Minimum Data Set Supportive Documentation Guidelines
RUG-III, Version 5.12, 34 Grouper
June 1, 2012

Overall documentation instructions

- Supportive documentation in the medical record must be dated during the assessment reference period to support the MDS 3.0 responses. The assessment reference period is established by identifying the assessment reference date (A2300) and the previous six days or 13 days, depending on the instructions in the *Resident Assessment Instrument (RAI) Manual* on the cms.gov website (Home > Medicare > Nursing Home Quality Initiative > MDS 3.0 RAI Manual).

- The Assessment Reference Date (ARD) is defined on page A-23 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. Most frequently, this look-back period, also called the observation period or assessment period, is a seven-day period ending on the ARD. Look-back periods may cover the seven days ending on this date, 14 days ending on this date, and so on. For purposes of this document, the look-back time period ending on the ARD will be referred to as the observation period.

- Each page or individual document in the medical record must contain the resident identification information.

- Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all medical 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 (that is, on the MDS). When electronic signatures are used, there must be policies to identify those who are authorized to sign electronically, and safeguards must be in place to prevent unauthorized use of electronic signatures.

- Multipage supportive documentation forms completed by one staff member may be signed and dated at the end of the form, given each page is identified with the resident's identification information and the observation period is clearly designated on the form (with the exception of activities of daily living—ADLs).

- Corrections/Obliterations/Errors/Mistaken Entries: At a minimum, the audit teams must see one line through the incorrect information, the staff's initials, the date the correction was made, and the correct information.

- Changes to the Electronic Health Record—The following information is based on the article citation: Quinsey, Carol Ann. "Is 'Legal EHR' a Redundancy?" *Journal of American Health Information Management Association* (AHIMA) 78, no. 2 (February 2007): 56-57:
  - Error correction in the electronic record applies the same principles as those for the paper medical record. Some indication that a previous version of the entry exists must be present to the caregiver or other person viewing the entry. Management of revisions, although challenging in some Electronic Health Records (EHRs), is imperative and must be appropriate to maintain a legally sound record.

  - Late entries into a health record represent another issue that must be addressed as the EHR system is set up. Late entries may be counted in days, months, or even years, but as soon as it is determined that something was missed or incorrect in the original record, a late entry note should be permitted by the EHR system. Such entries should be clearly labeled as late entries and contain the current date, time, and authorized signature. Amendments are a form of late entry. These may be updates or corrections provided by the patient or caregiver. Again, these updates or corrections should be clearly labeled as an addendum or amendment, and include the current date, time, and authorized signature.

  - Healthcare organizations should outline a policy for who is authorized to make amendments and late entries, and to correct errors. Procedure should clearly dictate how these changes to an EHR are made.

Note: This document contains RAI instructions current as of April 1, 2012. Please refer periodically to the Centers for Medicare & Medicaid Services (CMS) website at cms.gov for updates to the RAI instructions.

MDS 3.0, Version 5.12, 34 Grouper, Effective for Assessments Dated on or after June 1, 2012			
MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
B0100 Comatose **(7-day look back)**	-Clinically Complex (contributes to the Extensive Services count) -Impaired Cognition (contributes to the Extensive Services count)	Includes only a diagnosis of coma or persistent vegetative state. For example, some residents in advanced stages of progressive neurologic disorders such as Alzheimer's disease may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here.	Documented neurological diagnosis of coma or persistent vegetative state from physician, nurse practitioner, physician assistant, or clinical nurse specialist not employed by the facility.
B0700 Makes Self Understood **(7-day look back)**	-Impaired Cognition -(contributes to the Extensive Services count)	The resident's ability 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. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing and/or gesturing.	Documented example of resident's ability to make self understood and method or tools used.
C0200 Repetition of Three Words **(7-day look back)**	-Impaired Cognition -(contributes to the Extensive Services count)	The maximum number of words that the resident correctly repeated on the first Brief Interview for Mental Status (BIMS) attempt.	MDS will be considered source document. Evidence of interview during the look-back period must be present.
C0300A,B,C Temporal Orientation – Year, Month, **Day** **(7-day look back)**	-Impaired Cognition (contributes to the Extensive Services count)	In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings. Ability to report correct year, month and day of the week.	MDS will be considered source document. Evidence of interview during the look-back period must be present.

