MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Section B: Hearing, Speech, and Vision *(7-day look back)*			
B0100 Comatose (CPS)	*~Special Care High* *~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Active and documented diagnosis of coma or persistent vegetative state documented by physician, physician assistant, nurse practitioner, or clinical nurse specialist. • ADLs must be consistent with diagnosis. • Care plan must focus on eliminating or minimizing complications related to comatose. ***Does NOT include:*** • Resident in advanced stages of progressive neurologic disorders (i.e. Alzheimer's).	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes** **Secondary: ADL flow sheet** **Optional: MAR/TAR**
B0700 Makes Self Understood (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of the resident's verbal and 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, or a combination. • Care plan must identify the best methods to facilitate communication for the resident. ***Does include:*** • Reduced voice volume. • Difficulty in producing sounds. • Difficulty in finding the right word, making sentences, writing, and/or gesturing.	**Primary: Care plan/nurses notes/social work notes/plan of care** **Secondary: personal observation** **Optional: speech therapy evaluation/psych evaluation**
Section C: Cognitive Patterns *(7-day look back)*			
C0200 Repetition of 3 words **C0300 A, B, C** Temporal Orientation (BIMS) **C0400 A, B, C** Recall (BIMS)	*~Behavioral Symptom and Cognitive Performance*	***Does require:*** • Validation of completion of items C0200, C0300A,B,C, C0400A,B,C at Z0400 dated on or before the ARD date and within the observation period. **OR** • Documentation in the medical record validating the resident interview of BIMS items was completed on or before the ARD date and within the • Care plan must focus on reorientation and recall strategies; optimize remaining function, and promoting as much social and functional independence as possible while maintaining health and safety.	**Primary: Care plan/nurses notes/social work notes** **Secondary: physician orders (diagnosis)/physician notes** **Optional: personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
C0700 Short-Term Memory (CPS)	*~Behavioral Symptom and Cognitive Performance*	***Does require:*** • Example(s) documenting an event 5 minutes after it occurred validated by documenting the resident's response. **OR** • Example(s) documenting the lack of follow through on a direction given 5 minutes earlier. • Example(s) must reference 5 minute time frame. • Care plan must focus on assessing for additional support needed by resident; optimize remaining function, and promoting as much social and functional independence as possible while maintaining health and safety.	**Primary: Care plan/nurses notes/social work notes/ plan of care** **Secondary: physician orders (diagnosis)/physician notes/personal observation** **Optional: occupational therapy evaluation**
C1000 Cognitive Skills for Daily Decision Making (CPS)	*~Behavioral Symptom and Cognitive Performance*	***Does require:*** • Example(s) documenting the degree of compromised decision-making about everyday decisions for tasks or activities of daily living. • Care plan must assess for additional support needed by resident, optimize remaining function, and promoting as much social and functional independence as possible while maintaining health and safety. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan. • Seeking information from others to plan the day. • Acknowledging need to use appropriate assistive equipment (i.e. walker). ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.	**Primary: Care plan/nurses notes/social work notes/psych notes** **Secondary: ADL flowsheet/speech therapy notes** **Optional: personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Section D: Mood (14-day look back)			
D0200A-I, Column 2 Resident Mood Interview (Symptom Frequency)	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Validation of completion of items D0200 A-I at Z0400 dated on or before the ARD date and within the observation period. **OR** • Documentation of resident mood interview (PHQ-9©) in medical record completed on or before the ARD date and within the observation period. • Care plan must assess for additional support needed by the resident including interventions and promote as much social and functional independence as possible while maintaining health and safety.	**Primary: Care plan/nurses notes/social work notes** **Secondary: physician orders (diagnosis)/physician notes** **Optional: psychiatric evaluation**
D0500A-J, Column 2 Staff Assessment of Resident Mood (Symptom Frequency)	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Example(s) that demonstrates the resident's mood specific to each D0500A-J mood including interventions. • Documentation of frequency of each mood. • Care plan must assess for additional support needed by the resident including interventions and promote as much social and functional independence as possible while maintaining health and safety.	**Primary: Care plan/nurses notes/social work notes** **Secondary: physician orders (diagnosis)/physician notes** **Optional: psychiatric evaluation**
Section E: Behavior *(7-day look back)*			
E0100A Hallucinations	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of the resident's perception of the presence of something that is not actually there. • Care plan must focus on management strategies to minimize the amount of disability and distress. ***Does include:*** • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.	**Primary: Care plan/nurses notes/social work notes/plan of care/behavior tracking chart** **Secondary: Physician orders (diagnosis)/physician notes** **Optional: Psychiatric evaluation/personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
E0100B Delusions	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. • Care plan must focus on management strategies to minimize the amount of disability and distress. ***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	**Primary: Care plan/nurses notes/social work notes/plan of care/behavior tracking chart** **Secondary: Physician orders (diagnosis)/physician notes** **Optional: Psychiatric evaluation/personal observation**
