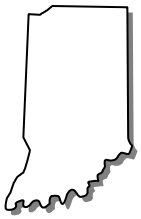
INDIANA HEALTH COVERAGE PROGRAMS



PROVIDER BULLETIN

BT200704 FEBRUARY 6, 2007

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 2006 Supportive Documentation Guidelines apply to MDS assessments with an assessment reference date (ARD) (A3a date) on or after April 1, 2007. **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. There must be **signatures/initials** (more than one set) and dates to authenticate the services provided. As noted above, **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, a hospital administration record or other evidence of administration must be provided. **Must provide evidence of fluid being administered for nutrition or hydration, such as a physician order noting this as the reason, or a nurse's note documenting the need to rehydrate.**
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 that can deliver 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 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.

(Continued)

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**
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) received 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. If asking the resident to repeat three words, the documentation must identify the time frame of the test and the three words given with the results. If asking the resident about a meal or activity just concluded, the facility must document that the individual conducting the resident assessment knew what the appropriate response would be and the time frame. 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 identified on the MDS should reflect the level of impairment. 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, use of a communication board, or a combination of these. Please note that the inability of facility staff to understand a resident's native language does not justify coding this element.	Provide examples demonstrating the resident's degree of ability to make self understood. The code identified on the MDS should reflect the level of impairment. One appropriate example within the observation period will be sufficient.

(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**
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. For example, documentation of sad, pained, worried facial expressions must include a description of the resident's face, such as furrowed brow, down-turned mouth, grimace, etc. 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 (actions and/or verbalizations) must occur and be documented within the observation period. Frequency of behavior required within the seven-day period ending with the A3a date.
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 as it occurs, not as pre-charted on a scheduling plan or assignment grid.
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 as it occurs, not as pre-charted on a scheduling plan or assignment grid.

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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**
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 is 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.
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. Quadriplegia 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.

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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**
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 two of the three 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) ("I'm the queen or I own this building") 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.	Documentation that establishes the baseline temperature must be found in the medical record.
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. What does the resident say he/she saw?
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.

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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**
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 such as a physician order noting this as the reason or a nurse's note documenting the need to rehydrate.**
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 that can deliver 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 (actually received) during the last seven days by IV or tube feeding. 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) received 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**
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. Each wound should be documented separately noting observation date, location, stage, and measurements. 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 as evidenced by a description of the wound being open and noting the depth and/or presence of any drainage.

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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.**	Documentation specifying the appearance of the wound and the deliverance of wound care during the observation period would be required to support the surgical wound coded. 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 for resident specific devices. Facilities providing pressure-reducing mattresses for all beds should have a documented policy noting such in their policy and procedure manual.
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 or 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.

(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**
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 (hands on care, not just observation) of the wound area or dressing must be recorded at least once within the observation period.
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) other than to feet.	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 on the foot 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 to be used 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 are 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.

(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,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.
P1a,c (page 3-182)	IV Medication **(14-day look back)**	Documentation of IV medication push or drip through a central or peripheral port. Includes IV medications dissolved in a diluent, as well as, IV push medications. Epidurals, intrathecal, and baclofen pumps may be coded here. 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. **IV medications administered with procedures, such as a 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. Documentation **must** include the dates and times of intermittent therapy and the rate administered.
P1a,h (page 3-183)	Radiation **(14-day look back)**	Evidence includes radiation therapy or a radiation implant.	If administered outside of the 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.	Documentation of nasopharyngeal or tracheal aspiration must be present within the observation period. Notations of suctioning only will not be supported.
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.	A session is defined as a treatment period. 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. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy providers. 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. An initial assessment completed by a physician, respiratory therapist, or trained nurse must be completed prior to the initiation of respiratory therapy treatments and must be evidenced in the medical record. Ongoing assessments must be completed by the RT or trained nurse at least once during the observation period. The licensed therapist (or trained nurse) is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided and coordinating with the resident's physician.

