**Goals of the MDS 3.0**

- **Clinical Relevancy** - MDS 3.0 Items are based upon clinically useful and validated assessment techniques.
- **Efficiency** - MDS 3.0 sections are formatted to facilitate usability and minimize staff burden.

**CMS Resources for MDS 3.0**


**RAI Manual**: click on RAI manual on left, scroll down to bottom of page.

**Item Set (MDS 3.0 Assessment tool)**: click on RAI technical information on left; scroll down to bottom of page.

**Case Mix Implications for MDS 3.0**
Case Mix Payment Items

Certain items coded as RUG III services, conditions, diagnoses and treatments on the MDS 3.0 assessment handout. RUG IV refers to payment items for PPS services.

*MaineCare Case Mix

Maine uses a modified RUG III Code for Case Mix purposes.

PPS / Medicare uses RUG IV codes

Supporting Documentation for Case Mix payment items is required.
Case Mix Weights

There are 7 Categories:
* Rehabilitation
* Extensive
* Special Care
* Clinically Complex
* Impaired Cognition
* Behavior
* Reduced Physical Function
* Default or Not Classified
Case Mix Quality Assurance Review

About every 6 months, a Case Mix nurse reviews a sample of MDS 3.0 assessments and resident records to check the accuracy of the MDS 3.0 assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS 3.0 may lead to an error.

Poor Documentation could also mean...

Lower payment than the facility could be receiving, OR

Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

Sanctions:

<table>
<thead>
<tr>
<th>Error rate</th>
<th>2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>34% or greater and less than 37%</td>
<td>5%</td>
</tr>
<tr>
<td>37% or greater and less than 41%</td>
<td>7%</td>
</tr>
<tr>
<td>41% or greater and less than 45%</td>
<td>13%</td>
</tr>
<tr>
<td>45% or greater</td>
<td>13%</td>
</tr>
<tr>
<td>If requested reassessments not completed within 7 days</td>
<td></td>
</tr>
</tbody>
</table>
**MaineCare Case Mix Documentation**

*Resident interviews will be accepted as coded on the MDS 3.0—NO additional supporting documentation is required.*

*Staff interviews must be documented in the resident’s record. If interviews are summarized in a narrative note, the interviewer must document the date of the interview, name of staff interviewed, and staff responses to scripted questions asked.*

*Follow all “Steps for Assessment” in the RAI Manual, for the interview items.*

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**Introducing the Maine Division of Licensing and Regulatory Services (DLRS) Training Portal**

Visit the portal at:


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**MDS 3.0**

Long Term Care Facility Resident Assessment Instrument (RAI) User’s Manual

Chapter 2

Effective Oct 2016
*Federal Requirements for the 3.0*

*Initial and periodic assessments for all their residents residing in the facility for 14 or more days.*

*This includes hospice, respite, and special populations such as Pediatric and Psychiatric.*

*Responsibility of NF for Reproducing/Maintaining 3.0*

Federal regulatory requirements at 42CFR483.20(d) requires NF to maintain all resident assessments completed within the previous **15 months** in the resident’s active clinical record.

*Responsibilities of NF for Reproducing/Maintaining 3.0*

Nursing Homes may:

1. Use electronic signatures for the MDS
2. Maintain the MDS electronically
3. Maintain the MDS and Care Plans in a separate binder in a location that is **easily and readily accessible** to staff, Surveyors, CMS etc.
The Alphabet Soup of MDS

OBRA = Omnibus Budget Reconciliation Act
PPS = Prospective Payment System
OMRA = Other Medicare Required Assessments (SOT, EOT, COT)
ARD = Assessment Reference Date

MDS 3.0
Long Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual
Chapter 3
Effective Oct 2016

Section A
Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.
**Coding Section A**

A0050 - Type of Record

* Code 1 for a new record that has not been previously submitted and accepted in the QIES ASAP system

* Code 2 to modify the MDS items for a record that has been submitted and accepted in the QIES ASAP system

* Code 3 to inactivate a record that already has been submitted and accepted in the QIES ASAP system

---

**Section A**

A0310 Purpose

Documents the reason for completing the assessment

Identifies the required assessment content information (determines item set)

There are several subsections to A0310

---

**Section A**

A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required
Electing or revoking the hospice benefit requires a significant change in status assessment.