E0200A (code 2 or 3) Physical Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's physical behavioral symptoms directed toward • Daily documentation supporting frequency. • Care plan must address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include, but not limited to:*** • 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.	**Primary: Care plan/nurses notes/social work notes/plan of care/behavior tracking chart** **Secondary: Physician orders (diagnosis)/physician notes** **Optional: Psychiatric evaluation/personal observation**
E0200B (code 2 or 3) Verbal Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's verbal behavioral symptoms directed toward • Daily documentation supporting frequency. • Care plan must address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include, but not limited to:*** • 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.	**Primary: Care plan/nurses notes/social work notes/plan of care/behavior tracking chart** **Secondary: Physician orders (diagnosis)/physician notes** **Optional: Psychiatric evaluation/personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
E0200C (code 2 or 3) Other Behavioral Symptoms *not directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's other behavioral symptoms NOT directed toward • Daily documentation supporting frequency. • Care plan must address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include, but not limited to:*** • 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. • Wandering.	**Primary: Care plan/nurses notes/social work notes/plan of care/behavior tracking chart** **Secondary: Physician orders (diagnosis)/physician notes** **Optional: Psychiatric evaluation/personal observation**
E0800 (code 2 or 3) Rejection of Care	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of 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. • Daily documentation supporting frequency. • Care plan must address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does include:*** • Behaviors that interrupt or interfere with the delivery or receipt of care including; verbally declining, statements of refusal or physical behaviors that • Hindering the delivery of care by disrupting the usual routine or process by which care is given. • Exceeding the level of resources that is usually present for the provision of ***Does NOT include:*** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals.	**Primary: Care plan/nurses notes/social work notes/plan of care** **Secondary: ADL flow sheet** **Optional: Psychiatric evaluation/personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
E0900 (code 2 or 3) Wandering	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's moving from place to place with or without a specified course or known direction. • Daily documentation supporting frequency. • Care plan must address the interventions to reduce the frequency of truly problematic behaviors and minimize any resultant harm. ***Does NOT include:*** • Pacing. • Traveling via a planned course to another specific place (dining room or	**Primary: Care plan/nurses notes/plan of care/behavior tracking chart** **Secondary: Psychiatric evaluation** **Optional: Personal observation**
Section G: Functional Status *(7-day look back)*			
G0110A, Column 1&2 Bed Mobility **G0110B,** Columns 1 and 2 Transfer **G0110H,** Columns 1 and 2 Eating **G0110I,** Columns 1 and 2 Toilet Use	*~Extensive Services* *~Rehabilitation* *~Special Care High* *~Special Care Low* *~Clinically Complex* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation over a 24 hour observation period while a resident. • Initials and dates to authenticate the services provided including signatures and titles to authenticate initials/or Master Signature list • The ADL key for self-performance and support provided must include all the MDS key options and be equivalent to the intent and definition of the MDS key (key of "7" self performance is optional). • ADL documentation must be communicated and understood by staff. • If using narrative notes to support ADLs, each occurrence must include the specific ADL(s) and degree of self-performance and support provided. Wording must be equivalent to MDS key definitions for example "extensive (weight-bearing) assist of one for transfers". • ADL documentation must be maintained as part of the legal medical record and be readily accessible during the on-site review. • Care plan must address functional status and interventions tailored to the resident's cognitive, physical/functional, and social abilities and improve quality ***Does NOT include:*** • Individuals hired, compensated or not, 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.	**Primary: Care plan/nurses notes/ADL flow sheets/plan of care** **Secondary: MAR/TAR** **Optional: Personal observation**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Section H: Bladder and Bowel *(7-day look back)*			
H0200C Current Urinary Toileting Program or Trial (Restorative Nursing)	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of a toileting program trial must include 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. • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern. • Documentation that the program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, or a written • Documentation of resident's response to 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. • Care plan must focus on steps toward ensuring that the resident receives appropriate treatment and have interventions to restore as much bladder function as possible and modify as appropriate. ***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 continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.	**Primary: Care plan/nurses notes/ADL flow sheets/plan of care** **Secondary: MAR/TAR and physicians' orders** **Optional: Personal observation**
H0500 Bowel Toileting Program (Restorative Nursing)	*~Rehabilitation* *`Reduced Physical Function*	***Does require:*** • Implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern. • Documentation that the program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, or a written report • Documentation of resident's response to program by a licensed nurse within the observation period. • Care plan must focus on steps toward ensuring that the resident receives appropriate treatment and have interventions to restore as much bowel function as possible and modify as appropriate. ***Does NOT include:*** • Simply tracking of bowel continence status. • Changing pads or soiled garments.	**Primary: Care plan/nurses notes/ADL flow sheets/plan of care** **Secondary: MAR/TAR and physicians' orders** **Optional: Personal observation**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
		• Random assistance with toileting or hygiene.	
Section I: Active Diagnoses *(7-day and 60-day look back)*			

