Indiana Health Coverage Programs

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

B T 2 0 0 1 1 8 M A Y 1 , 2 0 0 1

To: **All Indiana Health Coverage Programs Nursing Facility Providers**

Subject: **Supportive Documentation Guidelines Related to Resource Utilization Group (RUG)-III Version 5.01**

Overview

The purpose of this bulletin is to remind Indiana Health Coverage Programs (IHCP)-certified nursing facilities of the requirements for Minimum Data Set (MDS) supportive documentation. Please be advised that supportive documentation for all MDS data elements that are used to classify nursing facility residents in accordance with the Resource Utilization Group (RUG)-III resident classification system must be routinely maintained in each resident's medical chart. Such supportive documentation shall be maintained by the nursing facility for all residents.

Attached are revised Supportive Documentation Guidelines that will assist you in identifying and documenting all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system. **This revision is the direct result of recent HCFA MDS element clarification.**

*Note: Revisions have been **bolded** for convenience.*

If there are any questions about the information contained in this bulletin, please contact the Myers and Stauffer help desk at (317) 816-4122. For questions about the Supportive Documentation Guidelines and the EDS review process, please contact the EDS Long Term Care Unit at (317) 488-5099.

Prepared by the Office of Medicaid Policy and Planning, May 1, 2001 (Version 4)

Table 1.1 – Special Rehabilitation

MDS 2.0 VERSION 5.01			
SPECIAL REHABILITATION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary.	NN, SSN, SN, CP, NR
K5a **ADL ONLY** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock, where IV fluids have been given continuously or intermittently, must be cited in the medical chart. Does not include administration of IV medications only.	NN, SN, PO, PPN, CP, hospital records
K5b **ADL ONLY** (page 3-130)	Feeding tube	Documented evidence of a feeding tube that can deliver food/nutritional substances, fluids, and medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
P1b a,b,c Col. A,B (page 3-150)	Therapies	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. See the *Special Notes* section for additional information.	TN, PO
P3a-i **LOW INTENSITY ONLY** (page 3-155)	Nursing rehab/ restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the total time that is then converted to days on the MDS. **See the *Special Notes* section for additional information.**	NR, NN, SN, CP

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

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Table 1. 2 – Extensive Services

MDS 2.0 VERSION 5.01			
EXTENSIVE SERVICES			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary.	NN, SSN, SN, CP, NR
K5a***** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock, where IV fluids have been given continuously or intermittently, must be cited in the medical chart. Does not include administration of IV medications only.	NN, SN, PO, PPN, CP, hospital records
K5b **ADL ONLY** (page 3-130)	Feeding tube	Documented evidence of a feeding tube that can deliver food/nutritional substances, fluids, and medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
P1a,i***** (page 3-149)	Suctioning	Evidence of nasopharyngeal or tracheal aspiration must be cited in the medical chart. Oral suctioning is not permitted to be coded in this field.	NN, SN, PO, PPN, CP, TN, hospital records
P1a,j***** (page 3-149)	Tracheostomy care	Evidence of tracheostomy and cannula cleansing administered by staff must be cited in the medical chart.	NN, SN, PO, PPN, CP, TN, hospital records
P1a,l (page 3-149)	Ventilator or respirator	Evidence of ventilator or respirator assistance must be cited in the medical chart. Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days should be coded. Neither CPAP nor BiPAP are considered ventilator devices, and are not permitted to be coded in this field.	NN, SN, PO, PPN, CP, TN, hospital records

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

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

Table 1.3 – Special Care

MDS 2.0 VERSION 5.01			
SPECIAL CARE			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary.	NN, SSN, SN, CP, NR
I1w***** (page 3-115)	Multiple Sclerosis	An active physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, NR
I1z***** (page 3-112)	Quadriplegia	An active physician diagnosis must be present in the medical chart. Paralysis of all four limbs must be cited in the medical record. Causes include cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.	PO, PPN ,NN, CP, SN, NR
I2g***** (page 3-116)	Septicemia	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 audit validation.	PO, PPN, NN, LAB, SN
K5b***** (page 3-130)	Feeding tube	Documented evidence of a feeding tube that can deliver food/nutritional substances, fluids, and medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
M2a***** (page 3-135)	Pressure ulcer (stage 3 or 4)	All pressure ulcers must be described and staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN, SN, PO, PPN, CP, DN, TN, wound record
M4b***** (page 3-137)	Burns	All second and third degree burns must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN, skin sheet
P1a,c***** (page 3-149)	IV medications	Documentation must be present in the medical chart.	NN, MAR, PO, CP, hospital records
P1a,h***** (page 3-149)	Radiation	This includes radiation therapy or a radiation implant. Documentation must be available in the medical chart.	NN, SN, PO, PPN, SSN, DN, CP, hospital records
B1****** (page 3-42)	Comatose	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, NN, CP, SN
N1d****** (page 3-141)	Time awake (none of above)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the response.	NN, SN, PPN, CP, SSN, NR, CNAN

