

MDS Charting Guidelines

Documenting so every code on the assessment is backed by the record

The 8 rules of MDS charting

1. Chart in real time, on the shift it happened — not the day the assessment is due.	5. Correct with one line, initials and date — never erase or use correction fluid.
2. Chart what the resident actually does, not what staff do for them or what they could do.	6. Never copy forward: cloned notes repeat yesterday and hide real change.
3. Be measurable: “refused breakfast, ate one third of tray” beats “poor appetite.”	7. Chart the look-back. A 7-day item needs evidence inside those 7 days.
4. Date, time and sign every entry with your credentials; approved abbreviations only.	8. If it is not documented, it cannot be coded, defended or billed.

What each section needs in the chart

Section	What the record must show	Look-back
B Hearing, speech, vision	The resident's own answers; note whether glasses or hearing aids were worn and working.	7 days
C Cognition	A completed BIMS interview, or the documented reason the resident could not be interviewed.	7 days
D Mood	The resident's answers to the mood interview items; if staff answered, record who and why.	14 days
E Behavior	Each episode: what happened, when, who was there, what staff did and the outcome.	7 days
GG Functional abilities	Observation of the resident doing the activity, with the set-up, assist or supervision needed.	7 days
H Bladder and bowel	Continence pattern, product use, and whether a catheter stayed in place during the period.	7 days
I Active diagnoses	A physician-documented diagnosis significant in planning care, with its ICD-10 code.	7 (some 60)
J Health conditions	The condition, how it was treated during the stay, and the resident's current status.	7 days*
K Swallowing, nutrition	Intake by meal, diet consistency, swallowing safety signs, and any tube feeding.	7 days
M Skin	Every wound: location, stage, measurements, treatment, and the date first seen.	7 days
N Medications	The current medication list, high-risk or antipsychotic use, and the reason for it.	7 days
O Special treatments	Treatments, procedures and programs the resident actually received in the period.	14 days
Z Assessment admin	Who completed each part, when, and the reason for any correction to a prior assessment.	—

Swap these charting habits

Instead of this	Chart this instead
<i>“No changes”</i>	What you observed today and what you did about it.
<i>“Patient doing well”</i>	The specific function, mood or intake you actually saw.
<i>“Family says he’s fine”</i>	Who you spoke with, when, and exactly what they reported.
<i>A blank field</i>	The reason it was not assessed, and who tried.
<i>“Same as last week”</i>	Today's observation, dated, timed and signed.
<i>“Will call physician”</i>	Who was called, when, and the order or response received.

Before you transmit — quick check

- ✓ Every required item answered — no blanks left on the form.
- ✓ Every code backed by a dated entry inside the item's look-back.
- ✓ Physician-documented diagnoses coded in Section I.
- ✓ Interviews completed, or the reason documented.
- ✓ Baseline care plan within 48 hours; full care plan within 7 days of CAA completion.
- ✓ Correction reason set on Z0400; transmitted within 14 days of the ARD.

* Look-backs shown are the standard periods. Always confirm the period printed on the item. Educational quick reference from the MDS Coordinator Masterclass — it does not replace the CMS MDS 3.0 RAI User's Manual (v1.20.11, effective October 1, 2026) or your facility's policies.