Active Diagnosis Definition:

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 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 (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.
- ADLs must be consistent with the diagnosis.
- Care plan must focus on how the diagnosis has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death and the interventions.

Does include:

- *Functional limitations* – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.
- *Nursing monitoring* – nursing monitoring includes 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**.**

MDS 3.0 Validation
Minimum Review Standards

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I2000 Pneumonia	*~Special Care High* *~Clinically Complex*	***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization.	**Primary: Physician orders (diagnosis)/physician notes/consultation reports/MAR/TAR** **Secondary: Care plan/nurses notes/lab reports/X-ray report/plan of care** **Optional: ADL flow sheets**
I2100 Septicemia	*~Special Care High*	***Does NOT include:*** • A hospital discharge note referencing septicemia during hospitalization.	
I2900 Diabetes Mellitus (DM)	*~Special Care High*	***Does include:*** • Diabetic retinopathy. • Nephropathy. • Neuropathy.	
I4400 Cerebral Palsy	*~Special Care Low*	***See above:***	
I4900 Hemiplegia/Hemiparesis	*~Clinically Complex*	***See above:***	
I5100 Quadriplegia	*~Special Care High*	***Does require:*** • Physician documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs). ***Does NOT include:*** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs.	
I5200 Multiple Sclerosis (MS)	*~Special Care Low*	***See above:***	

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I5300 Parkinson's Disease	*~Special Care Low*	***See above:***	
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	*~Special Care High*	***Does include:*** • Chronic bronchitis. • Restrictive lung diseases (such as asbestosis).	
I6300 Respiratory Failure	*~Special Care Low*	***See above:***	
Section J: Health Conditions *(7-day look back)*			
J1100C Shortness of Breath (dyspnea) when lying flat	*~Special Care High*	***Does require:*** • Documentation of shortness of breath or trouble breathing when lying flat. • Care plan must address underlying cause(s) that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible. ***Does include:*** • Avoidance of lying flat because of shortness of breath.	**Primary: Care plan/nurses notes/ADL flow sheets/plan of care** **Secondary: Physician orders/physician notes/MAR/TAR** **Optional: Personal observation**
J1550A Fever	*~Special Care High*	***Does require:*** • Consistent/documented route (rectal, oral, etc.) of temperature measurement between the baseline and the elevated temperature. • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established prior to the ARD. ***Does include:*** • A temperature of 100.4 degrees F. on admission is a fever.	
J1550B Vomiting	*~Special Care High*	***Does require:*** • Documentation of regurgitation of stomach contents.	