A "significant change" is a factor or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by a registered nurse or other licensed health provider, or will require substantial interventional or supportive care for the resident, and
2. Impacts more than one area of the resident's health status, and
3. Requires intangible, intangible, review and or revision of the care plan.

A0310A Hospice Benefit

Electing or revoking the hospice benefit
requires a significant change in status assessment.

Significant Error

A "significant error" is an error in an assessment where:
1. The resident's overall clinical status is not correctly represented (i.e., misdiagnosed) on the assessment, and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.
Includes scheduled and unscheduled assessments

* Section A  
** A0310B PPS Assessment  
Includes scheduled and unscheduled assessments

* Coding Section A  
** A0310F Entry/Discharge Reporting

01. Entry tracking record  
10. Discharge assessment - return not anticipated  
11. Discharge assessment - return anticipated  
12. Death in facility tracking record  
99. None of the above
Discharge refers to the date a resident leaves the facility for anything other than a temporary LOA.

A discharge assessment is required for:
1. Discharge return not anticipated
2. Discharge return anticipated
3. Part A PPS Discharge

Part A PPS Discharge Assessment:
- Completed when a resident's Medicare Part A stay ends (A2400C), and the resident remains in the facility; or
- May be combined with an OBRA Discharge (A0310F = 10) if the Part A stay ends on the same day or the day before the resident’s Discharge Date (A2000).

If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000) of a planned discharge (A0310G=1), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined.

When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).
* If the resident is remaining in the facility:

F. Entitlement reporting:
   - Entry tracking record
   - Discharge assessment not anticipated
   - Discharge assessment system anticipated
   - Other: checking the discharge record

G. Type of discharge
   - Discharged
   - Unplanned
   - Other: checking the discharge record

H. Is this a SNF Part A PPS Discharge?

* A0310F will be coded as ‘99’, as this is not an OBRA discharge

* Therefore, A0310G will be skipped, as this is completed only if A0310F = 10 or 11

* A0310H will be coded ‘Yes’, for a Part A PPS discharge

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OBRA Assessment Schedule After Discharge Return Anticipated

No new OBRA admission assessment required after re-admission from hospital. Submit entry tracking form and continue previously established OBRA schedule, or complete a significant change as appropriate.

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*A0410. Unit Certification or Licensure Designation

1. Unit is Medicare and/or Medicaid certified or MDS data is not required by the State
2. Unit is Medicare and/or Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified
Section A
Resident Data
A0500 through A1300
Check and double check the accuracy of the name and all numbers - social security, Medicare and MaineCare numbers, Date of Birth

Section A
A2300 Assessment Reference Date (ARD)
*Designates the end of the look-back period so that all assessment items refer to the resident’s status during the same period of time.
*Anything that happens after the ARD will not be captured on that MDS.
The look-back period includes observations and events through the end of the day (midnight) of the ARD.

Section S
This section is specific data requirements for the State of Maine only.
S0120 Residence Prior to Admission
Enter the zip code of the community address where the resident last resided prior to nursing facility admission.
S0170. Advanced Directive

A. Guardian
B. Durable power of attorney for health care
C. Living will
D. Do not resuscitate
E. Do not hospitalize
F. Do not intubate
G. Feeding restrictions
H. Other treatment restrictions
I. None of the above

S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?
0. No → Skip to S3300 Weight-based Equipment Needed
1. Yes → Continue to S0511 PASRR Date
9. Unknown → Skip to S3300 Weight-based Equipment Needed

S0511. PASRR Level I Date:
(Complete only if S0510 = 1)

[Date field]
S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

I. Screen was sent to the HP for diagnosis, suspected diagnosis or need for specialized services
II. Screen was sent for determination of need for Level III screen due to diagnosis, suspected diagnosis or need for specialized services related to mental illness, intellectual disability, or other related condition

S3300. Weight-based Equipment Need

Did this resident require specialized equipment based on weight since last assessment?

