MDS 3.0 Item	Item Description	RUG III Categories Description	Documentation Requirement
B0100	Comatose/ Persistent Vegetative State (CPS)	*Clinically Complex Impaired Cognition*	Physician documented diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Does not include residents with advanced stages of progressive neurological disorders. The service plan or care plan must also describe the specific care needs of the resident due to his condition.
B0700	Resident makes self-understood (CPS)	*Impaired Cognition*	Documentation of resident's degree of impairment, 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, or a combination, over **all shifts**. This may include reduced voice volume, difficulty producing sounds or difficulty finding the right words, making sentences, writing and/or gesturing. Observations and interviews with family and/or speech pathologist that were used to justify the coding on the MDS must be documented in the medical record.
C0200 – C0500	Resident interview for cognition (BIMS)	*Impaired Cognition*	Validation of completion of items C0200-C0500 at **Z0400** on or before the ARD Date,**OR** Documentation the resident interview of BIMS items was completed *preferably the day before or day of the ARD.*
C0700	Short term memory (CPS)	*Impaired Cognition*	Documentation to determine the resident's short-term memory status by requesting that staff from **each shift**, validate resident's response to an event 5 minutes after it occurred. See RAI Manual, Section C for instructions.
C1000	Cognitive skills for daily decision making	*Impaired Cognition*	*Documentation by direct-care staff across **all shifts*** within the 7-day look-back period *demonstrating the degree of compromised decision-making about tasks of everyday living, including choosing clothing, knowing when to go to meals, using environmental cues to organize and plan, seeking*

			information from others to plan the day. This does not include the resident's decision to exercise his right to decline treatment.
D0200 A-I, Column 2	Resident mood interview	*Clinically Complex*	Validation of completion of items D0200A-I at **Z0400** on or before the ARD Date, **OR** Documentation of Resident Mood Interview (PHQ-9) in medical record **within the observation period** *preferably the day before or day of the ARD.*
D0500 A-J, Column 2	Staff assessment of resident mood	*Clinically Complex*	Documentation of "scripted interviews...across **all shifts** with staff who know the resident best," which must include date interviewed, names of staff interviewed, their responses & name of staff performing the interviews, *preferably the day before or day of the ARD.*
E0100A	Hallucinations	*Behavior Problems*	Documented occurrence(s) and example(s) of a resident's perception of the presence of something that is not actually there within the 7-day look-back period. May include auditory, visual, tactile, olfactory, or gustatory false sensory perceptions that occur in the absence of any real stimuli.
E0100B	Delusions	*Behavior Problems*	Documented occurrence(s) and example(s) of fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary within the 7-day look-back period.
E0200A	Physical Behavioral Symptoms directed toward others	*Behavior Problems*	Documented occurrence(s) and example(s) of physical behavioral symptoms directed toward others, including hitting, kicking, pushing, scratching, grabbing, and sexual abuse, across all shifts within the 7-day look back period. Documentation must support the frequency coded. Code the behavior even if staff have become used to the behavior.
E0200B	Verbal Behavioral Symptoms directed toward others	*Behavior Problems*	Documented occurrence(s) and example(s) of verbal behavioral symptoms directed toward others, including threatening others, screaming at others, and cursing at others, across all shifts

Commented [PS1]: Would you expect to see an incident report or nursing documentation to report to a physician if this was an ongoing pattern? If it is coded would you expect to see it addressed on the care plan?

			within the 7-day look back period. Documentation must support the frequency coded.
E0200C	Other behavioral symptoms not directed toward others	*Behavior Problems*	Documented occurrence(s) and example(s) of behavioral symptoms not directed toward others, including hitting or scratching self, pacing, rummaging, public sexual acts, disrobing, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming or disruptive sounds, across all shifts within the 7-day look-back period.
E0800	Rejection of care	*Behavior Problems*	Documented occurrence(s) and example(s) of rejection of care that is necessary to achieve the resident's goals for health and well-being, within the 7-day look-back period. Do NOT include behaviors that have already been addressed (e.g., by discussion and care planning with the resident or family) and determined to be consistent with the resident's values, preferences, or goals. Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."
E0900	Wandering	*Behavior Problems*	Documented occurrences(s) and frequency during the 7-day look-back period. Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. • Care plans should consider the impact of wandering on resident safety and disruption to others and should be focused on minimizing these issues. (RAI Manual Section E E)
G0110A, Column 1&2 Bed Mobility **G0110B**,	Activities of Daily Living: Bed Mobility, Transfer, Toilet use, and Eating	*Extensive Services* *Rehabilitation* *Special Care* *Clinically Complex* *Impaired Cognition*	Requirement is documentation 24 hours per day during the 7-day look-back period; Initials and dates to authenticate the services provided including signatures and titles to authenticate initials; The ADL key for self-performance and support provided

