Nevada Supportive Documentation Guidelines
Available online at dhcfp.nv.gov (Nursing Facility Information/MDS guidelines)
Resource Utilization Group, Version III, Revised
For MDS 3.0 Assessments with an ARD on or after //2016 Source Document: MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
B0100 Comatose **(7-day look back)**	-Clinically Complex -Impaired Cognition (Contributes to ES count)	**Comatose:** A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g. pain). **Persistent Vegetative State:** Some comatose individuals regain wakefulness but do not display any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of coma or persistent vegetative state within the observation period.
B0700 Makes Self Understood **(7-day look back)**	-Impaired Cognition (Contributes to ES count)	Documentation that the resident is able to express or communicate requests, needs, opinions, urgent problems, and to conduct social conversation, whether in speech, writing, sign language, or a combination of these. Deficits in the ability to make one self understood can include reduced voice volume and difficulty in producing sound, or difficulty in finding the right word, making sentences, writing, and/or gesturing.	As Evidenced By (AEB) examples describing an accurate picture of the resident within the observation period.
C0500 Summary Score (BIMS) **(7-day look back)**	-Impaired Cognition	Rules for stopping the interview before it is complete: Stop the interview after completing CO300C if: • All responses have been nonsensical, OR • There has been no verbal or written responses to any question up to this point, OR • There has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response. If the interview is stopped, do the following: • Code dash (-) in CO400A, CO400B, and CO400C. • Code 99 in the summary score in CO500. • Code 1, yes in CO600. • Complete the Staff Assessment for Mental Status CO700-C1000.	Document date and signature of professional clinical staff (i.e. licensed nurse or licensed social worker) conducting the interview within observation period in the medical records. The interview completion date (the date the interview was actually conducted) must be date specific if written in a quarterly, annual, or summary note. The interview completion date in the medical records must match the signature date for the interview section entered at Z0400. The BIMS score coded on the MDS should match the score reported by professional clinical staff.
C0700 Short-Term Memory **(7-day look back)**	-Impaired Cognition (Contributes to ES count)	Determine the resident's short term memory status by asking him/her to describe an event 5 minutes after it occurred OR to follow through on a direction given 5 minutes earlier. Observation should be made by staff across all shifts & departments and others with close contact with the resident. If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard "no information" code (a dash, "-") to indicate that the information is not available because it could not be assessed.	If resident is coded with a memory problem (1) at C0700, a memory test must be attempted (see Steps for Assessment in C0700 section of RAI manual) and documented As Evidenced By (AEB) example within the observation period