Table 1.3 – Special Care

MDS 2.0 VERSION 5.01			
SPECIAL CARE			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
J1h** (page 3-120)	Fever	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, etc.) of temperature measurement must be consistent between the baseline and the elevated temperature.	NN, SN, Vital sign sheet
I2e** (page 3-116, 3-117)	Pneumonia	An active physician diagnosis must be present in the medical chart. Often there is a chest X-ray, medication order and notation of fever and symptoms.	PO, PPN, NN, SN, X-ray
J1c** (page 3-119)	Dehydration; output exceeds input	Supportive documentation might include intake/output records and thorough nurses' documentation describing the resident's symptoms and/or fluid loss that exceeds intake.	PO, PPN, NN, CP, SN, LAB
J1o** (page 3-121)	Vomiting	Documented evidence of regurgitation of stomach contents.	NN, SN, SSN, PPN
K3a** (page 3-128)	Weight loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN, SN, DN, CP, SSN PPN, weight sheet

****Special combination considerations:**

When B1=coma, all ADL self-performance (G1a,b,h,i) are coded with a 4 or 8 and time awake (N1d-none of above) is checked.

When J1h, fever is checked, one of the following must also be checked; I2e, pneumonia; J1c, dehydration; J1o, vomiting; K3a, weight loss.

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

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

Table 1.4 – Clinically Complex

MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary across shifts.	NN, SSN, SN, CP, NR
I1r***** (page 3-111)	Aphasia	An active physician diagnosis must be present in the medical chart. Aphasia is defined as difficulty in communicating orally, through sign, or in writing, or the inability to understand such communication. This difficulty must be cited in the medical chart.	NN, SSN, SN, CP, PPN, PO
I1s***** (page 3-111)	Cerebral Palsy	An active physician diagnosis must be present in the medical chart, along with evidence of paralysis related to developmental brain defects or birth trauma.	PO, PPN, NN, CP, SN
I1v***** (page 3-112)	Hemiplegia/ Hemiparesis	An active physician diagnosis must be present in the medical chart. Left or right-sided paralysis is acceptable as a diagnosis.	PO, PPN, NN, CP, SN, NR
I2e***** (page 3-116)	Pneumonia	An active physician diagnosis must be present in the medical chart. Often there is a chest X-ray, medication order and notation of fever and symptoms.	PO, PPN, NN, SN, X-ray
I2j***** (page 3-116)	Urinary Tract Infection	Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record in the last 30 days.	PO, PPN, NN, LAB, SN
J1c***** (page 3-119)	Dehydration; output exceeds input	Supportive documentation might include intake/output records and thorough nurses' documentation describing the resident's symptoms and/or fluid loss that exceeds intake.	PO, PPN, NN, CP, SN, LAB
J1j***** (page 3-120)	Internal bleeding	Clinical evidence must be cited in the medical chart such as: black, tarry stools; "coffee grounds emesis;" hematuria; hemoptysis; or severe epistaxis.	NN, SN, PO, PPN
J1k***** (page 3-120)	Recurrent lung aspirations	Clinical indicators required in the medical chart might include: productive cough, shortness of breath or wheezing.	NN, SN, PO, PPN, CP, X-ray, TN