Column 1&2 Transfer **G0110I**, Column 1&2 Toilet Use **G0110H**, Column 1 ONLY Eating		*Behavior Problems* *Reduced Physical Function*	must include all the MDS key options and be equivalent to the intent and definition of the MDS key. Does NOT include Individuals hired, whether compensated or not, outside of the facility's management and administration. The Planning for Care section in the RAI Manual, Section G, has tips for developing the resident's care plan around ADL Care Needs. **CMS will not address lack of documentation, because they expect the responsible staff to be interviewed (the clarification note(s) must be specific to the date, shift & quotes of the responsible staff member**(s).
H0200C	Current urinary toileting plan or trail (Restorative Nursing)	*Rehabilitation* *Impaired Cognition* *Behavior Problems* *Reduced Physical Function*	• Documentation of a toileting program **trial** since the most recent admission/entry or reentry, or since urinary incontinence was first noted in the facility. • Documentation of **response** to the trial toileting program • Implementation of a resident-specific individualized toileting program based on assessment of the resident's unique voiding pattern • Evidence that the program was communicated verbally to staff and the resident as well as documented in the care plan • Documentation of the resident's response to the toileting program and subsequent quarterly evaluations. • Documentation of a systematic toileting program that is being used to manage the resident's incontinence 4 or more days of the 7-day look back period. Does not include simply tracking incontinence status, changing pads or wet garments or random assistance with toileting or hygiene

Commented [PS2]: CMS will not address lack of documentation, because they expect the responsible staff to be interviewed (the "clarification note(s) must be specific to the date, shift & quotes of the responsible staff member(s). This statement should remain part of the training. The RAI Manual indicates review records and speak with staff. The information should be consistent I believe most facilities rely on the documentation and then interview if they disagree with the ADL flow sheets. Section G is used only for long term care, which would be regulated by each state.

H0500C	Current urinary toileting plan or trail (Restorative Nursing)	*Rehabilitation* *Impaired Cognition* *Behavior Problems* *Reduced Physical Function*	• Implementation of an individualized, resident-specific bowel toileting program that was based on an assessment of the resident's unique bowel pattern • Evidence that the program was communicated verbally to staff and documented in the care plan • Documentation of the resident's response to the toileting program and subsequent quarterly evaluations. Does not include simply tracking bowel continence status, changing pads or soiled garments or random assistance with toileting or hygiene

Two look back periods for all items in Section I:

- Physician, nurse practitioner, or physician assistant documented diagnosis within the 60-day look back period;
- Documentation supporting active diagnosis in the 7-day look-back period,
- 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. Note: Urinary Tract Infections have a different look-back period.

Do NOT include:
Conditions that have been resolved or do not affect the resident's status within the 7-day look back period;

I2000	Pneumonia	*Special Care* *Clinically Complex*	
I2100	Septicemia	*Clinically Complex*	Sepsis and septicemia are not the same condition. Documentation of positive blood cultures.
I2900	Diabetes	*Clinically Complex*	
I4300	Aphasia	*Special Care*	
I4400	Cerebral Palsy	*Special Care*	
I4900	Hemiparesis/Hemiplegia	*Clinically Complex*	
I5100	Quadriplegia	*Special Care*	Quadriplegia must be a primary diagnosis of complete paralysis (spinal cord injury), not the result of another condition.