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C0400A,B,C Recall **(7-day look back)**	-Impaired Cognition (contributes to the Extensive Services count)	The ability to recall each of the three words the resident was asked to repeat earlier in Item C0200 with cueing, if necessary.	MDS will be considered source document. Evidence of interview during the look-back period must be present.
C0700 Short-Term Memory Ok **(7-day look back)**	-Impaired Cognition (contributes to the Extensive Services count)	Based on all information collected regarding the resident's short-term memory during the 7-day look-back period, identify and code according to the most representative level of function.	Documented example of the resident's short-term memory status such as ability to describe an event 5 minutes after it occurred or follows through on a direction given 5 minutes earlier. (See RAI Manual for examples).
C1000 Cognitive Skills for Daily Decision Making **(7-day look back)**	-Impaired Cognition (contributes to the Extensive Services count)	Daily decision making includes choosing clothing; knowing when to go to meals; using environmental cues to organize and plan, in the absence of environmental cues seeking information appropriately from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events; acknowledging need to use appropriate assistive equipment such as a walker. The intent of this item is to record what the resident is doing (performance).	Documented example of the resident's ability to make decisions about tasks of everyday living. (See RAI Manual for examples).

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D0200A-I, 2 Resident Mood Interview (PHQ-9©) **(14-day look back)**	-Clinically Complex (PHQ-9© Resident or Staff Assessment score of 10 or greater is considered depressed)	9-Item Patient Health Questionnaire (PHQ-9©) is a validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. Record the resident's responses as they are stated, regardless of whether the symptoms are attributed to something other than mood. Conduct the interview preferably the day before or the day of the ARD.	Resident Mood Interview (PHQ-9©) symptom frequency codes are sufficient. MDS will be considered source document.
D0500A-J, 2 Staff Assessment of Resident Mood (PHQ-9-OV©) **(14-day look back)**	-Clinically Complex (PHQ-9© Resident or Staff Assessment score of 10 or greater is considered depressed)	Staff should complete the PHQ-9-OV© Staff Assessment of Mood, when patients are unable or unwilling to complete the PHQ-9© Resident Mood Interview so that any behaviors, signs, or symptoms of mood distress are identified. (See RAI Manual for interview tips).	Documented examples demonstrating the presence and frequency of clinical mood indicators must be provided during the observation period.
E0100A Hallucinations **(7-day look back)**	-Behavior Problems	The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.	Documented example of the hallucination(s) during the observation period.
E0100B Delusions **(7-day look back)**	-Behavior Problems	A fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary.	Documented example of the delusion(s) during the observation period.

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E0200A Physical behavioral symptoms directed toward others **(7-day look back)**	-Behavior Problems	The presence of symptoms that occurred and their frequency. These symptoms are not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.	Documented evidence of the resident's specific physical behavioral symptoms and frequency of occurrence. Frequency may be determined by a tracking tool/log and/or by narrative notes describing the resident's specific behavior.
E0200B Verbal behavioral symptoms directed toward others **(7-day look back)**	-Behavior Problems	The presence of symptoms that occurred and their frequency. These symptoms are not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.	Documented evidence of the resident's specific verbal behavioral symptoms and frequency of occurrence. Frequency may be determined by a tracking tool/log and/or by narrative notes describing the resident's specific behavior.
E0200C Other behavioral symptoms not directed toward others **(7-day look back)**	-Behavior Problems	The presence of symptoms that occurred and their frequency. These symptoms are not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.	Documented evidence of the resident's specific behavioral symptoms and frequency of occurrence. Frequency may be determined by a tracking tool/log and/or by narrative notes describing the resident's specific behavior.

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E0800 Rejection of Care – Presence and Frequency **(7-day look back)**	-Behavior Problems	The resident's care preferences reflect desires, wishes, inclinations, or choices for care. Preferences do not have to appear logical or rational to the clinician. Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment." Determine whether a previous discussion identified an objection to the type of care or the way in which the care was provided.	Documented evidence of the resident's rejection of care and frequency of occurrence. Frequency may be determined by a tracking tool/log and/or by narrative notes describing the resident's specific behavior.
E0900 Wandering – Presence and Frequency **(7-day look back)**	-Behavior Problems	Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place without a specified course or known direction. Wandering may be aimless. The behavior may or may not be driven by confused thoughts or delusional ideas. Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering. Wandering may occur even if resident is in a locked unit.	Documented evidence of the resident's wandering behavior and frequency of occurrence. Frequency may be determined by a tracking tool/log and/or by narrative notes describing the resident's specific behavior.