I. No → Skip to S0520 Specialized Needs
II. Yes → Continue to S3305 Requirements for Weight

S3305. Requirements for Care, Specifically related to Weight

A. Lifting device, transfer belt assessment, was a specialized lifting device required?
B. Wheelchair or mobility device, transfer belt assessment, was an assistive device identified or other mobility device required?
C. Matt. Special assessment, was a specialized, non-standardized equipment?
D. Slinging, special assessment, was a specialized, non-standardized equipment?
E. More than 2 staff with last assessment, was more assistance needed to perform task used MDS 1.0?
F. Other, transfer assessment, was a specialized, non-standardized equipment required?
S6020. Specialized needs specifically related to a resident’s need for a Ventilator/Respirator

A. An occupational therapist needs to work on ventilator weaning;
B. DVT/Phlebitis prevention
C. Therapy (OT, PT, SN) to prevent complications;
D. Equipment: Resident needs specialized equipment;
E. Other (please list below);
F. Some of the above

S6022. Direct care by a Licensed Nurse

Enter a response for A, B, and C to indicate the number of days the resident required direct care described

A. Number of days: the resident required direct care by a licensed nurse on a hourly basis;
B. Number of days: the resident required direct care by a licensed nurse on 15-minute basis;
C. Number of days: the resident required direct care by a licensed nurse on a variable basis;

S6023. Direct Care by a CNA

A. Number of days: the resident required direct care by a CNA on an hourly basis;
B. Number of days: the resident required direct care by a CNA on a 15-minute basis;
C. Number of days: the resident required direct care by a CNA on a variable basis;
### S6024. Direct Care by a Respiratory Therapist

| A. Number of days the resident required direct care by a licensed respiratory therapist on an hourly basis. Totaling 15 or more hours of therapy per day. |
| B. Number of days the resident required direct care by a licensed respiratory therapist in increments of 15 minutes for therapy to non-resident care (i.e., companion therapy) per day. |
| C. Number of days the resident required direct care by a licensed respiratory therapist in increments of 15 minutes to non-resident care (i.e., companion therapy) per day. |

### Resident Stays Outside of the Facility:

- **S6200. Hospital Stays**
- **S6205. Observation Stays**
- **S6210. Emergency Room (ER) Visits**

### Resident Stays

<table>
<thead>
<tr>
<th>S6200. Hospital Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospital stays, separate columns for resident and non-resident, separate columns for resident and non-resident treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S6205. Observation Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of observation stays, separate columns for resident and non-resident.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S6210. Emergency Room (ER) Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ER visits, separate columns for resident and non-resident.</td>
</tr>
</tbody>
</table>

18
S8010 Payment Source - To determine payment source that covers the *daily per diem* or ancillary services for the resident’s stay in the nursing facility, **as of the ARD date**.

- C3 - MaineCare per diem. Do not check if MaineCare is pending
- G3 MaineCare pays Medicare or insurance Co-pay
- S8099 None of the above

S8510. MaineCare Therapeutic Leave Days

*Leave of Absence, or LOA, refers to:*

- Temporary home visit
- Temporary therapeutic leave
- Hospital observation stay of less than 24h where resident is not admitted to hospital
**Section B**

**Hearing, Speech, and Vision**

*Intent:* The intent of items in this section is to document the resident’s ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

- **S8512. MaineCare Hospital Bed-Hold Days**
  - **Intent:** The intent of items in this section is to document the resident’s ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

- **Section B**
  - **B0100: Comatose**
  - **B0200:** Ability to Hear (with hearing aid if normally used)
  - **B0300:** Hearing Aid
  - **B0600:** Speech Clarity
  - **B0700:** Makes Self Understood
  - **B0800:** Ability to Understand Others
  - **B1000:** Vision (with adequate light)
  - **B1200:** Corrective Lenses
**Section C Cognitive Patterns**

Intent: The items in this section are intended to determine the resident’s attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

*Should the Brief Interview for Mental Status (BIMS) be conducted??*

Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment.

Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available.

**IMPAIRED COGNITION CATEGORY**

B0100- Comatose (requires supporting documentation)

AND

- C0200
- C0300
- C0400
- C0500

OR

- B0700
- C0700
- C1000

Staff Assessment
Section C

C0200-C0500: BIMS resident interview questions (scripted interview)

C0600: Should the staff assessment be conducted?

C0700-C1000 Staff assessment:
- C0700 Short-Term Memory
- C0800 Long-Term Memory
- C0900 Memory/Recall Ability
- C1000 Cognitive Skills for Daily Decision Making

Documentation required to confirm responses

DEFINITIONS

DELIRIUM
A neuropsychiatric disturbance characterised by new or exacerbating confusion, disorientation, disorganised expression of thoughts, change in level of consciousness or hallucinations.

DISORGANIZED THINKING
Evidenced by rambling, irrelevant, or incoherent speech.

ALTERED LEVEL OF CONSCIOUSNESS

WAKfulness - awareness of one's environment
VIGILANT - aware and able to give attention to any verbal or tactile
HEMS/HEMI - half of hemisphere or half of body
STUPID - no awareness of environment or self
COMA - loss of brainstem function
C1310 Signs and Symptoms of Delirium

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

Section D

Mood

D0100: Should Resident Mood Interview Be Conducted?

If yes...

D0200 (Resident Interview - PHQ9®)

Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation. Case mix nurses check for timely completion according to Z0400.
D0300 Total Severity Score

A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Total score must be between 00 and 27.

Section D

D0500

Staff Assessment of Resident Mood

Look-back period for this item is 14 days.

Interview staff from all shifts who know the resident best.

Supporting documentation is required.
* Section E
Behavior

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.

* BEHAVIORAL SYMPTOMS
Payment Items

- **E0100A** Hallucinations
- **E0100B** Delusions
- **E0200A** Physical behaviors
- **E0200B** Verbal behaviors
- **E0200C** Other behaviors
- **E0800** Rejection of care
- **E0900** Wandering
Section E
E0200

E0300: Overall Presence of Behavioral Symptoms
E0500: Impact on Resident
E0600: Impact on Others

Section E
E0800 and E0900

E0800: Rejection of Care - Presence & Frequency
E0900: Wandering - Presence & Frequency

E1000: Wandering - Impact
E1000A Risk to Self
E1000B Intrusion on others
E1100: Change in Behavior or Other Symptoms

Section G
Functional Status

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
Section G  Payment Items

G0110A1, 2 Bed mobility: Self-performance & Support
G0110B1, 2 Transfer: Self-performance & Support
G0110I 1, 2 Toileting: Self-performance & Support
G0110H1 Eating: Self-performance Only

Section G  G0110

1. N/A: No Performance
   2. Independent: no supervision required
   3. Limited assistance: staff assistance needed
   4. Supervision: staff must be present
   5. Extensive assistance: staff must be present
   6. Total dependence: staff must be present

Section G  Self Performance

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent. exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all.
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).
- If none of the above are met, code supervision.
* Do NOT include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110.

* Differentiating between guided maneuvering and weight-bearing assistance: determine who is supporting the weight of the resident’s extremity or body. For example, if the staff member supports some of the weight of the resident’s hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is “weight-bearing” assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident’s hand to his or her mouth, this is guided maneuvering.

* Code Supervision for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.

* General supervision of a dining room is not the same as individual supervision of a resident and is not captured in the coding for Eating.

* Code extensive assistance (1 or 2 persons): if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).

* Code totally dependent in eating: only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).
Coding activity did not occur, 8:

* Toileting would be coded 8, activity did not occur: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.

* Locomotion would be coded 8, activity did not occur: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100% of the time over the entire 7-day look-back period.

* Eating would be coded 8, activity did not occur: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.