Commented [PS3]: Sepsis and septicemia are not the same condition. Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. A bacterial infection anywhere in the body may set off the response that leads to sepsis. If the assessor is not sure of the diagnoses, he or she should consult with the physician. So long as there is a documented diagnosis in the last 60 days and it has a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period, either or both of these diagnoses can be captured on the MDS in Active Diagnoses in the Last 7 Days . (Response from CMS)

			Reference to the original accident/injury, must be documented in the resident's record
I5200	Multiple Sclerosis	*Special Care*	
I5500	Traumatic Brain Injury	*Extensive Services*	There must be reference to the original accident/injury (external force), must be documented in the resident's record
J1550A	Fever	*Special Care*	Documentation to support the resident's elevated temperature meets the facility policy definition of being above baseline, within the 7-day look back period. "Baseline temperature must be established before the ARD" in accordance with the specific facility's policy/protocol.
J1550B	Vomiting	*Special Care*	Documented occurrence(s) within the 7-day look-back period.
J1550C	Dehydration	*Special Care* *Clinically Complex*	Documentation of two or more of the following potential indicators for dehydration within the 7-day look-back period: • Resident 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) • Resident has one or more potential clinical signs (indicators) 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 • Resident's fluid loss exceeds the amount of fluids he or she takes in by any route.
J1550D	Internal Bleeding	*Clinically Complex*	Documented occurrence(s) sources and symptoms of bleeding, within the 7-day look-back period. Nose bleeds that are easily controlled, menses, or a *urinalysis* that shows a small amount of red blood cells should not be coded as internal bleeding.

Commented [PS4]: I have always asked for the facility's protocol on establishing the meaning of "baseline." How can you determine if the resident meets the guidelines until you know what are the guidelines.

K0300	Weight Loss (30 / 180 days)	*Special Care*	Documentation of weight for 30 and 180 days back from the current MDS ARD, and documentation of the current weight that is coded on the MDS
K0510A	Parenteral/IV feeding	*Extensive Services* *ADL Score*	Documented administration of parenteral/IV feeding(s), "introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous) for nutrition and/or hydration" within the 7-day look-back period in Column 1 and Column 2. Current physician order required for coding in Column 2
K0510B	Feeding Tube	*Special Care* *Clinically Complex* *ADL Score*	**While NOT a resident (column 1):** Documentation must support the *presence* of a nasogastric or abdominal feeding tube, prior to admission, during the 7-day look-back period. **While a resident (column 2):** Documentation of the *presence* of a nasogastric or abdominal feeding tube, after admission, during the 7-day look-back period.
K0710A	Total IV/TF calories	*Special Care* *Clinically Complex* *ADL Score*	Documentation to support the proportion of calories actually received for nutrition or hydration through parenteral or tube feeding during the entire 7-day observation period. *For residents receiving both P.O. nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* 1. Calories tube feeding provided within observation period 2. Calories oral feeding provided within observation period 3. Percent of total calories provided by tube feeding
K0710B	Total IV/TF fluids per day	*Special Care* *Clinically Complex* *ADL Score*	Documentation to support average fluid intake per day by IV and/or tube feeding during the entire 7-day observation period. *Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include:*

			1. Adding the total amount of fluid received each day by IV or tube feedings only 2. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day (Divide by 7 even if the resident did not receive IV fluids or tube feeding on each of the 7 days)
M0300A	Stage 1 pressure ulcers	*Special Care*	For each pressure ulcer, there must be documentation by RN or MD that includes the deepest anatomical stage. and description including location, dimensions, drainage, tissue type and color, etc. within the 7-day observation period. Do not reverse or back stage. Consider current and historical levels of tissue involvement. Definitions, care planning, assessment and coding tips are in Section M of the RAI Manual. The ulcer would continue to be referred to according to the highest stage documented in the history of the ulcer. For example, if an ulcer was a stage 3 at is worst, it would always be referred to as a stage 3. It may have started as a 2, progressed to a 3, and then became a healing stage 3 and then a healed stage 3. Once tissue is damaged or destroyed, it never heals or fills in with the same type of tissue. This leaves the area at risk for future development of another ulcer at the same site. If, after an ulcer is completely healed, a new ulcer develops at the same site it would be assessed as a new ulcer, such as a new stage 2 at the site of a previously healed stage 3. The RAI Manual, Chapter 3, Section M has information on documentation recommendations for pressure ulcers.
M0300B	Stage 2 pressure ulcers		
M0300C	Stage 3 pressure ulcers		
M0300D	Stage 4 pressure ulcers		
M0300F	Unstageable due to slough/eschar		
M1030	Venous/arterial ulcers	*Special Care*	Documentation must include a description of the ulcer such as location, dimensions, drainage, tissue color, etc. The presence of an ulcer related to impaired circulation must be made by a RN or physician, within the 7-day look-back period. The specific type of vascular ulcer (i.e. venous or arterial) must be determined by a physician. There must be a diagnosis of PVD or PAD, as appropriate.

