Welcome to
MDS 3.0 Training 2026
Session #2 part 1

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DIVISION OF HEALTH SERVICE REGULATION

Disclaimer

This presentation is not a substitute for reading and reviewing the

Long-Term Care Resident Assessment Instrument 3.0 User's Manual

Version 1.20.1, October 2025

Item Sets Version 1.20.4 October 2025

or

State Operations Manual Appendix PP

Revised 7/23/25

Objectives:

Session #2

- Review Section B- Hearing, Speech, and Vision
- Review Section F- Preferences for Customary Routine and Activities
- Review Section K- Swallowing/Nutritional Status

Code of Federal Regulations (CFR)

State Operations Manual Appendix PP revised 7/23/25 : https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Quality of Care Treatment/Devices to Maintain Hearing/Vision

- Regulation F685

Quality of Life- Activities

- Regulation F679-F680

Food and Nutrition Services

- Regulation F800-F814

F685 Treatment/Devices to Maintain Hearing/Vision

Regulation: Vision and hearing

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

1. In making appointments, and

2. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

INTENT

The intent of this regulation is to ensure the facility assists the resident in gaining access to vision and hearing services by making appointments and by arranging for transportation.

F685 Guidance

This requirement does not mean that the facility must provide refraction, glasses, contact lenses or other assistive devices, conduct comprehensive audiological evaluations (other than the screening that is a part of the required) or provide hearing aids or other devices.

The facility's responsibility is to assist residents and their representatives in locating and utilizing any available resources for the provision of the services the resident needs. This includes making appointments and arranging transportation to obtain needed services.

In situations where the resident has lost their device, facilities must assist residents and their representative in locating resources, as well as in making appointments, and arranging for transportation to replace the lost devices.

This does not absolve the facility from assisting residents to keep track of their devices.

Section B:
Hearing, Vision, and Speech

Need examples and dates in the resident documentation!

B0100 Comatose: needs to be documented by a physician to count.

B0200 Hearing: should be conducted in a private, quiet spot. The resident may need to use an amplifier. The resident does not need to own the device to use it for the assessment.

B0600 Speech Clarity: if the resident is “aphasic” but is able to speak 1-2 words clearly, this should be coded as “clear speech.” It is about the clarity of the words, not the content or intended message.

Section B0600 Speech Clarity and B0700 Makes Self Understood are assessing different things!

B0700: Makes Self Understood

This item cannot be coded as Rarely/Never understood if the resident completed any of the resident interviews. As the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make them self understood during the entire 7 day look back.

This includes the ability to express or communicate requests, needs, opinions and to conduct social conversations in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make oneself understood can included reduced voice volume and difficulty in producing sounds, finding the right word, making sentences, writing and/or gesturing.

This should be coded after 11:59 PM of the ARD, taking into account all information.

While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

Section B1300 Health Literacy

Resident self-reported item

Completed for 5-day PPS or Planned PPS Discharge

Should include this information on the resident's care plan.

F552 Right to be Informed/Make Treatment Decisions

Glossary A-10

Health Literacy *The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.*

F552 Right to be Informed/ Make Treatment Decisions

Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:

- Even without capacity or declared incompetent the resident may be able to express their needs. Documentation should be in the resident's medical record who made the decisions and participated in the care planning process.

The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

- Includes psychotropic medication use.

Section F: Preferences for Customary Routine and Activities

F0300: If the resident is ever understood, the interview needs to be attempted. Use the resident's primary method of communication. *DO NOT* consult B0700 to decide to do the interview or not.

If the interview is not possible, the resident is rarely or never understood, then conduct the interview with the family or significant other. If the interview could not be completed, then skip to the staff assessment.

Documentation would be expected if the resident or family were not interviewed.

If the assessment should have been done during the look back period and *WAS NOT*, code F0300 as YES and dash (-) the information.

Section F (continued)

Section F is about the quality of their life. These questions are only asked on comprehensive assessments, but it is okay to ask these questions more frequently.

Please include preferences in the care plan!

Surveyors ask many of these questions when while interviewing residents.

Get there before they do!

Activities Meet Interest/Needs of Each Resident
F679

The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Intent

To ensure that facilities implement an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning).

Section K: Swallowing/Nutritional Status

The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration.

This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches.

The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

Section K: Swallowing/Nutritional Status cont.

K0100 Swallowing Disorder: need to observe the resident and ask staff who work with the resident if any of these signs and symptoms were present during the look back period.

K0200B Weight: Record the weight, on the most recent measure in the last 30 days, *closest* to the ARD.

K0300 Weight Loss: Since this looks back 6 months, it may not capture weight loss from 3 months ago. If weight loss has been recognized and the resident has already regained some weight this would still need to be addressed. Explain in the CAA or the resident's record.

- This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

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 physician-prescribed weight loss regimen in the medical record.
- Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan.

K0300: Weight loss

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. It is important that weight loss is intentional.

To code K0300 as 1, yes, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.

Quality Measure:
Percent of Residents Who Lose Too Much Weight

The measure captures the percentage of long-stay residents who had a weight loss of 5% or more in the last month or 10% or more in the last 6 months who were not on a physician prescribed weight loss regimen noted in an MDS assessment during the selected quarter.

K0300 Weight Loss & K0310 Weight Gain

Steps for Assessment

This item compares the resident's weight in the current observation period with their weight at two snapshots in time:

At a point closest to 30-days preceding the current weight.

At a point closest to 180-days preceding the current weight.

The resident's weight captured closest to these two time points are the only two weights considered for this item, but the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

In cases in which multiple weights for the resident may exist during the time period being evaluated, select the weight on the date closest to the appropriate time point. -Examples

For a New Admission

Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.

