Kentucky Department for Medicaid Services

SUPPORTIVE DOCUMENTATION REQUIREMENTS USER GUIDE

PATIENT DRIVEN PAYMENT MODEL (PDPM) NURSING COMPONENT

Myers and Stauffer LC

Effective for Assessment ARD Dated October 1, 2023 and After

Revised Date ~~October 24~~November 27, 2023

Table of Contents

Introduction

Accuracy of the MDS item responses is very important for many reasons: responses guide the care provided to the resident; Quality Measures assist state survey in identifying potential care problems in a nursing facility; and the Medicare Prospective Payment System rates are set based on MDS responses.

These Supportive Documentation Requirements apply to all Kentucky Medicaid-certified nursing facilities that are scheduled for PDPM case mix reviews on or after October 1, 2023.

SOURCE OF DOCUMENTATION REQUIREMENTS

Good documentation is expected of all trained and licensed health care professionals. The submitted MDS data for each resident should accurately reflect the resident's condition as documented in the resident's clinical records maintained by the nursing facility.

The information in these Requirements has been compiled in conjunction with the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual), instructions that are printed on the MDS 3.0 form itself, and the Data Submission Specifications for MDS 3.0. Nursing facility personnel should review these resources thoroughly to accurately understand MDS coding and meet all federal requirements. If later guidance is released by the Centers for Medicare & Medicaid Services (CMS) that augments guidance provided in this document, the more current information from the CMS becomes the minimum acceptable standard.

MDS ITEMS FOR REVIEW

While good documentation and accurate coding of the MDS is essential for all MDS item responses, the Nursing Component of the PDPM classification system uses only a subset of the MDS assessment items; those that may have an impact on your facility's reimbursement rate. As such, these requirements identify only those MDS items used in the Nursing Component of the PDPM system.

OVERALL DOCUMENTATION INSTRUCTIONS

According to the RAI manual in Chapter 1, "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."

There are several standard conventions to be used when completing the MDS assessment, as follows:

- The standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated.
- With the exception of certain items the look-back period does not extend into the preadmission period unless the item instructions state otherwise.
- In the case of reentry, the look-back period does not extend into time prior to the reentry, unless instructions state otherwise.
- When determining the response to items that have a look-back period relating back to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to iQIES.
- PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to iQIES and therefore should not be considered when determining the "prior assessment."

Documentation in the clinical record should consistently support the MDS item response and reflect care related to the symptom/problem. Documentation must apply to the appropriate look-back period and reflect the resident's status on all shifts. Conflicting documentation identified within the observation period shall be deemed as unsupported documentation.

Documentation from all disciplines and all portions of the resident's clinical record within the look-back period may be used to verify an MDS item response. Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all clinical records. At a minimum, the signature must include the first initial, last name, and title/credential. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there must also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS).

When electronic signatures are used, there must be a written policy in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs and must include safeguards to prevent unauthorized use of electronic signatures.

In cases of corrections, obliterations, errors or mistaken entries, the author of the original entry must, at a minimum draw a line through the incorrect information and include the original author's initials, the date the correction was made and the correct information.

Z0400

Z0400 requires the **signature, title, sections and dated sections completed** by all persons completing any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.

Z0400 certification reads as follows:
"I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment for such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

MDS assessment date requirements may be found in the RAI Manual, Chapter 2.

Supportive Documentation Requirements

REQUIREMENTS TABLE EXPLANATION

The Supportive Documentation Requirements table contains a header per section as well as three columns described below.

Column 1 - MDS 3.0 Item Location and Item Description

This column identifies the MDS 3.0 item location by section letter, item number and the label of the MDS item. A notation of BIMS indicates the MDS item is associated with the Brief Interview for Mental Status severity score. A notation of Restorative Nursing in this column indicates the MDS item is used in the count of Restorative Nursing programs in the PDPM system.

Column 2 - PDPM Categories Impacted

This column identifies the PDPM group(s) impacted by the MDS item. Additionally, there may be informational data in a particular area denoted by *Informational Only*.