M1040A	Infection of the foot	*Clinically Complex*	Documentation and description of infection (i.e. cellulitis, purulent drainage) of the foot, within the 7-day look-back period. Do not include ankle problems or pressures ulcers coded at M0300.
M1040B	Diabetic foot ulcer	*Clinically Complex*	Documentation of unhealed/healing diabetic ulcer of the foot by a RN or physician, within the 7-day look-back period. The type of ulcer must be determined by a physician. Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot). Do **not** include pressure ulcers that occur on residents with diabetes mellitus here.
M1040C	Open lesion(s) on the foot	*Clinically Complex*	Documentation indicating the lesion is **open** with a description of the area, including location and appearance, within the 7-day look-back. Do not include ulcers coded at M0300
M1040D	Open lesion(s) other than ulcers, rashes, and cuts	*Special Care*	Documentation indicating the lesion is **open** with description of the area, including location and appearance **and** develop as part of a Physician documented diagnosis of the disease/condition, within the 7-day look-back. Do not code rashes, skin tears, cuts/lacerations here. Wounds coded in this section include Open lesions that develop as **part of a disease or condition** and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item, as referenced in the RAI Manual.
M1040E	Surgical Wound(s)	*Special Care*	Documentation of "any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites." Does **not** include surgical debridement of a pressure ulcer. If an ulcer has been excised and a graft and/or flap applied, it would then be considered a surgical wound.
M1040F	Burns (2^{nd} or 3^{rd} degree)	*Clinically Complex*	Documentation of assessment of a 2^{nd} or 3^{rd} degree burn in any stage of healing, including location and appearance, within the

			7-day look-back period. Documentation of the original burn, including the degree of the burn as determined by a RN or physician. and evidence of treatment to the burn within the look back period. Treatment includes all interventions, including assessment. May include burns due to heat or chemicals.
M1200A	Pressure Reducing Device- Chair	*Special Care*	(1)-MD order or policy/procedure (2)-must be on care plan and (3)-evidence of delivery within the 7-day look back period.
M1200B	Pressure Reducing Device- Bed	*Special Care*	(1)-MD order or policy/procedure (2)-must be on care plan and (3)-evidence of delivery within the 7-day look back period
M1200C	Turning/Repositioning	*Special Care*	Documentation of a consistent program that is specific to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours), that includes MD order, care planning, or facility policy/procedure and evidence of delivery with periodic (at least quarterly) evaluation, which describes progress toward effectiveness of the intervention.
M1200D	Nutrition/Hydration Program	*Special Care*	Physician order or an MD-approved dietician consult, recommending nutritional interventions with the purpose of preventing or treating specific skin conditions. These interventions should be referenced in the care plan, tailored to the resident's needs, conditions, and prognosis, with documented delivery within the 7-day look back period.
M1200E	Pressure Ulcer Care	*Special Care*	Physician's order for treatment and documentation of delivery of any intervention for treating pressure ulcers coded in M0300A-G. May include topical dressings, chemical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

