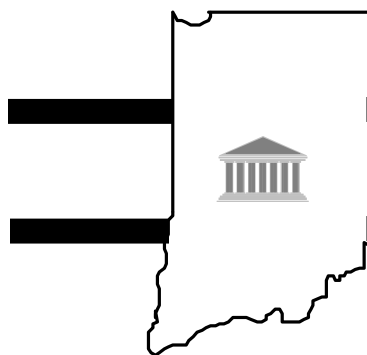

INDIANA MEDICAID UPDATE

November 6, 1998

TO: All Indiana Medicaid-Enrolled Nursing Facilities

SUBJECT: Supporting Documentation Guidelines

The purpose of this bulletin is to remind Medicaid-certified nursing facilities of the requirements for MDS supporting documentation. Please be advised that supporting documentation for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system must be routinely maintained in each resident's medical chart. Such supporting documentation shall be maintained by the nursing facility for all residents.

Attached are supporting documentation guidelines that will assist you in identifying and documenting all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system.

If you have any questions regarding the information contained in this bulletin, please contact the Myers and Stauffer help desk at (317) 816-4122.

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CHART

Column A	Column B	ADL Score
0 or 1	any number	1
2	any number	3
3 or 4	2	4
3, 4, or 8	3 or 8	5

Step 2 To calculate the eating ADL score, first examine K5a (parenteral/IV) and K5b (feeding tube). If either or both are checked, give the eating ADL score a "3" and total all four components of the ADL scores. If neither K5a nor K5b are checked go to Step 3 to calculate the eating ADL score.

Step 3 When neither K5a nor K5b are checked then examine the response to G1hA and score the eating ADL component based on the following chart.

FORMULA
If the response on the MDS in column "A" is ____, based on the chart below, the ADL score for eating will total ____.

CHART

Column A	ADL Score
0 or 1	1
2	2
3, 4, or 8	3

Step 4 Now total the ADL score for bed mobility, transfer, toileting and eating.

MDS 2.O VERSION 5.01

SPECIAL REHABILITATION

MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CHARTING GUIDELINES*	*POSSIBLE CHART LOCATION*
G1a,b,h,i Col. A,B **ADL ONLY**	Physical Functioning and Structural Problems ADL's	Because ADL's impact the classification process so strongly, four of the ADL's must be addressed in the medical chart for purposes of validating the MDS answers. These ADL's include bed mobility, transfer, toileting, and eating. Consider the resident's performance and support during all shifts, as functionality may vary.	NN,SSN,SN,CP,NR
K5a **ADL ONLY**	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart.	NN,SN,PO,PPN,CP
K5b **ADL ONLY**	Tube Feeding	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system.	NN,SN,DN,PO, PPN,CP
P1b a,b,c Col. A,B	Therapies	Days and minutes of each therapy modality must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided.	TN,PO
P3 **LOW INTENSITY ONLY**	Nursing Rehab/Restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support modality and the total time which is then converted to days on the MDS.	NR,NN,SN,CP

Very High Intensity	High Intensity	Medium Intensity	Low Intensity
450 minutes or more of therapy per week and one type of therapy at least 5 days a week and 2 or more therapies delivered.	300 minutes or more of therapy per week and one type of therapy at least 5 days a week delivered.	150 minutes or more of therapy per week and 5 days or more of one or a combination of therapy delivered.	45 minutes or more of therapy per week and 3 days or more of one or a combined therapy and 2 types or more of nursing restorative, 5 or more days per week.
ADL Score — RUG-III	**ADL Score — RUG-III**	**ADL Score — RUG-III**	**ADL Score — RUG-III**
14-18 RVC	**15-18 RHD**	**16-18 RMC**	**12-18 RLB**
8-13 RVB	**12-14 RHC**	**8-15 RMB**	**4-11 RLA**
4-7 RVA	**8-11 RHB**	**4-7 RMA**	
	4-7 RHA		