Column 3 - Minimum Documentation and Review Standards Required Within the Specified Observation Period

This column provides an overview of the requirements for minimum documentation required to support the MDS responses. The column may also contain additional information that may aid the user in correctly providing supporting documentation for the MDS item.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Extensive Services ***If Nursing Function Score is 15 or 16 – skip to Clinically Complex***		
O0110E1b Tracheostomy Care	***Extensive Services***	***Does require:*** • Documentation of cleansing of the tracheostomy and/or cannula during the observation period. ***Does include:*** • Documentation of the resident performing their own tracheostomy care. • Changing a disposable cannula. • Laryngectomy tube care.
O0110F1b Invasive Mechanical Ventilator **(ventilator or respirator)**	***Extensive Services***	***Does require:*** • Documentation of use of any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support their own respiration. ***Does include:*** • Any resident being weaned from the respiratory or ventilator during the observation period. • Any resident who was weaned from the respiratory or ventilator in the last 14 days. **Does NOT include:** • Times when used as a substitute for BiPAP or CPAP
O0110M1b Isolation or quarantine for active infectious disease (Does not include standard body/fluid precautions).	***Informational Only***	**Code for "single room isolation" only when all of the following conditions are met:** 1) The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2) Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3) The resident is in a room alone <u>because of active infection</u> and <u>cannot</u> have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. 4) The resident must remain in their room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).
O0110M1b Isolation or quarantine for active infectious disease (Does not include standard body/fluid precautions).	***Extensive Services***	**Does require:** • Documentation supporting active infectious disease, i.e., symptomatic and/or have a positive test and are in the contagious stage. • Documentation of need for transmission-based precautions and strict isolation alone in separate room. (See definition for "single room isolation" criteria) • Documentation of highly transmissible or epidemiologically significant pathogens acquired by physical contact, airborne or droplet transmission. **Does NOT include**: • Standard precautions. • History of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with roommate

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care High		
B0100 Comatose	***Special Care High***	**Does require:** • **All components of the nursing function score must = 1, 9, or 88** • Documentation of active diagnosis of coma or persistent vegetative state documented by a physician, nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. **Does NOT include:** • Resident in advance stages of progressive neurological disorders (i.e. Alzheimer's disease).
I2100 Septicemia	***~Special Care High***	**See Active Diagnoses Definition** **Does include:** • Sepsis **Does NOT include:** • A hospital discharge note referencing septicemia during hospitalization without active treatment during the observation period.
I2900 Diabetes Mellitus (DM)	***~Special Care High***	**See Active Diagnoses Definition.** ***Does include:*** • Diabetic retinopathy • Diabetic nephropathy • Diabetic neuropathy
N0350A Days of Insulin Injections	***~Special Care High***	***Does require:*** • Documentation must be consistent with physician orders and insulin administration records. • Documentation to include the number of days that insulin injections were received during the observation period. ***Does include:*** • The number of days the resident actually required a subcutaneous injection to restart the subcutaneous insulin pump.
N0350B Days of Orders for Insulin	***~Special Care High***	***Does require:*** • Documentation must include the number of days that the insulin orders changed during the observation period. ***Does include:*** • Sliding scale order that is new, discontinued, or is the first sliding scale order. ***Does NOT include:*** • A different dose of insulin administered based on an existing sliding scale order.
I5100 Quadriplegia	***~Special Care High***	**See Active Diagnoses Definition.** ***Does require:*** • **Nursing Function Score less than or equal to 11** • Physician documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs) and is not the result of another condition. ***Does NOT include:*** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care High *(Continued)*		
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	***~Special Care High***	**See Active Diagnoses Definition.** ***Does include:*** • Chronic bronchitis • Restrictive lung diseases (such as asbestosis, pulmonary fibrosis, etc.) • Emphysema ***Does NOT include:*** • Obesity hypoventilation syndrome • Chronic lung disease(s) may be coded at I6200 OR I8000 **but may not be coded at both**
J1100C Shortness of Breath or Trouble Breathing When Lying Flat	***~Special Care High***	***Does require:*** • Documentation of the presence of or observation of shortness of breath or trouble breathing, including symptoms experienced, when lying flat **during the observation period;** or, • Documentation of staff interview, including the date(s) staff reported resident experiencing shortness of breath or trouble breathing while lying flat and symptoms experienced; or • Documentation indicating resident's avoidance of lying flat due to shortness of breath including interventions applied to avoid shortness of breath while lying flat during the observation period.
J1550A Fever	***~Special Care High***	***Does require:*** • Consistent/documented route (oral, axillary, etc.) of temperature between the baseline and the elevated temperature. • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established prior to the ARD • Baseline must be updated annually. ***Does include:*** • A temperature of 100.4 degrees F. on admission (prior to the establishment of the baseline temperature).
I2000 Pneumonia	***~Special Care High***	**See Active Diagnoses Definition.** ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization without active treatment during the observation period.
J1550B Vomiting	***~Special Care High***	***Does require:*** • Documentation of regurgitation of stomach contents.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care High *(Continued)*		
K0300 (code 1 or 2) Weight Loss	**~Special Care High**	***Does require:*** • Documentation of resident's weight both 30 days and/or 180 days prior to the current weight during the observation period. • Documentation supporting the expressed goal for the weight loss for code of "1," on physician-prescribed weight loss regimen. ***Does include:*** • Mathematical rounding. • Planned or unplanned. • Weight loss via physician-prescribed weight loss regimen.
K0520B2 or K0520B3 *Feeding Tube ***K0710A3 51% or more of total calories, OR** ***K0710A3 26% to 50% of total calories AND K0710B3 is 501cc or more per day fluid enteral intake in the last 7 days.**	***~Special Care High***	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital as an outpatient or inpatient, provided the documentation supports the need for nutrition or hydration. ***Does include:*** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes. • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the GI system.
K0520A2 or K0520A3 Parenteral or IV Feedings ***While a Resident*** ***While NOT a Resident***	***~Special Care High***	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home, at the hospital as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. ***Does include:*** • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • IV running at KVO (keep vein open). • IV fluids contained in IV piggybacks. • Hypodermoclysis and subcutaneous ports in hydration therapy. • IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record. ***Does NOT include:*** • IV medications. • IV fluids used to reconstitute and/or dilute meds. • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • IV fluids administered in conjunction with chemotherapy or dialysis.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care High *(Continued)*		
***K0710A3 Proportion of Total Calories the Resident Received Through Tube Feeding** *Column 3-during entire 7 days* ***K0710A3 51% or more of total calories, OR** ***K0710A3 26% to 50% of total calories AND K0710B3 is 501cc or more per day fluid enteral intake in the last 7 days.**	***~Special Care High*** ***~Special Care Low***	***Does require:*** • Documentation to support the proportion of calories actually received for nutrition and/or hydration through tube feeding during the entire 7-day observation period. *Unless the resident is NPO, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* 1. Calories tube feeding provided each day within observation period. 2. Calories oral feeding provided each day within observation period. 3. Percent of total calories provided by tube feeding within the observation period.
***K0710B3 Average Fluid Intake Per Day by Tube Feeding.** *Column 3-during entire 7 days* ***K0710A3 51% or more of total calories, OR** ***K0710A3 26% to 50% of total calories AND K0710B3 is 501cc or more per day fluid enteral intake in the last 7 days.**	***~Special Care High*** ***~Special Care Low***	***Does require:*** • Documentation to support average fluid intake per day by 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 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.)*

