's values, preferences or goals; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited rejection of care, including description of rejection of care per occurrence(s). **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 receipt of care. • Hindering the delivery of care by disrupting the usual routine or process by which care is given. • Exceeding the level or intensity of resources that are usually available for the provision of care. **Does not include:** • Behaviors that have already been addressed and determined to be consistent with the resident's values, preferences or goals.

Section E: Behavior (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
E0900 (code 2 or 3) Wandering	~Behavioral Symptoms and Cognitive Performance	**Does require:** • Example(s) and date(s) of resident's act of moving (walking or locomotion in a wheel chair) from place to place with or without a specified course or known direction; OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident was wandering, including a description of the wandering per occurrence(s). **Does NOT include:** • Pacing • Traveling via a planned course to another specific place (dining room or activity)

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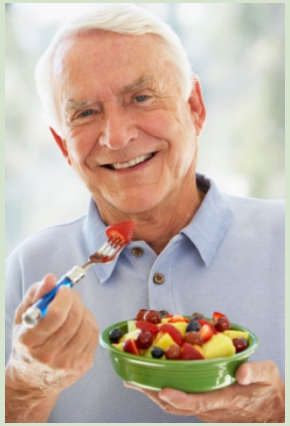
SECTION G: FUNCTIONAL STATUS

Section G: Functional Status (7-day look back)

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	**Informational** 	• Items are coded in this section to assess the need for assistance with activities of daily living (ADLs)
ADL Self-performance		• Measures what the resident actually did, NOT what he or she might be capable of doing
ADL Support		• Measures the most support, provided by staff over the last seven days, even if that level of support only occurred once

Section G: Functional Status (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
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 ADL self-performance and support-provided including signatures and titles to authenticate initials per episode. • 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. • ADL descriptions must include all tasks and components related to the specific ADL activity. • If using narrative notes to support ADLs, each occurrence must include the specific ADL(s) and degree of self-performance and support provided. • Wording must be equivalent to MDS key definitions for example “extensive **(weight-bearing)** assist of one for transfers.”

Section G: Functional Status (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
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 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).

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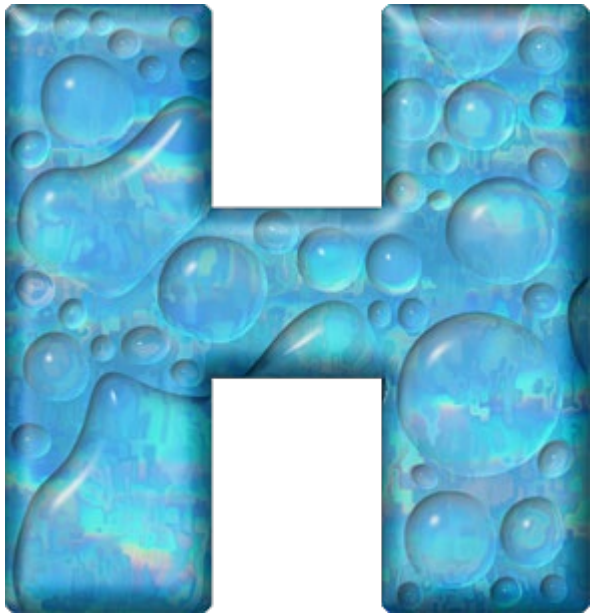
SECTION H:
BLADDER AND BOWEL



Section H: Bladder and Bowel (7-day look back)

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:** • Documentation of a trail of an individualized, resident-centered toileting program that includes at least 3 days of toileting patterns with prompting to toilet and recorded results to that toileting program in a bladder record or voiding diary. • Following program trial and response, documentation of a current toileting program being used to manage urinary continence must include: ➢ Implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding patter; ➢ Evidence that the individualized program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, and a written report; and ➢ Documentation of the resident's response to the toileting program within the quarter.

Section H: Bladder and Bowel (7-day look back)

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 include:** • Program if only used by day (when documented that the resident does not want to be 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.

Section H: Bladder and Bowel (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
H0500 Bowel Toileting Program Restorative Nursing	~Rehabilitation ~Behavioral Symptoms and Cognitive Performance ~Reduced Physical Function	**Does require:** • Documentation of 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 individualized program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, and a written report; and • Documentation of resident's response to the toileting program within the quarter. **Does NOT include:** • Simply tracking of bowel continence status • Changing pads or soiled garments

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SECTION I:
ACTIVE DIAGNOSIS

Section I: Active Diagnosis (7-day and 60-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period

Active Diagnosis Definition:

A physician documented diagnosis (Optometrist, nurse practitioner, clinical nurse specialist, or physician assistant, in accordance with the provisions of State licensure laws and Medicare) in the last 60 days that have a direct relationship to the resident's current functional status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

There are two look-back periods for this section:

1) Diagnosis identification (Step 1) is a 60-day look-back period.
2) Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for I2300 UTI, which does not use the 7-day look-back period).