(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 interventions. • 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 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. 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. For programs conducted in a group setting evidence of the 4:1 ratio of residents to staff must be available for review. **Active ROM includes Active Assisted ROM. Must specify either Active or Passive ROM on any and all forms.**
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. If a resident is evaluated by a physician off-site (e.g. while undergoing dialysis or radiation therapy), it can be coded as a physician visit. A licensed psychologist may not be included for a visit. Does not include exams completed in the emergency room or as part of an acute care hospital stay.	Must include documentation establishing an exam by the physician to be counted as a visit. Documentation in the nurses notes that states physician was in the facility 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 signed and 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. For B2a, B4, C4, E1-p, and E4a-e a quarterly summary dated after the assessment reference period will be accepted if the summary notes the date the activity actually occurred. 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. If a multiple page document identifies the resident by name and a patient ID number on page one, the remainder of the pages may identify the resident by that ID number alone if the document follows an outline format and the pages are numbered sequentially. **Each page must be dated during the assessment reference period.**

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 **(all of which must be present, as applicable)** 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

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EDS | Long Term Care

Consolidated Q&A: Supportive Documentation Guidelines

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Key	**Q** or **C** = **Association Questions/Comments** *RAI* = *RAI Manual* A = State Answers

C: Please define an acceptable order change for P8.

RAI: Includes written, telephone, fax, or consultation orders for new or altered treatment. Does not include standard admission orders, renewal orders, or clarifying orders without changes. 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.

A: An acceptable order is any change in order to impact the care of the resident that is not a clarification or a d/c of a therapy that the goal is met and/or adding a diagnosis with a medication or treatment change. Example: Changes to therapy order (i.e., original stated "therapy x 3 wks" then therapy d/c'd before 3 weeks was up or extended beyond 3 wks). Example: A resident receives MS 2 mg. IM and is changed to MS 10 mg. IM.

C: Please give examples of order changes that are not acceptable.

*RAI: Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes.*

A: A phone order for room change only. A phone order for d/c of therapy at the end of the original prescribed treatment time (for example original order for treatment x 8 wks, now at end of 8 wks, phone order to d/c due to met goal). Admission orders, re-admission orders, clarification orders, and orders that define a diagnosis only. Addition of medications on return admission to NH would not count as an order change because these are part of the admission orders.

Q: Please ask EDS to discuss pharmacy consultant order change requests as related to determining the acceptability of the order. If the pharmacist makes the recommendation, is the change in medication automatically disregarded?

RAI: And do not count orders written by a pharmacist.

A: As noted previously in this section, an acceptable order is any change in order to impact the care of the resident that is not a clarification. Pharmacy consultants may recommend medications or treatment modifications; however, they cannot give orders. If the physician chooses to act on the pharmacist's recommendation and makes an order change that impacts the care of the resident, this would be acceptable. Example: A resident receives MS 2 mg IM and is changed to MS 10 mg IM. Example: A resident receives Humulin L at a.m. and p.m. and the physician accepts the pharmacist's recommendation and changes the order to Lantus at hs.

Q: Please define what is accepted as a respiratory assessment for supportive documentation at P1b,dA. Is an initial assessment required? Does this assessment have to be completed prior to the initiation of respiratory treatment or will any type of respiratory assessment during the observation period be accepted?

*RAI: Therapies that occurred after admission/readmission to the nursing facility, were ordered by the physician, and were performed by a qualified therapist. 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: Any assessment of lung sounds, oxygen saturation, and/or respiratory condition of resident. Either the initial assessment for new treatment or the documentation of ongoing respiratory assessments on or before the A3a date is acceptable. An acceptable assessment would be any assessment that includes breath sounds, vital signs, etc. The nursing facility must act within its established policy which should follow "Standard of Practice" guidelines.

Q: Are photocopies of the medical record accepted as supportive documentation?

A: Yes. The original medical record must be available for review. In some circumstances a photocopy may be acceptable.

C: Please specifically define the components of supportive documentation for impaired decision making skills at B4. Many facilities are having difficulty providing the supportive documentation required to support this MDS item.

A: Decision making should note the resident's performance in making everyday decisions about ADL's and/or tasks. Documentation detailing resident's difficulty with decision making would be accepted. Provide an example of how a resident makes a decision or does not make a decision.

- Needs cues to go to dining room for meals.
- Needs cues to change soiled clothing.
- Voids in trash can.
- Walks down hallway with no clothes on.
- Needs cues to put on clothes properly.

C: The supportive documentation guidelines state:

"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."

Please note that examples to support the resident's inappropriate decision making listed on the Nursing Summary of Care were questioned in that the auditors stated that the choosing of appropriate items of clothing and going to scheduled meals would be considered the resident's right, rather than appropriate decisions to be evaluated. However, the facility contends that these issues are assessed as related to the resident's "need" to wear appropriate clothing and/or to go to meals due to nutritional needs. The facility contends that it does differentiate between a resident's right to refuse (or make an informed choice) versus making poor choices (i.e., inappropriate decisions). These decision making examples are taken from the RAI manual. Please clarify.