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care High *(Continued)*		
O0400D2 Respiratory Therapy Days	***~Special Care High***	***Does require:*** • Physician order that includes a statement of treatment specific to the resident's needs. • Documentation of actual direct minutes on a daily/shift/occurrence basis. • Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided. • Care planned and periodically evaluated to ensure the resident receives needed therapies and that treatment plans are effective • Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. • Documentation that the respiratory nurse (licensed nurse) has been trained in the modalities provided through specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws. • Respiratory evaluation during the observation period by a licensed nurse. ***Does include:*** • Coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. **Does NOT include:** • Treatment for less than 15 direct minutes per day. • Time that a resident self-administers a nebulizer treatment without the supervision of the respiratory therapist or respiratory nurse. • Metered-dose or dry powder inhalers.
D0150A-I, Column 2 Resident Mood Interview (PHQ-2 to 9)	***~Special Care High***	***Does require:*** • Validation of completion of interview items D0150 A - I at Z0400 dated on or before the ARD and within the observation period.
D0500A-J, Column 2 Staff Assessment of Resident Mood (PHQ-9-OV)	***~Special Care High***	***Does require:*** • Documentation of the date(s) staff member(s) interviewed across all shifts, dates of staff observations, and the frequency reported for each applicable item D0500 A-J. • If family member(s) or significant other(s) were interviewed, the date the interview was conducted, dates of family member(s) or significant other(s) observations and the frequency reported for each applicable item at D0500 A-J.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care Low		
I4400 Cerebral Palsy	***~Special Care Low***	**See Active Diagnoses Definition.** **Does Require:** • **Nursing Function Score less than or equal to 11**
I5200 Multiple Sclerosis (MS)	***~Special Care Low***	**See Active Diagnoses Definition.** **Does Require:** • **Nursing Function Score less than or equal to 11**
I5300 Parkinson's Disease	***~Special Care Low***	**See Active Diagnoses Definition.** **Does Require:** • **Nursing Function Score less than or equal to 11** ***Does include:*** • Paralysis agitans • Shaking palsy ***Does NOT include:*** • Parkinsonism
I6300 Respiratory Failure	***~Special Care Low***	**See Active Diagnoses Definition.** **Does NOT include:** • I6300 Respiratory Failure may not be coded under I6200
O0110C1b Oxygen Therapy	***~Special Care Low***	***Does require:*** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Documentation of precipitating event for PRN usage resulting in the application of oxygen. ***Does include:*** • Resident places or removes his/her own oxygen mask, cannula. • Oxygen when used in BiPAP/CPAP. ***Does NOT include:*** • Hyperbaric oxygen for wound therapy.
K0520B2 or K0520B3 ***Feeding Tube** ***K0710A3** **51% or more of total calories, OR** ***K0710A3 26% to 50% of total calories AND K0710B3 is 501cc or more per day fluid enteral intake in the last 7 days.**	***~Special Care Low***	***Does require:*** • Documentation that includes any and all nutrition and hydration received by the resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided the documentation supports the need for nutrition or hydration. ***Does include:*** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes. • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the GI system.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care Low *(Continued)* *****Check pages 25 for required skin treatments***		
K0710A3 Proportion of Total Calories the Resident Received Through Tube Feeding *Column 3-during entire 7 days*	***~Special Care High*** ***~Special Care Low***	***Does require:*** • Documentation to support the proportion of calories actually received for nutrition and/or hydration through tube feeding during the entire 7-day observation period. *Unless the resident is NPO, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* 1. Calories tube feeding provided each day within observation period. 2. Calories oral feeding provided each day within observation period. 3. Percent of total calories provided by tube feeding within the observation period.
K0710B3 Average Fluid Intake Per Day by Tube Feeding. *Column 3-during entire 7 days*	***~Special Care High*** ***~Special Care Low***	***Does require:*** • Documentation to support average fluid intake per day by 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 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.)*
****M0300B1** Stage 2 ****M0300C1** Stage 3 ****M0300D1** Stage 4 ****M0300F1** Unstageable Due to Slough/Eschar	***~Special Care Low***	***Does require:*** • Documentation of pressure ulcer(s)/injury within the observation period must include but is not limited to; identification of wound as a pressure ulcer, location, and description. • Documentation must include complete history of pressure ulcer(s)/injury when the reported stage is numerically higher than the current stage and description. ***Does NOT include:*** • Pressure ulcers/injuries that are healed during the look-back period. • A pressure ulcer/injury surgically repaired with a flap or graft. • If pressure is NOT the primary cause. • Oral mucosal ulcers caused by pressure (report at L0200C). • Skin tears, tape burns, moisture associated skin damage, or excoriation.
****M1030** Venous/Arterial Ulcers	***~Special Care Low***	***Does require:*** • Documentation of the venous/arterial ulcer must include but is not limited to; identification of the wound as a venous/arterial ulcer, location and description. ***Does NOT include:*** • Pressure ulcers/injuries coded in M0300.
M1040A Infection of the Foot	***~Special Care Low***	***Does require:*** • Documentation of signs and symptoms of infection of the foot. ***Does include:*** • Cellulitis. • Purulent drainage. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care Low *(Continued)*		
M1040B Diabetic Foot Ulcer	***~Special Care Low***	***Does require:*** • Documentation of diabetic foot ulcer must include but is not limited to identification of the wound as a diabetic foot ulcer, location and description. ***Does include:*** • Ulcers caused by neuropathic and small blood vessel complications of diabetes. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300. • Pressure ulcers/injuries that occur on the heel of a diabetic resident.
M1040C Other Open Lesion on the Foot, (e.g. cuts, fissures)	***~Special Care Low***	***Does require:*** • Documentation of open lesion must include but is not limited to location and description. • Lesion must be open during observation period. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0300.
M1200I Applications of Dressings to Feet	***~Special Care Low***	***Does require:*** • 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/injury.** ***Does NOT include:*** • Dressings to pressure ulcers/injuries; use pressure ulcer/injury care (M1200E). • Dressing application to the ankle. The ankle is not considered part of the foot.
O0110B1b Radiation	***~Special Care Low***	***Does require:*** • Documentation of administration of radiation inside or outside of facility. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant.
O0110J1b Dialysis	***~Special Care Low***	***Does require:*** • Documentation of the administration of peritoneal or renal dialysis that occurred inside or outside facility. • Documentation must indicate that the resident actually received the dialysis and not just left the building (or remained in the building) with the intent to receive dialysis. ***Does include:*** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). • Resident performing their own dialysis. ***Does NOT include:*** • IV, IV medication and blood transfusion administered during dialysis.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Special Care Low *(Continued)*		
D0150A-I, Column 2 Resident Mood Interview (PHQ-2 to 9)	***~Special Care Low***	***Does require:*** • Validation of completion of interview items D0150 A - I at Z0400 dated on or before the ARD and within the observation period.
D0500A-J, Column 2 Staff Assessment of Resident Mood (PHQ-9-OV)	***~Special Care Low***	***Does require:*** • Documentation of the date(s) staff member(s) interviewed across all shifts, dates of staff observations, and the frequency reported for each applicable item D0500 A-J. • If family member(s) or significant other(s) were interviewed, the date the interview was conducted, dates of family member(s) or significant other(s) observations and the frequency reported for each applicable item at D0500 A-J.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Clinically Complex ******Refer to Appropriate Skin Treatments on Page 25***		
I2000 Pneumonia	***~Clinically Complex***	**See Active Diagnoses Definition.** ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization without active treatment during the observation period.
I4900 Hemiplegia/ Hemiparesis	***~Clinically Complex***	**See Active Diagnoses Definition.** **Does require:** • **Nursing function score less than or equal to 11** ***Does include:*** • Left or right sided paralysis. ~~***Does NOT include:***~~ • ~~Left or right sided weakness.~~
