

Resource Utilization Group, Version III, Revised
Final Supportive Documentation Guidelines
For MDS 3.0 Assessments with an ARD on or after 10/01/2010

<i>MDS 3.0 Location, Field Description, Observation Period</i>	<i>MDS 2.0</i>	<i>RUG-III Categories Impacted</i>	<i>Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One</i>
Section B: Hearing, Speech, and Vision			
B0100 Comatose (CPS) <i>(7-day look back)</i> (pages: B1-2)	B1	~Clinically Complex ~Impaired Cognition ~(Contributes to ES count)	Comatose is defined as a pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The resident 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 is defined as a resident who does 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. Does require: <ul style="list-style-type: none"> • Diagnosis of coma or persistent vegetative state
B0700 Makes Self Understood (CPS) <i>(7-day look back)</i> (pages: B6-7)	C4	~Impaired Cognition ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Example of the resident's ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination of these
Section C: Cognitive Patterns			
C0200 Repetition of three words (BIMS) <i>(7-day look back)</i> (pages: C2-8)	None	~Impaired Cognition ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Validation of completion of item at Z0400 OR • Evidence of resident interview of BIMS items in medical record
C0300 A,B,C Temporal Orientation (BIMS) <i>(7-day look back)</i> (pages: C8-11)	None	~Impaired Cognition ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Validation of completion of item at Z0400 OR • Evidence of resident interview of BIMS items in medical record
C0400 A,B,C Recall (BIMS) <i>(7-day look back)</i> (pages: C12-14)	None	~Impaired Cognition ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Validation of completion of item at Z0400 OR • Evidence of resident interview of BIMS items in medical record
C0500 BIMS summary score (pages: C15-16)	None	<i>Informational Only</i>	Brief Interview for Mental Status (BIMS) defined: Score range is 0-15 <ul style="list-style-type: none"> • Score <=9, cognitively impaired • Score >=10, cognitively intact
C0700 Short-Term Memory (CPS) <i>(7-day look back)</i> (pages: C18-20)	B2a	~Impaired Cognition ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Example describing an event 5 minutes after it occurred OR • Example describing a follow through on a direction given 5 minutes earlier

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C1000 Cognitive Skills for Daily Decision Making (CPS) <i>(7-day look back)</i> (pages: C23-25)	B4	<i>~Impaired Cognition</i> <i>~(Contributes to ES count)</i>	Does require: <ul style="list-style-type: none"> • Example demonstrating degree of compromised daily decision-making that reflects resident's actual performance Does NOT include: <ul style="list-style-type: none"> • Resident's decision to exercise his/her right to decline treatment or recommendations by staff
Section D: Mood			
D0200A-I, Column 2 A. Little interest or pleasure in doing things B. Feeling down, depressed, or hopeless C. Trouble falling or staying asleep, or sleeping too much D. Feeling tired or having little energy E. Poor appetite or overeating F. Feeling bad about yourself-or that you are a failure or have let yourself or your family down G. Trouble concentrating on things, such as reading the newspaper or watching TV H. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual I. Thoughts that you would be better off dead, or of hurting yourself in some way <i>(14-day look back)</i> (pages: D3-8)	None	<i>~Clinically Complex</i>	Does require: <ul style="list-style-type: none"> • Validation of completion of item at Z0400 OR • Evidence of resident mood interview (PHQ-9) in medical record

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D0300 Total Severity Score (PHQ-9) (pages: D8-9)	None	<i>Informational Only</i>	Total Severity Score defined: <ul style="list-style-type: none"> • 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
D0500A, Column 2 Little interest or pleasure in doing things (14-day look back) (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). Does require: <ul style="list-style-type: none"> • Example that demonstrates resident's lack of interest or pleasure in doing things • Evidence of frequency of mood
D0500B, Column 2 Feeling or appearing down, depressed, or hopeless (14-day look back) (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). Does require: <ul style="list-style-type: none"> • Example that demonstrates resident's feeling or appearing down, depressed, or hopeless • Evidence of frequency of mood
D0500C, Column 2 Trouble falling or staying asleep, or sleeping too much (14-day look back) (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). Does require: <ul style="list-style-type: none"> • Example that demonstrates resident's trouble falling or staying asleep, or sleeping too much • Evidence of frequency of mood
D0500D, Column 2 Feeling tired or having little energy (14-day look back) (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). Does require: <ul style="list-style-type: none"> • Example that demonstrates resident's feeling tired or having little energy • Evidence of frequency of mood
D0500E, Column 2 Poor appetite or overeating (14-day look back) (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). Does require: <ul style="list-style-type: none"> • Example that demonstrates resident's poor appetite or overeating • Evidence of frequency of mood
D0500F, Column 2 Indicating that s/he feels bad about self, or is a failure, or has let self or family down (14-day look back) (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). Does require: <ul style="list-style-type: none"> • Example that demonstrates resident's indication that s/he feels bad about self, or is a failure, or has let self or family down • Evidence of frequency of mood