M1200F	Surgical Wound Care	*Special Care*	Physician's order for treatment and documentation of delivery of any intervention for treating surgical wounds coded in M1040E. May include any intervention for treating or protecting any type of surgical wound, topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings, suture/staple removal. Does not include post-op care for eye or oral surgery; does not include observation of a surgical wound.
M1200G	Nonsurgical Dressing, other than to feet	*Special Care*	Physician's order for treatment and documentation of delivery of nonsurgical dressing. Must be applied at least once during 7-day look-back period. May include dry gauze, saline or other solution-moistened dressings, transparent dressings, hydrogel dressings, dressings with hydrocolloid or hydro-active particles and/or compressions bandages. Does not include application of non-surgical dressings for pressure ulcers/injuries to feet or adhesive bandages, such as band-aids.
M1200H	Ointments/Medications, other than to feet	*Special Care*	Physician's order for treatment **and** documentation of delivery of ointments or medications used to treat a skin condition; may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions, within the 7 day look back period. Does not include ointments used to treat non-skin conditions (e.g., Nitropaste for chest pain, testosterone cream) or application of ointments/medications (e.g., chemical or enzymatic debridement) for treatment of pressure ulcers.
M1200I	Dressings to feet	*Clinically Complex*	Physician's order for treatment and documentation of delivery of interventions to treat any foot wound or ulcer **other than a pressure ulcer**. Do not code application of dressings to the ankle. The ankle is not considered part of the foot.
N0300	Injections	*Clinically Complex*	Current physician order(s) and documentation that injections were administered for the number of days coded on the MDS 3.0, within the 7-day look-back period. Includes any medication or vaccine administered subcutaneous, intramuscular, or

			intradermal; includes subcutaneous pumps only on the days an injection was required to restart the pump.
O0100	Special Treatments, Procedures and Programs – **General Information**		**Column 1:** Documentation of treatments, procedures, and programs received or performed by the resident prior to admission/entry or reentry to the facility **and** within the 14-day look-back period. **Column 2:** Physician's order **and** evidence of delivery of the administration of treatments, procedures, and programs received or performed by the resident **after** admission/entry or reentry to the facility and within the 14-day look-back period. Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff.
O0100A	Chemotherapy	*Clinically Complex*	Documentation of any type of chemotherapy agent administered as an antineoplastic given by any route **for cancer treatment** AND a documented diagnosis of cancer. May include clinical note that resident went out for chemotherapy treatment including a corresponding physician order. Documentation of any type of chemotherapy agent administered as an antineoplastic, aimed at destruction (the killing) of malignant cells, given by any route for cancer treatment **AND** a documented diagnosis of cancer. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are *not considered chemotherapy for the purpose of coding the MDS.* May include clinical note that resident went out for chemotherapy treatment including a corresponding physician order.
O0100B	Radiation	*Special Care*	Documentation of intermittent radiation therapy, as well as radiation administered via radiation implant in this item. May include clinical note that resident went out for

			radiation treatment including a corresponding physician order.
O0100C	Oxygen Therapy	*Clinically Complex*	Documentation of continuous or intermittent oxygen administered via mask, cannula, etc., *delivered* to a resident to relieve hypoxia in this item; code whether oxygen is placed/removed by resident or facility staff within the 14-day look back period.
O0100D	Suctioning	*Extensive Services*	Documentation of tracheal and/or nasopharyngeal suctioning per a physician's order **and** documentation of delivery *for each type of suctioning* that occurred within the 14-day look back period. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.
O0100E	Tracheostomy care	*Extensive Services*	Physician order and documentation of cleansing of the tracheostomy and/or cannula, whether tracheostomy care is performed by resident or facility staff.
O0100F	Ventilator/respirator	*Extensive Services*	Documentation to support use of any type of *closed-system mechanical ventilator* devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item; closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (nasally or orally intubated) as well as residents with a tracheostomy. A resident being weaned off a ventilator within the last 14 days should be coded here. Does **not** include ventilator being used as a substitute for BiPAP or CPAP

O0100H	IV medications	*Extensive Services*	Documentation of physician's order for and administration of: any medication given by IV push, or drip via central or peripheral port; includes epidural, intrathecal or baclofen pumps Does **not** include: • Subcutaneous pumps • Flushes to keep an IV access patent • IV fluids without medications • IV meds given during dialysis or chemo When coding epidural, intrathecal or baclofen pumps, documentation must include: • Physician's order supporting an epidural pump, • documentation the epidural pump is being managed by nursing, **and** • documentation that includes, but not limited to, medication effectiveness and side effects/effects of current dose
O0100I	Transfusion	*Clinically Complex*	Documentation of administration of blood or any blood products directly into the bloodstream received during the 14-day look back period. Coding may include transfusions received prior to admission, entry, or re-entry **and** within the 14-day look back period. Does **not include** transfusions administered during dialysis or chemotherapy
O0100J	Dialysis	*Clinically Complex*	Documentation of a Physician's order and delivery of peritoneal or renal dialysis in the nursing facility or at another facility. Supporting documentation may include a clinical note or documentation on a treatment administration record (TAR) in addition to a physician's order. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not**