****M1040D** Open Lesion Other Than Ulcers, Rashes, Cuts	***~Clinically Complex***	***Does require:*** • Description of open lesion must include but is not limited to location and description. • Lesion must be open during observation period. ***Does include:*** • Open lesions that develop as a result of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles. ***Does NOT include:*** • Pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears, cuts/lacerations, abrasions, or rashes.
****M1040E** Surgical Wound	***~Clinically Complex***	***Does require:*** • Description of the surgical wound must include but is not limited to identification of the wound as a surgical wound, location and description. ***Does include:*** • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. • Pressure ulcers/injury(s) that are surgically repaired with grafts and flap procedures. ***Does NOT include:*** • Healed surgical sites and healed stomas. • Lacerations that require suturing or butterfly closure. • PICC sites, central line sites, peripheral IV sites. • Pressure ulcers/injuries that have been surgically debrided.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Clinically Complex *(Continued)*		
M1040F Burn(s)	***~Clinically Complex***	***Does require:*** • Description of the second or third degree burn must include but is not limited to location and description. ***Does include:*** • Any stage of healing. • Skin and tissue injury caused by heat or chemicals. ***Does NOT include:*** • First-degree burns (changes in skin color only).
O0110A1b Chemotherapy *While a Resident*	***~Clinically Complex***	***Does require:*** • Documentation of administration of any type of chemotherapy agent (anticancer drug) given by any route for the sole purpose of cancer treatment. ***Does NOT include:*** • IV administered during chemotherapy. • IV medication administered during chemotherapy. • Blood transfusions administered during chemotherapy. • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer.
O0110C1b Oxygen Therapy	***~Clinically Complex***	***Does require:*** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Documentation of precipitating event for PRN usage resulting in the application of oxygen. ***Does include:*** • Resident places or removes his/her own oxygen mask, cannula. • Oxygen when used in BiPAP/CPAP. ***Does NOT include:*** • Hyperbaric oxygen for wound therapy.
O0110H1b IV Medications	***~Clinically Complex***	***Does require:*** • Documentation of the administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port. ***Does include:*** • Epidural, intrathecal, and baclofen pumps. ***Does NOT include:*** • Flushes to keep an IV port patent. • IV fluids without medication. • Subcutaneous pumps. • IV medications administered during dialysis or chemotherapy. • Dextrose 50% and/or Lactated Ringers.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Clinically Complex *(Continued)*		
O0110I1b Transfusions	***~Clinically Complex***	***Does require:*** • Documentation of the administration of blood or any blood products directly into the bloodstream. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.
D0150A-I, Column 2 Resident Mood Interview (PHQ-2 to 9)	***~Clinically Complex***	***Does require:*** • Validation of completion of interview items D0150A - I at Z0400 dated on or before the ARD and within the observation period.
D0500A-J, Column 2 Staff Assessment of Resident Mood (PHQ-9-OV)	***~Clinically Complex***	***Does require:*** • Documentation of the date(s) staff member(s) interviewed across all shifts, dates of staff observations, and the frequency reported for each applicable item D0500 A-J. • If family member(s) or significant other(s) were interviewed, the date the interview was conducted, dates of family member(s) or significant other(s) observations and the frequency reported for each applicable item at D0500 A-J.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Behavioral Symptoms and Cognitive Performance		
C0200 Repetition of Three Words (BIMS) **C0300 A,B,C Temporal Orientation (BIMS)** **C0400 A,B,C Recall (BIMS)**	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • Validation of completion of interview items C0200, C0300A, B, C, C0400A, B, and C at Z0400 dated on or before the ARD and within the observation period.
B0100 Comatose	***~Behavioral Symptoms and Cognitive Performance***	**Does require:** • **All components of the nursing function score must = 1, 9, or 88** • Documentation of active diagnosis of coma or persistent vegetative state documented by a physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. **Does NOT include:** • Resident in advance stages of progressive neurological disorders (i.e. Alzheimer's disease).
C1000 Cognitive Skills for Daily Decision Making (CPS)	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of the resident's actual performance documenting the degree of compromised daily decision-making about everyday decisions for tasks or daily activities. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan (e.g. clocks, calendars, posted event notices). • Seeking information from others to plan the day. • Acknowledging need to use appropriate assistive equipment (i.e. walker). • Awareness of strengths and limitations to regulate the day's events. ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.
B0700 Makes Self Understood	***~Behavioral Symptoms and Cognitive Performance***	**Does require:** • **Example(s) and date(s)** of the resident's verbal and/or non-verbal 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, gestures or a combination of these. **Does include:** • Reduced voice volume • Difficulty in producing sounds • Difficulty in finding the right word, making sentences, writing, and/or gesturing
C0700 Short-Term Memory (CPS)	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** **Example(s) and date(s)** documenting the resident's ability to: • Describe an event 5 minutes after it occurred if the resident's response can be validated, **OR** • Follow through on a direction given 5 minutes earlier.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Behavioral Symptoms and Cognitive Performance *(Continued)*		
E0100A Hallucinations	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of the resident's perception of the presence of something that is not actually there, OR • Documentation of the date(s) the staff interview was conducted and the date(s), including a description of the hallucination(s) per occurrence(s). ***Does include:*** • Auditory, visual, or involve smells, tastes or touch.
E0100B Delusions	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary, OR • Documentation of the date(s) the staff interview was conducted and the date(s), including a description of the delusion(s) per occurrence(s). ***Does NOT include:*** • A resident's expression of a false belief when the resident easily accepts a reasonable alternative explanation. • A belief that cannot be shown to be false or is impossible to determine if it is false.
E0200A (code 2 or 3) Physical Behavioral Symptoms *directed toward others*	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's physical behavioral symptoms directed toward others, OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited physical behavioral symptoms directed toward others, including a description of the physical behavioral symptoms directed toward others, per occurrence(s). ***Does include:*** • Hitting, kicking, pushing, scratching, grabbing, and abusing others sexually. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0200B (code 2 or 3) Verbal Behavioral Symptoms *directed toward others*	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's verbal behavioral symptoms directed toward others, OR • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited verbal behavioral symptoms directed toward others, including a description of the verbal behavioral symptoms directed toward others, per occurrence(s). ***Does include:*** • Threatening others, screaming at others, cursing at others. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Behavioral Symptoms and Cognitive Performance *(Continued)*		
E0200C (code 2 or 3) Other Behavioral Symptoms *not directed toward others*	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's other behavioral symptoms NOT directed toward others. • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited other behavioral symptoms not directed toward others, including a description of the other behavioral symptoms not directed toward others, per occurrence(s). ***Does include:*** • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0800 (code 2 or 3) Rejection of Care	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's values, preferences or goals; **OR** • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited rejection of care, including a description of the rejection of care, per occurrence(s). ***Does include:*** • Behaviors that interrupt or interfere with the delivery or receipt of care including; verbally declining, statements of refusal or through physical behaviors that convey aversion to, result in avoidance of, or interfere with the receipt of care. • Hindering the delivery of care by disrupting the usual routines or processes by which care is given. • Exceeding the level or intensity of resources that are usually available for the provision of care. ***Does NOT include:*** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals.
E0900 (code 2 or 3) Wandering	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • **Example(s) and date(s)** of resident's moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction; **OR** • Documentation of the date(s) the staff interview was conducted and the date(s) the staff member reported that the resident exhibited wandering, including a description of the wandering, per occurrence(s). ***Does NOT include:*** • Pacing (repetitive walking with a driven/pressured quality) within a constrained space. • Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity).