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D0500G, Column 2 Trouble concentrating on things, such as reading the newspaper or watching TV <i>(14-day look back)</i> (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <i>Does require:</i> <ul style="list-style-type: none"> • Example that demonstrates resident's trouble concentrating on things, such as reading the newspaper or watching TV • Evidence of frequency of mood
D0500H, Column 2 Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that s/he has been moving around a lot more than usual <i>(14-day look back)</i> (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <i>Does require:</i> <ul style="list-style-type: none"> • Example that demonstrates resident's moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that s/he has been moving around a lot more than usual • Evidence of frequency of mood
D0500I, Column 2 States that life isn't worth living, wishes for death, or attempts to harm self <i>(14-day look back)</i> (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <i>Does require:</i> <ul style="list-style-type: none"> • Example that demonstrates resident's statements that life isn't worth living, wishes for death, or attempts to harm self • Evidence of frequency of mood
D0500J, Column 2 Being short tempered, easily annoyed <i>(14-day look back)</i> (pages: D11-14)	None	<i>~Clinically Complex</i>	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <i>Does require:</i> <ul style="list-style-type: none"> • Example that demonstrates resident's being short tempered, easily annoyed • Evidence of frequency of mood
D0600 Total Severity Score (PHQ-9-OV) (pages: D14-15)	None	<i>Informational Only</i>	<i>Total Severity Score defined:</i> <ul style="list-style-type: none"> • Sum of all frequency items (D0500 Column 2) • Total Severity Score range is 00-30 • Score >=10 resident is depressed • Score <10 resident is not depressed

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Section E: Behavior			
E0100A Hallucinations <i>(7-day look back)</i> (pages: E1-3)	J1i	<i>~Behavior Problems</i>	Does require: <ul style="list-style-type: none"> • 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
E0100B Delusions <i>(7-day look back)</i> (pages: E1-3)	J1e	<i>~Behavior Problems</i>	Does require: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • A resident’s expression of a false belief when easily accepts a reasonable alternative explanation
E0200A (code 2 or 3) Physical behavioral symptoms <i>directed toward others</i> Presence & Frequency <i>(7-day look back)</i> (pages: E4-6)	E4cA	<i>~Behavior Problems</i>	Does require: <ul style="list-style-type: none"> • Example and frequency of physical behavior symptoms directed toward others • Hitting, kicking, pushing, scratching, grabbing, abusing others sexually
E0200B (code 2 or 3) Verbal behavioral symptoms <i>directed toward others</i> Presence & Frequency <i>(7-day look back)</i> (pages: E4-6)	E4bA	<i>~Behavior Problems</i>	Does require: <ul style="list-style-type: none"> • Example and frequency of verbal behavior symptoms directed toward others • Threatening others, screaming at others, cursing at others
E0200C (code 2 or 3) Other behavioral symptoms <i>not directed toward others</i> Presence & Frequency <i>(7-day look back)</i> (pages: E4-6)	E4dA	<i>~Behavior Problems</i>	Does require: <ul style="list-style-type: none"> • Example and frequency of other behavioral 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
E0800 (code 2 or 3) Rejection of Care Presence & Frequency <i>(7-day look back)</i> (pages: E13-17)	E4eA	<i>~Behavior Problems</i>	Does require: <ul style="list-style-type: none"> • Example of the resident’s rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident’s goals for health and well-being Does NOT include: <ul style="list-style-type: none"> • Behaviors that have already been addressed and/or determined to be consistent with resident values, preferences or goals