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Section K: Swallowing/Nutritional *(7-day look back)* *(*K0300 only; 30-day and 60-day look back)*			
***K0300** (code 1 or 2) Weight Loss	*~Special Care High*	***Does require:*** • Documentation of the resident's weight loss of 5% or more in last month **OR** 10% or more in last 6 months. • Percentage based on the actual weight. • Documentation supporting the expressed goal for the weight loss for code of "1", on physician-prescribed weight loss regimen. • Care plan must focus on measures to address the underlying causes(s), including any reversible issues and conditions that led to weight loss. ***Does include:*** • Mathematical rounding. • Planned or unplanned. • Weight loss via physician-prescribed weight loss regimen. ***Does NOT include:*** • A physician ordered diabetic or otherwise calorie-restricted diet when the diet is not intended to induce weight loss.	**Primary: Care plan/nurses notes/ADL flow sheets/weight sheets/plan of care** **Secondary: Dietary notes/physician orders (diagnosis)/ physician notes** **Optional: Personal observation**
K0510A Column 1 or 2 Parenteral/IV Feeding	*~Special Care High*	***Does require:*** • Documentation of the need for nutrition and/or hydration received by the resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, administered for nutrition and/or hydration. • Care plan must focus on maintaining or restoring fluid and electrolyte balance related to nutrition and/or hydration, and to address the underlying cause or causes of any current dehydration. ***Does include:*** • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • IV at KVO (keep vein open). • IV fluids contained in IV piggyback. • Hypodermoclysis and sub-Q ports in hydration therapy. • IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition or hydration. *(Prevention of dehydration must be clinically indicated and supporting documentation must be provided in* ***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.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/dietary notes/plan of care** **Secondary: ADL flow sheets/lab reports** **Optional: Personal observation**

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		• IV fluids administered in conjunction with chemotherapy or dialysis.	
K0510B Column 1 or 2 Feeding Tube	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation for the need for 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, administered for nutrition or hydration. • Care plan must include a reevaluation during the quarter of the appropriateness of the feeding tube approach 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.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/dietary notes/plan of care** **Secondary: ADL flow sheets/lab reports** **Optional: Personal observation**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
K0710A3 Proportion of Total Calories the Resident Received Through Parenteral or Tube Feeding **During Entire 7 days**	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support the proportion of calories actually received for nutrition or hydration through parenteral or tube feeding during the entire 7-day observation period. • Care plan must include a reevaluation during the quarter to assure adequate nutrition and hydration. *For residents receiving both P.O. nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* 1. Calories tube feeding provided within observation period. 2. Calories oral feeding provided within observation period. 3. Percent of total calories provided by tube feeding.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/dietary notes/plan of care** **Secondary: ADL flow sheets/lab reports** **Optional: Personal observation**
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding **During Entire 7 days**	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support average fluid intake per day by IV and/or tube feeding during the entire 7-day observation period. • Care plan must include periodic reevaluation to assure adequate nutrition and hydration. *Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include:* 1. Adding the total amount of fluid received each day by IV or tube feedings only. 2. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day (Divide by 7 even if the resident did not receive IV fluids or tube feeding on each of the 7 days.)	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/dietary notes/plan of care** **Secondary: ADL flow sheets/lab reports** **Optional: Personal observation**

MDS 3.0 Validation
Minimum Review Standards

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Section M: Skin Conditions *(7-day look back)*			
M0300B1 **M0300C1** Stage 3 **M0300D1** Stage 4 **M0300F1** Unstageable Due to Slough/Eschar	*~Special Care Low*	***Does require:*** • Description/documentation of pressure ulcer(s) within the observation period such as but not limited to; location, dimensions, drainage, tissue color, • Documentation must include complete history of pressure ulcer(s) including location, dimensions, drainage, tissue color and stage, etc. when the reported stage is numerically higher than the current description. • Care plan must focus on efforts to stabilize, reduce, or remove underlying risk factors and monitor the impact of the interventions to heal or close the pressure ulcer. ***Does NOT include:*** • Pressure ulcers that are healed before the look-back period (are reported at M0900). • Pressure ulcers that are healed during the look-back period, and were not present on prior assessment. • A pressure ulcer surgically repaired with a flap or graft. • If pressure is NOT the primary cause. • Oral mucosal ulcers caused by pressure (reported at L0200C).	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/weekly skin sheets/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
M1030 Venous/Arterial Ulcers	*~Special Care Low*	***Does require:*** • Description/documentation of the ulcer such as but not limited to; location, dimensions, drainage, tissue color, etc. • Care plan must focus on efforts to stabilize, reduce, or remove underlying risk factors and monitor the impact of the interventions to heal or close the venous and/or arterial ulcer. ***Does NOT include:*** • Pressure ulcers coded in M0210 through M0900.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/weekly skin sheets/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
M1040A Infection of the Foot	*~Special Care Low*	***Does require:*** • Documentation of signs and symptoms of infection of the foot. • Care plan must focus on efforts to stabilize, reduce, or remove underlying risk factors and monitor the impact of the interventions to heal the infection. ***Does include:*** • Cellulitis. • Purulent drainage. ***Does NOT include:*** • Ankle problems. • Pressure ulcers coded in M0300-M0900.	**Primary: Physician orders (diagnosis)/physician notes/care plan/ nurses notes/MAR/TAR/plan of care** **Secondary: Weekly skin sheets** **Optional: Personal observation**
M1040B Diabetic Foot Ulcer	*~Special Care Low*	***Does require:*** • Description/documentation of diabetic foot ulcer such as but not limited to; location and appearance.	**Primary: Physician orders (diagnosis)/physician notes/care plan/ nurses notes/MAR/TAR/plan of care**