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Behavioral Symptoms and Cognitive Performance/Nursing Restorative		
H0200C** Current Urinary Toileting Program or Trial** *(Restorative Nursing)*	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • Documentation of a toileting program trial that includes an individualized, resident-centered toileting program of at least 3 days of toileting patterns with prompting to toilet and a **documented response to the trial toileting program**. • Following program trial and response, documentation of a current toileting program being used to manage urinary continence during the 7-day look back period must include: 1) implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern; 2) documentation that the program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, and a written report; and 3) documentation of resident's response to the toileting program by a licensed nurse **during the observation period**. • Systematic toileting program that is being managed 4 or more days of the 7-day look back period. ***Does include:*** • Program if only used by day (when documented that the resident does not want awakened at night). ***Does NOT include:*** • Less than 4 days of a systematic toileting program. • Simply tracking of urinary continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.
H0500** Bowel Toileting Program** *(Restorative Nursing)*	***~Behavioral Symptoms and Cognitive Performance***	***Does require:*** • Documentation of implementation of an individualized, resident-specific bowel toileting program **based on an assessment of the resident's unique bowel pattern.** • Documentation that the individualized program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; **AND** • Documentation of resident's response to the toileting program by a licensed nurse **during the observation period**. ***Does NOT include:*** • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.