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Section H: Bladder and Bowel			
H0200C Current urinary toileting program or trial Restorative Nursing (7-day look back) (pages: H3-7)	H3a	~Rehabilitation ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions	Documentation must show that the following requirements have been met: Does require: <ul style="list-style-type: none"> • 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 4 or more 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: <ul style="list-style-type: none"> • Less than 4 days of a systematic toileting program • Simply tracking continence status • Changing pads or wet garments • Random assistance with toileting or hygiene
H0500 Bowel toileting program Restorative Nursing (7-day look back) (pages: H11-12)	H3a	~Rehabilitation ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions	Documentation must show that the following requirements have been met: Does require: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Simply tracking of bowel continence status • Changing pads or soiled garments • Random assistance with toileting or hygiene

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Section I: Active Diagnosis			
<u>Active Diagnosis look back period</u> 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.		<u>Documented Diagnosis look back period</u> A physician documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) 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.	
<u>Step 1</u> Determine diagnosis status: active or inactive in the 7-day look back period.			
<u>Step 2</u> Identify documented diagnosis in the 60-day look back period.			
I2000 Pneumonia (7-day look back) (page: I1-10)	I2e	~Special Care ~Clinically Complex ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Code only active diagnosis • Physician documented diagnosis Does NOT include: <ul style="list-style-type: none"> • A hospital discharge note referencing pneumonia during hospitalization
I2100 Septicemia I2900 Diabetes Mellitus I4900 Hemiplegia/ Hemiparesis (7-day look back) (pages: I1-10)	I2g I1a I1v	~Clinically Complex ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Code only active diagnosis • Physician documented diagnosis Does NOT include: <ul style="list-style-type: none"> • A hospital discharge note referencing septicemia during hospitalization
I4300 Aphasia I4400 Cerebral Palsy I5100 Quadriplegia I5200 Multiple Sclerosis (MS) (7-day look back) (page: I1-10)	I1r I1s I1z I1w	~Special Care ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Code only active diagnosis • Physician documented diagnosis

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Section J: Health Conditions			
J1550A Fever (7-day look back) (page: J24-26)	J1h	~Special Care ~(Contributes to ES count)	The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. Does require: <ul style="list-style-type: none"> • Fever of 2.4 degrees above the baseline • A baseline temperature established prior to the ARD • A temperature of 100.4 on admission is a fever
J1550B Vomiting (7-day look back) (page: J24-26)	J1o	~Special Care ~(Contributes to ES count)	Documentation of regurgitation of stomach contents.
J1550C Dehydrated; output exceeds intake (7-day look back) (page: J24-26)	J1c	~Special Care ~Clinically Complex ~(Contributes to ES count)	Documentation does require 2 or more of the 3 potential dehydration indicators. Does require: <ul style="list-style-type: none"> • Usually takes in less than 1500 cc 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: <ul style="list-style-type: none"> • A hospital discharge note referencing dehydration during hospitalization unless 2 of the 3 dehydration indicators are present and documented • A diagnosis of dehydration
J1550D Internal Bleeding (7-day look back) (pages: J24-26)	J1j	~Clinically Complex ~(Contributes to ES count)	Documentation of frank or occult blood. Does require: <ul style="list-style-type: none"> • Black, tarry stools • Vomiting “coffee grounds” • Hematuria • Hemoptysis • Severe epistaxis (nosebleed) that requires packing Does NOT include: <ul style="list-style-type: none"> • Nosebleeds that are easily controlled • Menses • Urinalysis that shows a small amount of red blood cells

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M0300C1 M0300D1 M0300F1 Pressure Ulcer <ul style="list-style-type: none"> • Stage III, IV or unstageable <i>(7-day look back)</i> (pages: M5-17 and M28-29)	M2a	~Special Care ~(Contributes to ES count)	Does require: <ul style="list-style-type: none"> • Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed • Description of the largest surface area of the unhealed ulcer including the length, width, depth and stage • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured Does NOT include: <ul style="list-style-type: none"> • Reverse staging • Pressure ulcers that are healed before the look-back period. (These are coded at M0900) • Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured • Documentation on a weekly skin report or log that includes multiple residents listed
M1040A Infection of the foot <i>(7-day look back)</i> (pages: M30-32)	M6b	~Clinically Complex ~(Contributes to ES count)	Documentation of signs and symptoms of infection of the foot. Does include: <ul style="list-style-type: none"> • Cellulitis • Purulent drainage Does NOT include: <ul style="list-style-type: none"> • Ankle problems • Pressure ulcers coded in M0300-M0900
M1040B Diabetic foot ulcer M1040C Other open lesion on the foot <i>(7-day look back)</i> (pages: M30-32)	M6c	~Clinically Complex ~(Contributes to ES count)	Documentation of signs and symptoms of foot ulcer or lesions. Does require: <ul style="list-style-type: none"> • Description of foot ulcer and or open lesion such as location and appearance Does NOT include: <ul style="list-style-type: none"> • Pressure ulcers coded in M0300-M0900 • Pressure ulcers that occur on residents with diabetes mellitus

