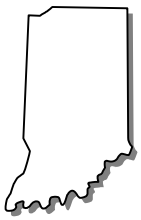
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

B T 2 0 0 3 7 0 D E C E M B E R 1 , 2 0 0 3

To: All Certified Nursing Facilities

Subject: Minimum Data Set Supportive Documentation Guidelines RUG-III, Version 5.12, 34 Grouper

Overview

The purpose of this bulletin is to update Indiana Health Coverage Programs (IHCP)-certified nursing facilities about the requirements for Minimum Data Set (MDS) supportive documentation. Supportive documentation for all MDS data elements used to classify nursing facility residents in accordance with the Resource Utilization Group (RUG)-III resident classification system must be routinely maintained in each resident's medical chart. The nursing facility must maintain this documentation for all residents. The 2003 Supportive Documentation Guidelines apply to MDS assessments with an assessment reference date (ARD) (A3a date) on or after December 1, 2003. **The most current Supportive Documentation Guidelines supercede any previously published Supportive Documentation Guidelines**

Tables 1.1 - 1.2 contain revised Supportive Documentation Guidelines that can assist providers with identifying and documenting all MDS data elements used to classify nursing facility residents in accordance with the RUG-III resident classification system.

> *Note: This bulletin contains numerous changes. Please ensure each entry is reviewed carefully.*

Refer questions about the information in this bulletin to the Myers and Stauffer help desk at (317) 816-4122. Refer questions about the Supportive Documentation Guidelines and the EDS review process to the EDS Long Term Care Unit at (317) 488-5089.

Table 1.1 – Activities of Daily Living (ADL)

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
G1a,b,i Col. A,B and G1h,A pages 3-76 to 3-100	Physical functioning and structural problems ADL's ***7-day look back***	These four ADLs include bed mobility, transfer, toileting, and eating, and must be documented for the full observation period in the medical chart for purposes of supporting the MDS responses. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	*Documentation requires 24 hours and 7 days during the observation period while in the facility. Must have signatures and dates to authenticate the services provided.*
K5a pages 3-153 to 3-154	Parenteral/IV ***7-day look back***	Evidence of intravenous (IV) fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently, must be cited in the medical chart. Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay. Do not include IVs provided during chemotherapy or dialysis.	*Administration records must be available during the observation period. IV piggyback included. If administration outside of facility, must provide hospital administration record.*
K5b pages 3-153 to 3-154	Feeding tube ***7-day look back***	Documented evidence of a feeding tube that can deliver food, nutritional substances, fluids, or medications directly into the gastrointestinal system.	*Evidence of feeding tube delivering nutrition during the observation period.*
K6a pages 3-154 to 3-155	Calorie intake ***7-day look back***	Documentation supports evidence of the proportion of all calories ingested (actually received) during the last seven days by IV or tube feeding that the resident actually received. This does not include calories taken p.o.	*Must know resident's calorie requirement to determine what percent is received by feeding tube or IV.*
K6b pages 3-156 to 3-158	Average fluid intake ***7-day look back***	Actual average amount of fluid by IV or tube feeding the resident received during the last seven days. IV flushes are not included in this calculation. The amount of fluid in an IV piggyback is included in the calculation.	*Must be able to calculate average amount of fluid (cc) over observation period.*

