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

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To: All Certified Nursing Facilities

Subject: MDS 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 April 15, 2003. **The most current Supportive Documentation Guidelines supercede any previously published Supportive Documentation Guidelines**

Tables 1.1 - 1.3 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: Revisions are in **bold** for convenience.*

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

MDS 2.0 Version 5.12, 34 – Grouper			
Activities of Daily Living (ADL)			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i **Col. A, B and** **G1h, A** (pages 3-76 to 3-100)	Physical Functioning and Structural Problems ADLs **(*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.	NN, SSN, SN, CP, NR
K5a (pages 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 insulin administered intravenously.**	NN, SN, PO, PPN, CP, Hospital records
K5b (page 3-153 to 3-154)	Feeding Tube ***(7-day look back)***	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
K6a (page 3-154 to 3-155)	Calories 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.	DN, NN, SN, MAR
K6b (page 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.**	DN, NN, SN, MAR

Table 1.2 – RUG Items

MDS 2.0 Version 5.12, 34 – Grouper			
Element Listing of RUG Items			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
B1 (page 3-42 to 3-43)	Comatose ***(7-day look back)***	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, H&P
B2a	Short-Term Memory	Short-term memory loss must be supported in the body of the medical chart with specific examples of	NN, SSN, SN, NR, CP

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(page 3-43 to 3-45)	***(7-day look back)***	body of the medical chart with specific examples of the loss. (E.g., 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.	CP
B4 (page 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).**	NN, SSN, SN, NR, CP
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.	CP, DN, CNAN, NN, SN, SSN, NR
E1a-p (page 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 i.e., 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 6 days a week.** **Code (2) exhibited 6 to 7 days a week.** **Documentation must reflect the frequency of the indicators of depression or sad mood manifested by the resident.**	NN, SSN, SN, NR, CP
E4a-e **Col.A only** (page 3-66 to 3-68) ***(7-day look back)***	Behavioral Symptoms (**Coded** 2 or 3)	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 4 to 6 days, but not daily** **Code (3) exhibited daily or more frequently, for example, multiple times each day. Documentation must reflect the frequency of the behavioral symptoms manifested by the resident.**	NN, SSN, SN, NR, CP

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MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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. Documentation must evaluate the resident's response to the toileting program.**	NN, NR, SN, CP, CNAN
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 must evaluate the resident's response to the toileting program.**	NN, NR, SN, CP, CNAN
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.	PO, PPN, H&P
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.** This difficulty must be cited in the medical chart.	PO, PPN, H&P
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.**	PO, PPN, H&P
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.	PO, PPN, H&P
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.**	PO, PPN, H&P

Table 1.2 – RUG Items

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MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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**.**	PO, PPN, H&P
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.	PO, PPN, H&P
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.	PO, PPN, H&P
J1c (page 3-138 to 3-140)	Dehydration; output exceeds intake ***(7-day look back)***	**Supporting documentation must include two or more of the following:** **1) Takes in less than 1500 cc of fluid daily.** **2) Signs of dehydration: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, and so forth.** **3) Fluid loss that exceeds intake.** **4) Insufficient fluid; did NOT consume all or almost all liquids provided during last three days (see special note).**	PO, PPN, NN, CP, SN, LAB
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.	PO, PPN, NN, SN, CP, SSN
J1h (page 3-139)	Fever ***(7-day look back)***	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, etc.) of temperature measurement must be consistent between the baseline and the elevated temperature.	NN, SN Vital sign sheet
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 perceptions that occur in the absence of any real stimuli.	NN, SN, PO, PPN, SSN, CP

Page numbers in the left column denote the location of the MDS element in the December 2002 RAI manual.

Table 1.2 – RUG Items

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Element Listing of RUG Items			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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.**	DN, NN, PO, PPN, SN
J1o (page 3-140)	Vomiting ***(7-day look back)***	Documented evidence of regurgitation of stomach contents.	DN, NN, PO, PPN, SN
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 <u>OR</u> 10 percent or more in last 180 days**	NN, SN, DN, CP, SSN, PPN Weight sheet
K5a (pages 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 insulin administered intravenously.**	NN, SN, PO, PPN, CP Hospital records
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/medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
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.	DN, NN, SN, MAR
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.**	DN, NN, SN, MAR
M1a-d (pages 3-159 to 3-160)	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. Reverse staging is required on the MDS. **Rashes without open areas, burns, desensitized skin and surgical wounds are NOT coded here.**	CP, DN, MAR, NN, PPN, SN, TN Skin sheet

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MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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.**	CP, DN, MAR, NN, PPN, SN, TN Skin sheet
M4b (page 3-165)	Burns ***(7-day look back)***	All second and third degree burns must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN Skin sheet
M4c (page 3-165)	Open lesions-other than ulcers, rashes, cuts ***(7-day look back)***	All open lesions must be documented in the medical chart. Documentation might include appearance, measurement, treatment, color, odor, etc. **Do not code skin tears or cuts here.**	NN, SN, PO, PPN, CP, DN, TN, TAR Skin sheet
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 might include appearance, measurement, treatment, color, odor, etc. Does not include healed surgical sites or stomas, or **lacerations that require suturing or butterfly closure as surgical wounds.** .	NN, SN, PO, PPN, CP, DN, TN, TAR Skin sheet
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.	CP, MAR, NN, PO, PPN, SN, NR, TN, TAR
M5b (pages 3-167 to 3-168)	Pressure Relieving Device/bed ***(7-day look back)***	Includes air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Does not include egg crate mattresses.	CP, MAR, NN, PO, PPN, SN, NR, TN, TAR
M5c (page 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.	CP, MAR, NN, PO, PPN, SN, NR, TN, TAR
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, that are used to manage a potential or active skin problem, should be coded here.**	CP, DN, MAR, NN, PO, PPN, SN, TAR
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.	CP, DN, MAR, NN, PPN, SN, TN, TAR Skin sheet