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G0110A, 1&2 **G0110B, 1&2** **G0110I, 1&2** **G0110H, 1** Activities of Daily Living (ADL) Assistance **(7-day look back)**	-All -included in Coma string impacting Extensive Services count in Clinically Complex and Impaired Cognition	These four ADLs include bed mobility, transfer, toileting, and eating. Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.	Documentation of these ADLs requires 24 hours/7 days within the observation period while in the facility. There must be signatures/initials (more than one set) and dates to authenticate the services provided. If using an ADL grid for supporting documentation, the key for self-performance and support provided must be equivalent in definition to the MDS key.

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H0200C Current Toileting Program or Trial **(7-day look back)**	-Nursing Restorative program count	Current Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene. (– See RAI Manual for Coding Tips for H0200A-C) Documentation in the medical record must show that the following three requirements have been met: • implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern; • evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and • Notations of the resident's response to the toileting program and subsequent evaluations, as needed.	Documented assessment of resident's unique voiding pattern attempted on admission/reentry or since incontinence was noted. Documented resident-specific program (e.g. care plan, flow records). Notations of resident's progress towards the program goal must be documented during the observation period. Evidence the program was carried out 4 or more days during the observation period.

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H0500 Bowel Toileting Program **(7-day look back)**	-Nursing Restorative program count	Documentation in the medical record must show that the following three requirements have been met: • implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern; • evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and • Notations of the resident's response to the toileting program and subsequent evaluations, as needed.	Documentation of a bowel toileting program. Evidence of the three requirements having been met. Notations of resident's progress towards the program goal must be documented during the look-back period.
I2000 Pneumonia **(7-day look back)**	-included in Fever string impacting Special Care (contributes to the Extensive Services count) -Clinically Complex (contributes to the Extensive Services count)	Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.	Active diagnosis signed by the physician. Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples).
I2100 Septicemia **(7-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.	Active diagnosis signed by the physician. Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples).

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I2900 Diabetes Mellitus **(7-day look back)**	included in the Diabetes string impacting Clinically Complex (contributes to the Extensive Services count)	A physician-documented diagnosis in the last 60 days. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. There are two look-back periods for this section: • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period.	Active diagnosis signed by the physician within the past 60 days (plus 10 day grace period permitted by 410 IAC 16.2-3.1-22(d) (2). Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples). Documentation must relate to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.
I4300 Aphasia **(7-day look back)**	-impacting the Feeding Tube string in Special Care (contributes to the Extensive Services count)	A physician-documented diagnosis in the last 60 days. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. There are two look-back periods for this section: • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period.	Active diagnosis signed by the physician within the past 60 days (plus 10 day grace period permitted by 410 IAC 16.2-3.1-22(d) (2). Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples). Documentation must relate to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.

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I4400 Cerebral Palsy **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	A physician-documented diagnosis in the last 60 days. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. There are two look-back periods for this section: • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period.	Active diagnosis signed by the physician within the past 60 days (plus 10 day grace period permitted by 410 IAC 16.2-3.1-22(d) (2). Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples). Documentation must relate to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.

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I4900 Hemiplegia/ Hemiparesis **(7-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	A physician-documented diagnosis in the last 60 days. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. There are two look-back periods for this section: • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period.	Active diagnosis signed by the physician within the past 60 days (plus 10 day grace period permitted by 410 IAC 16.2-3.1-22(d) (2). Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples). Documentation must relate to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.
I5100 Quadriplegia **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	A physician-documented diagnosis in the last 60 days. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. There are two look-back periods for this section: • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period.	Active diagnosis signed by the physician within the past 60 days (plus 10 day grace period permitted by 410 IAC 16.2-3.1-22(d) (2). Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples). Documentation must relate to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.

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I5200 Multiple Sclerosis **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	A physician-documented diagnosis in the last 60 days. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. There are two look-back periods for this section: • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period.	Active diagnosis signed by the physician within the past 60 days (plus 10 day grace period permitted by 410 IAC 16.2-3.1-22(d) (2). Documentation supporting that the diagnosis was active during the 7- day look-back period. (See RAI Manual for examples). Documentation must relate to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.