			to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions).
O0400A O0400B O0400C	Speech Therapy Occupational Therapy Physical Therapy	*Rehabilitation*	Documentation of Physician's order prior to evaluation; for Medicare B services the plan of care must be certified by physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist ***prior*** to the start of therapy services in the facility or outside the facility. When the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A (RAI Manual, Chapter 3, page O-20). Evidence of periodic evaluation to ensure current treatment plans are effective.
O0400D2	Respiratory therapy	*Special Care Reduced Physical Function*	Current physician order which "includes a statement of frequency, duration, and scope of treatment." Qualified "professional" means registered nurse or respiratory therapist. Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Documentation of a change in condition requiring RN/Respiratory therapist intervention e.g. exacerbation of a chronic respiratory condition or onset of a new respiratory condition. O04001: Documented delivery of the total number of minutes respiratory therapy was provided during the 7-day look-back period. (this is not a payment item.) O0400D2: • Documentation of number of ***days*** respiratory therapy was administered for a total of at least 15 minutes/24hours in the 7-day look-back period.

			• Documentation that services are directly and specifically related to an active written treatment plan • Documentation that services were provided by qualified personnel (RAI Manual, Appendix A)
O0500A-J	Restorative Nursing	*Rehabilitation* *Impaired Cognition* *Behavior Problems* *Reduced Physical Function*	RNP actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. For each program coded on the MDS: • Evidence of measurable objectives and interventions documented in the care plan. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. • Evidence of periodic (at least quarterly) evaluation, which *describes* progress toward goals (i.e. more than "goal met" or "effective--continue plan as written"). • Documented delivery the *number of days* on which the technique, training or skill practice was performed for a total of at least 15 minutes per 24-hour period during the 7-day look-back period. • Staff must be trained in the proper techniques • Supervision by nursing ADL documentation may reviewed in conjunction with restorative programs to confirm delivery of program. Facility is responsible to ensure that **all documentation** to support the coding is present, accurate and available for review.
O0600	Physician exam/visit days	*Clinically Complex*	Documentation of *number of days* that *physician progress notes* reflect that a physician examined the resident (or since admission if less than 14 days ago); includes full or partial examination, in the facility or a physician's office, includes telehealth.

			• Do not include physician examinations that occurred ***prior to admission or readmission*** to the facility (e.g., during the resident's acute care stay). See RAI Manual, Chapter 3, Section O0600 for additional information.
O0700	Physician order change days	*Clinically Complex*	Documentation of *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. • Do not count orders prior to the date of admission or re-entry. See RAI Manual, Chapter 3, Section O0700 for additional information.
Z0400	Signatures of Persons Completing the Assessment	All	***All*** staff who completed any part of the MDS must enter their signatures, titles, sections or portions they completed, and the date completed. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement. *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.* See RAI Manual, Chapter 3, Section Z0400 for additional coding tips.
Z0500	Signature of RN Assessment Coordinator Verifying Assessment Completion	All	Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete **with all documentation submitted and verified as accurate**. For Z0500B, use the actual date that the MDS **was completed,**

			reviewed, and signed as complete by the RN assessment coordinator. **This date must be equal to or later than the latest date at Z0400.** **Clarifying documentation dated after the Z0500 date will not be accepted as supporting documentation.**

(a) MDS Correction Forms received in the central repository or included in the clinical record will be the basis for review when completed before the day of the review and included as part of the resident's clinical record. (MBM Chap III, Section 67)

The case mix nurse will review the submitted/accepted assessment that appears on the roster, until a validation report confirming submission and acceptance on the date of or prior to the date of the review has been presented.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. (RAI Manual)

MaineCare Benefits Manual, Chapter III, Section 67 Principles of Reimbursement for Nursing Facilities

16.2.3 Quality Review of the MDS Process

16.2.3.1 (4) "Assessment review error rate" is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have MaineCare reimbursement. MDS Correction Forms received in the central repository or included in the clinical record will be the basis for review when completed before the day of the review and included as part of the resident's clinical record.