DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

NEVADA MEDICAID MDS SUPPORTIVE DOCUMENTATION GUIDELINES

PATIENT DRIVEN PAYMENT MODEL (PDPM)
NURSING, NON-THERAPY ANCILLARY, AND SPEECH LANGUAGE PATHOLOGY COMPONENTS

Myers and Stauffer LC
Effective for Assessments
With an Assessment
Reference Date (ARD) of
January 1, 2025 and After

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Introduction

Accuracy of the minimum data set (MDS) item responses is 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 (PPS) rates are set based on MDS responses.

These Nevada supportive documentation requirements apply to all Nevada Medicaid-certified nursing facilities that are scheduled for PDPM case mix reviews on or after January 1, 2025.

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 (RAI) 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, non-therapy ancillary (NTA), and speech language pathology (SLP) components of the PDPM classification system use 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 those components of the PDPM system.

OVERALL DOCUMENTATION INSTRUCTIONS

- ✓ The facility must grant access to requested medical records in a read-only or other secure format.
- ✓ The facility is responsible for ensuring data backup and security measures are in place.
- ✓ Access to electronic health records must not impede the review process.
- ✓ Medicaid clients must have their pre-admission screening and resident review (PASRR) and level of care (LOC) in the active electronic health record.

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."*

All Federal requirements must be met. In addition, State requirements may be more stringent and will supersede the Federal requirements for the RAI and its components. It is the responsibility of the provider to be in compliance with both Federal and State requirements.

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 Omnibus Budget Reconciliation Act of 1987 (OBRA) or scheduled PPS assessment (whichever is most recent), staff must only consider those assessments that are required to be submitted to the Internet Quality Improvement & Evaluation System (iQIES).
- PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to iQIES and 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.

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

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

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

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

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.”

Nevada Supportive Documentation Requirements

REQUIREMENTS TABLE EXPLANATION

The Nevada supportive documentation requirements table contains a header per section and four 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.

Column 3 – Minimum Documentation and Review Standards Required During the Specified Observation Period Denoted in Column One

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.

Column 4 – Nevada Specific Requirements

This column provides an overview of the requirements for minimum documentation required by the State of Nevada to support MDS responses.

Nevada Supportive Documentation Guidelines
Available online at: *http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing* (Resources/MDS Guidelines)
Patient Driven Payment Model (PDPM)
For MDS 3.0 Assessments with an ARD on or after January 1, 2025 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		Section B	
B0100 Comatose **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1** **Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	**Comatose:** A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g. pain). **Persistent Vegetative State:** Some comatose individuals regain wakefulness but do not display any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres. **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 within the last 60 days. • For coma, documentation should include indications that neither arousal (wakefulness, alertness) nor awareness exists. Documentation may also include a lack of response to painful or noxious stimuli with an inability to arouse the resident. Additionally, documentation may include the resident's lack of ability to open their eyes, inability to speak and move their extremities on command. • For persistent vegetative state, documentation may include wakefulness without purposeful behavior or cognition. Additionally, documentation may include the resident's ability to open eyes, grunt, yawn, pick with their fingers, and have random body movements. **Does NOT include:** • Resident in advance stages of progressive neurological disorders (i.e. Alzheimer's disease).	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of coma or persistent vegetative state within the 60-day look back period.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
B0700 Makes Self Understood **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	Documentation that the resident is able to express or communicate requests, needs, opinions, urgent problems, and to conduct social conversation, whether in speech, writing, sign language, or a combination of these. Deficits in the ability to make one self-understood can include reduced voice volume and difficulty in producing sound, or difficulty in finding the right word, making sentences, writing, and/or gesturing. **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	As Evidenced By (AEB) examples describing an accurate picture of the resident within the observation period.
		Section C	
C0200 Repetition of Three Words (BIMS) **C0300 A,B,C** Temporal Orientation (BIMS) **C0400 A,B,C** Recall (BIMS)	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	**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.	

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
C0700 Short-Term Memory **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	Determine the resident's short term memory status by asking him/her to describe an event five minutes after it occurred OR to follow through on a direction given five minutes earlier. Observation should be made by staff across all shifts & departments and others with close contact with the resident. If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard "no information" code (a dash, "-") to indicate that the information is not available because it could not be assessed. **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.	If resident is coded with a memory problem (1) at C0700, a memory test must be attempted (see Steps for Assessment in C0700 section of RAI manual) and documented As Evidenced By (AEB) example within the observation period.
C1000 Cognitive Skills for Daily Decision Making **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	Observations should be made by staff across all shifts and departments and others with close contact with the resident. Focus on the resident's actual performance. Includes choosing clothing, knowing when to go to meals; using environmental clues to organize and plan (e.g. clocks, calendars, posted event notices). In the absence of environmental cues seeks information appropriately (not repetitively) from others in order to plan their day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker. **Does 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.	Document the resident's actual performance in making everyday decisions about tasks or activities of daily living (ADL'S). Does not include financial decision making or statements relating to diagnosis (i.e. dementia). Decisions should relate to the residents life in the facility. Documentation needs to include the observing staff member's title and As Evidenced By (AEB) examples of the decisions made by the resident within the observation period. If all residents' needs are anticipated, then an AEB is required. The example needs to be specific not just a reference to the residents safety awareness etc.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		Does NOT include: • Resident's decision to exercise his/her right to decline treatment or recommendations by staff. • Reference to the resident's safety awareness.	
		Section D	
D0150A-I, Column 2 Resident Mood Interview (PHQ-2 to 9)	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1** **~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**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)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1** **~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	**Does require:** • Staff-provided example(s) that demonstrates each applicable item in D0500 A – J. • Documentation of the date(s) staff member(s) interviewed across all shifts, dates of staff observations **(identifying the specific item)**, 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**.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
	~Clinically Complex **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**		
D0500A, Column 2 Staff assessment Little interest or pleasure in doing things **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's lack of interest or pleasure in doing things.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500B, Column 2 Staff assessment Feeling or appearing down, depressed, or hopeless **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J) • Example that demonstrates resident's feeling or appearing down, depressed or hopeless.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500C, Column 2 Staff assessment Trouble falling or staying asleep, or sleeping too much **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's trouble falling or staying asleep, or sleeping too much.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500D, Column 2 Staff assessment Feeling tired or having little energy **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's feeling tired or having little energy.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500E, Column 2 Staff assessment Poor appetite or overeating **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's poor appetite or overeating.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500F, Column 2 Staff assessment Indicating that he/she feels bad about self, or is a failure, or has let self or	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's indication that she/he feels bad about self, or is a failure, or has let self or family down.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
family down **(14-day look back)**			
D0500G, Column 2 Staff assessment Trouble concentrating on things, such as reading the newspaper or watching TV **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's trouble concentrating on things, such as reading the newspaper or watching TV.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500H, Column 2 Staff assessment Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that she/he has been moving around a lot more than usual **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless she/he has been moving around a lot more than usual.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500I, Column 2 Staff assessment States that life isn't worth living, wishes for death, or attempts to harm self **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's statements that life isn't worth living, wishes for death, or attempts to harm self.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500J, Column 2 Staff assessment Being short tempered, easily annoyed **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's being short tempered, easily annoyed.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