*******H0200C (Urinary Toileting Program) and H0500 (Bowel Toileting Program) count as one service even if both are provided.***

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Nursing Restorative Programs		
O0500A-J**** Restorative Nursing Program Days	***~Behavioral Symptoms and Cognitive Performance*** ***~Reduced Physical Function***	***Does require:*** • Documentation of actual direct minutes on a daily/shift/occurrence basis for each program provided within a 24-hour period. • Associated initials/signature(s) on a daily basis to support the total number of minutes of restorative nursing program(s) provided. • Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented. • Time must be documented separately for each restorative program. • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1. Measurable objectives and interventions must be documented in the care plan and in the medical record; and 2. Evaluation of the program by a licensed nurse. (For the case mix review, reassess progress, goals and duration/frequency of each program within the observation period.); and 3. Staff trained in the proper techniques; and 4. Supervised by licensed nurse; and 5. No more than 4 residents per supervising helper or caregiver. • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device and reposition the limb in correct alignment within the observation period. ***Does include:*** • An evaluation of the program written by the CNA and co-signed by a licensed nurse once the purpose and objectives have been established (contingent upon state Nurse Practice Act and any other applicable state laws). ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • For both passive and active range of motion, movement by a resident that is incidental to care does not count as part of a formal restorative nursing program. • Treatment for less than 15 direct minutes per day.