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J1550A Fever **(7-day look back)**	-included in Fever string impacting Special Care (contributes to the Extensive Services count)	Recorded temperature 2.4 degrees higher than the baseline temperature. The resident's baseline temperature should be established prior to the ARD. A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.	Documentation of the resident's baseline temperature established prior to the ARD. Documentation of recorded temperature of at least 2.4 degrees higher than the baseline temperature. OR Documentation of a recorded temperature of 100.4 degrees F (38 degrees C) on admission prior to establishment of the baseline temperature.
J1550B Vomiting **(7-day look back)**	-included in Fever string impacting Special Care (contributes to the Extensive Services count)	Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).	Documented evidence of regurgitation of stomach contents.

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J1550C **Dehydrated** **(7-day look back)**	-included in Fever string impacting Special Care (contributes to the Extensive Services count) -Clinically Complex (contributes to the Extensive Services count)	The resident has two or more of the following indicators: 1. Resident usually takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards. 2. Resident has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity). 3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).	Documentation of two or more of the three indicators.
J1550D **Internal Bleeding** **(7-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nosebleeds that are easily controlled should not be coded in internal bleeding.	Documented evidence of internal bleeding.

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K0300 Weight Loss **(30 and 180-day look back)**	-included in Fever string impacting Special Care (contributes to the Extensive Services count)	This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time: • At a point closest to 30-days preceding the current weight. • At a point closest to 180-days preceding the current weight. This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight gain or loss assessed and addressed on the care plan as necessary. Use mathematical rounding to determine the resident weight.	Documentation of -Current weight closest to the observation period within the past 30 days. -Weight at a point closest to the 30 days preceding the current weight. -Weight at a point closest to the 180 days preceding the current weight.

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K0510A, 1 or 2 Parenteral/IV **(7-day look back)**	-Extensive Services count -included in ADL calculation	Parenteral/IV feeding—The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition and hydration need. This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy: — IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently — IV fluids running at KVO (Keep Vein Open) — IV fluids contained in IV Piggybacks — Hypodermoclysis and subcutaneous ports in hydration therapy — Do NOT include: • IV Medications—Code these in (O0100H) IV medication. • IV fluids administered solely for the purpose of "prevention" of hydration. Active diagnosis of dehydration must be present in order to code this fluid in K0500A. • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.	Administration records must be available within the observation period. If administration occurs at a hospital as an outpatient or an inpatient, a hospital administration record or other evidence of administration must be provided. Must provide evidence of fluid being administered for nutrition or hydration, such as a physician order noting this as the reason, or a nurse's note documenting the need to rehydrate.

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K0510B, 1 or 2 Feeding Tube **(7-day look back)**	-included in ADL calculation -Extensive Services count in Special Care (as part of the Fever string or w/Aphasia) -Special Care (as part of the Fever string or w/Aphasia)	Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.	Documented evidence of feeding tube that can deliver nutrition must be included in the record within the observation period. If administered outside of facility, evidence of administration record must be provided within the observation period.

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K0700A Proportion of Total Calories the resident received through parenteral or tube feeding **(7-day look back)**	-included in ADL calculation -Special Care (w/Feeding Tube) -Clinically Complex(w/Feeding Tube)	Calculation of the proportion of total calories received through parenteral or tube feeding routes.	Documentation must support the proportion of all calories actually received for nutrition or hydration through parenteral or tube feeding. ***For residents receiving P.O. nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include:*** ***1) Calories tube feeding provided during observation period*** ***2) Calories oral feeding provided during the observation period*** ***3) Percent of total calories provided by tube feeding*** ***4) Calories by tube/total calories consumed***