Nevada Supportive Documentation Guidelines
Available online at: *http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing* (Resources/MDS Guidelines)
Patient Driven Payment Model (PDPM)
For MDS 3.0 Assessments with an ARD on or after January 1, 2025 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		Section E	
E0100A Hallucinations **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	**Hallucinations defined:** • Example of a resident's perception of the presence of something that is not actually there. • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli. **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.	Document As Evidenced By (AEB) example within the observation period.
E0100B Delusions **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	**Delusions defined:** • Example of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. **Does 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.	Document As Evidenced By (AEB) example within the observation period.
E0200A (code 2 or 3) Physical behavioral symptoms *directed toward others* **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	• Example and frequency of physical behavior symptoms direct toward others. • Hitting, kicking, pushing, scratching, and abusing others sexually. **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).	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		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* **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	• Example and frequency of verbal behavior symptoms directed toward others. **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.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200C Other behavioral symptoms *not directed toward others* **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	• Example and frequency of other behavior symptoms NOT directed toward others. **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	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		judgment that the behavior can be explained or should be tolerated.	
E0800 **(code 2 or 3)** **Rejection of Care Presence and frequency** **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	When rejection/decline of care is first identified, it is investigated to determine if the rejection/decline of care is a matter of the resident's choice. Education is provided (risks and benefits) and the resident's choice becomes part of the plan of care. On future assessments, this behavior would not be coded again in this item. **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.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0900 **(code 2 or 3)** Wandering - Presence and Frequency **(7-day look back)**	-Behavior Problems **~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1**	Example and frequency of wandering from place to place without a specified course or known direction. **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.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		• Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity).	
Section GG			
GG0130A Self-Care: Eating *The ability to use suitable utensils to bring food to the mouth and swallow food and/or liquid once the meal is placed before the resident.* *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. • Assess the resident's self-care performance based on direct observation, incorporating self-reports and reports from qualified clinicians, care staff or family documented in the resident's medical record during the assessment period. • CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period. • 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 • Corrections must be made in accordance with the Medical Record Correction Policy. • The IDT should be involved in assessment of the resident's usual performance. • Documentation for usual performance should be determined based on data gathered during the look-back period and entered 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. • Entries that do not have supporting documentation will be assigned a	
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).*			