*******O0500A (Passive Range of Motion) and O0500B (Active Range of Motion) count as one service even if both are provided.***

*******O0500D (Bed Mobility) and O0500F (Walking) count as one service even if both are provided.***

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section GG: Functional Abilities and Goals ***Look-back period for Section GG (Admission) – First three days of the stay*** ***Look-back period for OBRA/Interim – ARD plus 2 previous calendar days***	
GG0130A Self-Care: Eating *Tube feedings and parenteral nutrition are not considered when coding this activity.*	***Does require:*** • **Documentation during the observation period to accurately capture resident usual performance.** • **Initials and dates to authenticate the medical record entries including signatures and titles to authenticate initials per episode.** • **The key for coding Section GG must include all the MDS options and be equivalent to the intent and definition of the MDS key.** • **Key definitions must align with the definition in the RAI manual and must be available to the RN Reviewer and understood by facility staff.** • **Self-Care and Mobility definitions must include all tasks and components related to the specific activity.** • **If using narrative notes to support Section GG, each occurrence must include the specific activity. Wording must be equivalent to MDS key definitions for example "The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident".** • **Facilities utilizing one designated documentation collection tool should note corrections or references to additional documentation on that tool.** • **During the IDT meeting, facilities should determine usual performance based on the data gathered, document the IDT decision, and enter into the medical record.** • **All documentation to be considered for the review must be clearly identified and presented to the reviewer in an organized manner representing how the usual performance was determined.** • **Documentation must be maintained as part of the permanent original legal medical record and be readily accessible during the review.** ***Does NOT include:*** • **Individuals hired, compensated or not, by individuals outside the facility's management and administration.** • **Services provided other than by staff in the facility; such as family, hospice staff, nursing/CNA students and other visitors.**
GG0130C Self-Care: Toileting Hygiene *Managing clothing and perineal cleansing – takes place before and after the use of the toilet, commode, bedpan or urinal.*	
GG0170B Mobility: Sit to Lying *The ability to move from sitting on side of bed to lying flat on the bed.*	
GG0170C Mobility: Lying to sitting on side of bed *The ability to move from lying to sitting on the side of the bed and with no back support.*	
GG0170D Mobility: Sit to stand *The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.*	
GG0170E Mobility: Chair/bed to chair transfer *The ability to transfer to and from a bed to a chair (or wheelchair).*	
GG0170F Mobility: Toilet transfer *The ability to get on and off a toilet or commode.*	