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C1000 Cognitive Skills for Daily Decision Making **(7-day look back)**	-Impaired Cognition (Contributes to ES count)	Observations should be made by staff across all shifts and departments and others with close contact with the resident. Focus on the resident's actual performance. Includes choosing clothing, knowing when to go to meals; using environmental clues to organize and plan (e.g. clocks, calendars, posted event notices). In the absence of environmental cues seeks information appropriately (not repetitively) from others in order to plan their day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker. **Does NOT include**: Resident's decision to exercise his/her right to decline treatment or recommendations by staff.	Document the resident's actual performance in making everyday decisions about tasks or activities of daily living (ADL'S). Does not include financial decision making or statements relating to diagnosis (i.e. dementia). Decisions should relate to the residents life in the facility. Documentation needs to include the observing staff member's title and As Evidenced By (AEB) examples of the decisions made by the resident within the observation period. If all residents' needs are anticipated then an AEB is required. The example needs to be specific not just a reference to the residents safety awareness etc.
D0300 Total Severity Score (PHQ-9) **(7-day look back)**	-Clinically Complex	**Total Security Score defined:** • Sum of all frequency items (D0200 Column 2). • Total Severity Score range is 00-27. • Score >=10 resident is depressed. • Score <=10 resident is not depressed. **Total Severity Score interpreted** • 20-27; severe depression. • 15-19; moderately severe depression. • 10-14; moderate depression. • 5-9; mild depression. • 1-4; minimal depression.	Document date and signature of professional clinical staff (i.e. licensed nurse or licensed social worker) conducting the interview within observation period in the medical records. The interview completion date (the date the interview was actually conducted) must be date specific if written in a quarterly, annual, or summary note. The interview completion date in the medical records must match the signature date for the interview section entered at Z0400. The PHQ-9 score coded on the MDS should match the score reported by professional clinical staff.
D0500A, Column 2 Staff assessment Little interest or pleasure in doing things **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's lack of interest or pleasure in doing things.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
DO500B, Column 2 Staff assessment Feeling or appearing down, depressed, or hopeless **(14-day look back)**	-Clinically complex	If resident is unable to unwilling to be interviewed: refer to Staff Assessment of Mood (DO500A-J). • Example that demonstrates resident's feeling or appearing down, depressed or hopeless.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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D0500C, Column 2 Staff assessment Trouble falling or staying asleep, or sleeping too much **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's trouble falling or staying asleep, or sleeping too much.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500D, Column 2 Staff assessment Feeling tired or having little energy **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's feeling tired or having little energy.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500E, Column 2 Staff assessment Poor appetite or overeating **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's poor appetite or overeating.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500F, Column 2 Staff assessment Indicating that he/she feels bad about self, or is a failure, or has let self or family down. **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's indication that he/she feels bad about self, or is a failure, or has let self or family down.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500G, Column 2 Staff assessment Trouble concentrating on things, such as reading the newspaper or watching TV **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's trouble concentrating on things, such as reading the newspaper or watching TV.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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D0500H, Column 2 Staff assessment Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that she/he has been moving around a lot more than usual. **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that he/she has been moving around a lot more than usual.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500I,Column 2 Staff assessment States that life isn't worth living, wishes for death, or attempts to harm self **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's statements that life isn't worth living, wishes for death, or attempts to harm self.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500J,Column 2 Staff assessment Being short tempered, easily annoyed **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's being short tempered, easily annoyed.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0600 Total Severity Score (PHQ-9-OV) **(7-day look back)**	-Clinically Complex	**Total Severity Score defined:** • Sum of all frequency items (D0500 Column 2). • Total Severity Score range is 00-30. • Score>=9.5 resident is depressed. • Score <=9.5 resident is not depressed. Total Severity Score interpreted: • 20-27; severe depression. • 15-19; moderately severe depression. • 10-14; moderate depression. • 5-9; mild depression. • 1-4; minimal depression.	Documentation needs to include staff interviewed (e.g. day shift nurse, activities personnel). Staff interviewed should be from a variety of shifts and staff who know the resident well. Documented date and signature of the professional clinical staff (i.e. licensed nurse or licensed social worker) performing assessment within the observation period. The PHQ-9-OV score coded on the MDS should match the score reported by professional clinical staff.

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E0100A Hallucinations **(7-day look back)**	-Behavior Problems	**Hallucinations defined:** • Example of a resident's perception of the presence of something that is not actually there. • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.	Document As Evidenced By (AEB) example within the observation period.
E0100B Delusions **(7-day look back)**	-Behavior Problems	**Delusions defined:** • Example of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. **Does NOT include:** • A resident's expression of a false belief when easily accepts a reasonable alternative explanation.	Document As Evidenced By (AEB) example within the observation period.
E0200A Physical behavioral symptoms *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of physical behavior symptoms direct toward others. • Hitting, kicking, pushing, scratching, abusing others sexually.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200B Verbal behavioral symptoms *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of verbal behavior symptoms directed toward others. • Threatening others, screaming at others, cursing at others.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200C Other behavioral symptoms <u>not</u> *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of other behavior symptoms NOT directed toward others. • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0800 Rejection of Care Presence and frequency **(7-day look back)**	-Behavior Problems	Example of the resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goal for health and well-being. When rejection/decline of care is first identified, it is investigated to determine if the rejection/decline of care is a matter of the resident's choice. Education is provided (risks and benefits) and the resident's choice becomes part of the plan of care. On future assessments, this behavior would not be coded again in this item.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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E0900 Wandering - Presence and Frequency **(7-day look back)**	-Behavior Problems	Example and frequency of wandering from place to place without a specified course or known direction. **Does NOT include:** • Pacing, walking for exercise or out of boredom. • Traveling via a planned course to another specific place (dining room or activity).	Document As Evidenced By (AEB) example within the observation period – must include frequency.
ADL Self-Performance **G0110A,** Bed Mobility **G0110B,** Transfers **G0110H,** Eating **G0110I,** Toilet Use **Column 1 ONLY** **(7-day look back)**	-Extensive Services -Rehabilitation -Special Care -Clinically Complex -Impaired Cognition -Behavior Problems -Reduced Physical Functions	• Documentation 24 hours/7 days within the observation period while in the facility. • Initials and dates to authenticate the services provided. • Signature to authenticate initials of staff providing services. **ADL Keys:** For either ALD grids, or electronic data collection tools, the key for self-performance must be equivalent to the intent and definition of the MDS key. **ADLs NOT supported:** • If there is NO ADL key associated with the values, the ADL values will be considered unsupported. • ADL keys with words for self-performance such as limited, extensive, etc, without the full definitions will be considered unsupported. • ADL tools that lack codes for all possible MDS coding options will be considered unsupported.	The facility must provide **one** source document (i.e. ADL flow sheet, nurses, or staff notes) containing data reported over all shifts for the 7 day observation period to support MDS coding.
ADL Support **G0110A**, Bed Mobility **G0110B,** Transfers **G0110I,** Toilet Use **Column 2 ONLY** **(7 day-look back)**	Extensive Services -Rehabilitation -Special Care -Clinically Complex -Impaired Cognition -Behavior Problems -Reduced Physical Functions	ADL support measures the highest level of support provided by the staff over the last 7 days, even if that level of support only occurred once. This is a different scale and is entirely separate from the ADL self-performance assessment.	The facility must provide **one** source document (i.e. ADL flow sheet, nurses, or staff notes) containing data reported over all shifts/departments for the 7 day observation period to support MDS coding.