Table 1.4 – Clinically Complex

MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
J5c***** (page 3-126)	End-stage disease	A physician's terminal diagnosis of a deteriorating clinical course is required in the medical chart.	PO, PPN, NN, SN, CP, SSN, hospice notes
K5a***** **ADL ONLY** (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock, where IV fluids have been given continuously or intermittently, must be cited in the medical chart. Does not include administration of IV medications only.	NN, SN, PO, PPN, CP, hospital records
K5b **ADL ONLY** (page 3-130)	Feeding tube	Documented evidence of a feeding tube that can deliver food/nutritional substances, fluids, and medications directly into the gastrointestinal system	NN, SN, DN, PO, PPN, CP
M2b***** (page 3-135)	Stasis ulcer (Stage 1, 2, 3, or 4)	All stasis ulcers must be described and staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN, SN, PO, PPN, CP, DN, TN, wound record
P1a,a***** (page 3-148)	Chemotherapy	**This includes any type of chemotherapy (anticancer drug) given by any route for the sole purpose of chemotherapy treatment. Evidence must be cited in the medical chart. See *Special Notes section* for more information.**	NN, SN, PO, PPN, CP, DN, SSN, MAR, hospital records
P1a,b***** (page 3-149)	Dialysis	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, DN, SSN, hospital records
P1a,g***** (page 3-149)	Oxygen therapy	Oxygen therapy shall be defined as the administration of oxygen, continuously or intermittently, via mask, cannula, or other route. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, SSN, TN, hospital records
P1a,k***** (page 3–149)	Transfusions	Evidence of transfusions of blood or any blood products administered by staff must be cited in the medical chart.	NN, SN, PO, PPN, CP, hospital records
P1b,d A***** (page 3-151)	Respiratory therapy	Days and minutes of respiratory therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided.	TN, PO
P8***** (page 3-161)	Physician orders (4 or more)	Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders, or renewal orders without changes.	PO, PPN

Table 1.4 – Clinically Complex

MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
M4c**** (page 3-137)	Open lesions other than ulcers, rashes, cuts	All open lesions must be documented in the medical chart. Documentation might include appearance, measurement, treatment, color, odor, etc.	NN, SN, PO, PPN, CP, DN, TN, skin sheet
M4f**** (page 3-138)	Skin tears or cuts	A skin tear or cut is any traumatic break in the skin penetrating to subcutaneous tissue. Documentation might include the appearance, measurement, treatment, color, odor, etc.	NN, SN, PO, PPN, CP, DN, TN, skin sheet
M5i**** (page 3-139)	Other preventative or protective skin care (other than to feet)	This includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads, etc. Evidence of preventative or protective care must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, NR, skin sheet, treatment sheet
M6f** (page 3-140)	Applications of dressings (feet)	Evidence of dressing changes to the feet must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, skin sheet, treatment sheet
M4g** (page 3-138)	Surgical wounds	Includes healing and non-healing, open or closed surgical incisions, skin grafts, or drainage sites on any part of the body. Documentation might include appearance, measurement, treatment, color, odor, etc. **Does include a severe laceration requiring suturing or butterfly bandaging.** Does not include healed or surgical sites or stomas.	NN, SN, PO, PPN, CP, DN, TN, skin sheet
M5f** (page 3-139)	Surgical wound care	Includes any intervention for treating or protecting any type of surgical wound. Evidence of wound care must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN, skin sheet
**Special combination considerations: M4c, open lesions must also include coding for M5i, other skin care or M6f, foot dressings. M4f, skin tears/cuts must also include coding for M5i, other skin care or M6f, foot dressings.			
*The resident must qualify for one of the above conditions. The resident who met criteria for Extensive Services or Special Care but whose ADL score was below 7, would classify as Clinically Complex. Once classified in Clinically Complex, the resident is evaluated for Depression using the items in Table 1.4 on the following page.			

Table 1.4 – Clinically Complex

MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX – DEPRESSION ELEMENTS			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
E2 (page 3-60)	Mood persistence (1 or 2)	The medical chart must cite results of the frequency and attempts to alter the indicator(s) coded in E1.	NN, SSN, SN, NR, CP
E1a,g,j,n,o,p (page 3-58 to 3-60)	Indicators of depression, anxiety, sad mood (1 or 2***)***	Examples of verbal and/or non-verbal expressions of distress, that is, depression, anxiety, and sad mood, must be found in the medical chart. See MDS (E1) for specific details.	NN, SSN, SN, NR, CP
E4e Col. A (page 3-62 to 3-65)	Resists care (1, 2, or 3)	Acknowledgment and examples of the resident's behavior symptom patterns must be provided in the medical chart. **The record must reflect the frequency of behavioral symptoms manifested by the resident.**	NN, SSN, SN, NR, CP
N1d (page 3-141)	Time awake (None of Above)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer.	NN, SN, PPN, CP, SSN, NR, CNAN
N1a,b,c (page 3-141)	Time awake (total checked equal 0 or 1)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer.	NN, SN, PPN, CP, SSN, NR, CNAN
B1 (page 3-42)	Comatose (equal 0)	Must have a documented neurological diagnosis of coma or persistent vegetative state from a physician.	PO, PPN, NN, CP, SN
K3a (page 3-128)	Weight loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN, SN, DN, CP, SSN, PPN, Weight sheet
I1ee (page 3-114 to 3-115)	Depression	An active physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, SSN
I1ff (page 3-312)	Manic depression (bipolar disease)	An active physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, SSN