Does include:

- Functional limitations – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.
- Nursing monitoring – clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.)

Section I: Active Diagnosis (7-day and 60-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period

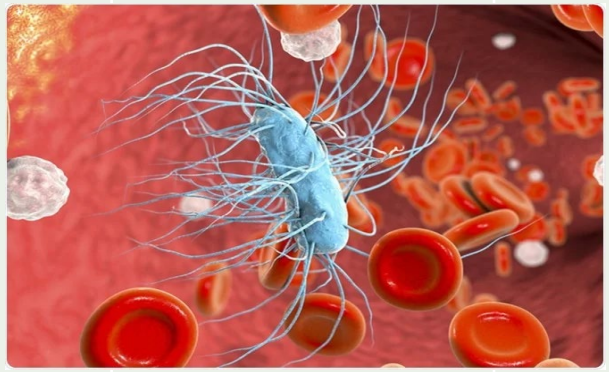
Active Diagnosis Definition:

Does NOT include:

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

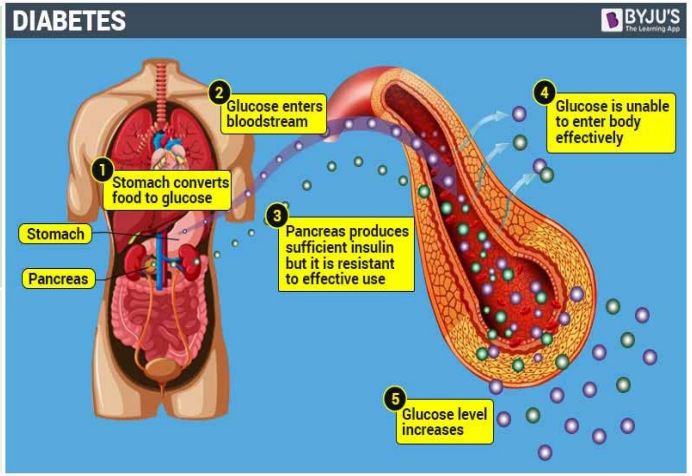
Section I: Active Diagnosis (7-day and 60-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
I2000 Pneumonia	~Special Care High ~Clinically Complex	See Active Diagnosis Definition
I2100 Septicemia	~Special Care High	See Active Diagnosis Definition

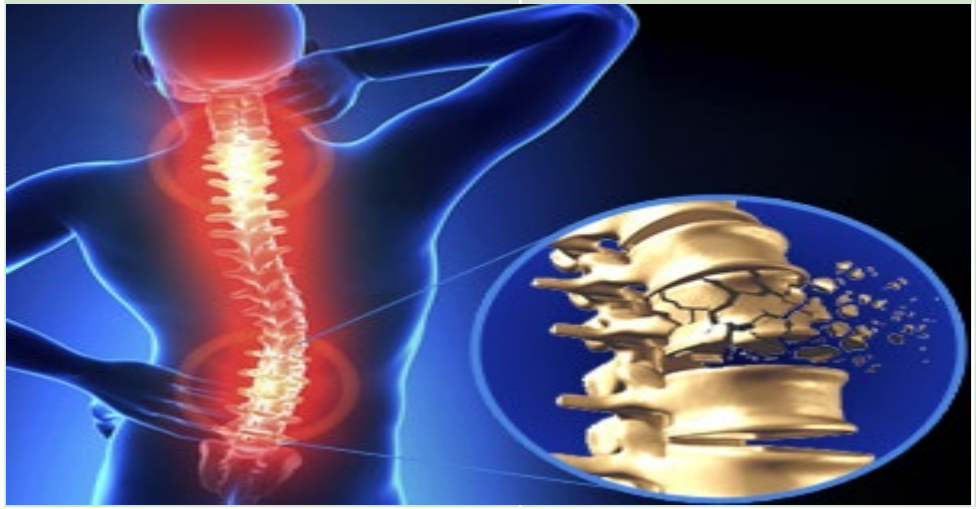


Section I: Active Diagnosis (7-day and 60-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
I2900 Diabetes Mellitus (DM)	~Special Care High	See Active Diagnosis Definition **Does include:** • Diabetic retinopathy • Nephropathy • Neuropathy
I4400 Cerebral Palsy	~Special Care Low	See Active Diagnosis Definition
I4900 Hemiplegia/ Hemiparesis	~Clinically Complex	See Active Diagnosis Definition **Does include:** • Left or right sided paralysis **Does not include:** • Left or right sided weakness



Section I: Active Diagnosis (7-day and 60-day look back)