Consult the resident's physician, review transfer documentation, and compare with admission weight.

If the admission weight is more than the previous weight, calculate the percentage of weight gain.

Complete the same process to determine and calculate weight gain comparing the admission weight to the weight 30 and 180 days ago.

Section K (continued)

K0520 Nutritional Approaches:

- Trial diets are not captured RAI page K-13

K0520 A Parenteral/IV feeding: Needs documentation that reflects the need for additional fluids to address nutrition, hydration or prevention.

K0520B Feeding tube: Only mark this if used for nutrition or hydration.

Section K0520

Nutritional Approaches include new time frames

1. On Admission: Assessment period is days 1-3 of the SNF PPS starting with A2400B

2. While Not a Resident: Performed while not a resident of the facility and within the last 7 days. If the resident entered 7 or more days ago, leave column 2 blank.

3. While a Resident: Performed while a resident and within the last 7 days.

4. At Discharge: Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C.

K0520A: Parenteral/IV Feeding

Include only if given for nutrition or hydration and when there is documentation addressing the need.

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
- IV fluids running at KVO (Keep Vein Open)
- IV fluids contained in IV Piggybacks
- Hypodermoclysis and subcutaneous ports in hydration therapy

K0520B Feeding Tube

Enteral feeding formulas: Should not be coded as a mechanically altered diet.

Should only be coded as **K0520D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to residents with diabetes.

Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B.

K0520C Mechanically Altered Diet

A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake.

- Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

Assessors should not capture a trial of a mechanically altered diet (e.g., pureed food, thickened liquids) during the observation period in K0520C, mechanically altered diet.

K0520D Therapeutic Diet

RAI page K-13

A therapeutic diet is a diet intervention prescribed by a physician or other authorized nonphysician practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of treatment of disease or clinical condition, to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet

Therapeutic diets are not defined by the content of what is provided or when it is served, but ***why*** the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.

A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be ***part*** of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0520D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).

Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.

Fluid restriction ordered for a disease or clinical condition may be considered a therapeutic diet.

K0520D Therapeutic Diet

What all this means is that a nutritional supplement in and of its own to address protein calorie malnutrition, weight loss, or protein supplement does not meet the requirements for coding K0510D Therapeutic Diet, on the MDS. A nutritional supplement combined with a diet in which a specific substance(s) (e.g. sodium, potassium, calories) are eliminated, decreased or increased to address the resident's altered nutritional status, which is attributed to a disease or clinical condition.

Similarly, Diets that are prescribed or adhered to per the residents' choice/preference, in the absence of an altered nutritional state due to a disease or clinical condition, not meet the RAI manual definition of a therapeutic diet and should not be coded on the MDS as a therapeutic diet.

For example, if a gluten free diet is prescribed by a practitioner as part of a treatment for a disease or clinical condition that alters the resident's nutritional status, then it should be coded on the MDS. If the diet is not prescribed for this reason, it cannot be coded on the MDS.

(CMS December 31, 2018)

Food and Nutrition Services
F801 Qualified Dietary Staff (in part)

A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional.

GUIDANCE

…While these functions may be defined by facility management, at a minimum they should include, but are not limited to: • Assessing the nutritional needs of residents

F806 Resident Allergies, Preferences and Substitutes

Each resident receives and the facility provides—

Food that accommodates resident allergies, intolerances, and preferences;

Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice…

GUIDANCE

Facilities should be aware of each resident's allergies, intolerances, and preferences, and provide an appropriate alternative. A food substitute should be consistent with the usual and/or ordinary food items provided by the facility.

F806 (continued) Surveyor considerations
POTENTIAL TAGS FOR FURTHER INVESTIGATION

During the investigation of F806, the surveyor may have identified concerns with additional requirements related to outcome, process, and/or structure requirements. The surveyor is advised to investigate these related requirements before determining whether non-compliance may be present at these other tags. Examples of some of the related requirements that may be considered when non-compliance has been identified include, but are not limited to, the following:

F636, Comprehensive Assessments ○ Determine if the resident's allergies, intolerances, preferences, or need for a therapeutic diet were comprehensively assessed.

F656, Comprehensive Care Plans ○ Determine if a comprehensive care plan was developed to include the resident's allergies, intolerances, preferences, or need for a therapeutic diet.

F657, Comprehensive Care Plan Revision ○ Determine if the care plan was reviewed and revised by appropriate staff, in conjunction with the interdisciplinary team and with input from the resident or his/her legal representative, to try to address any allergies, intolerances, preferences, or need for a therapeutic diet.

F658, Care provided by Qualified Persons in Accordance with the Plan of Care ○ Determine whether the care plan for a resident with allergies, intolerance, preferences, or a therapeutic diet is adequately and/or correctly implemented.

F692, Nutrition/Hydration ○ Determine if the facility has managed the resident's nutritional interventions to meet the resident's nutritional needs, while accommodating the resident's allergies, intolerances, preferences, or need for a therapeutic diet.

F808 Therapeutic Diet Prescribed by Physician

Therapeutic diets must be prescribed by the attending physician. The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.

INTENT

To assure that residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment, plan of care, in accordance with their goals and preferences.

DEFINITIONS

"**Therapeutic Diet**" means a diet ordered by a physician or delegated registered or licensed dietitian as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).

"**Mechanically altered diet**" means one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' or delegated registered or licensed dietitian order.

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Thank you!

Thank you for all the work you do to ensure the care, comfort and safety of our most vulnerable in society. This is not an easy job you do, and it must come from the heart. Weariness and frustration can easily become your best friends, but don't let them take over! Know that you are not alone in your work. Reach out, make friends and contacts who will encourage your soul.

Please know that you are welcome to call or email me anytime.

Sincerely, Janet