* During the look-back period, Mr. S was able to toilet independently without assistance 18 times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance.

The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision. (RAI Manual, page G-23)

Toilet use occurred 20 times during the look-back period. Non-weight-bearing assistance was provided two times and 18 times the resident used the toilet independently. When the assessor began looking at the ADL Self-Performance coding level definitions, she determined that independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as independent (0), the resident must complete the ADL without any help or oversight from staff every time. Since Mr. S did require assistance to complete the ADL two times, Code 0 does not apply. Code 7, Activity occurred only once or twice, did not apply to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor also determined that the assistance provided to the resident does not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period, and that the ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor continued to apply the coding instructions, looking at the Rule of 3. The First Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice. The second Rule of 3 does not apply because even though the ADL occurred three or more times it did not occur three times at multiple levels and the third Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur at multiple levels or three times at any one level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, there is one final instruction to the provider, that when none of the ADL Self-Performance coding level definitions and the Rule of 3 do not apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1). Therefore, in G0100I, Toilet use the code Supervision (1) was entered.
**Section H**

Bladder and Bowel

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

*Section H*

H0100: Appliances

H0200: Urinary Toileting Program
  A: Trial of a toileting program?
  B: Response to trial
  C: Current toileting program or trial

H0300: Urinary Continence

H0400: Bowel Continence

H0500: Bowel Toileting Program

H0600: Bowel Patterns
*Scheduled Toileting/Retraining*

**H0200C and H0500** are part of the Restorative Nursing Program and will be reviewed with Section O

*Section I
Active Diagnoses*

Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

*Section I Active Diagnoses*

1. Identify diagnoses in the last 60 days
   * Must be physician-documented
2. Determine status of diagnosis
   * 7-day look-back period,
   * Active diagnoses have a direct relationship to the resident's functional, cognitive, mood or behavior status, medical treatments or nursing monitoring
   * Only active diagnoses should be coded
**DIAGNOSES (Case Mix Items)**

- I2000 - Pneumonia
- I2100 - Septicemia
- I2900 - Diabetes (if N0300 = 7 and O0700 = 2 or more)
- 14300 - Aphasia (and a feeding tube)
- 14400 - Cerebral palsy
- 14900 - Hemiplegia/hemiparesis
- 15100 - Quadriplegia
- 15200 - Multiple Sclerosis
- 15500 - Traumatic brain injury (Maine only)

**Section J**

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident’s functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls.

**Section J**

Problem Conditions

- J1550:
  - A. Fever
  - B. Vomiting
  - C. Dehydrated
  - D. Internal Bleeding
  - Z. None of the above

Seven (7) day look-back period
* Section K
Swallowing/Nutritional Status

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

* Section K
Weight Loss/Gain

K0100: Swallowing disorder
K0200: Height and Weight
**K0300: Weight Loss**
K0310: Weight gain

* Section K - Nutritional Approaches

K0510: Approaches
A. Parenteral / IV Feeding
B. Feeding Tube
C. Mechanically Altered Diet
D. Therapeutic Diet
Z. None of the above
K0510 Assessment Guidelines

The following items are NOT coded in K0510A:

- IV medications
- 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

RAI Manual pages K-10 through K-12

K0710 Percent Intake by Artificial Route

A. Proportion of total calories the resident received through parenteral or tube feeding
   1. 25% or less
   2. 26-50%
   3. 51% or more

B. Average fluid intake per day by IV or tube feeding
   1. 500 cc/day or less
   2. 501 cc/day or more

K0710B.3 is a payment item

If the resident took no food or fluids by mouth (NPO) or took just sips of fluid, stop here and code 3, 51% or more.

If the resident had more substantial oral intake than this, consult with the dietician.

K0710B Average Fluid Intake per Day by IV or Tube Feeding

Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.