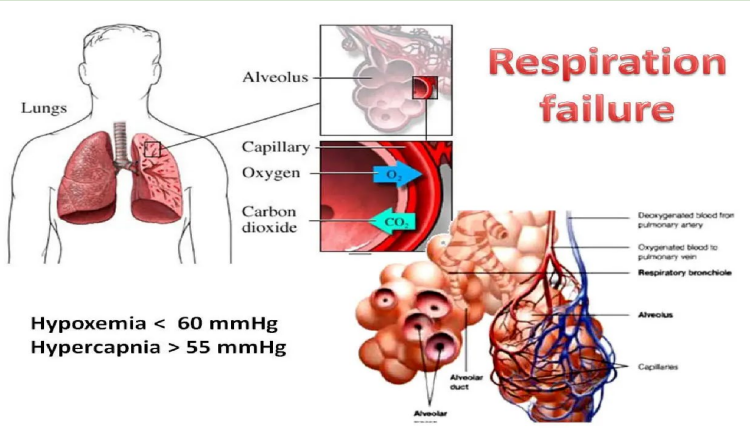
MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
I5100 Quadriplegia 	~Special Care High	See Active Diagnosis Definition **Does require:** • Physician documentation of an injury to the spinal cord resulting in total paralysis of all four limbs (arms and legs). **Does NOT include:** • Functional quadriplegia • Complete immobility due to severe physical disability or frailty that extends to all limbs.

Section I: Active Diagnosis (7-day and 60-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
I5200 Multiple Sclerosis (MS)	~Special Care Low	See Active Diagnosis Definition
I5300 Parkinson's Disease	~Special Care Low	See Active Diagnosis Definition **Does include:** • Paralysis agitans • Shaking palsy **Does NOT include:** • Parkinsonism

Section I: Active Diagnosis (7-day and 60-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	~Special Care High	See Active Diagnosis Definition **Does include:** • Chronic bronchitis • Restrictive lung diseases (such as asbestosis) **Does not include:** • Obesity hypoventilation syndrome
I6300 Respiratory Failure	~Special Care Low	See Active Diagnosis Definition



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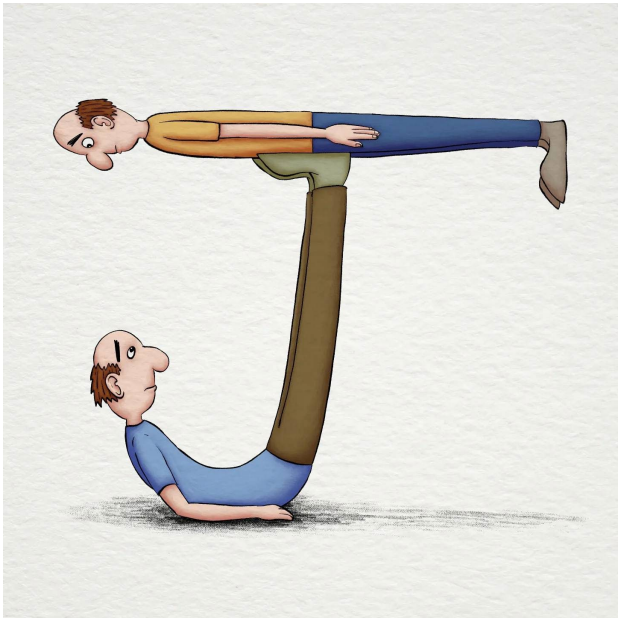
SECTION J:
HEALTH CONDITIONS



Section J: Health Conditions (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
J1100C Shortness of Breath or Trouble Breathing When Lying Flat	~Special Care High	**Does require:** • Documentation of the presence of or observation of shortness of breath or trouble breathing, including symptoms experienced, when lying flat during the observation period; OR • Documentation of staff interview including the date(s) staff reported resident experiencing shortness of breath or trouble breathing while lying flat and symptoms experienced; OR • Documentation indicating resident's avoidance of lying flat due to shortness of breath including interventions applied to avoid shortness of breath while lying flat during the 7-day look-back period.

Section J: Health Conditions (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
J1550A Fever	~Special Care High	**Does require:** • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established prior to the ARD. **Does include:** • A temperature of 100.4 degrees F. on admission (prior to the establishment of the baseline temperature).
J1550B Vomiting	~Special Care High	**Does require:** • Documentation of regurgitation of stomach contents.