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M1040D Open lesions other than ulcers, rashes, cuts (7-day look back) (page: M30-32)	M4c	~Special Care ~(Contributes to ES count)	Does include: <ul style="list-style-type: none"> • Skin lesions that develop as a result of diseases and conditions such as syphilis and cancer Does require: <ul style="list-style-type: none"> • Description of the open lesion such as location and appearance • Documentation in the care plan Does NOT include: <ul style="list-style-type: none"> • Pressure ulcers coded in M0300-M0900 • Skin tears, cuts, abrasions
M1040E Surgical Wounds (7-day look back) (page: M30-32)	M4g	~Special Care ~(Contributes to ES count)	Does include: <ul style="list-style-type: none"> • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body • Pressure ulcers that are surgically repaired with grafts and flap procedures Does require: <ul style="list-style-type: none"> • Description of the surgical wound such as location and appearance Does NOT include: <ul style="list-style-type: none"> • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure • PICC sites, central line sites, peripheral IV sites • Pressure ulcers that have been surgically debrided
M1040F Burns (7-day look back) (pages: M30-32)	M4b	~Clinically Complex ~(Contributes to ES count)	Documentation to include a description of the appearance of the second or third degree burns. Does include: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • First-degree burns (changes in skin color only)

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<p>M1200A Pressure Reducing Device/<i>chair</i></p> <p>M1200B Pressure Reducing Device/<i>bed</i></p> <p><i>(7-day look back)</i> (pages: M32-36)</p>	<p>M5a</p> <p>M5b</p>	<p>~<i>Special Care</i> ~(Contributes to ES count)</p>	<p>Equipment aimed at reducing pressure away from areas of high risk.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Foam, air, water, gel, or other cushioning • Pressure relieving, reducing, redistributing devices <p>Does NOT include:</p> <ul style="list-style-type: none"> • Egg crate cushions of any type • Doughnut or ring devices
<p>M1200C Turning/ repositioning program</p> <p><i>(7-day look back)</i> (pages: M32-36)</p>	<p>M5c</p>	<p>~<i>Special Care</i> ~(Contributes to ES count)</p>	<p>Documentation of a consistent <u>program</u> for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.</p> <p>Does require:</p> <ul style="list-style-type: none"> • Documentation of the intervention and frequency of program • Documentation of monitoring and reassessing the program to determine the effectiveness of the intervention • Documentation by licensed nurse describing an evaluation of the resident's response to the program within the observation period
<p>M1200D Nutrition or hydration intervention to manage skin problems</p> <p><i>(7-day look back)</i> (pages: M32-36)</p>	<p>M5d</p>	<p>~<i>Special Care</i> ~(Contributes to ES count)</p>	<p>Documentation of dietary intervention(s) to prevent or treat specific skin conditions.</p> <p>Does require:</p> <ul style="list-style-type: none"> • Description of specific skin condition <p>Does include:</p> <ul style="list-style-type: none"> • Vitamins and or supplements
<p>M1200E Ulcer Care</p> <p><i>(7-day look back)</i> (pages: M32-36)</p>	<p>M5e</p>	<p>~<i>Special Care</i> ~(Contributes to ES count)</p>	<p>Documentation to include any intervention for treating pressure ulcers coded at M0300.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Use of topical dressings • Chemical or surgical debridement • Wound irrigations • Negative pressure wound therapy (NPWT) • Hydrotherapy • Dressing for pressure ulcer on the foot