- Code 1: 500 cc/day or less
- Code 2: 501 cc/day or more

K0710B and B (column 3) are payment items for Residents receiving nutrition via IV or Tube Feeding
Section M

Skin Conditions

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

http://surveyortraining.cms.hhs.gov/Courses/126/SectionMVideo/SectionMVideo.mp4

Section M

M0300A: Number of Stage 1
M0300B: Number of Stage 2
   number present on admission
date of oldest stage 2 if known
M0300C: Number of Stage 3
   number present on admission
M0300D: Number of Stage 4
   number present on admission
MDS 3.0 Payment Items and Documentation

Section M - M0300

M0300B2, C2, and D2: Determine “Present on Admission”

For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

Section M

M0300 Unhealed Pressure Ulcers

Pressure Ulcers Present on Admission

RAI Manual, Chapter 3, page M-7:

3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident’s stay, the pressure ulcer is coded at that higher stage, and that higher stage should not be considered as “present on admission.”
4. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable.

If it subsequently increases in numerical stage, that higher stage should not be considered “present on admission.”

5. If a resident who has a pressure ulcer that was originally acquired in the facility is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer should not be coded as “present on admission” because it was present and acquired at the facility prior to the hospitalization.

6. If a resident who has a pressure ulcer that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.
7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it should be coded as “present on admission” at that higher stage upon reentry.

*Pressure Ulcer Guidelines*

- Do not reverse stage
- “If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage.”
- Determine the deepest anatomical stage of each pressure ulcer
- Enter number of pressure ulcers for each stage
- Pressure Ulcers are payment items
  - 2 or more treatments are required

*Section M*

- M0610: Dimensions of Unhealed Stage 3 or 4 or Eschar
- M0700: Most Severe Tissue Type for any Ulcer
- M0800: Worsening Pressure Ulcer Status
- M0900: Healed Pressure Ulcers
- M1030: Number of Venous and Arterial Ulcers
**Section M**

**M1040 Other Ulcers, Wounds, and Skin Problems**

- Check off that apply
  - A. Ulcers of the foot (e.g., callus, chronic or diabetic)
  - B. Ulcers of the lower leg (e.g., varicose ulcer, stasis ulcer)
  - C. Other ulcer(s) listed above
  - D. Opened fracture and/or amputation stump
  - E. Wound (abrasion, laceration, incision, surgical incision)
  - F. External burn
  - G. Necrotic area (e.g., decubitus ulcer, pressure ulcer)
  - H. Burns associated with exsanguination
  - I. Other

**M1200 Skin and Ulcer Treatments**

- A. Pressure reducing device for chair
- B. Pressure reducing device for bed
  - Do not include egg crate cushions of any type, donut or ring devices for chairs
- C. Turning/repositioning program
  - Specific approaches for changing resident’s position and re-aligning the body
  - Specific intervention and frequency
  - Requires supporting documentation of monitoring and periodic evaluation
- D. Nutrition and hydration

**M1200 Skin and Ulcer Treatments**

- E. Pressure Ulcer Care
- F. Surgical Wound Care
- G. Non-surgical Dressing (other than feet)
  - Do NOT include Band-aids
- H. Ointments/medications (other than feet)
- I. Dressings to feet
- Z. None of the above
**Section N Medications**

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection (subcutaneous, intramuscular or intradermal), insulin, and/or select medications were received by the resident.

**Section N INJECTIONS**

**N0300**

Record the number of days (during the 7-day look-back period) 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.*

**N0350 Insulin:** *Not a payment item for RUG III (MaineCare), but is a payment item for RUG IV (Medicare).*

A. Insulin Injections administered  
B. Orders for insulin
The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- The DrugLib.com Index of Drugs by Category, [http://www.druglib.com/drugindex/category](http://www.druglib.com/drugindex/category/)

*Section N
New Drug References*

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.
### Section O
Special Treatments, Procedures, and Programs

- **00400A.** Speech-Language Pathology and Audiology Services
- **00400B.** Occupational Therapy
- **00400C.** Physical Therapy

<table>
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### Section O
Special Treatments, Procedures, and Programs

- **00400D Respiratory Therapy**
  - Total minutes
  - # Days therapy was administered at least 15 minutes

- **00400E Psychological Therapy**
- **00400F Recreational Therapy**

### Section O
Restorative Nursing Programs

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Nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible.