MDS 2.O VERSION 5.01

EXTENSIVE SERVICES

MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CHARTING GUIDELINES***	***POSSIBLE CHART LOCATION***
G1a,b,h,i Col. A,B **ADL ONLY**	Physical Functioning and Structural Problems ADL's	Because ADL's impact the classification process so strongly, four of the ADL's must be addressed in the medical chart for purposes of validating the MDS answers. These ADL's include bed mobility, transfer, toileting, and eating. Consider the resident's performance and support during all shifts, as functionality may vary.	NN,SSN,SN,CP,NR
K5a*	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart.	NN,SN,PO,PPN,CP
K5b **ADL ONLY**	Tube Feeding	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system.	NN,SN,DN,PO, PPN,CP
P1a,i*	Suctioning	Evidence of nasopharyngeal or tracheal suctioning must be cited in the medical chart.	NN,SN,PO,PPN, CP,TN (Hospital records)
P1a,j*	Tracheostomy Care	Evidence of tracheostomy care administered by staff must be cited in the medical chart.	NN,SN,PO,PPN,CP, TN (Hospital records)
P1a,l*	Ventilator or Respirator	Evidence of ventilator or respirator assistance must be cited in the medical chart. Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days should be coded.	NN,SN,PO,PPN,CP, TN (Hospital records)

*At least one of the above treatments must be coded and have an ADL score of 7 or more. If the ADL score is 6 or less, the record will classify in the Clinically Complex group.

TREATMENTS	**RUG-III**
3 or more	**SE3**
2	**SE2**
1	**SE1**

MDS 2.O VERSION 5.01

SPECIAL CARE

MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CHARTING GUIDELINES***	***POSSIBLE CHART LOCATION***
G1a,b,h,i Col. A,B **ADL ONLY**	Physical Functioning and Structural Problems ADL's	Because ADL's impact the classification process so strongly, four of the ADL's must be addressed in the medical chart for purposes of validating the MDS answers. These ADL's include bed mobility, transfer, toileting, and eating. Consider the resident's performance and support during all shifts, as functionality may vary.	NN,SSN,SN, CP,NR
I1w*	Multiple Sclerosis	A physician diagnosis must be present in the medical chart. ADL's and other documentation must support this diagnosis.	PO,PPN,NN, CP,SN, NR
I1z*	Quadriplegia	A physician diagnosis must be present in the medical chart. ADL's and other documentation must support this diagnosis. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	PO,PPN,NN, CP,SN,NR
I2g*	Septicemia	A physician diagnosis must be present in the medical chart. Often there is a medication order and notation of fever and symptoms. Septicemia is a morbid condition associated with bacterial growth in the blood.	PO,PPN,NN, LAB,SN
K5a **ADL ONLY**	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart.	NN,SN,PO, PPN,CP
K5b*	Tube Feeding	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system.	NN,SN,DN, PO,PPN,CP
M2a*	Pressure Ulcer (stage 3 or 4)	All pressure ulcers must be staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN,SN,PO, PPN,CP,DN, TN (Wound record)
M4b*	Burns	All second and third degree burns must be documented in the medical chart.	NN,SN,PO, PPN,CP,DN, TN (Skin sheet)
P1a,c*	IV Medications	Documentation must be present in the medical chart or be provided from the transferring hospital records.	NN,MAR,PO,CP (Hospital records)
P1a,h*	Radiation	Includes radiation therapy or a radiation implant. Documentation must be available in the medical chart.	NN,SN,PO, PPN,SSN,DNCP (Hospital records)
B1**	Comatose	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO,PPN,NN, CP,SN
N1d**	Time Awake (None of Above)	Evidence of time awake or nap frequency could be cited in the medical chart to validate the answer.	NN,SN,PPN, CP,SSN,NR, CNAN

MDS 2.O VERSION 5.01

SPECIAL CARE "continued"

MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CHARTING GUIDELINES*	*POSSIBLE CHART LOCATION*
J1h**	Fever	Recorded temperature 2.4 degrees greater than the baseline temperature.	NN,SN Vital sign sheet
I2e**	Pneumonia	A physician diagnosis must be present in the medical chart. Often there is a chest x-ray, medication order and notation of fever and symptoms.	PO,PPN,NN,SN (X-RAY)
J1c**	Dehydration; output exceeds input	Supporting documentation might include intake/output records and thorough nurses documentation describing the residents symptoms and/or fluid loss which exceeds intake.	PO,PPN,NN,CP,SN, LAB
J1o**	Vomiting	Evidence must be cited in the medical chart.	NN,SN,SSN,PPN
K3a**	Weight Loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN,SN,DN,CP, SSN,PPN (Weight sheet)

**Special combination considerations:
When B1=coma, all ADL self-performance (G1a,b,h,i) are coded with a 4 or 8 and time awake (N1d-None of Above) is checked.
When J1h, fever is checked, one of the following must also be checked; I2e, pneumonia; J1c, dehydration; J1o, vomiting; K3a, weight loss.

*At least one of the above conditions must be coded and have an ADL score of 7 or more. If the ADL score is 6 or less, the record will classify in the Clinically Complex group.

ADL Score	**RUG-III**
17-18	**SSC**
14-16	**SSB**
7-13	**SSA**

		hematuria; hemoptysis; or severe epistaxis.	NN,SN,PO,PPN
J1k*	Recurrent Lung Aspirations	Clinical indicators required in the medical chart might include; productive cough, shortness of breath or wheezing.	NN,SN,PO,PPN,CP, (X-RAY),TN
J5c*	End-stage Disease	A physician diagnosis is required in the medical chart of a deteriorating clinical course.	PO,PPN,NN,SN, CP,SSN Hospice notes
K5a* **ADL ONLY**	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart.	NN,SN,PO,PPN,CP

MDS 2.O VERSION 5.01			
CLINICALLY COMPLEX "continued"			
MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CHARTING GUIDELINES***	***POSSIBLE CHART LOCATION***
K5b **ADL ONLY**	Tube Feeding	Documented evidence of a feeding tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system.	NN,SN,DN,PO, PPN,CP
M2b*	Stasis Ulcer (stage 1,2,3,or4)	All stasis ulcers must be staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN,SN,PO,PPN,CP, DN,TN (Wound record)
P1a,a*	Chemotherapy	Includes any type of chemotherapy (anticancer drug) given by any route. Evidence must be cited in the medical chart.	NN,SN,PO,PPN,CP, DN,SSN,MAR (Hospital records)
P1a,b*	Dialysis	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical chart.	NN,SN,PO,PPN,CP, DN,SSN (Hospital records)
P1a,g*	Oxygen Therapy	Oxygen therapy shall be defined as the administration of oxygen continuous or intermittent via mask, cannula, etc. Evidence must be cited on the medical chart.	NN,SN,PO,PPN,CP, SSN,TN (Hospital records)
P1a,k*	Transfusions	Evidence of transfusions of blood or any blood products administered by staff must be cited in the medical chart.	NN,SN,PO,PPN,CP (Hospital records)
P1b,d A*	Respiratory Therapy	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.	TN,PO
P8*	Physician Orders (4 or more)	Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders, or renewal orders without changes.	PO
M4c**	Open Lesions other than ulcers, rashes, cuts	All open lesions must be documented in the medical chart. Documentation might include appearance, measurement, treatment, color, odor, etc.	NN,SN,PO,PPN,CP, DN,TN (Skin sheet)
M4f**	Skin Tears or Cuts	A skin tear or cut is any traumatic break in the skin penetrating to subcutaneous tissue. All skin tears and cuts must be documented in the medical chart. Documentation might include appearance, measurement, treatment, color, odor, etc.	NN,SN,PO,PPN,CP, DN,TN (Skin sheet)
M5i**	Other preventative or protective skin care (other than to feet)	Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads, etc. Evidence of preventive or protective care must be documented in the medical chart.	NN,SN,PO,PPN,CP, TN,NR (Skin sheet) (Treatment sheet)