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H0200C Current toileting program or trial **(7-day look back)**	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must show that the following requirements have been met: • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern. • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report. • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period.** • Toileting plan that is being managed during days of the 7-day look back period with some type of systematic toileting program. • A specific approach that is organized, planned, documented, monitored, and evaluated. **Does NOT include:** • Less than 4 days of a systematic toileting program. • Simply tracing continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a program or trial. The individual resident's toileting schedule must be daily (7 days a week), available and easily accessible to all staff. No time documentation is required for this item.
H0500 Bowel toileting program **(7-day look back)**	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must show that the following requirements have been met: • 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 and through a care plan, flow records, and a written report. • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period.** **Does NOT include:** • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a program or trial. The individual resident's toileting schedule must be daily (7 days a week), available and easily accessible to all staff. No time documentation is required for this item.

Section I: Active Diagnosis in the Last 7 Days Criteria		
***Active Diagnosis* look back period** Diagnosis that has a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look back period	**Documented Diagnosis *look back period*** A healthcare practitioner documented diagnosis in the last 60 days that has a relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.	The monthly recap may be used for diagnosis **IF** it is signed and dated by the physician, nurse practitioner, physician assistant or clinical nurse specialist within the look back period. ADL documentation cannot be used to document active treatment, as all residents receive ADL assistance.
Step 1 Identify diagnosis in the 60-day look back period. **Step 2** Determine diagnosis status: active or inactive in the 7-day look back period.		

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I2000 Pneumonia **(60-7 day look back)**	-Special Care -Clinically Complex (Contributes to ES count)	Inflammation of the lungs; most commonly of bacterial or viral origin. An active physician diagnosis must be present in the medical record. **Does NOT include:** • A hospital discharge note referencing pneumonia during hospitalization.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of pneumonia within the observation period is required. Documentation of **current (within 7 day look back period)** treatment of diagnosis must be present in the medical record. X-ray report signed by radiologist may be used to confirm diagnosis.
I2100 Septicemia **(60-7 day look back)**	-Clinically Complex (Contributes to ES count)	Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted provided the physician has documented the septicemia diagnosis in the resident's clinical record. Urosepsis is not considered for MDS review verification **Does NOT include:** • A hospital discharge note referencing septicemia during hospitalization.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of septicemia within the observation period. Documentation of **current (within 7 day look back period)** treatment of diagnosis must be present in the medical record.
I2900 Diabetes Mellitus **(60-7 day look back)**	-Clinically Complex (Contributes to ES count)	An active physician documented diagnosis must be present in the medical record.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. May include diet controlled diabetes.