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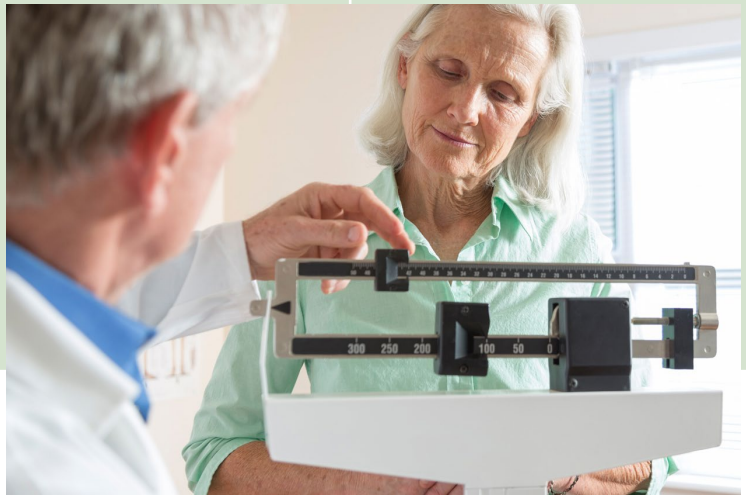
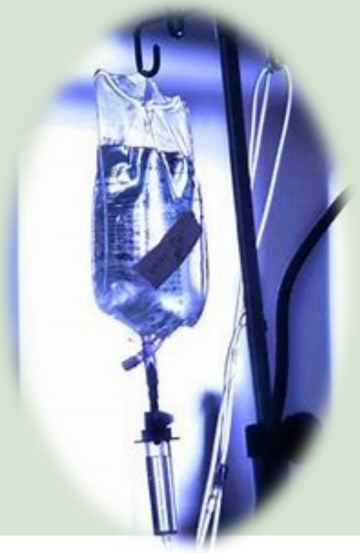
SECTION K: SWALLOWING/NUTRITIONAL

Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
K0300 (code 1 or 2) Weight Loss 	~Special Care High	**Does require:** • Documentation of resident's weight both 30 days and/or 180 days prior to the current weight during the observation period. • Documentation supporting the expressed goals for the weight loss for code of "1", on physician-prescribed weight loss regiment. **Does include:** • Mathematical rounding • Planned or unplanned • Weight loss via physician-prescribed weight loss regimen.

Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
K0510A (code 1 or 2) Parenteral / IV Feeding 	~Special Care High	**Does require:** • Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital, or as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. Does include: • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • IV fluids running at KVO (keep vein open). • IV fluids contained in IV piggybacks. • Hypodermoclysis and sub-q ports in hydration therapy. • IV fluids administered for the purpose of “prevention” of dehydration if specifically documented for nutrition and/or hydration.

Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
K0510A (code 1 or 2) Parenteral / IV Feeding	~Special Care High	**Does NOT include:** • IV medications. • IV fluids used to reconstitute and/or dilute meds. • 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.

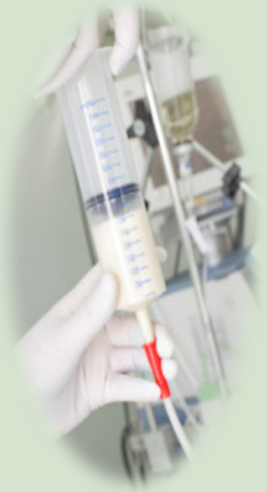
Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)

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:** • Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital, or as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. **Does include:** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes. • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the GI system.

Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
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:** • Documentation to support the proportion of calories actually received for nutrition and/or hydration through tube feeding or parenteral during the entire 7-day observation period Unless the resident is NPO documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include: 1. Calories tube feeding provided each day within observation period. 2. Calories oral feeding provided each day within observation period. 3. Percent of total calories provided by tube feeding within the observation period.

Section K: Swallowing/Nutritional (7-day look back) (K0300 only; 30-day and 180-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding Column 3 - During Entire 7 days	~Special Care High ~Special Care Low 	**Does require:** • Documentation to support average fluid intake per day by tube feeding or IV during the entire 7-day observation period. • Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include: 1. Adding the total amount of fluid received each day by tube feedings or IV feedings only. 2. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day (Divide by 7 even if the resident did not receive IV fluids or tube feeding on each of the 7 days.)

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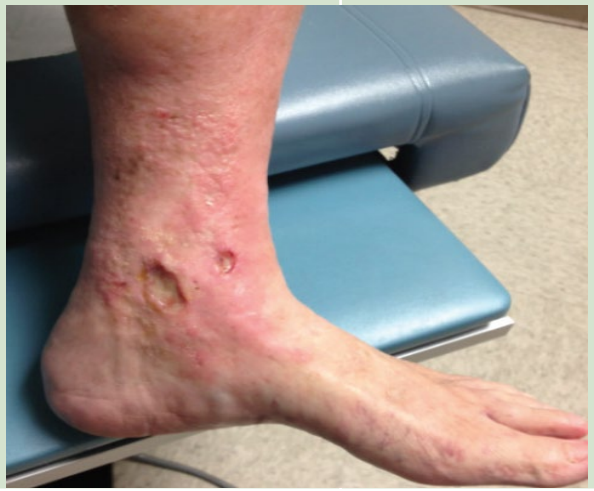
SECTION M:
SKIN CONDITIONS