Table 1.2 – RUG Items

MDS 2.0 Version 5.12, 34 – Grouper			
Element Listing of RUG Items			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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.	NN, SN, PO, PPN, CP, DN, TN, TAR Skin sheet
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.	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
M5h (pages 3-167 to 3-168)	Application of ointments/ 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 (such as nitropaste).**	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
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.**	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
M6c (pages 3-168 to 3-169)	Open lesion on the foot ***(7-day look back)***	Evidence of cuts, ulcers, or fissures.	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
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.	NN, SN, PO, PPN, CP, TN, TAR, Skin sheet
N1a,b,c (pages 3-170 to 3-171)	Time Awake (total checked equal 0 or 1) ***(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. Documentation must reflect the frequency of the time awake manifested by the resident.**	NN, SN, PPN, CP, SSN, NR, CNAN
O3 (pages 3-178 to 3-179)	Injections ***(7-day look back)***	Evidence includes the number of days during the last seven that the resident received any medication by subcutaneous, intramuscular, or intradermal injection. This does include antigen and vaccines. This does not include IV fluids or IV medications.	CP, DN, MAR, NN, PO, PPN, SN
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.	NN, SN, PO, PPN, CP, DN, SSN, MAR Hospital records

Table 1.2 – RUG Items

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MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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.	NN, SN, PO, PPN, CP, DN, SSN Hospital records
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.**	NN, MAR, PO, CP Hospital records
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, etc. Evidence of administration must be cited on the medical chart. **(Does not include hyperbaric oxygen for wound therapy.)**	NN, SN, PO, PPN, CP, SSN, TN Hospital records
P1a,h (page 3-183)	Radiation ***(14-day look back)***	Evidence includes radiation therapy or a radiation implant.	CP, MAR, NN, PO, PPN, SN, SSN Hospital records
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.	NN, SN, PO, PPN, CP, TN Hospital records
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.	NN, SN, PO, PPN, CP, TN Hospital records
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.	NN, SN, PO, PPN, CP Hospital records
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. **Do not include CPAP or BiPAP devices in this field.**	NN, SN, PO, PPN, CP, TN Hospital records
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.	TN, PO

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MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
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.**	TN, PO
P3a-j Nursing restore score only (pages 3-191 to 3-195)	Nursing Rehab/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 then converted to days on the MDS. **Documentation must meet the five qualifying points to meet the definition of a nursing restorative program.**	NR, NN, SN, CP
P7 (pages 3-204 to 3-205)	Physician Visits ***(14-day look back)***	Evidence includes the **number of days**, **not** 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.	PO, PPN, NN
P8 (pages 3-205 to 3-206)	Physician Orders ***(14-day look back)***	Evidence includes the **number of days**, **not** 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, or 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/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.**	PO, PPN

Table 1.3 – Key for Possible Chart Location

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

Special Notes About Documentation

1) **Regarding *J1c-Dehydration*, liquids can include water, juices, coffee, gelatins, and soups. This item should be coded only when the resident is receiving, but not consuming, the proper amount of fluids to meet their daily minimum or assessed requirements. This item should not be coded for residents who may request excessive amounts above and beyond what could reasonably be expected to be consumed.**

2) **Regarding *P7-Physician Visits* and *P8-Physician Orders*, visits and/or orders by physician assistants (PA) or nurse practitioners (NP) employed by the facility are not included.**

3) **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 may have been 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.**

4) **IV's, IV medications, and blood transfusions in conjunction with dialysis are not coded under the respective items *K5a-Parenteral/IV*, *P1ac-IV-Medications*, and *P1ak-Transfusions*.**

5) The history and physical (H&P) may be an excellent source of supportive documentation for any of the RUG-III elements.

6) 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.

7) 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 that on certain MDS questions the reference period may be greater than or less than seven days).

8) Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.

9) Old unrelated diagnosis or diagnoses that do not meet the definition on the MDS 2.0 for Section I1 should not be coded on the MDS.

10) Nursing rehabilitation/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.

11) ADL documentation must reflect the assessment period.

12) Information contained in the clinical record must be consistent and cannot be in conflict with the MDS.

13) Therapy minutes provided simultaneously by two or more therapists must be split accurately between disciplines (section P1b,a-c)

14) Group therapy is limited to four residents per session and only 25 percent of the total therapy minutes per discipline may be contributed to group therapy (section P1b,a-c).

15) The time it takes to perform an initial evaluation and develop the treatment goals and the plan of care for the patient cannot be counted as minutes of therapy received by the patient. Re-evaluations, once therapy is underway, may be counted.

16) Do not code services that were provided solely in conjunction with a surgical procedure such as IV, medications or ventilators.

17) 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 (MM/DD/YY).

18) Signatures are required to authenticate all medical records. At a minimum, the signature should include the first initial, last name, and title/credential.

19) Any time a facility chooses to use initials in any part of the record for authentication of an entry there has to be 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).