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I4300 Aphasia **(60-7 day look back)**	-Special Care (Contributes to ES count)	A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e. speaking, writing) or understanding spoken or written language. Includes aphasia due to CVA.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the documentation of active treatment involved which would indicate the resident does have aphasia.
I4400 Cerebral Palsy **(60-7 day look back)**	-Special Care (Contributes to ES count)	Paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I4900 Hemiplegia/ Hemiparesis **(60-7 day look back)**	-Clinically Complex (Contributes to ES count)	Hemiplegia/ hemiparesis: Paralysis/ partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. Right or left sided weakness or CVA will not be accepted for this item.
I5100 Quadriplegia **(60-7 day look back)**	-Special Care (Contributes to ES count)	Paralysis (temporary or permanent impairment of sensation, function, motion) of all 4 limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.)	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I5200 Multiple Sclerosis(MS) **(60-7 day look back)**	-Special Care (Contributes to ES count)	Chronic disease affecting the central nervous system with remissions and relapses of weakness, parenthesis, speech and visual disturbances.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
J1550A Fever **(7-day look back)**	-Special Care (Contributes to ES count)	The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. • Fever of 2.4 degrees above the baseline • A baseline temperature established prior to the observation period. • A temperature of 100.4 on admission is a fever.	Documentation of specific occurrences of fever in the observation period. A baseline temperature must be established and documented prior to the observation period for comparison.
J1550B Vomiting **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of regurgitation of stomach contents; may be caused by many factors (e.g. drug toxicity, infection, psychogenic).	Documentation of vomiting in the observation period including description of vomitus (type and amount).

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J1550C Dehydrated **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count)	Documentation does require 2 or more of the 3 dehydration indicators. **Does include:** • Usually takes in less than 1500cc of fluid daily. • 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, abnormal lab values, etc. • Fluid loss that exceeds intake daily. **Does NOT include:** • A hospital discharge note referencing dehydration during hospitalization unless 2 of the 3 dehydration indicators are present and documented. • A diagnosis of dehydration.	Documentation of signs of dehydration in the observation period.
J1550D Internal Bleeding **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of frank or occult blood. • Black, tarry stools. • Vomiting "coffee grounds." • Hematuria. • Hemoptysis. • Severe epistaxis (nosebleed) requires packing. **Does NOT include:** • Nosebleeds, that are easily controlled, menses, or UA with small amount of red blood cells.	Documentation of specific occurrences of internal bleeding in the observation period including description.
K0300 Weight Loss **(30 and 180 day look back)**	-Special Care (Contributes to ES count)	Documentation that compares the resident's weight in the current observation period with his/her weight at two snapshots in time: • Weight loss of 5% a point closest to 30 days preceding current observation period. • Weight loss of 10% at a point closest to 180 days preceding current observation period. Mathematically round weights prior to completing the weight loss calculation. Physician prescribed weight loss regimen is a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie restricted diet or other weight loss diets and exercise. Also includes planned dieresis for weight loss. It is important that weight loss is intentional.	Must have a documented weight within the current observation period (7 day-look back) for comparison. Documentation, including dates with weights and prescribed diet if applicable are required.

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K0510A either as not a resident (1) or as a resident (2) Parenteral/IV Feeding **(7-day look back)**	-Extensive Services -ADL Score	Documentation of IV administration (while a resident or while not a resident) for nutrition or hydration. **Does include:** • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently. • IV at KVO (keep vein open). • IV fluids contained in IV Piggybacks. • Hypodermoclysis and sub-Q ports in hydration therapy. • IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. **The following items are NOT to be coded in K0510A:** • IV medications-**Code these when appropriate in O0100H, IV Medications.** • IV fluids used to reconstitute and/or dilute medications for IV administration. • IV fluids administered as a routine part of operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • IV fluids administered during chemotherapy or dialysis.	Documentation of parenteral/IV administration during the observation period which may include medicine administration records (MAR's) and treatment records. For fluids given while not a resident, facility records are required with amounts administered.
K0510B either 1 or 2 Feeding Tube **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	Documentation of any type of feeding tube for nutrition and hydration while a resident or while not a resident. • Documentation of any type of tube that can deliver food/nutritional substance directly into the GI system. **Does include:** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes.	Presence of the feeding tube is sufficient to code this item.
K0710A Calorie Intake through parental or tube feeding. **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	Documentation must support the proportion of all calories actually received for nutrition or hydration through parenteral or tube feeding. **For residents receiving PO nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include:** • Total calories from parental route. • Total calories from tube feeding route. • Calculation used to find percentage of calories consumed by artificial routes.	Dietary notes can be used to support MDS coding.