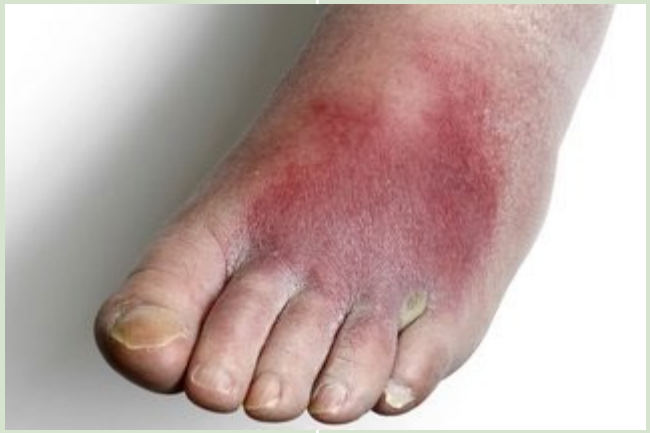
Section M: Skin Conditions
(7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M0300B1 Stage 2 M0300C1 Stage 3 M0300D1 Stage 4 M0300F1 Unstageable Due to Slough/Eschar	~Special Care Low	**Does Require:** • Documentation of healing pressure ulcer(s)/injuries must include descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) within the 7-day observation period, OR • Using a validated pressure ulcer healing tool • Documentation must include the complete history of the pressure ulcer(s)/injury when the reported stage is numerically higher than the current stage and description. **Does not include:** • Pressure ulcers/injuries that are healed during the look-back period. • A pressure ulcer/injury surgically repaired with a flap or graft. • If pressure is not the primary cause. • Oral mucosal ulcers caused by pressure (report at L0200C) • Skin tears, tape burns, moisture associated skin damage, or excoriation.

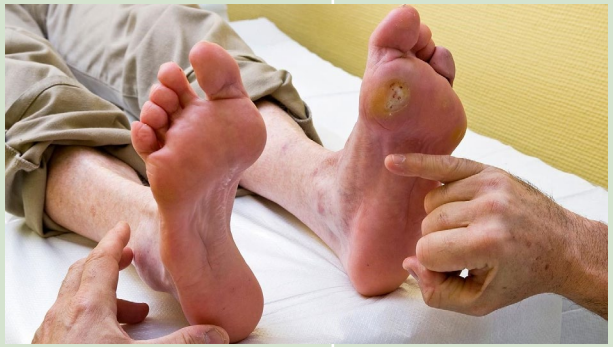
Section M: Skin Conditions *(7-day look back)*

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	**Does require:** • Description of the venous/arterial ulcer must include but is not limited to: identification of the wound as a venous/arterial ulcer, location and appearance. **Does not include:** • Pressure ulcers/injuries coded in M0210 through M0300.

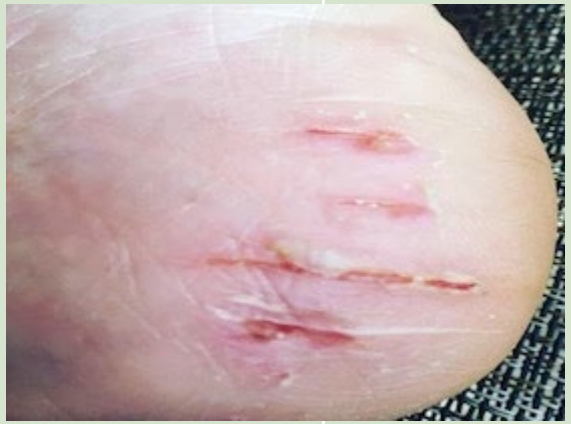
Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1040A Infection of the Foot 	~Special Care Low	**Does require:** • Documentation of signs and symptoms of infection of the foot. **Does include:** • Cellulitis • Purulent drainage **Does NOT include:** • Pressure ulcers/injuries coded in M0210 – M0300.

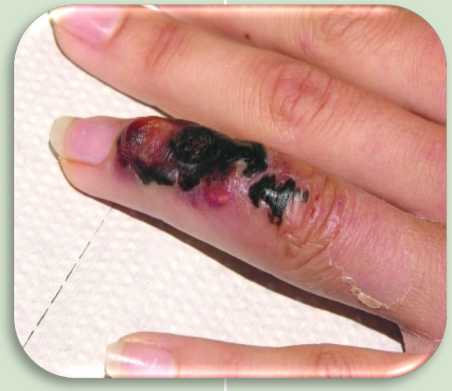
Section M: Skin Conditions *(7-day look back)*

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:** • Description of diabetic foot ulcer must include but is not limited to identification of the wound as a diabetic foot ulcer, location and appearance. **Does include:** • Ulcers caused by neuropathic and small blood vessel complications of diabetes. **Does not include:** • Pressure ulcers/injuries coded in M0210 – M0300 • Pressure ulcers/injuries that occur on the heel of a diabetic resident.