- Measureable objectives and interventions
- Periodic evaluation by a licensed nurse
- CNAs must be trained in the techniques
- Does not require a physician’s order, but a licensed nurse must supervise the activities

Nursing staff are responsible for coordination and supervision. Does not include groups with more than 4 residents. Code number of days a resident received 15 minutes or more in each category. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.

H0200C Current toileting program
An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.
Section O
Restorative Nursing Programs

H0500 Bowel Training Program

Three requirements:

* Implementation of an individualized, resident-specific bowel toileting program.
* Evidence that the program was communicated to staff and resident through care plans, flow sheets, etc.
* Documentation of the response to the toileting program and periodic evaluation

O0600 Physician Examination

Days Assessment Guidelines

Over the last 14 days, on how many days did the physician examine the resident?

Examinations can occur in the facility or in the physician’s office.

Do not include:

* Examinations that occurred prior to admission/readmission to the facility
* Examinations that occurred during an ER visit or hospital observation stay

O0700 Physician Order Change

Days Assessment Guidelines

Over the last 14 days, on how many days did the physician change the resident’s orders?

Do not include the following:

* Admission or re-admission orders
* Renewal of an existing order
* Clarifying orders without changes
* Orders prior to the date of admission
* Sliding scale dosage schedule
* Activation of a PRN order
This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident’s functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident’s status and needs, are to be used to develop, review, and revise each resident’s comprehensive plan of care.

**Section X Correction Request**

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record).

In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

**A modification request is used to correct a QIES ASAP record containing incorrect MDS item values due to:**
- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification.
An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) so that it will not be used for reporting purposes.

A Manual Deletion Request is required only in the following three cases:
1. Item A0410 Submission Requirement is incorrect.
2. Inappropriate submission of a test record as a production record.
3. Record was submitted for the wrong facility.

X0150 Type of Provider
X0200 Name of Resident
X0300 Gender
X0400 Date of Birth
X0500 Social Security Number
X0600 Type of Assessment
X0700 Date on existing record
**Section X**
Correction Request

X0800 Correction number
X0900 Reasons for Modification
X1050 Reasons for Inactivation
X1100 Name, Title, Signature, Attestation Date

---

**RAI Manual Chapter 5**
Submission and Correction of MDS

5.1 Transmitting MDS Data:
The provider indicates the submission authority for a record in item A0410, Submission Requirement.

5.2 Timeliness Criteria
5.3 Validation Edits
5.4 Additional Medicare Submission Requirements that Impact Billing Under SNF PPS

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**Section Z**
Assessment Administration

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.
Section Z
Assessment Administration

The majority of this section is completed by your software.

Z0100 Medicare Part A Billing (RUG IV)
Z0150 Medicare Part A Non-Therapy (RUG IV)
Z0200 State Medicaid Billing (RUG III)
Z0250 Alternate State Medicaid Billing
Z0300 Insurance Billing

To check your final validation report:
https://sms.muskie.usm.maine.edu/

Section Z
Assessment Administration

Z0400 Attestation Statement

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Section Z
Assessment Administration

Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion

Section Z
Assessment Administration

Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting.
**Z0400 Attestation Statement**

**Coding Instructions**

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

---

**FYI...**

Chapter 110, Regulations Governing the Licensing and Function of Skilled Nursing Facilities and Nursing Facilities


Chapter 2.B.1.b Comprehensive Assessment (page 2)

b. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00
Call the MDS Help Desk to register or inquire about training opportunities!

Contact Information:
* MDS Help Desk: 624-4019 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
* Lois Bourque RN: 592-5909
  Lois.Bourque@maine.gov
* Darlene Scott-Rairdon RN: 215-4797
  Darlene.Scott@maine.gov
* Maxima Corriveau RN: 215-3589
  Maxima.Corriveau@maine.gov
* Sue Pinette RN: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dhrs/mds/training/