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		• Care plan must focus on efforts to stabilize, reduce, or remove underlying risk factors and monitor the impact of the interventions to heal or close the diabetic foot ulcer. ***Does NOT include:*** • Ankle problems. • Pressure ulcers coded in M0300 through M0900. • Pressure ulcers that occur on residents with diabetes mellitus.	**of care** **Secondary: Weekly skin sheets** **Optional: Personal observation**
M1040C Other Open Lesion on the Foot, (e.g. cuts, fissures)	*~Special Care Low*	***Does require:*** • Description/documentation of open lesion such as but not limited to; location and appearance. • Wound must be open during observation period. • Care plan must focus on efforts to stabilize, reduce, or remove underlying risk factors and monitor the impact of the interventions to heal or close the open lesion on the foot. ***Does NOT include:*** • Ankle problems. • Pressure ulcers coded in M0300-M0900.	**Primary: Physician orders (diagnosis)/physician notes/care plan/ nurses notes/MAR/TAR/plan of care** **Secondary: Weekly skin sheets** **Optional: Personal observation**

MDS 3.0 Validation
Minimum Review Standards

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M1040D Open Lesion Other Than Ulcers, Rashes, Cuts	*~Clinically Complex*	***Does require:*** • Description/documentation of the open lesion such as but not limited to; location and appearance. • Wound must be open during observation period. • Care plan must focus on efforts to stabilize, reduce, or remove underlying risk factors and monitor the impact of the interventions to heal or close the ***Does include:*** • Skin lesions that develop as a result of diseases and conditions such as syphilis and cancer. ***Does NOT include:*** • Pressure ulcers coded in M0300-M0900. • Skin tears, cuts, abrasions, rashes.	**Primary: Physician orders (diagnosis)/physician notes/care plan/ nurses notes/MAR/TAR/plan of care** **Secondary: Weekly skin sheets** **Optional: Personal observation**
M1040E Surgical Wound	*~Clinically Complex*	***Does require:*** • Description/documentation of the surgical wound such as but not limited to; location and appearance. • Care plan must focus on efforts to stabilize and monitor the impact of the interventions to heal or close the surgical wound. ***Does include:*** • Any healing or 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 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 that have been surgically debrided.	**Primary: Physician orders (diagnosis)/physician notes/care plan/ nurses notes/MAR/TAR/plan of care** **Secondary: Weekly skin sheets** **Optional: Personal observation**
M1040F Burn	*~Clinically Complex*	***Does require:*** • Description/documentation of the second or third degree burn such as but not limited to; location and appearance. • Care plan must focus on efforts to stabilize and monitor the impact of the interventions to heal the burn. ***Does include:*** • 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).	**Primary: Physician orders (diagnosis)/physician notes/care plan/ nurses notes/MAR/TAR/plan of care** **Secondary: Weekly skin sheets** **Optional: Personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
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. • Care plan must include program intervention(s) including frequency and effectiveness of interventions related to skin problems. ***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.	**Primary: Physician orders/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
M1200C Turning/Repositioning Program	*~Special Care Low*	***Does require:*** • Documentation substantiating utilization of a consistent program for changing the resident's position and realigning the body. • Documentation of interventions and frequency of program. • Documentation by licensed nurse describing an evaluation of the resident's response to the program within the observation period. • Care plan must include specific, individualized program intervention(s) including frequency and effectiveness of interventions related to skin problems.	**Primary: Physician orders/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
M1200D Nutrition or Hydration Intervention to Manage Skin Problems	*~Special Care Low*	***Does require:*** • Confirmation or suspicion of nutritional deficiencies through a nutritional assessment. • Description/documentation of specific skin condition being prevented or treated • Nutrition or hydration factors that are influencing the skin problem and or wound healing. • Care plan must focus on the interventions tailored to resident's needs, condition and prognosis related to skin problems. ***Does include:*** • Vitamins and/or supplements.	**Primary: Physician orders/physician notes/care plan/nurses notes/weekly skin sheets/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
M1200E Pressure Ulcer Care	*~Special Care Low*	***Does require:*** • Documentation of intervention for treating pressure ulcers coded at M0300. • Care plan must focus on the interventions tailored to heal or close the pressure ulcer. ***Does include:*** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy.	**Primary: Physician orders/physician notes/care plan/nurses notes/weekly skin sheets/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
M1200F Surgical Wound Care	*~Clinically Complex*	***Does require:*** • Documentation of intervention for treating or protecting any type of surgical wound. • Care plan must focus on the interventions tailored to heal or close the surgical wound. ***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 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. • Observation only of the surgical wound.	**Primary: Physician orders/physician notes/care plan/nurses notes/weekly skin sheets/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
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. • Care plan must focus on the interventions tailored to resident's needs related to non-surgical dressings other than to 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 to the ankle. ***Does NOT include:*** • Non-surgical dressings for pressure ulcers other than to foot; use ulcer care (M1200E). • Band-Aids.	**Primary: Physician orders/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: ADL flow sheets/weekly skin sheets** **Optional: Personal observation**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
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. • Care plan must focus on the interventions tailored to resident's needs related to ointments/medications 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; use ulcer care (M1200E). • Ointments used to treat non-skin conditions (e.g. nitropaste for chest pain).	**Primary: Physician orders/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: ADL flow sheets/weekly skin sheets** **Optional: Personal observation**
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. • Care plan must focus on the interventions tailored to resident's needs related to dressings to the feet. ***Does NOT include:*** • Dressings to pressure ulcers; use ulcer care (M1200E). • Dressing application to the ankle.	**Primary: Physician orders/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: ADL flow sheets/weekly skin sheets** **Optional: Personal observation**
Section N: Medications *(7-day look back)*			
N0350A Days of Insulin Injections	*~Special Care High*	***Does require:*** • Documentation must be consistent with physician orders and treatment/medication administration records. • Documentation to include the number of days that insulin injections were received for the last 7 (seven) days. • Care plan must address need for injection and monitor for adverse effects of injected insulin. ***Does include:*** • Subcutaneous insulin pumps, the number of days the resident actually required a subcutaneous injection to restart the pump.	**Primary: Physician orders/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Lab reports** **Optional: Personal observation**
N0350B Days of Orders for Insulin	*~Special Care High*	.***Does include:*** • Sliding scale order that is new, discontinued, or is the first sliding scale order • Documentation to include the number of days that the insulin orders changed for the last 7 (seven) days.	