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K0700B Average Fluid Intake Per Day by IV or Tube Feeding **(7-day look back)**	-included in ADL calculation -Special Care (w/Feeding Tube) -Clinically Complex(w/Feeding Tube)	The average number of cc's of fluid the resident received per day by IV or tube feeding. Record what was actually received by the resident, not what was ordered.	Documentation of administration of actual fluid intake via IV or tube feeding must be included in the record within the observation period.
M0300A Number of Stage 1 Pressure Ulcers **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.	Documentation must include staging of the pressure ulcer(s) within the observation period. Each ulcer should have an entry noting observation date, location and measurement/description.
M0300B,1-Number of Stage 2 **M0300C,1-**Number of Stage 3 **M0300D,1-**Number of Stage 4 **M0300F,1-** Number of Unstageable **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement. Identify Unstageable Pressure Ulcers. Pressure ulcers that are covered with eschar or necrotic tissue should be coded as unstageable until debridement of enough necrotic tissue has occurred such that the depth of the tissue layers involved in the wound can be determined.	Documentation must include staging of the pressure ulcer(s) within the observation period. Each ulcer should have an entry noting observation date, location and measurement/description.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
M1030 Number of Venous and Arterial Ulcers **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	Venous Ulcers are ulcers caused by peripheral venous disease, which most 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 ulcers caused by peripheral arterial disease, which commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus.	Documentation must include description of the ulcer(s) within the observation period. Each ulcer should have an entry noting observation date, location and measurement/description.
M1040A Infection of the foot (e.g., cellulitis, purulent drainage) **(7-day look back)**	-Clinically complex (contributes to the Extensive Services count	Pressure ulcers coded in M0200 through M0900 should NOT be coded here.	Documentation must include description of the infection within the observation period.
M1040B Diabetic Foot Ulcer **(7-day look back)**	-Clinically complex (contributes to the Extensive Services count)	Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful. Pressure ulcers coded in M0200 through M0900 should NOT be coded here.	Documentation must include description of the ulcer(s) within the observation period. Each ulcer should have an entry noting observation date, location and measurement/description.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
M1040C Other Open Lesion on the Foot **(7-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Pressure ulcers coded in M0200 through M0900 should NOT be coded here.	Documentation must include description of the open lesion(s) within the observation period. Each open lesion should have an entry noting observation date, location and measurement/description.
M1040D Open Lesion(s) other than ulcers, rashes, cuts **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears, cuts, or abrasions here. Although not recorded on the MDS assessment, these open lesions need to be addressed in the care plan. Pressure ulcers coded in M0200 through M0900 should NOT be coded here.	Documentation must include description of the open lesion(s) within the observation period. Each open lesion should have an entry noting observation date, location and measurement/description.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
M1040E Surgical Wound(s) **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites and stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds. Do not code pressure ulcers that have been surgically debrided as surgical wounds. They continue to be coded as pressure ulcers. This coding is appropriate for pressure ulcers that are surgically repaired with grafts and flap procedures.	Documentation must include description of the surgical wound(s) within the observation period. Each surgical wound should have an entry noting observation date, location and measurement/description.
M1040F Burn(s) **(7-day look back)**	-Clinically complex (contributes to the Extensive Services count)	Second or Third degree burns only. Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.	Documentation must include description of the burn/affected area(s) within the observation period. Entry should include observation date, location and description.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
M1200A,B Pressure-Reducing Device for chair, bed **(7-day look back)**	-Special Care impacting strings with staged wounds (contributes to the Extensive Services count)	Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating. Do not include egg crate cushions of any type in this category. Do NOT include doughnut or ring devices in chairs.	Evidence proving pressure-relieving, pressure-reducing, and pressure-redistributing devices. Documentation at least once within the observation period must be noted in the chart for resident specific devices. Facilities providing pressure-reducing mattresses for all beds should have a documented policy noting such in their policy and procedure manual.
M1200C Turning/ repositioning program **(7-day look back)**	-Special Care impacting strings with staged wounds (contributes to the Extensive Services count)	Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.	Requirements: 1) program must be care planned, 2) recorded daily within the observation period, and 3) documentation is made describing and evaluating the effectiveness of interventions (i.e. program) within the observation period. The resident's response must be noted within the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
M1200D Nutrition or hydration intervention to manage skin problems **(7-day look back)**	-Special Care impacting strings with staged wounds (contributes to the Extensive Services count)	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.	Documentation of the intervention administration must be noted in the chart at least once within the observation period.
M1200E Pressure Ulcer Care **(7-day look back)**	-Special Care impacting strings with staged wounds (contributes to the Extensive Services count)	Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300). Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, wound vacuum assisted closure (VAC), and/or hydrotherapy.	Documentation of treatment (care) must be noted in the chart at least once within the observation period.
M1200F Surgical Wound Care **(7-day look back)**	-Special Care impacting strings with surgical wounds (contributes to the Extensive Services count)	Do not include post-operative care following eye or oral surgery. Surgical debridement of a pressure ulcer continues to be coded as a pressure ulcer. Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.	Documentation of treatment (hands on care, not just observation) of the surgical wound area or dressing must be noted at least once within the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