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		value representing "independent."	
GG0170F Mobility: Toilet transfer *The ability to get on and off a toilet or commode.*		**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.	
Section H			
H0200C Current urinary toileting program or trial *(Restorative Nursing)* **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1** **~Reduced Physical Function** **PDE2** **PBC2** **PA2** **PDE1** **PBC1** **PA1**	Documentation must show that the following requirements have been met: • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern. • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report. • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period**. • Toileting plan that is being managed during days of the 7-day look back period with some type of systematic toileting program. • A specific approach that is organized, planned, documented, monitored, and evaluated. **Does 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. • The individual resident's toileting schedule must be daily (7-days a week), available and easily accessible to all staff. • The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient for validation of a Program or a Trial Program. **Does include:**	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a. The individual resident's toileting schedule must be daily (7-days a week), available and easily accessible to all staff. No time documentation is required for this item.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		• Program if only used by day (when documented that the resident does not want awakened at night). • Bladder toileting program still in progress that has not yet been evaluated. **Does NOT include:** • Time spent for the toileting trial or program. • Less than 7 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)* **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1** **~Reduced Physical Functioning** **PDE2** **PBC2** **PA2** **PDE1** **PBC1** **PA1**	Documentation must show that the following requirements have been met: • Implementation of an individualized, resident- specific bowel toileting program that was based on an assessment of the resident's unique bowel pattern. • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report. • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period**. **Does NOT include:** • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene. **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**. • The individual resident's toileting schedule must be daily (7-days a week), available and easily accessible to all staff. • The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient for validation of a Program or a Trial Program. **Does NOT include:** • Time spent for the toileting program.	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a program or trial. The individual resident's toileting schedule must be daily (7-days a week), available and easily accessible to all staff. No time documentation is required for this item.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		• Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.	
Section I			
Active Diagnosis in the Last 7 Days Criteria			
***Active Diagnosis* look back period** Diagnosis that has a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look back period.		**Documented Diagnosis *look back period*** A healthcare practitioner documented diagnosis in the last 60 days that has a relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.	The monthly recap may be used for diagnosis IF it is signed and dated by the physician, nurse practitioner, physician assistant or clinical nurse specialist within the look back period. ADL documentation cannot be used to document active treatment, as all residents receive ADL assistance.
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.). • Monthly "recap" orders if signed and dated by an Optometrist, nurse practitioner, physician assistant, or clinical nurse specialist within the look-back period. **Does NOT include:** • ADL documentation cannot be used to document active treatment, as all residents receive ADL assistance. • 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. NOTE: Diagnoses should be checked off in the appropriate area in items I0100 – I7900. If a disease or condition is **not** specifically listed in these areas, enter the diagnosis and International Classification of Diseases (ICD) code in item I8000, Additional active diagnosis. • Care plans presented for "active" diagnosis when listed interventions are not documented as completed during the 7-day look-back period.			
Step 1 Identify diagnosis in the 60-day look back period. **Step 2** Determine diagnosis status: active or inactive in the 7-day look back period.			
I2000 Pneumonia **(60 and 7-day look back)**	**~Special Care High** **HDE2**	Inflammation of the lungs; most commonly of bacterial or viral origin. An active physician diagnosis must be present in the medical record.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
	HBC2 **HDE1** **HBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**Does Include:** X-ray report signed by radiologist may be used to confirm diagnosis. **Does NOT include:** • A hospital discharge note referencing pneumonia during hospitalization. **See Active Diagnoses Definition.**	pneumonia within the observation period is required. Documentation of **current (within 7-day look back period)** treatment of diagnosis must be present in the medical record. X-ray report signed by radiologist may be used to confirm diagnosis.
I2100 Septicemia **(60 and 7-day look back)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted provided the physician has documented the septicemia diagnosis in the resident's clinical record. ***Urosepsis is not considered for MDS review verification.*** **See Active Diagnoses Definition.** **Does include:** • Sepsis - For sepsis to be considered septicemia, there needs to be inflammation due to sepsis and evidence of a microbial process. • If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia. • Documentation of current (within 7-day look-back period) treatment of diagnosis must be present in the medical record. **Does NOT include:** • If the medical record **does not reflect inflammation due to sepsis and evidence of a microbial process,** enter the sepsis diagnosis and ICD code in item I8000, Additional Active Diagnoses. • A hospital discharge note referencing septicemia during hospitalization without active treatment during the observation period.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of septicemia within the observation period is required. Documentation of **current (within 7-day look back period)** treatment of diagnosis must be present in the medical record.
I2900 Diabetes Mellitus (DM) **(60 and 7-day look back)**	**~Special Care High** **~Non-Therapy Ancillary** **HDE2** **HBC2** **HDE1** **HBC1**	An active physician documented diagnosis must be present in the medical record. **See Active Diagnoses Definition.** **Does include:** • Diagnosis can be accepted from the monthly "recap" orders if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. May include diet controlled diabetes.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		• May include diet controlled diabetes. • Diabetic retinopathy • Diabetic nephropathy • Diabetic neuropathy	
I4400 Cerebral Palsy **(60 and 7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	Paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy. **See Active Diagnoses Definition.** **Does Require:** • **Nursing Function Score less than or equal to 11** • Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I4900 Hemiplegia/ Hemiparesis **(60 and 7-day look back)**	**~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	Hemiplegia/ hemiparesis: Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor. **See Active Diagnoses Definition.** **Does require:** • **Nursing function score less than or equal to 11** **Does include:** • Left or right sided paralysis. • **Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.** **Does NOT include:** • **Right or left sided weakness or cerebral vascular accident (CVA) will not be accepted for this item.**	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. Right or left sided weakness or CVA will not be accepted for this item.
I5100 Quadriplegia **(60 and 7-day look back)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	Paralysis (temporary or permanent impairment of sensation, function, motion) of all 4 limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.) **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	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		the result of another condition. **Does include:** • Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. **Does NOT include:** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs. • Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.	
I5200 Multiple Sclerosis (MS) **(60 and 7-day look back)**	**~Special Care Low** **~Non-Therapy Ancillary** **LDE2** **LBC2** **LDE1** **LBC1**	Chronic disease affecting the central nervous system with remissions and relapses of weakness, paresthesis, speech and visual disturbances. **See Active Diagnoses Definition.** **Does Require:** • **Nursing Function Score less than or equal to 11** • Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I5300 Parkinson's Disease **(60 and 7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	**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 and Parkinson's Syndrome	
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease **(60 and 7-day look back)**	**~Special Care High** **~Non-Therapy Ancillary** **HDE2** **HBC2** **HDE1** **HBC1**	**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**	

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		be coded at both. (See Coding Instructions page I-8 of the RAI Manual).	
I6300 Respiratory Failure **(60 and 7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	**See Active Diagnoses Definition.** **Does NOT include:** • I6300 Respiratory Failure may not be coded under I6200	
		Section J	
J1100C Shortness of Breath or Trouble Breathing When Lying Flat **(7-day look back)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	**Does require:** • Documentation of the presence of or observation of shortness of breath or trouble breathing, 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; 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 **(7-day look back)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. • Fever of 2.4 degrees above the baseline. • A baseline temperature established prior to the observation period. • A temperature of 100.4 on admission is a fever. **Does require:** • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established prior to the observation period. • The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. **Does include:** • A temperature of 100.4 degrees F. on admission (prior to the establishment of the baseline temperature).	Documentation of specific occurrences of fever in the observation period. A baseline temperature must be established and documented prior to the observation period for comparison.
J1550B Vomiting **(7-day look back)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	Documentation of regurgitation of stomach contents; may be caused by many factors (e.g. drug toxicity, infection, psychogenic.) **Does require:** • Documentation of vomiting in the observation period including description of vomitus (type and amount).	Documentation of vomiting in the observation period including description of vomitus (type and amount).
		Section K	
K0300 (code 1 or 2)	**~Special Care High**	Documentation that compares the resident's weight in the current observation	Must have a documented weight within

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
Weight Loss **(30 and 180 day look-back)**	**HDE2** **HBC2** **HDE1** **HBC1**	period with his/her weight at two snapshots in time: • Weight loss of 5% a point closest to 30 days preceding current observation period. • Weight loss of 10% at a point closest to 180 days preceding current observation period. Mathematically round weights prior to completing the weight loss calculation. Physician prescribed weight loss regimen is a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie restricted diet or other weight loss diets and exercise. Also includes planned dieresis for weight loss. It is important that weight loss is intentional. **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. • Documentation, including dates with weights and prescribed diet if applicable are required.	the current observation period (within 30 days of ARD) for comparison. Documentation, including dates with weights and prescribed diet if applicable are required.
K0520A2 or K0520A3 Parenteral or IV Feedings *While a Resident* *While NOT a Resident* **(7-day look back)**	**~Special Care High** **~Non-Therapy Ancillary** **HDE2** **HBC2** **HDE1** **HBC1**	**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 hyper alimentation, including total parenteral nutrition (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.	