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K0710B Average Daily Fluid Intake through parental or tube feeding. **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	Documentation must support average fluid intake per day by IV and/or tube feeding. This is calculated by reviewing the intake records, adding the total amount of fluid received each day by IV and/or tube feedings only. Divide the week's total fluid intake by the number of days in the observation period. This will provide the average fluid intake per day.	Dietary notes may be used to support MDS coding. Documentation to include evidence of the average fluid intake per day by IV or tube feeding during the entire seven days observation period. Refers to the actual amount of fluid the resident received by these modes (not the amount ordered).
M0300A No. of Stage 1 **M0300B1** No. of Stage 2 **M0300C1** No. of Stage 3 **M0300D1** No. of Stage 4 **M0300F1** No. of unstageable **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed. • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured. • Description of the ulcer including the stage. **Does NOT include:** • Reverse staging. • Pressure ulcers that are healed before the look-back period (these are coded at M0900). • Coding un-stageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured.	Documentation must indicate the number of pressure ulcers on any part of the body observed during the observation period. Pressure ulcer staging must be clearly defined by description and/or measurement in order to support MDS coding during the observation period. Documentation must include date, clinician signature, and credentials.
M1030 No. of Venous/Arterial Ulcers **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Venous Ulcers: 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: Ulcers caused by peripheral artery disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.	Documentation must indicate the number of venous or arterial ulcers observed during the observation period. Documentation must include date, clinician signature, and credentials.
M1040A Infection of the foot **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of signs and symptoms of infection of the foot. **Does include:** • Cellulitis. • Purulent drainage. **Does NOT include:** • Ankle problems. • Pressure ulcers coded in M0300-M0900.	Documentation of signs and symptoms of infection of the foot must be present in the medical record to support the MDS coding. Documentation to include description and location of the infection. Documentation must include date, clinician signature, and credentials.

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M1040B Diabetic foot ulcer **M1040C** Other open lesion on the foot **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of signs and symptoms of foot ulcer or lesions. • Description of foot ulcer and/or open lesions such as location and appearance. **Does NOT include:** • Pressure ulcers coded in M0300-M0900. • Pressure ulcers that occur on residents with diabetes mellitus.	Documentation of sign and symptoms of foot ulcer or other lesion on the foot must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials.
M1040D Open lesions other than ulcers, rashes, cuts **(7-day look back)**	-Special Care (Contributes to ES count)	**Does include:** • Skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. • Description of the open lesion such as location and appearance. • Documentation in the care plan. **Does NOT include:** • Pressure ulcers coded in M0300-M0900. • Skin tears, cuts, abrasions.	Documentation of signs and symptoms of open lesion other than ulcers, rashes or cuts must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials. RAI manual examples are not all inclusive, other lesions will be considered for inclusion in this item. (i.e. shingles lesions or weeping wounds).
M1040E Surgical Wounds **(7-day look back)**	-Special Care (Contributes to ES count)	**Does include:** • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage site on any part of the body. • Pressure ulcers that are surgically repaired with grafts and flap procedures. • Description of the surgical wound such as location and appearance. **Does NOT include:** • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure. • PICC sites, central line sites, IV sites. • Pressure ulcers that have been surgically debrided.	Documentation of a surgical wound must be present in the medical record to support the MDS coding during the observation period. Cannot be coded after the site is healed even though cleansing and a dressing may still be applied (example healed stoma or G-tube site). Documentation must include date, clinician signature, and credentials.
M1040F Burns **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation to include a description of the appearance of the second or third degree burns. **Does include:** • Second or third degree burns only; may be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. **Does NOT include:** • First-degree burns (changes in skin color only).	Documentation of signs and symptoms of second and third degree burns must be present in the medical record to support MDS coding during the observation period. Documentation must include date, clinician signature, and credentials.

