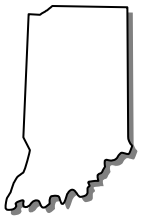

P R O V I D E R B U L L E T I N

B T 2 0 0 5 1 9 S E P T E M B E R 1 , 2 0 0 5

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 is used to classify nursing facility residents in accordance with the Resource Utilization Group (RUG)–III resident classification system and must be routinely maintained in each resident's medical chart. The nursing facility must maintain this documentation for all residents. The 2005 Supportive Documentation Guidelines apply to MDS assessments with an assessment reference date (ARD) (A3a date) on or after October 17, 2005. **The most current Supportive Documentation Guidelines supersede any previously published Supportive Documentation Guidelines.**

Table 1 contains 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 many changes in **bold.** Please review each entry carefully.*

Providers should refer questions about the Supportive Documentation Guidelines and the EDS review process to the EDS Long Term Care Unit at (317) 488-5089.

Note: The page numbers in the left column of Table 1 denote the location of the MDS element in the December 2002 Resident Assessment Instrument (RAI) manual.

Table 1 – Activities of Daily Living (ADL)

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
G1a,b,i **Col. A,B and** **G1h,A** (page 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.	Documentation requires 24 hours/7 days within the observation period while in the facility. Must have signatures/initials and dates to authenticate the services provided. One signature/initial to authenticate the ADL grid is not sufficient. **If using an ADL grid, key for self-performance and support provided must be equivalent to the MDS key.**
K5a (page 3-153 to 3-154)	Parenteral / IV **(7-day look back)**	**Include ONLY fluids administered for nutrition or hydration such as:** • **IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently** • **IV fluids running at KVO (Keep Vein Open)** • **IV fluids administered via heparin locks** • **IV fluids contained in IV Piggybacks** • **IV fluids used to reconstitute medications for IV administration** **Do NOT include:** • **IV medications** • **IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay** • **IV fluids administered solely as flushes** • **Parenteral/IV fluids administered during chemotherapy or dialysis**	Administration records must be available within the observation period. If administration occurs outside of facility, hospital administration record or other evidence of administration must be provided. **Must provide evidence of fluid being administered for nutrition or hydration.**
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.	Evidence of feeding tube delivering nutrition within the observation period.
K6a (page 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: 1) resident's calorie requirement and 2) calories actually delivered to determine what percent is received by feeding tube or IV. If resident is on a p.o. diet also, documentation of the percent of total calories that the tube provided within the observation period must be made.
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.	Must be able to calculate average amount of fluid (cc) within the observation period.