RAI: Intent: To record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Examples: Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize or plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's

events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

A: Audit teams would need supportive documentation that details examples within the observation time of the resident's inability to make decisions or examples of decisions that were made and why this was an inappropriate decision.

C: Supportive documentation for MDS item E1l (sad, worried, pained facial expressions) has not been validated if the resident was noted to be crying. An auditor stated that sometimes she cries when she is mad, so crying does not meet the definition of a sad facial expression, but that a furrowed brow would. Since it is difficult to determine the intent behind the facial expression, a list of acceptable descriptions of sad facial expressions is needed.

RAI: To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior). Header: Sad, Apathetic, Anxious Appearance…Sad, Pained, Worried Facial Expressions – e.g., furrowed brows.

A: Audit teams would be looking for supportive documentation that recorded the resident's facial expressions (appearance), not describing their behavior or action for E1l. Examples: Furrowed brow, frowning, grimacing, down turned mouth.

Note: Crying is an acceptable response for E1m (crying, tearfulness).

Q: A Medicare resident had a 5 day Medicare assessment completed with an ARD of 5/1. The resident was admitted to the hospital on 5/1. The resident returned on 5/3 with the hospital records supporting administration of IV medication on 5/1. Is it acceptable to code IV medication administered on the original 5 day Medicare assessment?

A: The IV documented after the discharge from the facility is not counted on the original 5 day Medicare assessment. Once the resident was discharged this ended the original 5 day Medicare assessment observation period. Capture the IV on the next scheduled assessment, if within the observation period.

Q: A resident had a cardiac catheterization during the MDS observation period and returned from the hospital with orders for dressing changes to the wound. Would this be considered a surgical wound?

A: Documentation specifying the "appearance, measurement, treatment, color, odor, etc." of the non-healed wound in the observation period would be required to support the surgical wound coded. The audit team would require documentation supporting surgical wound care occurring during the observation period (not just ordered in that time) to support surgical wound care being coded on the MDS. Observation alone is not wound care.

Q: There have been some inconsistencies regarding electronic grids. "Our regional person for IN stated that EDS at the state level has said they will not accept the electronic grid. However, in the Northern part of IN, the review team for EDS has been accepting them."

A: Electronic grids have been and are being accepted for documentation such as ADL's, minutes of therapy and restorative, and hospital documentation. For a more detailed response, please forward a copy of the not accepted grid for review.

Q: What will EDS accept for supportive documentation of IVF for Nutrition and/or Hydration?

A: Documentation that the IV is for nutrition or hydration. The only other documentation acceptable would be if the resident had an active documented diagnosis of dehydration during the observation period. Documentation that the resident is NPO and the IV was started for replacement. Labs results do not fulfill the documentation requirements.

A dietary assessment detailing nutritional issues or the resident's "at risk" status and then a subsequent MD phone order for fluids is acceptable. A phone order to start fluids with no dx or reason given, but with a nurse's note on the same day detailing dehydration and stating that this is the purpose of the order is acceptable.

C: The supportive documentation guidelines state:

"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 presented function, not the highest". "Provide examples demonstrating short term memory for this specific resident. One appropriate example within the observation period will be sufficient."

During a recent EDS audit, it was stated that the following question on the nursing Summary of Care utilized by the AmeriCare facilities, "Ask resident to tell you what the last meal he/she had was and to describe what he/she had to eat" was unacceptable to evaluate short term memory in that it does not state which meal the interviewer is referring to. This question is preceded with a section to list the last meal and what was served and is followed with instructions to the interviewer to write resident's exact response. Please clarify how we could revise this question in an effort to be able to utilize it as supportive documentation for short term memory.

A: The form needs to require staff to detail what resident had at last meal (as resident may have received alternative choices and type of meal is not an indicator that staff knows the items served to this resident) and to specify the time frame from meal to question. Suggest the facility staff complete forms in their entirety. Many forms are good, but facility staff leave blanks, etc., negating the effectiveness of this documentation tool.

C: The timeframe waited (i.e., 5 minutes, 30 minutes, etc.) was also questioned at the time of audit. The facility responded that even though this question did not specify to wait five minutes (or other specified timeframe) to evaluate the resident's memory, the next question requires the interviewer to ask the resident to remember three words (truck, chair, and paper) and after five minutes, ask the resident to state the three words. Again, please clarify how this question could be utilized as supportive documentation for short term memory.