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M1200A Pressure Relieving Device/chair **M1200B** Pressure Relieving Device/bed **(7-day look back)**	-Special Care (Contributes to ES count)	Equipment aimed at relieving pressure away from areas of high risk. **Does include:** • Foam, air, water, gel, or other cushioning. • Pressure relieving, reducing, redistributing devices. **Does NOT include** • Egg crate cushions of any type. • Doughnut or ring devices.	Documentation and/or description of pressure relieving, reducing, or redistributing devices in the medical record to support MDS coding during the observation period. Each device must be documented separately. (e.g. "Pressure relieving for chair/bed" will not be accepted). Use of the device must be noted in the medical record at least one time during the observation period Additionally, the term "pressure relieving," "pressure reducing" or "pressure redistributing" needs to be verifiable through Manufacturer documentation and available upon request by the Review Team.
M1200C Turning/ repositioning program **(7-day look back)**	-Special Care (Contributes to ES count)	The turning/repositioning program is specific as 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). Progress notes, assessments, and other documentation (as directed by facility policy, should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The goals of the program must be measurable and must occur a minimum of 6 days per week. Evaluation by a licensed nurse during the observation period is required: Co-signing by the nurse will not be accepted. Documentation must be specific if the program is for maintenance or improvement and must include a description of the resident's response to the program within the observation period. Does not include: "Standard of Care Statement", (i.e. q 2 hour turning).

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M1200D Nutrition/hydration intervention to manage skin problems **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of dietary intervention(s) to prevent or treat specific skin conditions. • Description of specific skin condition. **Does include:** • Vitamins and/or supplements.	Nutrition and /or hydration interventions for the purpose of preventing or treating specific skin conditions (i.e. wound healing) ONLY. The MAR's must note that the medication, vitamin, or supplement is for treatment of a skin condition to support MDS coding of this item.
M1200E Pressure Ulcer Care **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation to include any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at each Stage (M0300 A-G). **Does include:** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy.	Documentation of pressure ulcer treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.
M1200F Surgical Wound Care **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation to include any intervention for treating or protecting any type of surgical wound. **Does include:** • Topical cleaning. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. **Does NOT include:** • Post-operative care following eye or oral Surgery. • Surgical debridement of pressure ulcer. • The observation of the surgical wound.	Documentation of surgical wound treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.

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M1200G Application of non-surgical dressings; other than to the feet **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. **Does include:** • Dressing application even once. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydro active particles. **Does NOT include:** • Dressing application to the ankle. • Dressing for pressure ulcer on the foot.	Documentation of application of non-surgical dressing to body part other than the feet must include dressing type, date and clinician signature with credentials in the medical record to support MDS coding.
M1200H Application of ointments/ medications other than to the feet **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of application of ointment/medications (**used to treat or prevent a skin condition**) other than to the feet. **Does include:** • Topical creams. • Powders. • Liquid sealants.	Documentation of application of ointment/medication used to treat or prevent a skin condition other than to the feet must include product, date and clinician signature with credentials in the medical record to support MDS coding.
M1200I Application of Dressings (feet) **(7-day look back)**	Clinically Complex (Contributes to ES count)	Documentation of dressing changes to the feet (with or without topical medication) • Interventions to treat any foot wound or ulcer other than a pressure ulcer.	Documentation of intervention to treat any foot wound or ulcer other than a pressure ulcer must include treatment, date and clinician signature with credentials in the medical record to support MDS coding.
N0300 Injections **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation includes the number of days that the resident received any medication, antigen, vaccine, etc., by subcutaneous, intramuscular or intradermal injection <u>while resident is in facility.</u> **Does include:** • Subcutaneous pumps, only the number of days that the resident actually required a subcutaneous injection to restart the pump. • Insulin injections.	Documentation of number of day's injections given must include clinician signature and credentials in the medical record to support MDS coding. Source document for this item may include MAR and/or Diabetic administration flow sheet.
O100A, either as not a resident (1) or as a resident (2) Chemotherapy **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation to include the administration of any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment.	Documentation of chemotherapy administration, including MAR, while a resident or while not a resident must include date, clinician signature, and credentials. Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.