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
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.	Requires active diagnosis of coma or persistent vegetative state, signed by the physician within the past 12 months.
B2a (page 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, the patient may not be able to describe breakfast 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.	Provide examples demonstrating short-term memory for this specific resident. One appropriate example within the observation period will be sufficient.
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 believes the resident might be capable of doing so. The intent of this item is to record what the resident is doing (performance).	Provide examples demonstrating degree of compromised daily decision making. The code reflects impairment level. One appropriate example within the observation period will be sufficient.
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. Code reflects impairment level. One appropriate example within the observation period will be sufficient.
E1a-p (page 3-61 to 3-63)	Indicators of Depression, Sad Mood, Anxiety (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. **Frequency may be determined by either a tracking tool or log, or by specific narrative notes. If using narrative notes, it would require a note for each incident.**	Examples demonstrating resident's specific depression, sad mood, or anxiety. Indicators must occur and be documented within the observation period. Frequency required within the 30-day period ending with the A3a date.
E4a-e **Col.A only** (page 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, such as multiple times each day. **Frequency may be determined by either a tracking tool or log, or by specific narrative notes. If using narrative notes, it would require a note for each incident.**	Examples demonstrating resident's specific behavior symptoms must occur and be documented within the observation period. Frequency of behavior required within the seven-day period ending with the A3a date.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
H3a NURSING RESTORATIVE SCORE ONLY (page 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, 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 must evaluate the resident's response to the toileting program.	Requirements: **1) program must be care planned,** 2) evidence is shown that a toileting plan occurred within the observation period, and 3) documentation is made describing the resident's response to the program. The resident's response must be noted within the observation period.
H3b NURSING RESTORATIVE SCORE ONLY (page 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 retraining program.	Requirements: **1) program must be care planned,** 2) evidence is shown that a retraining program occurred within the observation period, and 3) documentation is made 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 patients.	Active diagnosis 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 diagnosis 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 diagnosis 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 diagnosis 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, paresthesia, speech disturbances, and visual disturbances.	Active diagnosis signed by the physician within the past 12 months.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
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. The diagnosis is typically caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	Active diagnosis signed by the physician within the past 12 months. Quadriparesis is not acceptable. Spastic Quad secondary to CP may not be coded as Quadriplegia. **Quadraplegia secondary to severe organic syndrome of Alzheimer's type is not acceptable.**
I2e (page 3-135 to 3-137)	Pneumonia **(7-day look back)**	An active physician diagnosis must be present in the medical chart; for example, inflammation of the lungs that is supported by a chest X-ray, medication order, and notation of fever and symptoms.	Active diagnosis signed by the physician. A hospital discharge note referencing pneumonia during hospitalization is not sufficient unless current within the observation period.
I2g (page 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 diagnosis signed by the physician. A hospital discharge note referencing septicemia during hospitalization is not sufficient unless current within the observation period.
J1c (page 3-138 to 3-140)	Dehydrated; output exceeds intake **(7-day look back)**	Supporting documentation must include two or more of the following: 1) The patient usually takes in less than 1500 cc of fluid daily. 2) One or more clinical signs of dehydration, included but not limited to: dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, abnormal lab values, etc. 3) Fluid loss that exceeds intake daily. **A diagnosis of dehydration is not sufficient.**	Intake and output records. Documented signs of dehydration within the observation period. Must include two or more of the three dehydration indicators within the observation period. **A hospital discharge note referencing dehydration during hospitalization is not sufficient unless 2 of the 3 dehydration indicators are present within the observation period.**
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, etc.) 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 the observation period.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
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 stating "observed bright red blood," etc.
J1o (page 3-140)	Vomiting **(7-day look back)**	Documented evidence of regurgitation of stomach contents.	**Documented evidence of regurgitation of stomach contents.**
K3a (page 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)**	**Include only fluids administered for nutrition or hydration such as:** • **IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently** • **IV fluids running at KVO (Keep Vein Open)** • **IV fluids administered via heparin locks** • **IV fluids contained in IV Piggybacks** • **IV fluids used to reconstitute medications for IV administration** **Do not include:** • **IV medications** • **IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay** • **IV fluids administered solely as flushes** • **Parenteral/IV fluids administered during chemotherapy or dialysis**	Administration records must be available within the observation period. If administration occurs outside of facility, hospital administration record or other evidence of administration must be provided. **Must provide evidence of fluid being administered for nutrition or hydration.**
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.	Evidence of feeding tube delivering nutrition within the observation period.
K6a (page 3-154 to 3-156)	Calorie Intake **(7-day look back)**	Documentation supports evidence of the proportion of all calories ingested or those calories that are 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: 1) resident's calorie requirement and 2) calories actually delivered to determine what percent is received by feeding tube or IV. If resident is on a p.o. diet also, the percent of total calories that the tube provided within the observation period must be documented.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
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.	Must be able to calculate average amount of fluid (cc) within the observation period.
M1a-d (page 3-159 to 3-161)	Ulcers/Staging **(7-day look back)**	**Evidence of the number of skin ulcers at each stage, on any part of the body. For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment. Skin ulcers that develop because of circulatory problems or pressure are coded in item M1. Rashes without open areas, burns, desensitized skin, ulcers related to diseases such as syphilis and cancer, and surgical wounds are not coded here, but are included in item M4. Skin tears/shears are not coded here, (M1) unless pressure was a contributing factor.** • **All skin ulcers present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of skin ulcers, as observed during the assessment period.** • **If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.**	Must be coded in terms of what is seen within the observation period. Documentation must include staging of any type of skin ulcer within the observation period. If scab meets M1 definition of "ulcer," stage as "2" in M1. If necrotic eschar is present, prohibiting accurate staging, code the skin ulcers as stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging.
M2a (page 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 coded in terms of what is seen during the look back period.	Documentation must include pressure as cause of skin ulcer. Documentation must include staging of pressure ulcers in terms of what is seen (i.e., visible tissue) within the seven day observation period.
M4b (page 3-165)	Burns **(7-day look back)**	Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first-degree burns that result in changes in skin color only.	**Documentation must support evidence of second or third degree burns within the observation period.**
M4c (page 3-165)	Open Lesions/Sores **(7-day look back)**	All skin lesions must be documented in the medical chart. **Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer.** Documentation must include a description of what is seen within the observation period. Do not code skin tears or cuts here.	Documentation must include a description of what is seen within the observation period.