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		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. • Fluids given while not a resident unless facility records available with amounts administered.	
K0520B2 or K0520B3 (7-day look back) *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** **~Non-Therapy Ancillary** **HDE2** **HBC2** **HDE1** **HBC1** **~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	**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:** • Nasogastric (NG) tubes, gastrostomy tubes, J-tubes, percutaneous endoscopic gastrostomy (PEG) tubes. • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the gastrointestinal (GI) system.	
K0710A Calorie Intake through parenteral or tube feeding **(7-day look back)**		Documentation must support the proportion of all calories actually received for nutrition or hydration through parenteral or tube feeding. **For residents receiving PO nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include:** • Total calories from parenteral route. • Total calories from tube feeding route. • Calculation used to find percentage of calories consumed by artificial routes.	Dietary notes can be used to support MDS coding.
K0710A3** **Proportion of Total Calories the Resident Received Through Tube Feeding** **(7-day look back)** ***Column 3-during entire 7	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1** **~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. See example in the RAI Manual page K-16. *Unless the resident is advised nothing by mouth (NPO), documentation must demonstrate how the facility calculated the % of calorie intake the tube*	

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
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.**	**LDE2** **LBC2** **LDE1** **LBC1**	*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. **Does include:** • Dietary notes to support MDS coding.	
K0710B Average Fluid Intake Intake by IV or tube feeding. **(7-day look back)**	**~Special Care High** **~Special Care Low**	Documentation must support average fluid intake per day by IV and/or tube feeding. This is calculated by reviewing the intake records, adding the total amount of fluid received each day by IV and/or tube feedings only. Divide the week's total fluid intake by the number of days in the observation period. This will provide the average fluid intake per day.	Dietary notes may be used to support MDS coding. Documentation to include evidence of the average fluid intake per day by IV or tube feeding during the entire seven days' observation period. Refers to the actual amount of fluid the resident received by these modes (not the amount ordered).
***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** **HDE2** **HBC2** **HDE1** **HBC1** **~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	**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.) **Does include:** • Dietary notes to support MDS coding.	

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
Section M			
M0300B1 **Stage 2** **M0300C1** **Stage 3** **M0300D1** **Stage 4** **M0300F1** **Unstageable Due to Slough/Eschar** **(7-day look back)**	**~Special Care Low** **~Non-Therapy Ancillary** **LDE2** **LBC2** **LDE1** **LBC1**	Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed. • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured. • Description of the ulcer including the stage. **Does 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 (and/or measurements) aligning with RAI description requirements. • 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:** • Reverse staging. • 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. • Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured.	Documentation must indicate the number of pressure ulcers on any part of the body observed during the observation period. Pressure ulcer staging must be clearly defined by description and/or measurement in order to support MDS coding during the observation period. Documentation must include date, clinician signature, and credentials.
M1030 Venous/Arterial Ulcers **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	Venous Ulcers: Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg. Arterial Ulcers: Ulcers caused by peripheral artery disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus. **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 aligning with RAI description requirements. • Documentation must include date, clinician signature and credentials. **Does NOT include:** • Pressure ulcers/injuries coded in M0300.	Documentation must indicate the number of venous or arterial ulcers observed during the observation period. Documentation must include date, clinician signature, and credentials.

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
M1040A Infection of the foot **(7-day look back)**	**~Special Care Low** **~Non-Therapy Ancillary** **LDE2** **LBC2** **LDE1** **LBC1**	Documentation of signs and symptoms of infection of the foot. **Does require:** • Documentation of signs and symptoms of infection of the foot. • Documentation to include description and location of the infection. Documentation must include date, clinician signature and credentials. **Does include:** • Cellulitis. • Purulent drainage. **Does NOT include:** • Ankle problems. • Pressure ulcers/injuries coded in M0300.	Documentation of signs and symptoms of infection of the foot must be present in the medical record to support the MDS coding. Documentation to include description and location of the infection. Documentation must include date, clinician signature, and credentials.
M1040B Diabetic foot ulcer **(7-day look back)**	**~Special Care Low** **~Non-Therapy Ancillary** **LDE2** **LBC2** **LDE1** **LBC1**	Documentation of signs and symptoms of foot ulcer or lesions. • Description of foot ulcer and/or open lesions such as location and appearance. **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 aligning with RAI description requirements. • Documentation must include date, clinician signature and credentials. **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.	Documentation of sign and symptoms of foot ulcer or other lesion on the foot must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials.
M1040C Other open lesion on the foot (e.g. cuts, fissures) **(7-day look back)**	**~Special Care Low** **~Non-Therapy Ancillary** **LDE2** **LBC2** **LDE1** **LBC1**	Documentation of signs and symptoms of foot ulcer or lesions. • Description of foot ulcer and/or open lesions such as location and appearance. **Does require:** • Documentation of open lesion must include but is not limited to location and description. • Lesion must be open during observation period. • Documentation must include date, clinician signature and credentials. **Does NOT include:** • Pressure ulcers that occur on residents with diabetes mellitus.	Documentation of sign and symptoms of foot ulcer or other lesion on the foot must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials.