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O0100B, either as not a resident (1) or as a resident (2) Radiation **(14-day look back)**	-Special Care (Contributes to ES count)	**Does include:** • Intermittent radiation therapy. • Radiation administered via radiation implant. • A nurse's note that resident went out for radiation treatment will be sufficient if there is a corresponding physician order.	Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.
O0100C, either as not a resident (1) or as a resident (2) Oxygen Therapy **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include the administration of oxygen. • The administration of oxygen continuously or intermittently via mask, cannula, etc. • Code when used in BiPAP/CPAP. **Does NOT include:** • Hyperbaric oxygen for wound therapy.	Documentation of oxygen therapy while a resident or while not a resident with liter flow with date, signature/credentials of clinician/staff in the medical record to support MDS coding.
O0100D, either as not a resident (1) or as a resident (2) Suctioning **(14-day look back)**	-Extensive Services	Documentation of **ONLY** nasopharyngeal or tracheal suctioning. • Nasopharyngeal suctioning. • Tracheal suctioning. **Does NOT require:** • Oral suctioning.	Documentation of suctioning "while a resident" or "while not a resident" with signature/credentials of clinician in the medical record to support MDS coding.
O0100E, either as not a resident (1) or as a resident (2) Tracheostomy Care **(14-day look back)**	-Extensive Services	Documentation of tracheostomy and/or cannula cleansing. **Does include:** • Changing a disposable cannula.	Documentation of treatment "while a resident" or "while not a resident" with signature/credentials of clinician in the medical record to support MDS coding.
O0100F, either as not a resident (1) or as a resident (2) Ventilator or Respirator **(14-day look back)**	-Extensive Services	Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support devices. **Does include:** • Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days. **Does NOT include:** • CPAP or BiPAP in this field.	Documentation of ventilator use "while a resident" or "while not a resident" with date, signature/credentials of clinician in the medical record to support MDS coding.

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O0100H, either as not a resident (1) or as a resident (2) IV Medication **(14-day look back)**	-Extensive Services	Documentation of IV medication by push, epidural pump, or drip administration through a central or peripheral port. **Does include:** • Any drug or biological (contrast material). • Epidural, intrathecal, and Baclofen pumps. • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids. **Does NOT include:** • Saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. • Subcutaneous pumps. • IV medications administered only during chemotherapy or dialysis.	Documentation of IV medication administration must include signature/credentials of clinician in the medical record to support MDS coding.
O0100I, either as not a resident (1) or as a resident (2) Transfusions **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include transfusions of blood or any blood products administered directly into the blood stream. **Does NOT include:** • Transfusions administered during dialysis or chemotherapy.	Documentation must include product infused, signature/credentials of clinician in the medical record to support the MDS coding.
O0100J, either as not a resident (1) or as a resident (2) Dialysis **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. **Does include:** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). **Does NOT include:** • IV, IV medication and blood transfusion during dialysis.	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
O0400A, 1, 2 & 3 **O0400B, 1, 2 & 3** **O0400C, 1, 2 & 3** Therapy minutes **(7-day look back)**	-Rehabilitation **Individual therapy** Treatment of one resident at a time. **Concurrent therapy** Treatment of 2 residents at the same time in line-of-sight for Part A only. Residents may not be treated concurrently for Part B-instead report under Group therapy. **Group therapy** Treatment of 2 or 4 residents at the same time-Part A only. Treatment of 2 or more residents at the same time-Part B only.	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. • Only therapy provided while a resident in the facility. • Skilled therapy ONLY. • Physician order, treatment plan and assessment. • Actual therapy minutes ONLY. • Time provided for each therapy must be documented separately. **Does include:** • Subsequent reevaluations. • Set-up time. • Co-treatment when minutes are split between disciplines and do not exceed the total time. • Therapy treatment inside or outside the facility. **Does NOT include:** **Therapy services not medically reasonable and necessary.** • Therapy provided prior to admission. • Initial evaluation. • Conversion of units to minutes. • Rounding to the nearest 5th minute. • Therapy services that are not medically reasonable and necessary. • Therapy provided as restorative nursing. • Services provided by aides. • Services provided by a speech-language pathology assistant.	Documentation of direct therapy minutes with associated initials/signature (s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. Includes: • Only therapy provide while a resident in the facility. • Skilled therapy ONLY. • Therapy that is physician ordered, treatment planned and assessed. • Actual therapy minutes ONLY. • Time provided for each therapy must be documented separately. **Accepted documentation for therapy minutes can only be the computer generated therapy log/grid that is submitted for billing to CMS.**
O0400A4 **O0400B4** **O0400C4** Therapy days **(7-day look back)**	-Rehabilittion	Documentation of direct therapy days with associated initials/signatures(s) to be cited in the medical chart on a daily basis to support the total number of days of direct therapy provided. • Treatment for 15 minutes or more during the day. **Does NOT include:** • Treatment for less than 15 minutes during the day.	Documentation includes number of days, signature/credentials of clinician in medical record to support MDS coding. **Accepted documentation for therapy minutes can only be the computer generated therapy log/grid that is submitted for billing to CMS.**