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1040C Other Open Lesion on the Foot, (e.g., cuts, ulcers, fissures) 	~Special Care Low	**Does require:** • Description of open lesion must include but is not limited to location and appearance. • Lesion must be open during the observation period. **Does NOT include:** • Pressure ulcers/injuries coded in M0210 - M0300

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1040D Open Lesion Other Than Ulcers, Rashes, Cuts 	~Clinically Complex	**Does require:** • Description of open lesion must include but is not limited to location and appearance. • Lesion must be open during the observation period. **Does include:** • Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item. **Does NOT include:** • Pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, skin tears, cuts/lacerations, abrasions or rashes.

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1040E Surgical Wound	~Clinically Complex	**Does require:** • Description of surgical wound must include but is not limited to identification of the wound as a surgical wound, location and appearance. **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/injury(s) 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/injuries that have been surgically debrided.

Section M: Skin Conditions *(7-day look back)*

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:** • Description of the second or third degree burn must include but is not limited to location and appearance. **Does include:** • May be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. **Does not include:** • First-degree burns (changes in skin color only).

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200A Pressure Reducing Device/chair **M1200B** Pressure Reducing Device/bed 	~Special Care Low	**Does require:** • Documentation substantiating use of equipment that aims to relieve pressure away from areas of high risk during the observation period. • A facility policy identifying use of pressure reducing/relieving/redistributing mattresses on all resident beds will be considered sufficient documentation for the bed device. **Does include:** • Foam, air, water, gel, or other cushioning. • Pressure relieving, reducing, and pressure redistributing devices. **Does NOT include:** • Egg crate cushions of any type • Doughnut or ring device.

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200C Turning/ Repositioning Program	~Special Care Low	**Does require:** • Documentation substantiating utilization of a program with specific approaches for changing the resident's position and realigning the body. • Documentation of specific program interventions (e.g. reposition on side, pillows between knees) and frequency. (Program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs). • Evaluation by the licensed nurse describing the resident's response to the program within the observation period.

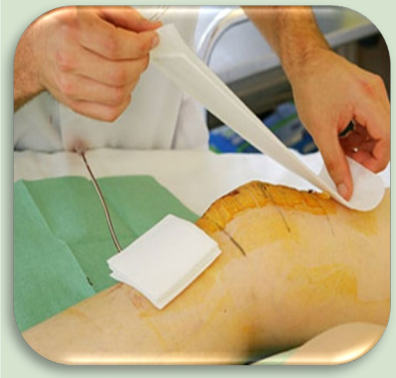
Section M: Skin Conditions *(7-day look back)*

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	**Does require:** • Documentation of an individualized nutritional assessment. • Documentation of 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 supplementation to prevent skin breakdown, high-protein diet supplementation for wound healing). **Does include:** • Vitamins and mineral supplements when administration is an intervention for managing a skin problem.

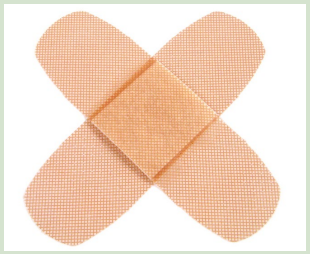
Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200E Pressure Ulcer Care	~Special Care Low	**Does require:** • Documentation of intervention(s) for treating pressure ulcers/injuries coded at M0300B, C, D, and F. **Does include:** • Use of topical dressing • Enzymatic, mechanical or surgical debridement • Wound irrigations • Negative pressure wound therapy (NPWT) • Hydrotherapy

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200F Surgical Wound Care 	~Clinically Complex	**Does require:** • Documentation of the intervention for treating or protecting any type of 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 • Pressure ulcers/injuries that require surgical intervention for closure (flap and/or graft coverage). **Does NOT include:** • Post-operative care following eye or oral surgery • Surgical debridement of pressure ulcer • Observation “only” of the surgical wound

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200G Application of Non-surgical Dressings (with or without medications) Other Than to Feet	~Special Care Low ~Clinically Complex 	**Does require:** • Documentation of the application of non-surgical dressing (with or without topical medications) to the body other than to the 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/injuries other than to feet; use pressure ulcer/injury care (M1200E) • Band-Aids • Wound closure strips

Section M: Skin Conditions *(7-day look back)*

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	**Does require:** • Documentation of application of ointments/medications (used to treat a skin condition) other than to the 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/injury care, item M1200E • Ointments used to treat non-skin conditions (e.g., nitropaste for chest pain)

Section M: Skin Conditions *(7-day look back)*

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
M1200I Applications of Dressings to Feet	~Special Care Low	**Does require:** • Documentation of dressing changes to the feet (with or without topical medication) • Interventions to treat any foot wound or ulcer other than a pressure ulcer/injury **Does NOT include:** • Dressings to pressure ulcers/injuries; use pressure ulcer/injury care (M1200E) • Dressing application to the ankle. (The ankle is not considered part of the foot).