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
B1 pages 3-42 to 3-43	Comatose ***7-day look back***	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	*Requires active diagnosis (Dx) of coma or persistent vegetative state, signed by the physician within the past 12 months.*
B2a pages 3-43 to 3-45	Short-term memory ***7-day look back***	Short-term memory loss must be supported in the body of the medical chart with specific examples of the loss. For example, can't describe breakfast meal or an activity just completed. If there is no positive indication of memory ability, documentation must be cited in the medical record. Identify the most representative level of function, not the highest.	*Examples demonstrating short-term memory for this specific resident. One good example during the observation period will suffice.*
B4 pages 3-46 to 3-47	Cognitive skills for daily decision making ***7-day look back***	Evidence by example must be found in the medical chart of the resident's ability to actively make everyday decisions about tasks or activities of daily living, and not whether staff believe the resident might be capable of doing so. The intent of this item is to record what the resident is doing (performance).	*Examples demonstrating degree of compromised daily decision making.* *One good example during the observation period will suffice.*
C4 page 3-54	Making self understood ***7-day look back***	Evidence by example of the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.	*Examples demonstrating resident's degree of ability to make self understood. One good example during the observation period will suffice.*
E1a-p pages 3-61 to 3-63	Indicators of depression, anxiety, sad mood (Coded 1 or 2) ***30-day look back***	Examples of verbal and/or non-verbal expressions of distress, such as depression, anxiety, and sad mood must be found in the medical chart irrespective of the cause. See MDS (E1) for specific details. Code (1) exhibited at least once during the last 30 days but less than six days a week. Code (2) exhibited six to seven days a week.	*Examples demonstrating indicators of sad mood, anxiety or depression for the specific resident. Frequency required during the 30-day period ending with the A3a date.*
E4a-e **Col.A only** pages 3-66 to 3-68	Behavioral symptoms (Coded 2 or 3) ***7-day look back***	Examples of the resident's behavior symptom patterns that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Code (2) exhibited four to six days, but not daily Code (3) exhibited daily or more frequently, that is multiple times each day	*Examples demonstrating resident's specific behavior symptoms during the observation period. Frequency of behavior required during the sevenday period ending with the A3a date.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
H3a **Nursing restore score only** pages 3-124 to 3-125	Any scheduled toileting plan ***14-day look back***	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding. Changing wet garments is not included in this concept. A *program* refers to a specific approach that is organized, planned, documented, monitored, and evaluated. Documentation should evaluate the resident's response to the toileting program.	*Requires evidence that toileting (plan) occurred during the observation period and documentation describing the resident's response to the program. The resident's response must be noted within the observation period.*
H3b **Nursing restore score only** pages 3-124 to 3-125)	Bladder retraining program ***14-day look back***	Evidence in the medical chart must support a retraining program where the resident is taught to delay urinating or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. Documentation should evaluate the resident's response to the retraining program.	*Requires evidence that a retraining program occurred during the observation period and documentation describing the resident's response to the program. The resident's response must be noted within the observation period.*
I1a page 3-127	Diabetes Mellitus ***7-day look back***	An active physician diagnosis must be present in the medical chart. Includes insulin-dependent and diet-controlled.	*Active Dx signed by the physician within the past 12 months.*
I1r page 3-128	Aphasia ***7-day look back***	An active physician diagnosis must be present in the medical chart. Aphasia is defined as a speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts, or understanding spoken or written language. Include aphasia due to CVA. This difficulty must be cited in the medical chart.	*Active Dx signed by the physician within the past 12 months.*
I1s page 3-128	Cerebral Palsy ***7-day look back***	An active physician diagnosis must be present in the medical chart with evidence of paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy.	*Active Dx signed by the physician within the past 12 months.*
I1v page 3-129	Hemiplegia/ Hemiparesis ***7-day look back***	An active physician diagnosis must be present in the medical chart. Paralysis or partial paralysis of both limbs on one side of the body. Left or right-sided paralysis is acceptable as a diagnosis.	*Active Dx signed by the physician within the past 12 months. Left or right-sided weakness not included.*
I1w page 3-129	Multiple Sclerosis ***7-day look back***	An active physician diagnosis must be present in the medical chart. Chronic disease affecting the CNS with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.	*Active Dx signed by the physician within the past 12 months.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
I1z page 3-129	Quadriplegia ***7-day look back***	An active physician diagnosis must be present in the medical chart. Paralysis of all four limbs must be cited in the medical record. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	*Active Dx signed by the physician within the past 12 months. Quadraparesis is not acceptable. Spastic Quad secondary to CP may not be coded as Quadriplegia.*
I2e pages 3-135 to 3-137	Pneumonia ***7-day look back***	An active physician diagnosis must be present in the medical chart. An inflammation of the lungs. Often there is a chest x-ray, medication order, and notation of fever and symptoms.	*Active Dx signed by the physician.*