M1200G Application of non-surgical dressings (other than to feet) **(7-day look back)**	-Special Care impacting strings with staged wounds and surgical wounds (contributes to the Extensive Services count)	Evidence of any type of dressing application (with or without topical medications) other than to feet. Do not code dressing for pressure ulcer on the foot in this item; use Ulcer Care item (M1200E). This category may include dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.	Documentation of treatment (care) must be noted in the chart at least once within the observation period.
M1200H Application of ointments/ medications other than to feet **(7-day look back)**	-Special Care impacting strings with staged wounds and surgical wounds (contributes to the Extensive Services count)	Includes ointments or medications used to treat a skin condition. (e.g., cortisone, antifungal preparations, chemotherapeutic agents). Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. This definition does not include ointments used to treat non-skin conditions. (e.g., nitropaste for chest pain)	Documentation of treatment (care) must be noted in the chart at least once within the observation period.
M1200I Application of dressings to feet(with or without topical medications) **(7-day look back)**	-Clinically Complex impacting strings with skin conditions of the foot (contributes to the Extensive Services count)	Includes interventions to treat any foot wound or ulcer other than a pressure ulcer. For pressure ulcers on the foot, use Ulcer Care item (M1200E).	Documentation of treatment (care) must be noted in the chart at least once within the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
N0300 Injections **(7-day look back)**	-Clinically Complex impacting Diabetes string (contributes to the Extensive Services count)	The number of days during the 7-day look-back period (or since admission/reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection. Insulin injections are counted in this item as well as in Item N0350.	Documentation of the number of days injection(s) were administered must be noted in the chart within the observation period.
O0100A, 1 or 2 Chemotherapy **(14-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Any type of chemotherapy agent administered as an antineoplastic given by any route. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment.	If administered outside of facility, evidence of administration record must be provided within the observation period.
O0100B, 1 or 2 Radiation **(14-day look back)**	-Special Care (contributes to the Extensive Services count)	Intermittent radiation therapy, as well as, radiation administered via radiation implant.	If administered outside the facility, evidence of procedure occurring within the observation period must be provided.
O0100C, 1 or 2 Oxygen Therapy **(14-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia; includes oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item.	Documentation of oxygen administration must be noted in the record within the observation period.
O0100D, 1 or 2 Suctioning **(14-day look back)**	-Extensive Services (not impacting the count)	Only tracheal and/or nasopharyngeal suctioning are included in this item. Do not code oral suctioning here.	Documentation must be noted in the record within the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
O0100E, 1 or 2 Tracheostomy Care **(14-day look back)**	-Extensive Services (not impacting the count)	Includes cleansing of the tracheostomy and/or cannula in this item.	Documentation must support tracheostomy or cannula cleansing or changing of disposable cannula within the observation period.
O0100F, 1 or 2 Ventilator or Respirator **(14-day look back)**	-Extensive Services (not impacting the count)	Any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration; includes a resident who is being weaned off of a respirator or ventilator in the last 14 days. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.	Documentation of ventilator or respirator must be noted in the record within the observation period.
O0100H, 1 or 2 IV Medications **(14-day look back)**	-Extensive Services impacting the count	Any drug or biological (e.g., contrast material) given by intravenous push, epidural pump, or drip through a central or peripheral port. Do not code saline or heparin flushes to keep a heparin lock patent, or IV fluids without medication here. Record the use of an epidural pump in this item. Epidural, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not code subcutaneous pumps in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy.	Documentation of any drug or biological administered by intravenous push, epidural pump, or drip through a central or peripheral port must be noted in the record within the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
O0100I, 1 or 2 Transfusions **(14-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream are recorded in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.	Documentation of transfusions of blood or blood products administered directly into the bloodstream during the observation period.
O0100J, 1 or 2 Dialysis **(14-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	Includes peritoneal or renal dialysis that occurs at the nursing home or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0500A (Parenteral/IV), O0100H (IV medications), and O0100I (transfusions).	Documentation must include evidence that the procedure occurred within the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
O0400A, 1, 2, 3 & 4 **O0400B, 1, 2, 3 & 4** **O0400C, 1, 2, 3 & 4** Therapies: Speech-Language Pathology and Audiology Services; Occupational Therapy and Physical Therapy **(7-day look back)**	-Rehabilitation	Only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician based on a qualified therapist's assessment and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility. Individual minutes—Individual services are provided by one therapist or assistant to one resident at a time. Concurrent minutes—The total number of minutes of therapy that was provided on a concurrent basis in the last 7 days. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are performing two different activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. For Part B, residents may not be treated concurrently; a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). Group minutes—The total number of minutes of therapy that was provided in a group in the last 7 days. Group therapy is defined as the treatment of 2	Must provide evidence of a physician order for rendered therapy services. Initial evaluation and documentation time may not be counted. Minutes for individual, concurrent and group therapy services with associated staff initials/signature must be provided.

