2	2.13	2-734	Added new definitions box. Prior change table listed as Page 74. **DEFINITIONS** **INTERVENING ASSESSMENT** Refers to an assessment with an ARD set for a day in the interim period between the last day of the appropriate ARD window for a late assessment (including grace days, when appropriate) and the actual ARD of the late assessment. **DAYS OUT OF COMPLIANCE** Refers to the number of days between the day following the last day of the available ARD window, including grace days when appropriate, and the late ARD (including the late ARD) of an assessment.
2	2.13	2-75	***Errors on a + Medicare Assessment***
2	2.14	2-76	Page number change.

Track Changes
from Chapter 3 Section A V1.08
to Chapter 3 Section A V1.09

Chapter	Section	Page	Change
3	A	A-3	Text was added to manual, but was not on the prior change table: C. State Provider Number (optional) This number is assigned by the Regional Office and provided to the intermediary/carrier and the State survey agency. When known enter the State Provider Number in A0100C. Completion of this item is not required; however, your State may require the completion of this item.
3	A	A-4	Text shifted information from page A-3 to A-4. This information was not provided on the prior change table.
3	A	A-17 through A-21	Integrated Errata v3 information related to Intellectual Disability/Developmental Disability. Please refer to previously published errata on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30-RAIManual-v108-Errata-v3.pdf
3	A	A-23	Text copy/paste caused removed language to still appear in the manual when it should have been deleted. The change was not provided on the prior change table. Code 09, long term care hospital (LTCH): if ~~discharge location is an institution patient~~ the resident was admitted from a hospital that is certified under Medicare as a short-term, acute- care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System I(PPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

Track Changes
from Chapter 3 Section K V1.08
to Chapter 3 Section K V1.09

Chapter	Section	Page	Change
3	K	K-4	Weight-gain definitions were repeated twice in the chapter. Reinserted weight-loss definitions: **DEFINITIONS** **5% WEIGHT LOSS IN 30 DAYS** Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight. **10% WEIGHT LOSS IN 180 DAYS** Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.
3	K	K-4	The Steps for Assessment blue box has had text reverted back to "current observation period" from "7-day look back". **Steps for Assessment** *This item compares the resident's weight in the ~~7-day look-back~~ current observation period with his or her weight at two snapshots in time:*

Track Changes
from Chapter 3 Section K V1.08
to Chapter 3 Section K V1.09

Chapter	Section	Page	Change
3	K	K-5	Physician-Prescribed Weight-Loss Regimen definition updated in chapter, but not provided on previous change table: DEFINITIONS PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN 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 diuresis.~~When a physician has ordered diuretics and weight loss is expected to occur it is included under this definition.~~ It is important that weight loss be intentional.

Track Changes
from Chapter 3 Section M V1.08
to Chapter 3 Section M V1.09

Chapter	Section	Page	Change
3	M	M-27	An additional header for this page is seen in the middle of the page. This header has been removed. Facilities do not need to replace this page in their current manual.
3	M	M-30	Definition box inserted into page from April v4 errata had formatting issues where the word "wound" was covering two words above it. This definition was reformatted and replaced. OLD: **DEFINITIONS** **DIABETIC FOOT ULCERS** Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful. **SURGICAL WOUNDS** Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites. **OPEN LESION OTHER THAN ULCERS, RASHES, CUTS** Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. **BURNS (SECOND OR THIRD DEGREE)** Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

Track Changes
from Chapter 3 Section M V1.08
to Chapter 3 Section M V1.09

Chapter	Section	Page	Change
			NEW: **DEFINITIONS** **DIABETIC FOOT ULCERS** Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful. **SURGICAL WOUNDS** Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites. **OPEN LESION OTHER THAN ULCERS, RASHES, CUTS** Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. **BURNS (SECOND OR THIRD DEGREE)** Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.
3	M	M-39 and M-40	Text was inadvertently moved from page M-39 to M-40 in the Section M file. Pages M-39 and M-40 will be restored to the previous format so that providers will not have to reprint these pages.
3	M	M-23,25,37-end of section	Dashes were changed to bullets. This change does not affect anything other than formatting. Facilities may choose to reprint these pages if so desired.

Track Changes
from Chapter 3, Section N V1.08
to Chapter 3, Section N V1.09

Chapter	Section	Page	Change
3	N	N-3	**Steps for Assessment** 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws ~~and Medicare~~) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed. **Coding Instructions for N0350B** • Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws ~~and Medicare~~) changed the resident's insulin orders.
3	N	N-4	**Health-related Quality of Life** • Residents taking medications in these ~~drug classes~~ medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life. • While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these ~~reduce the~~ medications wherever possible ~~need for or maximize the effectiveness of medications for all residents~~ and ensure that the medication is the most effective for the resident's assessed condition. ~~Therefore, a~~ • As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications.