MDS 2.O VERSION 5.01			
CLINICALLY COMPLEX "continued"			
MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CHARTING GUIDELINES***	***POSSIBLE CHART LOCATION***
M6f**	Applications of Dressings (feet)	Evidence of dressing changes to the feet must be documented in the medical chart.	NN,SN,PO,PPN,CP, TN (Skin sheet) (Treatment sheet)
M4g**	Surgical Wounds	Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. Documentation might include appearance, measurement, treatment, color, odor, etc. Does not include healed surgical sites or stomas.	NN,SN,PO,PPN,CP, DN,TN (Skin sheet)
M5f**	Surgical Wound Care	Includes any intervention for treating or protecting any type of surgical wound. Evidence of wound care must be documented in the medical chart.	NN,SN,PO,PPN,CP, DN,TN (Skin sheet)
**Special combination considerations: M4c, open lesions must also include coding for M5i, other skin care or M6f, foot dressings. M4f, skin tears/cuts must also include coding for M5i, other skin care or M6f, foot dressings.			
*The resident must qualify for one of the above conditions. The resident who met criteria for Extensive Services or Special Care but the ADL score was below 7 would classify as Clinically Complex. Once classified in Clinically Complex, next the resident is evaluated for Depression using the following items.			
DEPRESSION ELEMENTS			
E2	Mood Persistence (1 or 2)	Of the indicators described in E1, the medical chart must cite the results of attempts to alter the indicator(s)	NN,SSN,SN,NR,CP
E1a,g,j,n,o,p	Indicators of Depression, Anxiety, Sad Mood (1 or 2)	Examples of verbal and/or non-verbal expressions of distress i.e., depression, anxiety, and sad mood must be found in the medical chart. See MDS (E1) for specifics.	NN,SSN,SN,NR,CP
E4e Col.A	Behavioral Symptoms (1,2,or 3)	Acknowledgment and documentation of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect the frequency of behavioral symptoms manifested by the resident across all three shifts.	NN,SSN,SN,NR,CP
N1d	Time Awake (None of Above)	Evidence of time awake or nap frequency could be cited in the medical chart to validate the answer.	NN,SN,PPN,CP,SSN, NR,CNAN
N1a,b,c	Time Awake (total checked equal 0 or 1)	Evidence of time awake or nap frequency could be cited in the medical chart to validate the answer.	NN,SN,PPN,CP,SSN, NR,CNAN
B1	Comatose (equal 0)	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO,PPN,NN,CP,SN
K3a	Weight Loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN,SN,DN,CP, SSN,PPN (Weight sheet)

DEPRESSION ELEMENTS "continued"

MDS 2.0 LOCATION	*FIELD DESCRIPTION*	*CHARTING GUIDELINES*	*POSSIBLE CHART LOCATION*
I1ee	Depression	A physician diagnosis must be present in the medical chart. ADL's and other documentation must support this diagnosis.	PO,PPN,NN,CP,SN, SSN
I1ff	Manic Depression (bipolar disease)	A physician diagnosis must be present in the medical chart. ADL's and other documentation must support this diagnosis.	PO,PPN,NN,CP,SN, SSN

DEPRESSION EVALUATION

The resident is considered depressed if he/she meets either a combination of group A or group B of the following criteria:

GROUP A

E2 Persistent sad mood (1 or 2) and two other symptoms (only one symptom can be counted from groups 2 and 3):

1. E1a Negative statements (1 or 2)
2. E1n Repetitive movements (1 or 2)
   E1o Withdrawal (1 or 2)
   E1p Reduced interaction (1 or 2)
   E43A Resists care (1,2, or 3)
3. E1j Unpleasant AM mood (1 or 2)
   N1d Time awake (checked)
   N1a,b,c Awake only morning, afternoon, or evening (total checked = 0 or 1) and B1=0
4. E1g Terrible future (1 or 2)
   K3a Weight loss

OR

GROUP B

I1ee Depression and one symptom from the items above **or** I1ff Bipolar disease and one symptom from the items above.