Nevada Supportive Documentation Guidelines
Available online at: *http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing* (Resources/MDS Guidelines)
Patient Driven Payment Model (PDPM)
For MDS 3.0 Assessments with an ARD on or after January 1, 2025 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	PDPM Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
		• Ankle problems. • Pressure ulcers/injuries coded in M0300.	
M1040D Open lesions other than ulcers, rashes, cuts **(7-day look back)**	**~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**Does require:** • Description of open lesion must include but is not limited to location and description. • Lesion must be open during observation period. Documentation must include date, clinician signature and credentials. **Does include:** • Skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. • Description of the open lesion such as location and appearance. • Documentation in the care plan. • 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 coded in M0300-M0900. • Skin tears, cuts, abrasions. • Pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears, cuts/lacerations, abrasions, or rashes.	Documentation of signs and symptoms of open lesion other than ulcers, rashes or cuts must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials. RAI manual examples are not all inclusive, other lesions will be considered for inclusion in this item. (i.e. shingles lesions or weeping wounds).
M1040E Surgical Wounds **(7-day look back)**	**~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**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 aligning with RAI description requirements. Documentation must include date, clinician signature and credentials. **Does include:** • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage site on any part of the body. • Description of the surgical wound such as location and appearance. • Pressure ulcers/injury(s) that are surgically repaired with grafts and flap procedures. **Does NOT include:** • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure. • Peripherally inserted central catheter (PICC) sites, central line sites, and IV sites. • Pressure ulcers that have been surgically debrided.	Documentation of a surgical wound must be present in the medical record to support the MDS coding during the observation period. Cannot be coded after the site is healed even though cleansing and a dressing may still be applied (example healed stoma or G- tube site). Documentation must include date, clinician signature, and credentials.

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M1040F Burns **(7-day look back)**	**~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	Documentation to include a description of the appearance of the second or third degree burns. **Does require:** • Description of the second or third degree burn must include but is not limited to location and description. • Documentation must include date, clinician signature and credentials. **Does include:** • Second or third degree burns only; may be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. **Does NOT include:** • First-degree burns (changes in skin color only).	Documentation of signs and symptoms of second and third degree burns must be present in the medical record to support MDS coding during the observation period. Documentation must include date, clinician signature, and credentials.
M1200A Pressure Relieving Device/chair **M1200B** Pressure Relieving Device/bed **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	Equipment aimed at relieving pressure away from areas of high risk. **Does require:** • Documentation of use of equipment aimed at reducing pressure away from areas of high risk during the observation period. • The term "pressure relieving," "pressure reducing," or "pressure redistributing" needs to be verifiable through Manufacturer documentation and available upon request by the review team. • A facility policy identifying use of pressure reducing/relieving/redistributing mattresses on each resident bed will be considered sufficient documentation for the bed. • Each device must be documented separately. **Does include:** • Foam, air, water, gel, or other cushioning. • Pressure relieving, reducing, redistributing devices. **Does NOT include** • Egg crate cushions of any type. • Doughnut or ring devices.	Documentation and/or description of pressure relieving, reducing, or redistributing devices in the medical record to support MDS coding during the observation period. Each device must be documented separately. (e.g. "Pressure relieving for chair/bed" will not be accepted). Use of the device must be noted in the medical record at least one time during the observation period. Additionally, the term "pressure relieving," "pressure reducing" or "pressure redistributing" needs to be verifiable through Manufacture documentation and available upon request by the review team.
M1200C Turning/repositioning program **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. reposition on side, pillows between knees), and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as directed by facility policy), should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued,

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	~Clinically Complex **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**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 and include statement as to whether or not the program should be continued, discontinued or changed. • Documentation must indicate whether the program is implemented for maintenance or improvement. • The goals of the program must me measurable and must occur a minimum of 7-days per week.	discontinued or changed. All components must be present to support MDS coding. The goals of the program must be measurable and must occur a minimum of 7-days per week. Evaluation by a licensed nurse during the observation period is required: Co-signing by the nurse will not be accepted. Documentation must be specific if the program is for maintenance or improvement and must include a description of the resident's response to the program within the observation period. Does not include: "Standard of Care Statement," (i.e. q 2 hour turning).
M1200D Nutrition/hydration intervention to manage skin problems **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	Documentation of dietary intervention(s) to prevent or treat specific skin conditions. • Description of specific skin condition. **Does include:** • Vitamins and/or supplements when administration is linked to a skin problem. **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. • Medication Administration Record must note the medication, vitamin or supplement is for treatment of a skin condition to support MDS coding of this item.	Nutrition and/or hydration interventions for the purpose of preventing or treating specific skin conditions (i.e. wound healing) ONLY. The MAR's must note that the medication, vitamin, or supplement is for treatment of a skin condition to support MDS coding of this item.
M1200E Pressure Ulcer Care **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex**	Documentation to include any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at each Stage (M0300 A-G). **Does include:** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT).	Documentation of pressure ulcer treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.

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	CDE2 **CBC2** **CA2** **CDE1** **CBC1** **CA1**	• Hydrotherapy. **Does require:** • Documentation of intervention(s) for treating pressure ulcers/injuries identified at M0300B, C, D, and F.	
M1200F Surgical Wound Care **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	Documentation to include any intervention for treating or protecting any type of surgical wound. **Does require:** Documentation of intervention for treating or protecting any type of surgical wound identified at M1040E. **Does include:** • Topical cleaning. • 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. • The observation of the surgical wound.	Documentation of surgical wound treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.
M1200G Application of non-surgical dressings; other than to the feet **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1**	Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. **Does require:** Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. **Does include:** • Dressing application even once. • Compression bandages. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings.	Documentation of application of non-surgical dressing to body part other than the feet must include dressing type, date and clinician signature with credentials in the medical record to support MDS coding.