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SECTION N: MEDICATIONS

Section N: Medications (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
N0350A Days of Insulin Injections	~Special Care High	**Does require:** • Documentation must be consistent with physician orders and insulin administration records. • Documentation must include the number of days that insulin injections were received by the resident. **Does include:** • The number of days the resident actually required subcutaneous injection to restart the insulin pump.
N0350B Days of Orders for Insulin	~Special Care High	**Does require:** • Documentation must include the number of days that the insulin orders changed during the observation period. **Does include:** • Sliding scale order that is new, discontinued or is the first sliding scale order **Does NOT include:** • A sliding scale dosage schedule that is written to cover different dosages depending on lab values simply because a different dose is administered based on the current sliding scale guidelines.

SECTION O: SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
OO0100 Special Treatments, Procedures and Programs	**Informational Only**	**Does include:** • Special treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. • Items “while a resident” ONLY. **Does not include:** • Services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure, such as IV medications or ventilators. • Surgical procedures including routine pre- and post-operative procedures.

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100A Chemotherapy 	~Clinically Complex	**Does require:** • Documentation of administration of any type of chemotherapy agent (anti-cancer) given by any route for the sole purpose of cancer treatment. **Does not include:** • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer.

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100B Radiation 	~Special Care Low	**Does require:** • Documentation of administration of radiation therapy inside or outside of facility. **Does include:** • Intermittent radiation therapy • Radiation administered via radiation implant

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100C Oxygen Therapy	~Special Care Low ~Clinically Complex	**Does require:** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. **Does include:** • Resident places or removes his/her own oxygen mask, cannula • Oxygen when used in BiPAP/CPAP **Does NOT include:** • Hyperbaric oxygen for wound therapy

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100E Tracheostomy Care	~Extensive Services	**Does require:** • Documentation of cleaning of tracheostomy and/or cannula cleansing. **Does include:** • Changing a disposable cannula • Resident performing his/her own tracheostomy care

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100F Ventilator or Respirator	~Extensive Services	**Does require:** • Documentation substantiating utilization of any type of electrically or pneumatically powered closed system mechanical ventilator support device. **Does include:** • Any resident being weaned off the ventilator or respiratory during the observation period. • Any resident who was weaned from the respiratory or ventilator in the last 14 days. **Does NOT include:** • Times when used as a substitute for BiPAP or CPAP

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100H IV Medications	~Clinically Complex	**Does require:** • Documentation of the administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port. **Does include:** • Epidural, intrathecal, and baclofen pumps **Does NOT include:** • Flushes to keep an IV port patent • IV fluids without medication • Subcutaneous pumps • IV medications administered during dialysis or chemotherapy • Dextrose 50% and/or Lactated Ringers • IV medication during ECT treatment

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100I Transfusions 	~Clinically Complex	**Does require:** • Documentation of the administration of blood or any blood products (e.g. platelets, synthetic blood products) directly into the bloodstream. **Does NOT include:** • Transfusions administered during dialysis or chemotherapy

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100J, 2 Dialysis 	~Special Care Low	**Does require:** • Documentation of the administration of peritoneal or renal dialysis that occurred inside or outside facility. • Documentation should indicate that the resident actually received the dialysis and not just left the building (or remained in the building) with the intent to receive dialysis. **Does include:** • Hemofiltration • Slow Continuous Ultrafiltration (SCUF) • Continuous Arteriorvenous Hemofiltration (CAVH) • Continuous Ambulatory Peritoneal Dialysis (CAPD) • Resident performing his/her own dialysis **Informational:** • IV, IV medication and blood transfusion administered during dialysis are considered part of the dialysis procedure and are NOT to be coded under items K051A (Parenteral/IV feeding), O0100H (IV medications), or O0100I (Transfusions)

Section O: Special Treatments, Procedures, and Programs (14-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0100M Isolation or Quarantine for Active Infectious Disease 	**~Extensive Services**	Code for "Single Room Isolation" only when all four of the following conditions are documented in the medical record: 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. Transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 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 a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4. Must remain in room. All services must be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

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 medically necessary therapies that occurred after admission/readmission to the facility that were:
  1) Ordered by a physician (or other licensed professional as allowed by state law) based on a qualified therapist's assessment and treatment plan
  2) Documented in the resident's medical record
  3) Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective
- Therapy services may occur inside or outside the facility
- Services be preceded by an evaluation prior to the start of skilled therapy
- Resident's individualized assessment of the clinical condition demonstrates that the specialized judgement, knowledge, and skills of a qualified therapist are necessary for the performance of the services.
- Services are reasonable and necessary for condition.