Table 1.4 – Clinically Complex

MDS 2.0 VERSION 5.01

CLINICALLY COMPLEX – DEPRESSION ELEMENTS

DEPRESSION EVALUATION

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

GROUP A

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

1. E1a – Negative statements (1 or 2) (page 3-58)
2. E1n – Repetitive movements (1 or 2) (page 3-59)
   E1o – Withdrawal (1 or 2) (page 3-59)
   E1p – Reduced interaction (1 or 2) (page 3-59)
   E4eA – Resists care (1, 2, or 3) (page 3-63)
3. E1j – Unpleasant AM mood (1 or 2) (page 3-59)
   N1d – Time awake (checked) (page 3-141)
   N1a, b, c – Awake only morning, afternoon,
   or evening (total checked = 0 or 1) and B1=0 (page 3-141)
4. E1g – Terrible future (1 or 2) (page 3-59)
5. K3a – Weight loss (page 3-128)

"OR"

GROUP B

(I1ee) Depression and **one** symptom from the items above **or** (I1ff) Bipolar disease and **one** symptom from the items above. (page 3-112)

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

Table 1.5 – Impaired Cognition

MDS 2.0 VERSION 5.01			
IMPAIRED COGNITION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary.	NN, SSN, SN, CP, NR
B2a***** (page 3-42)	Short term memory	Short-term memory loss must be supported in the medical chart, with specific examples of the loss, such as, inability to describe breakfast meal or an activity just completed. If there is no positive indication of memory ability, documentation must be cited in the medical record.	NN, SSN, SN, NR, CP
B3a-d***** (page 3-43)	Memory/ recall ability	**Examples of all of the resident's memory or recall performance within the environment or circumstances must be found in the medical chart**. (For example, ask the resident "what is the current season," "what is the name of this place" or "what kind of place this is.") **See *Special Notes section* for additional information.**	NN, SSN, SN, NR, CP
B4***** (page 3-44)	Cognitive skills for daily decision making	Citations or examples must be found in the medical chart of the resident's ability to actively make decisions, not whether the staff believe the resident might be capable of doing so.	NN, SSN, SN, NR, CP
H3a **NURSING RESTORE SCORE ONLY** (page 3-108)	Any scheduled toileting plan	Evidence in the medical chart must support a plan whereby staff members, at scheduled times each day, either take the resident to the toilet; give the resident a urinal; or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN
P3a-i **NURSING RESTORE SCORE ONLY** (page 3-155)	Nursing rehab/ restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time that is then converted to days on the MDS. **See *Special Notes section* for additional information.**	NR, NN, SN, CP

Table 1.5 – Impaired Cognition

MDS 2.0 VERSION 5.01		
IMPAIRED COGNITION		
Nursing restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of five or more days of activity. P3d and/or P3f may be counted as a score of 1, but both may not be counted. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the nursing restorative score.		
Total ADL score must be 10 or less.		
The following criteria combination must be met:		
*B2a Short term memory = 1 and B3a-d Memory/Recall (any **not** checked) and B4 Decision making (1, 2, or 3)		
ADL Score	**Nursing Restorative Score**	**RUG-III**
6-10	**2 or more**	**IB2**
6-10	**0 or 1**	**IB1**
4-5	**2 or more**	**IA2**
4-5	**0 or 1**	**IA1**