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
		Does NOT include: • A day simply because a different dose of insulin is administered based on an existing sliding scale order.	

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*			
O0100 Special Treatments	*Informational Only*	• Includes special treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. • Does NOT include services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure. • Items O0100 includes while a resident ONLY. • Care plan must center on the specific interventions and the impact to ensure the continued appropriateness of the treatment, procedure, or program.	
O0100A Chemotherapy	*~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. • Care plan must include the monitoring of side effects associated with chemotherapy. ***Does include:*** • A nurse's note that resident went out for chemotherapy treatment including a corresponding chemotherapy center report and physician order.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Lab reports/consultations** **Optional: Personal observation**
O0100B Radiation	*~Special Care Low*	***Does require:*** • Documentation of administration of radiation inside or outside of facility. • Care plan must include the monitoring of side effects associated with radiation therapy. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant. • A nurse's note that resident went out for radiation treatment including a corresponding radiation center report and physician order.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Lab reports/consultations** **Optional: Personal observation**
O0100C Oxygen Therapy	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Related diagnosis that supports risk or evidence of hypoxia. • Care plan must monitor for the effectiveness to relieve hypoxia and ensure the continued appropriateness of oxygen therapy. ***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.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Respiratory therapy flow sheets** **Optional: Personal observation**