A: As long as staff details the resident's response, this format should be something the audit team could possibly use. The Mini-Mental Status Exam is a standardized test and it's well known that there is a five minute gap between questions. If this is a NF created form, there is no standard time established so the time frame should be indicated.

It is preferable to see actual life event examples that are resident specific and that demonstrate short term memory. If there is no indication of memory ability, an example of this should be documented in the medical record. Example: Ask the resident to remember three items such as chair, bag, and phone. Ask the resident to repeat them back to you in five minutes. Another example may be that the resident's family visited in the morning and by lunch time or early afternoon the resident has no recall of that event.

C: The supportive documentation guidelines state:

"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."

The facility making reference to the ADL/Resident Care Record and/or regimented times care planned for the toileting program has been questioned. One way in which the facilities have opted to verify documentation of a scheduled toileting plan is to list the specific times when resident is to be toileted either on the ADL/Resident Record, on the care plan, or on the CNA assignment sheet. Please clarify why this practice is or is not acceptable as supportive documentation, and if not acceptable, please give guidance as to what documentation will be accepted for scheduled toileting plan implementation.

A: Documentation by direct care staff detailing when resident was toileted would be acceptable. However, we have seen forms designed with the information computer generated/filled in regarding when the resident was toileted (corresponding to the plan) where no direct care staff ever indicate if this information is accurate or was completed according to the plan. In other words, a preprinted designated time would be acceptable with direct care staff initials per occurrence, supported by a signature sheet for those systems that pre-print the activity.

Again, documentation is acceptable as long as the supportive documentation has an area for initials and/or signatures, dates, and the plan. Just listing it on the care plan does not show that it is being done, as listing meds on a care plan does not indicate that they have been given. The assignment sheet usually states the program, not that it has been done, as it also tells the CNA what type of bath should be given but does not indicate it was given until charted. The supportive documentation should include a written response that shows how the resident responds to the toileting plan. Just the times by themselves don't give a true evaluation of the plan. The evaluation should indicate, for example "dry four out of eight times, skin intact." The resident's response to the program should be clear in stating that the resident is meeting the plan or making progress to it.

A "check and change" toileting approach is NOT acceptable. Per RAI/Supp Documentation Guidelines, the resident who is completely incontinent and dependent is a "check and change", not a Restorative Nursing Program candidate.

C: ADL grids:

- **Be cautious when making corrections. All corrections must line through the error response and have the date and initials of the individual making the correction.**
- **Please note that an EDS auditor did instruct a facility "not" to write the word "error" over a correction.**

A: It's our belief that the provider misunderstood the EDS auditors. NF's can write "error" if they choose, but it is NOT required. See page 1-26, first bullet point for correction policy in RAI manual.

C: Please specify the correct and acceptable practice for correcting errors.

A: At a **minimum** the audit teams must see one line thru the incorrect information, the staff's initials, the complete date (MM/DD/YY) the correction was made, and the correct information. This practice is the acceptable approach for correcting errors and should also be used to correct or clarify write-overs (where, for example, a two has been changed to a three so that it's not possible to tell what the actual documentation intended).

C: The question was posed as to whether auditors are correct when requesting or suggesting that the resident "ID number" (i.e., medical record number) be placed on the documents as well as the resident's name and a complete date.

Please note the supportive documentation guidelines state on page 13 of 14: "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 complete date."

The latest information we have been provided from EDS in reference to medical record numbers being required is that if resident's name and complete date are written on the supportive documentation records, this would be sufficient and the medical record number would not be required. Hence, a record would not be invalidated due to a medical record number not being included on supportive documentation. Is this still accurate information? If medical record number is required, what date did this become mandatory?

A: The 12/3/2003 Supportive Documentation Guidelines was the only time medical record number was published as a requirement. It is recommended that all forms be created to include space for a resident specific identifier as situations have arisen such as having Henry and Harriett Wilson both admitted to the same facility. In order to avoid medical record errors, all staff might become accustomed to completing an individual identifier on each piece of paper in addition to the resident's name. Confusion between individuals could be avoided in this way. It is not currently being required and records are not unsupported if a medical record number is not present. This has not been required since October 2005.

Please note that in response to HIPAA requirements some facilities are choosing to use patient identifiers in addition to, or in place of, the patient name. Therefore, 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. If a multiple page document identifies the resident by name and a patient ID number on page one, the remainder of the pages may identify the resident by that ID number alone, if the document follows an outline format and the pages are numbered sequentially. Each page must be dated during the assessment reference period.