ADL Score	**Depressed**	**RUG-III**
17-18	**YES**	**CD2**
17-18	**NO**	**CD1**
11-16	**YES**	**CC2**
11-16	**NO**	**CC1**
6-10	**YES**	**CB2**
6-10	**NO**	**CB1**
4-5	**YES**	**CA2**
4-5	**NO**	**CA1**

		performance and support during all shifts, as functionality may vary.	NN,SSN,SN,CP,NR
B2a*****	Short Term Memory	Short-term memory loss must be supported in the body of the medical chart with specific examples of the loss. (E.g., can't describe breakfast meal or an activity just completed).	NN,SSN,SN,NR,CP
B3a-d*****	Memory/Recall Ability	Examples of the resident's inability to recall items or circumstances must be found in the medical chart. (E.g., ask the resident "what is the current season, what is the name of this place or what kind of place this is.")	NN,SSN,SN,NR,CP
B4*****	Cognitive Skills for Daily Decision Making	Citations or examples must be found in the medical chart of the resident's ability to actively make decisions, and not whether staff believe the resident might be capable of doing so.	NN,SSN,SN,NR,CP
H3a **NURSING RESTORE SCORE ONLY**	Any Scheduled Toileting Plan	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.	NN,NR,SN,CP, CNAN
P3 **NURSING RESTORE SCORE ONLY**	Nursing Rehab/Restorative	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 modality and total time which is then converted to days on the MDS.	NR,NN,SN,CP

IMPAIRED COGNITION "continued"

Nursing Restorative care (P3) counts as a score of "1" for each item (P3 a,b,c,e,g,h,i) with an entry of 5 or more days of activity. P3d and/or P3f may be counted as a score of "1", but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of "1" to the Nursing Restorative Score.

Total ADL score must be 10 or less.

The following criteria combination must be met:

B2a Short term memory = 1 and B3a-d Memory/Recall (any not checked) and B4 Decision making (1, 2, or 3)

ADL Score	Nursing Restorative Score	RUG-III
6-10	**2 or more**	**IB2**
6-10	**0 or 1**	**IB1**
4-5	**2 or more**	**IA2**
4-5	**0 or 1**	**IA1**

MDS 2.O VERSION 5.01			
BEHAVIOR PROBLEMS			
MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CHARTING GUIDELINES***	***POSSIBLE CHART LOCATION***
G1a,b,h,i Col. A,B **ADL ONLY**	Physical Functioning and Structural Problems ADL's	Because ADL's impact the classification process so strongly, four of the ADL's must be addressed in the medical chart for purposes of validating the MDS answers. These ADL's include bed mobility, transfer, toileting, and eating. Consider the resident's performance and support during all shifts, as functionality may vary.	NN,SSN,SN,CP,NR
E4a,b,c,d* Col.A	Behavioral Symptoms	Acknowledgment and documentation of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect the frequency of behavioral symptoms manifested by the resident across all three shifts.	NN,SSN,SN,NR,CP
H3a **NURSING RESTORE SCORE ONLY**	Any Scheduled Toileting Plan	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.	NN,NR,SN,CP, CNAN
J1e*	Delusions	Evidence in the medical chart must describe examples of residents fixed, false beliefs not shared by others even when there is obvious proof or evidence to the contrary.	PO,PPN,NN,SN,CP, SSN
J1i*	Hallucinations	Evidence must be in the medical chart that describes examples of resident's auditory, visual, tactile, olfactory or gustatory false perceptions that occur in the absence of any real stimuli.	NN,SN,PO,PPN, SSN,CP
P3 **NURSING RESTORE ONLY SCORE**	Nursing Rehab/Restorative	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 modality and total time is then converted to days on the MDS.	NR,NN,SN,CP
Nursing Restorative care (P3) counts as a score of "1" for each item (P3 a,b,c,e,g,h,i) with an entry of 5 or more days of activity. P3d and/or P3f may be counted as a score of "1", but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of "1" to the Nursing Restorative Score.			

Total ADL score must be 10 or less.

One of the above must be coded.