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
O0100E Tracheostomy Care	*~Extensive Services*	***Does require:*** • Documentation of administration of tracheostomy and/or cannula cleansing. • Care plan must monitor for effectiveness and continued appropriateness of the tracheostomy care. ***Does include:*** • Changing a disposable cannula. • Resident performs his/her own tracheostomy care.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Respiratory therapy flow sheets** **Optional: Personal observation**
O0100F Ventilator or Respirator	*~Extensive Services*	***Does require:*** • Documentation of administration of any type of electrically or pneumatically powered closed system mechanical ventilator support device. • Care plan must monitor for effectiveness and ensure the continued appropriateness of the ventilator/respirator. ***Does include:*** • Any resident who was in the process of being weaned off the ventilator or respirator during the observation period, *including C-PAP if set on that 'mode' on the vent.* ***Does NOT include:*** • Times when used as a substitute for BiPAP or CPAP.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/respiratory therapy flow sheets/plan of care** **Secondary: Lab reports** **Optional: Personal observation**
O0100H IV Medications	*~Clinically Complex*	***Does require:*** • Documentation of administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port. • Care plan must monitor for effectiveness and reevaluate the appropriateness of the IV medications. ***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.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Lab reports** **Optional: Personal observation**
O0100I Transfusions	*~Clinically Complex*	***Does require:*** • Documentation of administration of blood or any blood products directly into the bloodstream.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
		• Care plan must monitor for effectiveness and ensure the continued appropriateness of the transfusion while monitoring for side effects. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.	**Secondary: Lab reports** **Optional: Personal observation**
O0100J Dialysis	*~Special Care Low*	***Does require:*** • Documentation of administration of peritoneal or renal dialysis that occurred at the facility or another facility. • Care plan must monitor for effectiveness and possible side effects of ***Does include:*** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). • A nurse's note that resident went out for dialysis treatment including a corresponding dialysis center report and physician order. • Resident performing his/her own dialysis. ***Does NOT include:*** • IV, IV medication and blood transfusion administered during dialysis.	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: Lab reports** **Optional: Personal observation**
O0100M, 2 Isolation or Quarantine for Active Infectious Disease	*Informational Only*	***Code for "Single Room Isolation" only when all the following conditions are met:*** 1. 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. 3. Resident is in a room alone <u>because of active infection and cannot</u> have a roommate. Must be in the room alone and not cohort with a roommate. 4. Must remain in room. All services must be brought to the resident.	
O0100M, 2 Isolation or Quarantine for Active Infectious Disease	*~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. • Care plan must define the necessity for isolation, interventions for the health and safety of the resident and staff, and address the residents functional status, cognition, physical, and social abilities and improve quality of life. ***Does NOT include:***	**Primary: Physician orders (diagnosis)/physician notes/care plan/nurses notes/MAR/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**

MDS 3.0 Item Location and Item Description	RUG-IV Categories Impacted	Minimum Documentation and Review Standards Required Within the Specified Observation Period	Best Practices - Recommended Documentation
		• Standard precautions. • History of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with roommate.	

Section O: Special Treatments, Procedures, and Programs
Therapies (*7-day look back)*

(A) Speech-Language Pathology Services (SLP) (B) Occupational therapy (OT) (C) Physical Therapy (PT)

General Therapy Requirements

Does require:

- Only skilled therapy provided while a resident in the facility.
- Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed ONLY by, or under the supervision of, a qualified therapist.
- Services are directly and specifically related to an active written treatment plan approved by the physician.
- An evaluation must be completed prior to the start of therapy.
- Resident's individualized assessment of the clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the services.
- Services are reasonable and necessary for condition.
- Care plan must define the necessity for, and the frequency and duration of each therapy modality and their respective services.

In addition for Part A services:

- Resident's medical needs must indicate that "daily" therapy is required.
- A valid medical reason why various therapy modalities cannot be furnished on the same day.

Medicare Benefit Policy manual; Chapter 8: 30.4.1.1 & 30.6

Does NOT include:

- Services at the request of the family that is not medically necessary.
- Non-skilled services (facility election, maintenance treatments, supervision of CNAs) time.
- Restorative services time.
- Therapy provided prior to admission.
- When services can be safely and effectively performed by supportive personnel, such as aides or nursing personnel, without the supervision of a licensed therapist, they do NOT constitute skilled therapy.
- Services involving activities for the general good and welfare of the resident do NOT constitute skilled therapy.