I2g pages 3-135 to 3-137	Septicemia ***7-day look back***	An active physician diagnosis must be present in the medical chart and may be coded when blood cultures have been drawn but "results" are not yet confirmed. Septicemia is a morbid condition associated with bacterial growth in the blood. Urosepsis is not considered for MDS review verification.	*Active Dx signed by the physician.*
J1c pages 3-138 to 3-140	Dehydrated; output exceeds intake ***7-day look back***	Supporting documentation must include two or more of the following: Takes in less than 1500cc of fluid daily. Signs of dehydration: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, and so forth. Fluid loss that exceeds intake daily.	
J1e page 3-139	Delusions ***7-day look back***	Evidence in the medical chart must describe examples of resident's fixed, false beliefs not shared by others even when there is obvious proof or evidence to the contrary.	*Resident specific example(s) demonstrating at least one episode of delusion(s) within the observation period.*
J1h page 3-139	Fever ***7-day look back***	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, and so forth) of temperature measurement must be consistent between the baseline and the elevated temperature.	*Must be able to calculate baseline unless the temperature is above 101 degrees.*
J1i page 3-139	Hallucinations ***7-day look back***	Evidence in the medical chart that describes examples of resident's auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.	*Resident specific example(s) demonstrating at least one episode of hallucination(s) within observation period.*
J1j page 3-139	Internal Bleeding ***7-day look back***	Clinical evidence of frank or occult blood must be cited in the medical chart such as: black, tarry stools; vomiting "coffee grounds"; hematuria; hemoptysis; or severe epistaxis. Nosebleeds that are easily controlled should not be coded as internal bleeding.	*Does not include urinalysis (UA) with positive red blood cells (RBCs), unless there is additional supporting documentation such as physician's note, nurse's notes "observed bright red blood" and so forth.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
J1o page 3-140	Vomiting ***7-day look ba***ck	Documented evidence of regurgitation of stomach contents.	
K3a pages 3-150 to 3-152	Weight Loss ***30 and 180-day look back***	Documented evidence in the medical chart of the resident's weight loss. Five percent or more in last 30 days **or** 10 percent or more in last 180 days	*The first step in calculating weight loss is to obtain the actual weights for the 30-day and 180-day time periods from the clinical record. Calculate percentage based on the actual weight. Do not round the weight.*
K5a page 3-153 to 3-154	Parenteral/IV ***7-day look back***	Evidence of IV fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently must be cited in the medical chart. Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay. Do not include IVs provided during chemotherapy or dialysis.	*Administration records must be available during the observation period. IV piggyback included. If administration outside of facility, must provide hospital administration record.*
K5b pages 3-153 to 3-154	Feeding tube ***7-day look back***	Documented evidence of a feeding tube that can deliver food, nutritional substances, fluids, or medications directly into the gastrointestinal system.	*Evidence of feeding tube delivering nutrition during the observation period.*
K6a pages 3-154 to 3-156	Calorie intake ***7-day look back***	Documentation supports evidence of the proportion of all calories ingested (actually received) during the last seven days by IV or tube feeding that the resident actually received. This does not include calories taken p.o.	*Must know resident's calorie requirement to determine what percent is received by feeding tube or IV.*
K6b pages 3-156 to 3-158	Average fluid intake ***7-day look back***	Actual average amount of fluid by IV or tube feeding the resident received during the last seven days. IV flushes are not included in this calculation. The amount of fluid in an IV piggyback is included in the calculation.	*Must be able to calculate average amount of fluid (cc) over observation period.*
M1a-d pages 3-159 to 3-161	Ulcers/staging ***7-day look back***	Evidence of the number of ulcers or open lesions, of any type, at each stage, on any part of the body. Ulcers must be reverse-staged for MDS coding and should be coded in terms of what you see. Rashes without open areas, burns, desensitized skin and surgical wounds are **not** coded here. Skin tears or shears are not coded here (M1) unless pressure was a contributing factor.	*Ulcers must be reverse-staged. Includes ulcers and open lesions. Documentation must include staging of any type of ulcer within the observation period. If scabbed wound meets M1 definition of "ulcer", stage as "2" in M1.*
M2a pages 3-161 to 3-164	Pressure ulcer ***7-day look back***	Record the highest stage caused by pressure resulting in damage of underlying tissues. Pressure ulcers must be reverse-staged for MDS coding and should be coded in terms of what you see.	*Ulcers must be reverse-staged. Documentation must include staging of pressure ulcer within the observation period.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
M4b page 3-165	Burns ***7-day look back***	All second and third degree burns must be documented in the medical chart.	
M4c page 3-165	Open lesions/sores-other than ulcers, rashes, cuts ***7-day look back***	All open lesions must be documented in the medical chart. Documentation must reflect what is seen, such as appearance, measurement, treatment, color, odor, and so forth. Do not code skin tears or cuts here.	
M4g page 3-166	Surgical Wounds ***7-day look back***	Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. Documentation should include what you see such as appearance, measurement, treatment, color, odor, and so forth. Does not include healed surgical sites or stomas, or lacerations that require suturing or butterfly closure as surgical wounds.	*PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.*
M5a pages 3-167 to 3-168	Pressure-relieving device/chair ***7-day look back***	Includes gel, air, or other cushioning placed on a chair or wheelchair. Does not include egg crate cushions.	*Evidence proving pressure-relieving device. Documentation at least once during the observation period must be noted in chart.*