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O0400D, 2 Respiratory Therapy days **(7-day look back)**	-Special Care (Contributes to ES count**)**	**A day of therapy is defined as 15 minutes or more of treatment in a 24 hour period.** **Does include:** • Subsequent reevaluation time. • Set-up time. **Does NOT include:** • Therapy provided prior to admission. • Time spent on documentation or initial evaluation. • Conversion of units to minutes. • Rounding to the nearest 5th minute. • Therapy services that are not medically necessary. Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). 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.	Documentation of therapy days with associated initials/signature (s) to be cited in the medical record on a daily basis to support MDS coding. • Only therapy provided while a resident in the facility. • Therapy must be physician ordered, treatment planned, and assessed. Oxygen on its own is not a respiratory therapy.
O500A-J Restorative Nursing Programs **(7-day look back)**	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must include the five criteria to meet the definition of a restorative nursing program. • Measurable objectives and interventions must be documented in the care plan and in the medical record. • Evidence of periodic evaluation by a licensed nurse must be present in the resident's medical record. Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period. • Staff must be trained in the proper techniques to promote resident involvement in the activity. • Restorative nursing program activity must be supervised by an RN or LPN. No more than 4 residents per supervising staff personnel. ****When residents are part of a group, provide documentation to identify the group, program, minutes and initials of person providing program.** **Does NOT require:** • Physician orders.	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. Program validation must include initials/signature(s) on a daily basis to support the total days and minutes of nursing restorative programs provided. Evaluation by a licensed nurse is required within the observation period. Includes: • Days for which 15 or more minutes of restorative nursing was provided within a 24 hour period for a minimum of 6 days. • Time provided for each restorative program must be documented separately. MDS review staff may ask to review the training records of the facilities restorative program staff. When residents are part of a group, provide documentation to identify the number of residents in the group and how many staff members are assisting. At least one staff member must be an RNA or licensed staff person.

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O0600 Physician examination **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include evidence of an exam by the physician or other authorized practitioners. **Record the number of days that a physician progress note reflects that a physician examined the resident (or since admission if less than 14 days ago).** **Does include:** • Partial or full exam in facility or in physician's office. **Does NOT include:** • Exams conducted prior to admission or readmission. • Exams conducted during an ER visit or hospital observation stay. • Exam by a Medicine Man.	Document the number of days a physician or other authorized practioner examined the resident. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.
O0700 Physician orders **(14-day look back)**	-Clinically Complex (Contributes to ES count)	**Does include:** • Written, telephone, fax, or consultation orders for new or altered treatment. • Orders written on the day of admission as a result of 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. **Does NOT include:** • Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes. • Activation of a PRN order already on file. • Monthly Medicare certification. • Orders written by a pharmacist. • Orders for transfer of care to another physician.	Document the number of days a physician or other authorized practitioner changed the resident's orders. Included medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician. Does not include sliding scale dose change based on guidelines already ordered.

Review Procedures

Supporting Documentation Related to the MDS/Case Mix Documentation Review:

a) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction within the observation period.

b) A quarterly, annual, or summary note will not substitute for Documentation which is date specific to the observation period.

c) Improper or illegible corrections will not be accepted for the MDS case mix documentation review.

d) All documentation, including corrections, must be part of the original legal medical record.

e) Any and all MDS coding and interpretation questions shall be referred to the local State RAI Coordinator.

f) Late entry documentation more than 72 hours from the ARD will not be accepted.

Signature Date at Z0400:

a) Interview items (BIMS and PHQ-9) must be conducted during the observation periods stated in the RAI Manual and the signature date entered at Z0400 must be prior to or on the ARD.

b) The signature date for these interview items entered at Z0400 must match the date the interview was actually conducted in the medical records. If these dates do not match, facility will not receive credits for these interview items due to conflicting documentation.

c) In the rare situation that interview items were collected (completed) by two people or by the same person but on different dates, (e.g. half of the interview questions were conducted on the next day), each person must enter the signature date at Z0400 and indicate specific interview questions conducted (e.g. D0200 2.A through D; D0200 2.E through I and D0300) in "Sections."

d) The definition of "date collected" and "date completed": date information was collected and coding decision were made. They are one, the same date. This is not the same as the data entry date.

Electronic Health Records (EHR)

a) The facility must grant access to requested medical records in a read-only or other secure format.

b) The facility is responsible for ensuring data backup and security measures are in place.

c) Access to EHR must not impede the review process.

d) Medicaid recipients must have their PASRR and LOC in the active EHR.