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Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
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 must 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. • **Do not code a debrided skin ulcer as a surgical wound.** • **If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.**	PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
M5a (page 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. **Include pressure-relieving, pressure-reducing, and pressure-redistributing devices.** Does not include egg crate cushions.	Evidence proving **pressure-relieving, pressure-reducing, and pressure-redistributing devices.** Documentation at least once within the observation period must be noted in chart.
M5b (page 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. **Include pressure-relieving, pressure-reducing, and pressure-redistributing devices.** Does not include egg crate mattresses.	Evidence proving **pressure-relieving, pressure-reducing, and pressure-redistributing devices.** Documentation at least once within the observation period must be noted in chart.
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. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."	Requirements: **1) program must be care planned,** 2) recorded daily within the observation period, and 3) documentation is made describing an evaluation of the resident's response to the program. The resident's response must be noted within the observation period.
M5d (page 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, which are 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** (i.e., to promote wound healing, to manage skin problems, etc.) at least once within the observation period.
M5e (page 3-167 to 3-168)	Ulcer Care **(7-day look back)**	**Includes any intervention for treating skin problems coded in M1, M2, and M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.**	Treatment (care) must be recorded at least once within the observation period.
M5f (page 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 (care) must be recorded at least once within the observation period.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
M5g (page 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 (care) must be recorded at least once within the observation period.
M5h (page 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 (e.g., nitropaste).	Treatment (care) must be recorded at least once within the observation period.
M6b (page 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. Ankle problems are not considered foot problems and should not be coded in M6.	Signs and symptoms must be recorded at least once within the observation period.
M6c (page 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 within the observation period.
M6f (page 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 (care) must be recorded at least once within the observation period.
N1a,b,c (page 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.)	**Flowcharts are not expected for information such as sleep and awake times.**
O3 (page 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, 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.	TB and flu injections included in this category. Do not count Vitamin B12 injections if given outside of observation period.
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 within 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 within the observation period.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
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. **IV medications administered with procedures such as colonoscopy or endoscopy are NOT included.**	Evidence of administration of IV medication at least once within the observation period must be provided. Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids, are included.
P1a,g (page 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.)	Evidence of administration of oxygen within 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 within the observation period must be provided.
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 within 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 within the observation period. **Changing a disposable cannula is included.**
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 that were administered during chemotherapy or dialysis.	Evidence of transfusions of blood or any blood products administered directly into the bloodstream within the observation period.
P1a,l (page 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 or BiPAP in this field.	**Does not include CPAP or BiPAP in this field.**

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
P1b **a,b,c** **Col. A,B** (page 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,. Also, includes **ONLY** therapies ordered by a physician, based on a therapist's assessment and treatment plan, that is documented in the clinical record. Group therapy is limited to four residents per session, and only 25% of the total therapy minutes per discipline may be contributed to group therapy (section P1b,a-c). Therapy minutes provided simultaneously by two or more therapists must be split accurately between disciplines (section P1b,a-c). 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, may be counted.	Direct therapy days and minutes with associated initials/signature(s) must be provided. Cannot count initial evaluation time. **Must provide evidence of physician order.**
P1b, d A (page 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 handheld 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. Also includes only therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. **A trained nurse may perform the assessment and the treatments when permitted by the state practice act.** 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 program.	Direct therapy days and minutes with associated initials/signature(s) 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. Must provide evidence of nurse training.

(Continued)

Table 2 – Element Listing of RUG Items

MDS 2.0, Version 5.12, 34 Grouper, Effective For Assessments Dated On Or After October 17, 2005			
MDS 2.0 Location	**Field Description**	**Documentation Guidelines**	**Minimum Documentation Standards**
P3a-j NURSING RESTORATIVE SCORE ONLY (page 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 criteria of a nursing restorative program: • Care plan with measurable objectives and intervention. • Periodic evaluation by a licensed nurse • Staff trained in the proper techniques • Supervision by nursing • No more than four residents per supervising staff personnel Nursing rehabilitation/restorative care includes nursing interventions that assist 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. Dentures are not considered to be prostheses for coding this item.	Documentation must include the five criteria of a nursing restorative program. Direct restorative days and minutes with associated initials/signature(s) and date must be provided. **Active ROM includes Active Assisted ROM. Must specify either Active or Passive ROM. "ROM" is not sufficient for the review.**
P7 (page 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.	Must include documentation establishing an exam by the physician to be counted as a visit. Documentation in the nurses notes that states physician was here to see the resident is not sufficient.
P8 (page 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, 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.	Documentation must include evidence of days with new or altered physician orders.

Special Notes About Documentation

1. The history and physical (H&P) may be used as a 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 reflect 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, such as P7 and P8, the reference period may be greater than seven days.

4. Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.
5. Previously 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 12 months.
6. Nursing rehabilitation/restorative care (P3) includes nursing interventions that assist or promote 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. **One signature to validate the ADL grid when no other initials or signatures are present is not sufficient.**
8. Information contained in the clinical record must be consistent and cannot be in conflict with the MDS. **Inconsistencies will be deemed unsupported.**
9. 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).
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, may 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 must contain the resident identification information. At a minimum, all charting entries must include the resident's name and a complete date (MM/DD/YY).
14. Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all medical records. At a minimum, the signature must include the first initial, last name, and title/credential. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there must also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS). When electronic signatures are used, there must be policies to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures.

15. Supportive documentation forms (such as the ADL grid) set up with entries completed by multiple staff members at different times must include dates and signatures or initials on the form itself, to clearly identify who completed each entry.
16. Multi-page supportive documentation forms completed by one staff member may be signed and dated at the end of the form, given each page is identified with the resident's name and the observation period is clearly designated on the form.
17. The entire medical record is subject to review.
18. 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.
19. 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).
20. The five criteria required to constitute a nursing restorative program are:
    - Care plan with measurable objectives and interventions
    - Periodic evaluation by a licensed nurse
    - Staff trained in the proper techniques
    - Supervision by a member of the nursing staff
    - Group with no more than four residents per supervising staff person