M5b pages 3-167 to 3-168	Pressure relieving device/bed ***7-day look back***	Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Does not include egg crate mattresses.	*Evidence proving pressure-relieving device. Documentation at least once during the observation period must be noted in chart.*
M5c pages 3-167 to 3-168	Turning/ repositioning program ***7-day look back***	Evidence of continuous, consistent program for changing the resident's position and realigning the body. *Program* is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."	*Program must be recorded daily during the observation period. The resident's response must be noted within the observation period.*
M5d pages 3-167 to 3-168	Nutrition/hydration intervention to manage skin problems ***7-day look back***	Evidence of dietary intervention received by the resident for the purpose of preventing or treating specific skin conditions. Vitamins and minerals, such as Vitamin C or Zinc, used to manage a potential or active skin problem, should be coded here.	*Intervention(s) to manage skin problems must be specified and purpose stated at least once during the observation period.*
M5e pages 3-167 to 3-168	Ulcer care ***7-day look back***	Evidence includes any intervention for treating an ulcer at any ulcer stage.	*Treatment, or care, must be recorded at least once during the observation period.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
M5f pages 3-167 to 3-168	Surgical wound care ***7-day look back***	Includes any intervention for treating or protecting any type of surgical wound. Evidence of wound care must be documented in the medical chart.	*Treatment, or care, must be recorded at least once during the observation period.*
M5g pages 3-167 to 3-168	Application of dressings; other than to feet ***7-day look back***	Evidence of any type of dressing application, with or without topical medications, to the body.	*Treatment, or care, must be recorded at least once during the observation period.*
M5h pages 3-167 to 3-168	Application of ointments or medications (other than to feet) ***7-day look back***	Evidence includes ointments or medications used to treat a skin condition. This item does not include ointments used to treat non-skin conditions (for example, nitropaste).	*Treatment, or care, must be recorded at least once during the observation period.*
M6b pages 3-168 to 3-169	Infection of the foot ***7-day look back***	Clinical evidence noted in the medical chart to indicate signs and symptoms of infection of the foot.	*Signs and symptoms must be recorded at least once during the observation period.*
M6c pages 3-168 to 3-169	Open lesion on the foot ***7-day look back***	Evidence of cuts, ulcers, or fissures. Ankle problems are not considered foot problems and should not be coded here.	*Cuts, ulcers or fissures must be recorded at least once during the observation period.*
M6f pages 3-168 to 3-169	Applications of dressings (feet) ***7-day look back***	Evidence of dressing changes to the feet , with or without topical medication, must be documented in the medical chart.	*Treatment, or care, must be recorded at least once during the observation period.*
N1a,b,c pages 3-170 to 3-171	Time awake ***7-day look back***	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer. No more than a total of a one-hour nap during any such period.	
O3 pages 3-178 to 3-179	Injections ***7-day look back***	Evidence includes the number of days during the last seven the resident received any medication by subcutaneous, intramuscular, intradermal injection, antigen or vaccines. This does not include IV fluids or IV medications. For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.	*Tuberculosis and flu injections included.* *Do not count Vitamin B12 injections if given outside of the observation period.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
P1a,a page 3-182	Chemotherapy ***14-day look back***	Includes any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment. Evidence must be cited in the medical chart.	*If administered outside of facility, evidence of administration record must be provided during the observation period.*
P1a,b page 3-182	Dialysis ***14-day look back***	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical chart.	*Documentation must include evidence that procedure occurred during the observation period.*
P1a,c page 3-182	IV medication ***14-day look back***	Documentation of IV medication push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Do not include IV medications provided during chemotherapy or dialysis. Includes IV medications dissolved in a diluent as well as IV push medications.	*Evidence of administration of IV medications at least once during the observation period must be available. Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids, are included.*
P1a,g pages 3-183 to 3-184	Oxygen therapy ***14-day look back***	Oxygen therapy shall be defined as the administration of oxygen continuously or intermittently via mask, cannula, and others. Evidence of administration must be cited on the medical chart. (Does not include hyperbaric oxygen for wound therapy.)	*Evidence of administration of oxygen during the observation period.*
P1a,h page 3-183	Radiation ***14-day look back***	Evidence includes radiation therapy or a radiation implant.	*If administered outside of facility, evidence of procedure occurring during the observation period.*
P1a,i page 3-183	Suctioning ***14-day look back***	Evidence of nasopharyngeal or tracheal aspiration must be cited in the medical chart. Oral suctioning is not permitted to be coded in this field.	*Nasopharyngeal or tracheal aspiration must be present during the observation period.*
P1a,j page 3-183	Tracheostomy care ***14-day look back***	Evidence of tracheostomy and cannula cleansing administered by staff must be cited in the medical chart.	*Evidence must support cannula cleansing by staff during the observation period.*
P1a,k page 3-183	Transfusions ***14-day look back***	Evidence of transfusions of blood or any blood products administered directly into the bloodstream by staff must be cited in the medical chart. Do not include transfusions administered during chemotherapy or dialysis.	*Evidence of transfusions of blood or any blood products administered directly into the bloodstream during the observation period.*
P1a,l pages 3-183 to 3-184	Ventilator or respirator ***14-day look back***	Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days should be coded. Does not include CPAP, nor BiPAP in this field.	