ADL Score	Nursing Restorative Score	RUG-III
6-10	**2 or more**	**BB2**
6-10	**0 or 1**	**BB1**
4-5	**2 or more**	**BA2**
4-5	**0 or 1**	**BA1**

MDS 2.O VERSION 5.01			
REDUCED PHYSICIAL FUNCTION			
MDS 2.0 LOCATION	***FIELD DESCRIPTION***	***CHARTING GUIDELINES***	***POSSIBLE CHART LOCATION***
G1a,b,h,i Col. A,B **ADL ONLY**	Physical Functioning and Structural Problems ADL's	Because ADL's impact the classification process so strongly, four of the ADL's must be addressed in the medical chart for purposes of validating the MDS answers. These ADL's include bed mobility, transfer, toileting, and eating. Consider the resident's performance and support during all shifts, as functionality may vary.	NN,SSN,SN,CP,NR
H3a **NURSING RESTORE ONLY SCORE**	Any Scheduled Toileting Plan	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.	NN,NR,SN,CP, CNAN
P3 **NURSING RESTORE ONLY SCORE**	Nursing Rehab/Restorative	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 modality and total time which is then converted to days on the MDS.	NR,NN,SN,CP

Nursing Restorative care (P3) counts as a score of "1" for each item (P3 a,b,c,e,g,h,i) with an entry of 5 or more days of activity. P3d and/or P3f may be counted as a score of "1", but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of "1" to the Nursing Restorative Score.

ADL Score	**Nursing Restorative Score**	**RUG-III**
16-18	**2 or more**	**PE2**
16-18	**0 or 1**	**PE1**
11-15	**2 or more**	**PD2**
11-15	**0 or 1**	**PD1**
9-10	**2 or more**	**PC2**
9-10	**0 or 1**	**PC1**
6-8	**2 or more**	**PB2**
6-8	**0 or 1**	**PB1**
4-5	**2 or more**	**PA2**
4-5	**0 or 1**	**PA1**

*KEY for possible chart locations in the medical record

CP - Care Plan	PO – Physician Orders
DN – Dietary Notes	PPN – Physician Progress Note
LAB - Laboratory	SN – Summary Notes (nurses)
MAR – Medicine Administration Record	SSN – Social Service Notes
CNAN – Certified Nursing Assistant Notes	NR – Nursing Restorative
NN – Nurses Notes	TN – Therapy Notes

Special Notes About Documentation:

- The history and physical (H&P) may also be an excellent source of supportive documentation for any of the RUG-III elements.
- Any responses 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 residents medical chart.
- Supportive documentation in the medical chart must be dated during the assessment reference period to support (validate) the MDS 2.0 responses. The assessment reference period is established by identifying the assessment reference date (A3a) and using that date and the previous 6 days. (Note that on certain MDS questions the reference period may be greater than 7 days.)
- Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.
- Old unrelated diagnosis or diagnosis that do not meet the definition on the MDS 2.0 for Section I1 should not be coded on the MDS.
- Facilities will be required to complete a new assessment after the cessation of all therapies.
- Rehabilitation/restorative care includes nursing intervention that assists or promotes the resident's ability to attain his/her maximum functional potential. It does not include procedures under the direction and delivery of qualified therapists.

  The following elements must be included in a nursing restorative program to meet the RAI restorative criteria:

  - Measurable objectives and interventions must be documented in the care plan and clinical record.
  - Evidence of periodic evaluation by a licensed nurse must be present in the clinical record.
  - Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
  - The activity must occur for at least fifteen (15) minutes in a twenty-four (24) hour period to be documented on the MDS. The 15 minutes per day does not have to occur consecutively; e.g. it could be five (5) minute intervals of activity at three different times during the course of one day.
  - The nursing restorative category does not apply to exercise groups of more than four (4) residents.

(Refer to pages 3-153 to 3-157 of the RAI manual for further clarification.)

- There are four specific ADL categories that influence the ADL score. These four categories include bed mobility, transfer, toilet use and eating. Supportive documentation must be included in the medical chart to validate responses to these MDS locations.