Table 1.6 – Behavior Problems

MDS 2.0 VERSION 5.01			
BEHAVIOR PROBLEMS			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary.	NN, SSN, SN, CP, NR
E4a,b,c,d***** Col. A (page 3-62 to 3-65)	Behavioral symptoms	Acknowledgment and examples of the resident's behavior symptom patterns must be provided in the medical chart. **The record must reflect the frequency of the behavioral symptoms manifested by the resident.**	NN, SSN, SN, NR, CP
H3a **NURSING RESTORE SCORE ONLY** (page 3-108)	Any scheduled toileting plan	Evidence in the medical chart must support a plan whereby staff members, at scheduled times each day, take the resident to the toilet; give the resident a urinal; or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN
J1e***** (page 3-120)	Delusions	Evidence in the medical chart must describe examples of the resident's fixed, false beliefs, not shared by others, even when there is obvious proof or evidence to the contrary.	PO, PPN, NN, SN, CP, SSN
J1i***** (page 3-120)	Hallucinations	Evidence in the medical chart must describe examples of the resident's auditory, visual, tactile, olfactory, or gustatory false perceptions that occur in the absence of any real stimuli.	NN, SN, PO, PPN, SSN, CP
P3a-I **NURSING RESTORE ONLY SCORE** (page 3-155)	Nursing rehab/ restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program**.** The total time is then converted to days on the MDS. **See *Special Notes section* for additional information.**	NR, NN, SN, CP

Table 1.6 – Behavior Problems

MDS 2.0 VERSION 5.01		
BEHAVIOR PROBLEMS		
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of five or more days of activity. P3d and/or P3f may be counted as a score of 1, but both may not be counted. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.		
Total ADL score must be 10 or less.		
*One of the above must be coded.		
ADL Score	**Nursing Restorative Score**	**RUG-III**
6-10	**2 or more**	**BB2**
6-10	**0 or 1**	**BB1**
4-5	**2 or more**	**BA2**
4-5	**0 or 1**	**BA1**

Table 1.7 – Reduced Physical Function

MDS 2.O VERSION 5.01			
REDUCED PHYSICIAL FUNCTION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,I Col. A,B and G1h,A **ADL ONLY** (page 3-77, 3-78, 3-82)	Physical functioning and structural problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as function may vary.	NN, SSN, SN, CP, NR
H3a **NURSING RESTORE ONLY SCORE** (page 3-108)	Any scheduled toileting plan	Evidence in the medical chart must support a plan whereby staff members, at scheduled times each day, either take the resident to the toilet; give the resident a urinal; or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN
P3a-I **NURSING RESTORE ONLY SCORE** (page 3-155)	Nursing rehab/restorative	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time, which is then converted to days on the MDS. **See *Special Notes section* for additional information.**	NR, NN, SN, CP

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

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

Table 1.8 – Key for Possible Chart Locations in the Medical Record

Abbreviation	Definition	Abbreviation	Definition
CP	Care plan	SN	Summary notes (nurse)
CNAN	Certified nursing assistant notes	PPN	Physician progress notes
DN	Dietary notes	SSN	Social service notes
MAR	Medicine administration record	PO	Physician's orders
LAB	Laboratory	NR	Nursing restorative
NN	Nurses notes	TN	Therapy notes

Special Notes About Documentation

- The history and physical (H&P) may also be an excellent source of supportive documentation for any of the RUG-III elements.
- Any response(s) on the MDS 2.0 that reflect(s) the resident's hospital stay prior to admission to the nursing facility must be supported by hospital supportive documentation and placed in the resident's medical chart.
- Supportive documentation in the medical chart must be dated during the assessment reference period to support the MDS 2.0 responses. The assessment reference period is established by identifying the assessment reference date (A3a) and the previous six days. (Note that on certain MDS questions the reference period may be greater than or less than seven days).
- Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.
- Old, unrelated diagnoses, or diagnoses that do not meet the definition on the MDS 2.0 for Section I1 should not be coded on the MDS.
- Facilities must complete a new assessment after the cessation of all therapies when the preceding assessment is in the Rehabilitation category (Rule *405 IAC 1-15-6*).
- Nursing rehabilitation/restorative care (P3) includes nursing intervention that assists or promotes the resident's ability to attain his or her maximum functional potential. It does not include procedures under the direction and delivery of qualified, licensed therapists. **All nursing restorative criteria must be met as defined on page 3-154 of the RAI manual.**
- ADL documentation must represent all shifts during the assessment period.
- Information in the clinical record must be consistent and cannot conflict with the MDS.
- Group therapy is limited to four residents per session and only 25 percent of the total therapy minutes may be contributed to group therapy.
- An MDS assessment is not considered erred unless the audited MDS values result in new RUG-III classification for the record.
- **For MDS assessments with an A3a date on or after April 1, 2001, Megace may not be coded for chemotherapy (P1aa) when used as an appetite stimulant.**
- **For each of the four items in B3 (a-d), cite an example to reflect the resident's ability to recall. (For example, a resident thinks she lives in a hotel and not in a nursing facility.)**