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
P1b **a,b,c** **Col. A,B** pages 3-185 to 3-190	Therapies ***7-day look back***	Days and minutes of each therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided. Includes only medically necessary therapies furnished after admission to the nursing facility, ordered by a physician, based on a therapist's assessment and treatment plan and is documented in the clinical record.	*Direct therapy minutes with associated signature must be provided. Cannot count initial evaluation time.*
P1b, d A pages 3-185 to 3-190	Respiratory therapy ***7-day look back***	Days and minutes of respiratory therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided. Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. Includes only medically necessary therapies furnished after admission to the nursing facility, ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.	*Direct therapy minutes with associated signature must be provided. Qualified individuals for the delivery of respiratory services include trained nurses. A trained nurse refers to a nurse who received training on the administration of respiratory treatments and procedures.*
P3a-j **Nursing** **restore score only** pages 3-191 to 3-195	Nursing rehabilitation or restorative ***7-day look back***	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time that is converted to days on the MDS. Documentation must meet the five qualifying points to meet the definition of a nursing restorative program.	*Documentation must meet the five qualifying points to meet the definition of a nursing restorative program. Direct restorative minutes with associated signature and date must be provided.*
P7 page 3-204 to 3-205	Physician visits ***14-day look back***	Evidence includes the **number of days, not the number of visits**, in the last 14 days a physician examined the resident. Can occur in the facility or in the physician's office. A licensed psychologist may not be included for a visit.	*Must include documentation establishing an exam by the physician to be counted as a visit.*