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Section N: Medications			
N0300 Injections (7-day look back) (pages: N1-2)	O3	~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: <ul style="list-style-type: none"> Subcutaneous pumps, only the number of days that the resident actually required a subcutaneous injection to restart the pump Insulin injections
Section O: Special Treatments, Procedures, and Programs			
O0100A, either 1 or 2 Chemotherapy (14-day look back) (pages: O1-2)	P1aa	~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. Does include: A nurse's note that resident went out for chemotherapy treatment will be sufficient if there is a corresponding physician order.
O0100B, either 1 or 2 Radiation (14-day look back) (pages: O1-2)	P1ah	~Special Care ~(Contributes to ES count)	Documentation of procedure must include administration inside or outside of facility. Does include: <ul style="list-style-type: none"> 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
O0100C, either 1 or 2 Oxygen Therapy (14-day look back) (pages: O1-2)	P1ag	~Clinically Complex ~(Contributes to ES count)	Documentation must include the administration of oxygen. Does require: <ul style="list-style-type: none"> The administration of oxygen continuously or intermittently via mask, cannula, etc. Code when used in BiPAP/CPAP Does NOT include: <ul style="list-style-type: none"> Hyperbaric oxygen for wound therapy
O0100D, either 1 or 2 Suctioning (14-day look back) (pages: O1-2)	P1ai	~Extensive Services	Documentation of ONLY nasopharyngeal or tracheal suctioning. Does require: <ul style="list-style-type: none"> Nasopharyngeal suctioning Tracheal suctioning Does NOT include: <ul style="list-style-type: none"> Oral suctioning

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<i>MDS 3.0 Location, Field Description, Observation Period</i>	<i>MDS 2.0</i>	<i>RUG-III Categories Impacted</i>	<i>Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One</i>
O0100E, either 1 or 2 Tracheostomy Care (14-day look back) (pages: O1-2)	P1aj	~Extensive Services	Documentation of tracheostomy and/or cannula cleansing. Does include: <ul style="list-style-type: none"> • Changing a disposable cannula • Cleansing of the trach and/or cannula
O0100F, either 1 or 2 Ventilator or Respirator (14-day look back) (pages: O1-3)	P1al	~Extensive Services	Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support devices. Does include: <ul style="list-style-type: none"> • Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days Does NOT include: <ul style="list-style-type: none"> • CPAP or BiPAP in this field
O0100H, either 1 or 2 IV Medication (14-day look back) (pages: O1-3)	P1ac	~Extensive Services	Documentation of IV medication by push, epidural pump, or drip administration through a central or peripheral port. Does include: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Saline or heparin flush to keep a heparin lock patent • IV fluids without medication • Subcutaneous pumps • IV medications administered only during dialysis or chemotherapy • Dextrose 50% and Lactated Ringers
O0100I, either 1 or 2 Transfusions (14-day look back) (pages: O1-3)	P1ak	~Clinically Complex ~(Contributes to ES count)	Documentation must include transfusions of blood or any blood products administered directly into the bloodstream. Does NOT include: <ul style="list-style-type: none"> • Transfusions administered during dialysis or chemotherapy

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<i>MDS 3.0 Location, Field Description, Observation Period</i>	<i>MDS 2.0</i>	<i>RUG-III Categories Impacted</i>	<i>Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One</i>
<p>O500A-J Restorative Nursing Programs</p> <p><i>(7-day look back)</i> <i>(pages: O27-34)</i></p>	<p>P3a-j</p>	<p><i>~Rehabilitation</i> <i>~Impaired Cognition</i> <i>~Behavior Problems</i> <i>~Reduced Physical Functions</i></p>	<p>Documentation must include the five criteria to meet the definition of a restorative nursing program:</p> <ol style="list-style-type: none"> 1) Care plan with measurable objectives and interventions 2) Periodic evaluation by a licensed nurse **Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period. 3) Staff trained in the proper techniques 4) Supervision by nursing 5) 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. <p>Program validation must include initials/ signature(s) on a daily basis to support the total days and minutes of nursing restorative programs provided.</p> <p>Does require:</p> <ul style="list-style-type: none"> • Days for which 15 or more minutes of restorative nursing was provided within a 24 hour period • For splint or brace assistance, assessment of the residents skin and circulation under the device, and reposition the limb in correct alignment • Time provided for each program must be documented separately <p>Does NOT include:</p> <ul style="list-style-type: none"> • Requirement for Physician orders • Procedures or techniques carried out by or under the direction of qualified therapists • Movement by a resident that is incidental to care