In addition for Part A services:

- Arbitrarily staggering the timing of various therapy modalities through the week merely in order to have some type of therapy session occur each day.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*

O0400 – Therapies (*7-day look back)*

(A) Speech-Language Pathology Services (SLP) **(B) Occupational Therapy (OT)** **(C) Physical Therapy (PT)**

Minutes of Therapy Requirements

Does require:	***Does include:***	***Does NOT include:***
• Only skilled therapy minutes are reported on the MDS.	• Therapist time spent on subsequent reevaluations conducted as part of the treatment process.	• Therapist time spent on documentation or initial evaluation.
• Only skilled services after the initial evaluation are reported on the MDS.	• Time required adjusting equipment or otherwise preparing for individualized therapy.	• Conversion of units to minutes or minutes to units.
• Reimbursable (actual) therapy minutes (RTM) ONLY.	• Family education when the resident is present and documented.	• Rounding to the nearest 5th minute.
• Documentation of RTM for each specific mode of therapy.	• Non-therapeutic rest periods.	• Non-therapeutic rest periods.
• Documentation be differentiated between RTM minutes and billable minutes/units.	• Treatment or portion of treatment that is not classified as skilled.	• Treatment or portion of treatment that is not classified as skilled.
• Therapy minutes are reviewed based on payer type requirements.	• SLP assistant time.	• SLP assistant time. • Initial evaluation minutes. • Unattended e-stim minutes. • Concurrent minutes reported for a resident under Part B. • Group minutes for less than 4 residents under Part A. • Therapy minutes while a resident is an inpatient at a hospital or rehabilitation center.

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*			
Therapy Minutes **O0400A1,2,3** Speech-Language Pathology and Audiology Services **O0400B1,2,3** Occupational Therapy **O0400C1,2,3** Physical Therapy	*~Rehabilitation*	***Does require:*** • RTM minutes with associated initials/signature(s) on a daily basis to support the total number of RTM minutes of actual therapy provided. • Physician order, treatment plan and assessment.	**Primary: Physician orders/physician notes/care plan/therapy notes + log of dates/minutes** **Secondary: Nurses notes/plan of care** **Optional: Personal observation**
Therapy Days **O0400A4** Speech-Language Pathology and Audiology Services **zo0400B4** Occupational Therapy **O0400C4** Physical Therapy	*~Rehabilitation*	***Does require:*** • Associated initials/signature(s) on a daily basis to support the total number of days therapy provided. • Treatment minimum of 15 minutes or more per day. • Documentation of therapy episode end date.	**Primary: Physician orders/physician notes/care plan/therapy notes + log of dates/minutes** **Secondary: Nurses notes/plan of care** **Optional: Personal observation**
O0400D2 Respiratory Therapy Days	*~Special Care High*	***Does require:*** • Physician order that includes a statement of treatment specific to the resident's needs (frequency, duration, and scope of treatment). • Documentation of actual minutes on a daily/shift/occurrence basis. • Documentation that the respiratory nurse (licensed nurse) has been trained in the modalities provided either through formal nursing or 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. • Care plan must include periodic reevaluation within the quarter of the ARD date of the appropriateness of the respiratory therapy services. ***Does include:*** • Coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. ***Does NOT include:*** • Treatment for less than 15 minutes per day. • Hand held medication dispensers.	**Primary: Physician orders/physician notes/care plan/therapy notes + log of dates/minutes** **Secondary: Nurses notes/plan of care** **Optional: Personal observation**
O0420	*~Rehabilitation*	***Does require:***	**Primary: SPL/OT/PT logs with**

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Distinct Calendar Days of Therapy		• Documentation of the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.	**dates and minutes** ***No need for Secondary or Optional documentation***
O0500A-J Restorative Nursing Program Days	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of actual minutes on a daily/shift/occurrence basis for each program provided within a 24-hour period. • Initials/signature(s) on a daily/shift/occurrence basis to support the total minutes of restorative nursing programs provided. • Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented. • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1. Care plan with measurable objectives and interventions; 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 staff personnel. • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device within the observation period. • Care plan must focus on achieving and maintaining optimal physical, mental, and psychological functioning and include measurable objectives and interventions. ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • Movement by a resident that is incidental to care. • Treatment for less than 15 minutes per day.	**Primary: Care plan/nurses notes/TAR/plan of care** **Secondary: ADL flow sheets** **Optional: Personal observation**
Section Z: Assessment Administration			
Z0400	Signature of Persons Completing the Assessment or Entry/Death Reporting	MDS must include complete signature, title, section(s) and date the section(s) completed as required to attest to the accuracy of the MDS responses.	Primary: MDS 3.0 Section Z

MDS 3.0 Validation
Minimum Review Standards

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*	*Best Practices - Recommended Documentation*
Z0500	Signature of RN Assessment Coordinator Verifying Assessment Completion	MDS must include complete signature and date RN assessment coordinator signed assessment as complete to certify assessment completion.	Primary: MDS 3.0 Section Z