(Continued)

Table 1.2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective December 1, 2003			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
P8 pages 3-205 to 3-206	Physician orders ***14-day look back***	Evidence includes the **number of days, not the number of orders**, in the last 14 days a physician changed the resident's orders. Includes written, telephone, fax, or consultation orders for new or altered treatment. Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. A licensed psychologist may not be included for an order. Orders written on the day of admission as a result of an unexpected change or deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.	

Special Notes About Documentation

1. The history and physical (H&P) could be an excellent source of supportive documentation for any of the RUG-III elements provided it is dated within the previous 12 months.
2. Any response(s) on the MDS 2.0 that reflects the resident's hospital stay prior to admission must be supported by hospital supportive documentation and placed in the resident's medical chart.
3. Supportive documentation in the medical chart must be dated during the assessment reference period to support the MDS 2.0 responses. The assessment reference period is established by identifying the assessment reference date (A3a) and the previous six days.

> *Note: On certain MDS questions the reference period may be greater than or less than seven days such as P7 and P8).*

4. Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.
5. Old unrelated diagnoses or diagnoses that do not meet the definition on the MDS 2.0 for Section I1 should not be coded on the MDS. Current and active diagnoses must be signed and dated by a physician within the previous 15 months.
6. Nursing rehabilitation or restorative care (P3) includes nursing intervention that assists or promotes the resident's ability to attain his or her maximum functional potential. It does not include procedures under the direction and delivery of qualified, licensed therapists. Nursing restorative criteria must be met as defined on page 3-192 of the RAI manual.
7. ADL documentation must reflect the entire assessment period.
8. Information contained in the clinical record must be consistent and cannot be in conflict with the MDS.
9. Group therapy is limited to four residents per session and only 25 percent of the total therapy minutes per discipline can be contributed to group therapy (*section P1b,a-c*).
10. Therapy minutes provided simultaneously by two or more therapists must be split accurately between disciplines (*section P1b,a-c*).
11. The time it takes to perform an initial evaluation and develop the treatment goals and the plan of care for the resident cannot be counted as minutes of therapy received by the resident. Re-evaluations, once therapy is underway, can be counted.

12. Do not code services that were provided solely in conjunction with a surgical procedure such as IV fluids, IV medications or ventilators. Surgical procedures include routine pre and post-operative procedures.
13. Each page or individual document in the medical record should contain the resident identification information. At a minimum, all charting entries should include the resident name, medical record number, and a complete date in MM/DD/YY format.
14. Signatures are required to authenticate all medical records. At a minimum, the signature should include the first initial, last name and title or credential.
15. Any time a facility chooses to use initials in any part of the record for authentication of an entry, must also have a corresponding full identification of the initials on the same form or on a signature legend. Initials should never be used where a signature is required by law, for example, on the MDS.
16. Qualified professionals for the delivery of respiratory services include **trained nurses**. A trained nurse refers to a nurse who received specific training on the administration of respiratory treatments and procedures. This training can be provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs.
17. IVs, IV medications, and blood transfusions in conjunction with dialysis or chemotherapy are **not** coded under the respective items *K5a* -- parenteral/IV, *P1ac* -- IV medications, and *P1ak* -- transfusions.
18. The following five criteria are required to constitute a nursing restorative program:
    - Care plan with measurable objectives and interventions
    - Periodic evaluation by a licensed nurse
    - Staff trained in the proper techniques
    - Supervision by nursing professional
    - No more than four residents per supervising staff personnel