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	CA1	• Dressings with hydrocolloid or hydro active particles. • Dressing application(s) to the ankle. **Does NOT include:** • Ointments/medications applied without non-surgical dressings. • 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 • Dressing for pressure ulcer on the foot.	
M1200H Application of ointments/medications other than to the feet **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	Documentation of application of ointment/medications **(used to treat or prevent a skin condition**) other than to the feet. **Does require:** • Documentation of application of ointments/medications (used to treat a skin condition) other than to feet. Documentation must include product, date and clinician signature with credentials. **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).	Documentation of application of ointment/medication used to treat or prevent a skin condition other than to the feet must include product, date and clinician signature with credentials in the medical record to support MDS coding.
M1200I Application of Dressings (feet) **(7-day look back)**	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	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. **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**. • Documentation must include treatment, date and clinician signature with	Documentation of intervention to treat any foot wound or ulcer other than a pressure ulcer must include treatment, date and clinician signature with credentials in the medical record to support MDS coding.

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		credentials in the medical record. **Does NOT include:** • Application of ointments/medications to the feet without dressings. • 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.	
		Section N	
N0350B Days of Orders for Insulin **(7-day look back)**	**~Special Care High** **HDE2** **HBC2** **HDE1** **HBC1**	**Does require:** • Documentation must include the number of days the insulin orders changed during the observation period. • Documentation to include the number of days insulin injections were received during the observation period. • Documentation must include date, clinician signature and credentials. **Does include:** • Sliding scale order that is new, discontinued, or is the first sliding scale order. • The number of days the resident actually required a subcutaneous injection to restart the subcutaneous insulin pump. **Does NOT include:** • A different dose of insulin administered based on an existing sliding scale order.	
		Section O	
O0110A1b Chemotherapy *While a Resident* ***(14-day look back)***	**~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**Does require:** • Documentation of administration of any type of chemotherapy agent (anticancer drug) given by any route for the sole purpose of cancer treatment. • Documentation must indicate that the resident actually received the chemotherapy and not just left the building (or remained in the building) with the intent to receive chemotherapy. • Documentation must include date, clinician signature and credentials. **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.	Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.

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O0110B1b Radiation ***(14-day look back)***	**~Special Care Low** **~Non-Therapy Ancillary** **LDE2** **LBC2** **LDE1** **LBC1**	**Does require:** • Documentation of administration of radiation inside or outside of facility. • Documentation must indicate that the resident actually received the radiation and not just left the building (or remained in the building) with the intent to receive radiation. **Does include:** • Intermittent radiation therapy. • Radiation administered via radiation implant.	Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.
O0110C1b Oxygen Therapy ***(14-day look back)***	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1** **~Clinically Complex** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**Does require:** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Documentation of oxygen therapy with liter flow including date, signature, and credentials of clinician. • 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 bi-level positive airway pressure (BiPAP) or continuous positive airway pressure (CPAP). **Does NOT include:** • Hyperbaric oxygen for wound therapy.	
O0110E1b Tracheostomy Care ***(14-day look back)***	**~Extensive Services** **~Non-Therapy Ancillary** **ES3** **ES2**	**Does require:** • Documentation of cleansing of the tracheostomy and/or cannula during the observation period. • Documentation including date and signature of clinician. **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) ***(14-day look back)***	**~Extensive Services** **~Non-Therapy Ancillary** **ES3** **ES2**	**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. • Documentation including date and signature of clinician. **Does include:** • Any resident being weaned from the respiratory or ventilator during the	

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		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.	
O0110H1b IV Medications ***(14-day look back)***	**~Clinically Complex** **~Non-Therapy Ancillary** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**Does require:** • Documentation of the administration of any drug or biological (contrast material) by IV push, epidural pump, or drip through a central or peripheral port. **Does include:** • Epidural, intrathecal, and baclofen pumps. **Does NOT include:** • Saline or heparin 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.	Documentation of IV medication administration must include signature/credentials of clinician in the medical record to support MDS coding.
O0110I1b Transfusions ***(14-day look back)***	**~Clinically Complex** **~Non-Therapy Ancillary** **CDE2** **CBC2** **CA2** **CDE1** **CBC1** **CA1**	**Does require:** • Documentation of the administration of blood or any blood products directly into the bloodstream. • Documentation must indicate that the resident actually received the transfusion and not just left the building (or remained in the building) with the intent to receive transfusion. **Does NOT include:** • Transfusions administered during dialysis or chemotherapy.	Documentation must include product infused, signature/credentials of clinician in the medical record to support the MDS coding.
O0110J1b Dialysis ***(14-day look back)***	**~Special Care Low** **LDE2** **LBC2** **LDE1** **LBC1**	**Does require:** • Documentation of the administration of peritoneal or renal dialysis that occurred inside or outside facility. • Documentation must include administration record from the treating facility with date, clinician's signature/credentials in the medical record to support MDS coding. • 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).	

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		• 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.	
O0110M1b Isolation or quarantine for active infectious disease (Does not include standard body/fluid precautions). ***(14-day look back)***	**RAI Requirements Page O-8**	**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 because of active infection and cannot 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). **(14-day look-back)**	**~Extensive Services** **~Non-Therapy Ancillary** **ES1**	**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. • Support documentation must be part of the resident's permanent legal medical record. **Does NOT include:** • Standard precautions. • Only has a history of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with roommate.	
O0400D, 2 Respiratory Therapy days **(7-day look back)**	**~Special Care High** **HDE2** **HBC2**	**A day of therapy is defined as 15 minutes or more of treatment in a 24-hour period.** Services that are provided by a qualified professional (respiratory therapists,	Documentation of therapy days with associated initials/signature(s) to be cited in the medical record on a daily basis to support MDS coding.