3	N	N-5	**Coding Instructions** • **N0410B, Antianxiety:** Record the number of days an ~~antianxiety~~ anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). • **N0410C, Antidepressant:** Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
3	N	N-6	• **N0410D, Hypnotic:** Record the number of days a~~n~~ hypnotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). **Coding Tips and Special Populations** • Code medications in Item N0410 according to ~~a drug's pharmacological classification,~~ the medication's therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use ~~used~~ as a hypnotic, it is ~~classified~~ categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.

3	N	N-7	N0410: Medications Received (cont.) • Doses of ~~psychopharmacologic~~ psychoactive medications differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident's function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines. • During the first year in which a resident on a ~~psychopharmacological~~ psychoactive medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically contraindicated. Information on GDR and tapering of medications can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** (the **State Operations Manual** can be found at http://www.cms.gov/Manuals/IOM/list.asp). • Prior to discontinuing a psychoactive ~~drug~~ medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).

3	N	N-8	• Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of herbal and alternative medicine ~~such~~ products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm **Example** 1. The Medication Administration Record for Mrs. P. reflects the following: **Coding:** Medications in N0410,would be checked as follows: **A. Antipsychotic,** resperidone is an antipsychotic ~~drug~~ medication, **B. Antianxiety,** lorazepam is an antianxiety ~~drug~~ medication, and **D. Hypnotic,** temazepam is a hypnotic ~~drug~~ medication. Please note: if a resident is receiving ~~drugs~~ medications in all three ~~classes~~ categories simultaneously there must be a clear clinical indication for the use of these ~~drugs~~ medications. Administration of these types of ~~drugs~~ medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.
3	N	N-9	N0410: Medications Received (cont.) Additional information on ~~psychopharmacologic~~ psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition** (**DSM-IV**) (or subsequent editions) (http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (http://www.cms.gov/Manuals/IOM/list.asp)].

Track Changes
from Chapter 3, Section O V1.08
to Chapter 3, Section O V1.09

Chapter	Section	Page	Change
3	O	O-26	NOTE: When an EOT-R is completed, the Therapy ~~s~~Start dDate (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the ~~date of~~ same as the ~~Resumption of~~ ~~t~~Therapy Start Date on the EOT-R ~~(O0450B)~~. If therapy is ongoing, the Therapy ~~e~~End ~~d~~Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

Track Changes
from Chapter 4 V1.08
to Chapter 4 V1.09

Chapter	Section	Page	Change
4	4.10	4-16	**NOTE**: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those MDS items that require a check mark response (e.g. H0100, J0800, K0510, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is **not** checked. Example: "I4800=0" means that a check mark has **not** been placed in the check box item I4800.
4	4.10	4-17 to 4-24	When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the resident is exhibiting a worsening or an acute change in mental status. Page length changes.
4	4.10	4-25	4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities: **F0800Q = 0~~not checked~~**
4	4.10	4-26 to 4-28	Page length change.
4	4.10	4-29	4. Any 6 items for staff assessment of activity preference item L through T are not checked as indicated by: **Any 6 of F0800L through F0800T = 0~~not checked~~**
4	4.10	4-29	**11. Falls** When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has had recent history of falls and balance problems.
4	4.10	4-30	7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410C> = 1 AND N0410C<=7**

Track Changes
from Chapter 4 V1.08
to Chapter 4 V1.09

Chapter	Section	Page	Change
4	4.10	4-31	Page length change.
4	4.10	4-32	**13. Feeding Tubes** When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has a need for a feeding tube for nutrition. 1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by: **K0510B1 = 1 OR K0510B2 = 1**
4	4.10	4-33 to 4-35	Page length change.
4	4.10	4-37	2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410B>= 1 AND N0410B<=7** 3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410C>= 1 AND N0410C<=7** 4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by: **N0410D>= 1 AND N0410D<=7**
4	4.10	4-37 to 4-41	Page length change.

Track Changes
from Chapter 5 V1.08
to Chapter 5 V1.09

Chapter	Section	Page	Change
5	5.1	5-1	All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans. After completion of the required assessment and/or tracking record information, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 web site at:
5	5.2	5-2	• **Completion Timing:** — For all non-comprehensive OBRA and PPS assessments, the MDS Completion Date (Z0500B) ~~may~~ must be no later than 14 days from the Assessment Reference Date (ARD) (A2300). — For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) ~~should~~ must be no more than 14 days from the Entry Date (A1600). — For the Annual assessment, the CAA Completion Date (V0200B2) ~~may~~ must be no later than 14 days from the ARD (A2300). — For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) ~~may~~ must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the signification correction respectively.
5	5.3	5-5	1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.
5	5.7	5-12	When errors in an OBRA comprehensive or quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or quarterly assessment (Item ~~A0130A~~ A0310A = 01through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status

Chapter	Section	Page	Change
			or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.
5	5.7	5-12	When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation. Inactivation Requests If the ARD or Type of Assessment is entered incorrectly, and the provider does not correct it within the encoding period, the provider must complete and submit a new MDS 3.0 record. Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid. In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.
5	5.8	5-13	Page number change.