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		to 4 residents, regardless of payer source, who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients at the same time is documented as group treatment. Days—A day of therapy is defined as treatment for 15 minutes or more during the day.	

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
O0400D2 Respiratory Therapy **(7-day look back)**	-Special Care (contributes to the Extensive Services count)	Days and minutes of respiratory therapy must be cited in the medical chart to support the total days of direct therapy provided. Include only medically necessary therapies that occurred after admission/readmission to the nursing home that were • ordered and approved by a physician directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by a qualified therapist • documented in the resident's medical record Therapy treatment may occur either inside or outside of the facility. Services that are provided by a qualified professional (respiratory therapist, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. Do not include hand-held medication dispenser.	Direct therapy days and minutes of respiratory therapy with associated staff initials/signature must be provided. Count only the time that the qualified professional spends with the resident. Individuals qualified for the delivery of respiratory services include nurses trained in the administration of respiratory treatments and procedures. Evidence of training must be provided. Must provide evidence of a physician order for rendered services. Assessment by the respiratory therapist or trained nurse must be documented at least once during the observation period.

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MDS 3.0 Location and Field Description	**RUG III Categories Impacted**	**RAI Instructions**	**Minimum Documentation Standards**
O0500,A,B,C,D,E,F,G,H,I,J Restorative Nursing Programs **(7-day look back)**	-impacting the Nursing Restorative Program count in Impaired Cognition, Behavior Problems and Reduced Physical Functioning	Days of restorative nursing must be cited in the medical chart. Minutes of service must be provided to support the program and total time that is then converted to days on the MDS. Documentation must meet the five criteria of a nursing restorative program: • Measurable objectives and interventions documented in the care plan and the medical record • Periodic evaluation by a licensed nurse in the medical record • Staff skilled in the techniques that promote involvement in the activity • Supervision by registered or licensed practical (vocational) nurse • No more than four residents per supervising staff helper or caregiver Restorative 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.	Documentation during the observation period must include the five criteria for restorative nursing program. Restorative days and minutes with associated staff initials/signature and date must be provided. For restorative nursing care given in a group setting, documentation of 4:1 ratio of residents to staff must be provided. A progress note written by a restorative aide and co-signed by a licensed nurse can meet the requirement of a periodic evaluation once the program has been established. ROM programs must specify whether the program is Active or Passive.

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O0600 Physician examinations **(14-day look back**)	-Clinically Complex (contributes to the Extensive Services count)	The number of days that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago). Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician. Examination (partial or full) can occur in the facility or in the physician's office. Includes evaluation by a physician off-site (e.g., while undergoing dialysis or radiation therapy), as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination. The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, Psychological Therapy. Does not include visits made by Medicine Men.	Must include documentation of examination by the physician or other authorized practitioner.

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O0700 Physician orders **(14-day look back)**	-Clinically Complex (contributes to the Extensive Services count)	The number of days during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident's orders. Includes written, telephone, fax, or consultation orders for new or altered treatment. Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines. When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted. Orders for transfer of care to another physician may not be counted. Do not count orders written by a pharmacist.	Documentation must include evidence of days with new or altered physician orders.