DEFINITION USUAL PERFORMANCE:

A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, ***record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.***

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Skin Treatments		
M1200A Pressure Reducing Device/*chair* **M1200B** Pressure Reducing Device/*bed*	***~Special Care Low***	***Does require:*** • Documentation of use of equipment aimed at reducing pressure away from areas of high risk during the observation period. • A facility policy identifying use of pressure reducing/relieving/redistributing mattresses on each resident bed will be considered sufficient documentation for the bed. ***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.
M1200C Turning/ Repositioning Program	***~Special Care Low***	***Does require:*** • Documentation substantiating utilization of a program with specific approaches for changing the resident's position and realigning the body. • Documentation of interventions and frequency of program. *(Program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs)* • Evaluation by the licensed nurse describing the resident's response to the program within the observation period.
M1200D Nutrition or Hydration Intervention to Manage Skin Problems	***~Special Care Low***	***Does require:*** • Documentation of an individualized nutritional assessment. • Description of specific skin condition being prevented or treated. • Documentation of nutrition or hydration factors that are influencing the skin problem and/or wound healing. ***Does include:*** • Vitamins and/or supplements when administration is linked to a skin problem.
M1200E Pressure Ulcer/Injury Care	***~Special Care Low***	***Does require:*** • Documentation of intervention(s) for treating pressure ulcers/injuries identified at M0300B, C, D, and F. ***Does include:*** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Skin Treatments *(Continued)*		
***M1200F** Surgical Wound Care	***~Clinically Complex***	***Does require:*** • Documentation of intervention for treating or protecting any type of surgical wound identified at M1040E. ***Does include:*** • Topical cleansing. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. • Pressure ulcers/injuries that require surgical intervention for closure (flap and/or graft coverage). ***Does NOT include:*** • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer/injury. • Observation only of the surgical wound.
****/*M1200G** Application of Non-surgical Dressings Other Than to Feet	***~Special Care Low*** ***~Clinically Complex***	***Does require:*** • Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. ***Does include:*** • Compression bandages. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydroactive particles. • Dressing application(s) to the ankle. ***Does NOT include:*** • Non-surgical dressings for pressure ulcers/injuries other than to feet; use pressure ulcer/injury care (M1200E). • Adhesive bandages (e.g. Band-Aids). • Wound closure strips
****/*M1200H** Application of Ointments/ Medications Other Than to Feet	***~Special Care Low*** ***~Clinically Complex***	***Does require:*** • Documentation of application of ointments/medications (used to treat a skin condition) other than to feet. ***Does include:*** • Topical creams. • Powders. • Liquid sealants. • Cortisone. • Antifungal preparation. • Chemotherapeutic agents. ***Does NOT include:*** • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers/injury(s); use pressure ulcer/injury care (M1200E). • Ointments used to treat non-skin conditions (e.g. nitropaste for chest pain).

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section Z: Assessment Administration		
Z0400	Signature of Persons Completing the Assessment or Entry/Death Reporting	***Does require:*** • All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. • If a staff member cannot sign Z0400 on the same day that they completed a section or portion of a section, when the staff member signs, **use the date the item originally was completed**. • Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a subset of items within a section should identify which item(s) they completed within that section.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*PDPM Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*

Active Diagnoses (7-day and 60-day look back)

Active Diagnosis Definition:
A physician-documented diagnosis (or by an Optometrist, nurse practitioner, physician assistant, or clinical nurse specialist) **in the last 60 days** that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Does require:
- **Physician (Optometrist, nurse practitioner, physician assistant, or clinical nurse specialist) documented diagnosis in the 60-day look-back period.**
- **Documentation supporting active diagnosis in the 7-day look-back period.**
- Documentation related to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis.

Does include:
- *Functional limitations* - loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.
- *Nursing monitoring* - clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).

Does NOT include:
- Conditions that have been resolved and do not affect the resident's current status or **do not drive the resident's plan of care within the 7-day look-back period;** these would be considered inactive diagnoses.