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	HDE1 **HBC1**	respiratory nurse). Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. **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. • Subsequent evaluation time • Set-up time **Does NOT include:** • Oxygen only. • Therapy provided prior to admission. • Time spent on documentation or initial evaluation. • Conversion of units to minutes. • Rounding to the nearest 5th minute. • 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. • When the performance of a maintenance. • Services that are not medically necessary. • Once program does not require the skills of a therapist because it can be safely accomplished by the resident or with assist of a non-therapist.	• Only therapy provided while a resident in the facility. • Therapy must be physician ordered, treatment planned, and assessed. • Oxygen on its own is not a respiratory therapy.

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O0500A-J Restorative Nursing Programs **(7-day look back)**	**~Behavioral Symptoms and Cognitive Performance** **BAB2** **BAB1** **~Reduced Physical Function** **PDE2** **PBC2** **PA2** **PDE1** **PBC1** **PA1**	Documentation must include the five criteria to meet the definition of a restorative nursing program: • Measurable objectives and interventions must be documented in the care plan and in the medical record. • Evidence of periodic evaluation by a licensed nurse must be present in the resident's medical record. Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period. • Staff must be trained in the proper techniques to promote resident involvement in the activity. • Restorative nursing program activity must be supervised by an RN or LPN. No more than 4 residents per supervising staff personnel. ****When residents are part of a group, provide documentation to identify the group, program, minutes and initials of person providing program.** **Does NOT require:** • Physician orders **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	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. Program validation must include initials/signature(s) on a daily basis to support the total days and minutes of nursing restorative programs provided. Evaluation by a licensed nurse is required within the observation period. Includes: • Days for which 15 or more minutes of restorative nursing was provided within a 24-hour period for a minimum of 6-days. • Time provided for each restorative program must be documented separately. • MDS review staff may ask to review the training records of the facilities restorative program staff. When residents are part of a group, provide documentation to identify the number of residents in the group and how many staff members are assisting. At least one staff member must be a Restorative Nursing Assistant (RNA) or licensed staff person.

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		licensed nurse once the purpose and objectives have been established (contingent upon state Nurse Practice Act and any other applicable state laws). • The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device. **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.	
		Section Z	
Z0400	**~Interview Items** **~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.**	

Review Procedures

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

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

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

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

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

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

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

Signature Date at Z0400:

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

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

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

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

Electronic Health Records (EHR)

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

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

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

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

GG Based Nursing Function Score

Safety and Quality of Performance – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices.	
06	**Independent –** Resident completes the activity by themselves with no assistance from a helper.
05	**Setup or clean-up assistance –** Helper sets up or cleans up, resident completes activity. Helper only assists prior to or following the activity.
04	**Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03	**Partial/moderate assistance –** Helper does **LESS THAN HALF** the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02	**Substantial/maximal assistance –** Helper does **MORE THAN HALF** the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01	**Dependent –** Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.
If activity was not attempted, code reason:	
07	**Resident refused**
09	**Not applicable – Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.**
10	**Not attempted due to environmental limitations (e.g. lack of equipment, weather constraints)**
88	**Not attempted due to medical condition or safety concerns**

Section GG items for Nursing Function Score		Score
GG0130A	Self-Care: Eating	0-4
GG0130C	Self-Care: Toileting Hygiene	0-4
GG0170B	Mobility: Sit to Lying	0-4 (average of 2 bed mobility items)
GG0170C	Mobility: Lying to Sitting on Side of Bed	
GG0170D	Mobility: Sit to Stand	0-4 (average of 3 transfer items)
GG0170E	Mobility: Chair/bed to Chair Transfer	
GG0170F	Mobility: Toilet Transfer	

Scoring for Section GG Items		Score
05, 06	Setup or Clean-Up Assistance, Independent	4
04	Supervision or Touching Assistance	3
03	Partial/Moderate Assistance	2
02	Substantial/Maximal Assistance	1
01, 07, 09, 10, 88, (-)	Dependent, Refused, Not Applicable, Not Attempted (environmental/medical/safety)	0

I0020/I0020B and J2100	
Completion of the following 2 items is required to in order to produce a full HIPPS code and thus a categorization into a nursing category. When these items are completed the software will produce a full HIPPS code that can then be used by the facility to determine nursing category. Failure to complete these items will result in an inaccurate nursing-only PDPM classification or will be categorized as BC1 due to the inability to classify the assessment or tracking form.	
I0020/I0020B	***Indicate the resident's primary medical condition category:*** *The diagnosis recorded here should be the primary diagnosis for the resident at the time of the MDS assessment completion when completed for OBRA assessments.*
J2100	***Recent Surgery Requiring Active SNF Care:*** *If neither Yes or No is appropriate (per guidance in the RAI Manual), code 8/Unknown.*

MDS 3.0 Item Location and Item Description	*Non-Therapy Ancillary Component*	*Points/Requirements*
HIV/AIDS (Claim)	~Non-Therapy Ancillary	**8 Points**/See Active Diagnosis Definition
I8000	~Lung Transplant	**3 Points**/See Active Diagnosis Definition
I8000	~Major Organ Transplant, Except Lung	**2 Points**/See Active Diagnosis Definition
I8000	~Opportunistic Infections	**2 Points**/See Active Diagnosis Definition
I8000	~Bone/Joint/Muscle Infections/Necrosis – Except Aseptic Necrosis of Bone	**2 Points**/See Active Diagnosis Definition
I8000	~Chronic Myeloid Leukemia	**2 Points**/See Active Diagnosis Definition
I2500	~Wound Infection Code	**2 Points**/See Active Diagnosis Definition
I8000	~Endocarditis	**1 Point**/See Active Diagnosis Definition
I8000	~Immune Disorders	**1 Point**/See Active Diagnosis Definition
I8000	~End-Stage Liver Disease	**1 Point**/See Active Diagnosis Definition
I8000	~Narcolepsy and Cataplexy	**1 Point**/See Active Diagnosis Definition
I8000	~Cystic Fibrosis	**1 Point**/See Active Diagnosis Definition
I1700	~Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	**1 Point**/See Active Diagnosis Definition
I8000	~Specified Hereditary Metabolic/Immune Disorders	**1 Point**/See Active Diagnosis Definition
I8000	~Morbid Obesity	**1 Point**/See Active Diagnosis Definition
I8000	~Psoriatic Arthropathy and Systemic Sclerosis	**1 Point**/See Active Diagnosis Definition
I8000	~Chronic Pancreatitis	**1 Point**/See Active Diagnosis Definition
I8000	~Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	**1 Point**/See Active Diagnosis Definition
I8000	~Complications of Specified Implanted Device or Graft	**1 Point**/See Active Diagnosis Definition
H0100D	~Bladder and Bowel Appliances: Intermittent Catheterization	**1 Point**/See Active Diagnosis Definition