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) time
- Nursing restorative services time
- Therapy provided prior to an admission
- When services can be safely and effectively performed by supportive personnel, without the supervision of a licensed therapist, does NOT constitute skilled therapy
- Services involving activities for the general good and welfare of the resident does NOT constitute therapy.

O0400 - Therapies (7-day look back)

Minutes of Therapy Requirements

Does require:

- Only skilled therapy minutes reported on the MDS
- Only skilled services after the initial 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
- Physician order, treatment plan and assessment
- RTM minutes with associated initials/signature(s) on a daily basis to support the total number of RTM minutes or actual therapy provided.
- Associated initials/signature(s) on a daily basis to support the total number of minutes each therapy modality was provided.

Does include:

- Therapist time spent on subsequent reevaluations conducted as part of the treatment process
- Time required adjusting equipment or otherwise preparing for individualized therapy
- Family education when the resident is present and is documented
- Set-up time
- Therapy services provided inside or outside the nursing facility

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 is not classified as skilled
- SLP assistant time
- Unattended e-stim minutes
- Concurrent minutes reported for a resident under Part B
- Group minutes for less than 2-6 participants
- Therapy minutes while an inpatient at a hospital or rehabilitation center.

O0400 - Therapies (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
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 each therapy modality was provided. • Treatment minimum of 15 direct minutes or more per day. 

O0400 - Therapies (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0420 Distinct Calendar Days of Therapy	~Rehabilitation	**Does require:** • Documentation of the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy or Physical Therapy for at least 15 direct therapy minutes during the observation period. **Does NOT include:** • The count of more than one day when multiple therapy disciplines provide services on the same calendar day.

O0400 - Therapies (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0400D Respiratory Therapy Days	~Special Care High	**Does require:** • Only medically necessary therapies that occurred after admission/readmission to the facility that were: 1. Ordered by a physician (or other licensed professional as allowed by state law) based on a qualified therapist's assessment and treatment plan 2. Documented in the resident's medical record 3. Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective • Therapy services may occur inside or outside the facility • Documentation of minutes that the respiratory therapist or respiratory nurse spends with the resident conducting the actual respiratory therapy treatment including the set-up and removal of treatment equipment. • Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided. • Respiratory evaluation during the observation period by a respiratory therapist or a trained respiratory nurse. • **A respiratory nurse must be proficient in the modalities provided either through formal nursing or specific training and may deliver these modalities as allowed under the State Nurse Practice Act and under applicable state laws.**

O0400 - Therapies (7-day look back)

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
O0400D Respiratory Therapy Days	~Special Care High	**Does include:** • Coughing, deep breathing, heated nebulizers, assessing breath sounds and mechanical ventilation, etc. **Does NOT include:** • Treatment for less than 15 minutes per day • Metered-dose and/or dry powder inhalers • Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse. **At a Minimum:** • **Documentation must indicate that the individual nurse is trained and proficient in the listed modalities (prior to the ARD) and that the activities performed during time reported as respiratory therapy on the MDS is within that nurse's scope of practice.** • Facilities may wish to include these activities in the initial orientation and/or annual skills validation.

O0500 – Restorative Nursing (7-day look back)

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	**Does require:** • Documentation of actual direct minutes on a daily/shift/occurrence basis for each restorative program. • Associated initials/signature(s) on a daily basis to support the total number of minutes of restorative nursing program(s) provided. • Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented. • Time must be provided separately for each restorative program. • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1. Measurable objectives and interventions must be documented in the care plan and in the medical record; and 2. Evaluation of the program by a licensed nurse. (For the case mix review, reassess progress, goals and duration/frequency of each program within the observation period.); and 3. Staff trained in the proper techniques; and 4. Supervised by licensed nurse; and 5. No more than 4 residents per supervising helper or caregiver. • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device within the observation period.

O0500 – Restorative Nursing (7-day look back)

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	**Does include:** • An evaluation of the program written by a CNA and co-signed by a licensed nurse once the purpose and objectives of treatment have been established. (Contingent on state rules) **Does NOT include:** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • For both active and passive range of motion movement by a resident that is incidental to care does not count as part of a formal restorative nursing program. • Treatment for less than 15 direct minutes per day.

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SECTION Z: ASSESSMENT ADMINISTRATION

Section Z: Assessment Administration

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period
Z0400	Signature of Persons Completing the Assessment or Entry/Death Reporting	**Does require:** • All persons who completed any part of the MDS must enter their signatures, titles, sections or portion(s) they completed and the date completed. • If an individual is unable to sign, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. • For interview sections, whereby the individual is unable to sign, the person signing the attestation should interview the resident to ensure accuracy and sign on the date this verification occurred.

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Thank you!