I1300	~Inflammatory Bowel Disease	**1 Point**/See Active Diagnosis Definition
I8000	~Aseptic Necrosis of Bone	**1 Point**/See Active Diagnosis Definition
O0110D1b	~Special Treatments/Programs: Suctioning Post-Admit Code	**1 Point**/See Active Diagnosis Definition
I8000	~Cardio-Respiratory Failure and Shock	**1 Point**/See Active Diagnosis Definition
I8000	~Myelodysplastic Syndromes and Myelofibrosis	**1 Point**/See Active Diagnosis Definition
I8000	~Systemic Lupus Erythematosus, Other Connective Tissue Disorders and Inflammatory Spondylopathies	**1 Point**/See Active Diagnosis Definition
I8000	~Diabetic Retinopathy – Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	**1 Point**/See Active Diagnosis Definition
I8000	~Severe Skin Burn or Condition	**1 Point**/See Active Diagnosis Definition
I8000	~Intractable Epilepsy	**1 Point**/See Active Diagnosis Definition
I8000	~Active Diagnoses: Malnutrition Code	**1 Point**/See Active Diagnosis Definition
I8000	~Disorders of Immunity – Except RxCC97: Immune Disorders	**1 Point**/See Active Diagnosis Definition
I8000	~Cirrhosis of Liver	**1 Point**/See Active Diagnosis Definition
H0100C	~Bladder and Bowel Appliances: Ostomy	**1 Point**/See Active Diagnosis Definition
I8000	~Respiratory Arrest	**1 Point**/See Active Diagnosis Definition
I8000	~Pulmonary Fibrosis and Other Chronic Lung Disorders	**1 Point**/See Active Diagnosis Definition

Determine the resident's NTA group using the guide below:

NTA Case-Mix Groups

NTA Score Range	NTA Case-Mix Group
12+	**NA**
9-11	**NB**
6-8	**NC**
3-5	**ND**
1-2	**NE**
0	**NF**

PDPM NTA Classification: _____

https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model

MDS 3.0 Item Location and Item Description	***ICD-10 Codes Acute Neurologic Condition***	***Requirements***
I8000	A01.01 through A87.9	See Active Diagnosis Definition
I8000	B00.82 through B69.0	See Active Diagnosis Definition
I8000	D32.0 through D43.9	See Active Diagnosis Definition
I8000 MELAS Syndrome	E88.41	See Active Diagnosis Definition
I8000	G00.0 through G98.8	See Active Diagnosis Definition
I8000	H47.42 through H47.642	See Active Diagnosis Definition
I8000	I60.00 through I97.821	See Active Diagnosis Definition
I8000	J10.81 through J11.81	See Active Diagnosis Definition
I8000 Immobility Syndrome (paraplegic)	M62.3	See Active Diagnosis Definition
I8000 Central nervous system complications of anesthesia during labor and delivery	O74.3	See Active Diagnosis Definition
I8000	P91.2 through P91.823	See Active Diagnosis Definition
I8000	Q04.3 through Q07.9	See Active Diagnosis Definition
I8000	R27.0 through R47.01	See Active Diagnosis Definition
I8000	S02.0XXA through S94.22XS	See Active Diagnosis Definition
I8000 Other specified complication of nervous system prosthetic devices, implants and grafts, initial encounter	T85.890A	

SLP-Related Comorbidities (not addressed elsewhere)	
MDS 3.0 Item Location and Item Description	***Requirements***
I4300 Aphasia	See Active Diagnosis Definition
I4500 CVA, TIA, or Stroke	See Active Diagnosis Definition
I5500 Traumatic Brain Injury	See Active Diagnosis Definition
I8000 Laryngeal Cancer	See Active Diagnosis Definition
I8000 Apraxia	See Active Diagnosis Definition
I8000 Dysphagia	See Active Diagnosis Definition
I8000 ALS	See Active Diagnosis Definition
I8000 Oral Cancer	See Active Diagnosis Definition
I8000 Speech and Language Deficits	See Active Diagnosis Definition

Cognitive Impairment	
PDPM Cognitive Level	**BIMS Score**
Cognitively Intact	13 - 15
Mildly Impaired	8 - 12
Moderately Impaired	0 - 7
Severely Impaired	-
Residents classify as Severely Impaired if one of the following conditions exist:	a. Comatose (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88). - In the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). - For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance. b. Severely impaired cognitive skills for daily decision making (C1000 = 3).

Swallowing Disorder Mechanically Altered Diet	
MDS 3.0 Item Location and Item Description	**Requirements**
KI0100 A - D Swallowing Disorder	**Does require:** • Documentation that the resident had difficulty swallowing during the 7-day look-back period as evidenced by: o Loss of liquids/solid from mouth when eating or drinking o Holding food in mouth/cheeks or residual food in mouth after meals o Coughing or choking during meals or when swallowing medications o Complaints or difficulty or pain with swallowing OR • Documentation of staff interview who work with the resident (on all shifts) and ask if any of the four listed symptoms were evident during the 7-day look-back period.
K0520C3 Mechanically Altered Diet	**Does require:** • Documentation that the resident is consuming a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. **Does include:** • Soft solids, puréed foods, ground meat, and thickened liquids.