



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Clinical Policy & Programs

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

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October 1, 2008

Dear Nursing Facility Administrator:

September 2008, the Department of Medical Assistance made available provider training and education throughout the state. This training included a "draft" update to the Supportive Documentation Guidelines. Subsequent to this training, the guidelines have been finalized.

To assist facilities in keeping instances of unsupported documentation to a minimum, we have approved an updated version of the Supportive Documentation Guidelines and a copy is enclosed with this letter. These guidelines address the MDS data elements used to classify nursing facility residents according to the Resource Utilization Group (RUG-III) resident classification system. The actual supportive documentation must be routinely maintained on each resident's clinical record. The Supportive Documentation Guidelines apply to all MDS assessments with an A3a date on or after 10/01/2008. These comply with all Center for Medicare and Medicaid Services (CMS) updates.

Should you have any questions about the new guidelines, please contact the Myers and Stauffer Help Desk at 1-800-763-2278.

Sincerely,

Margaret A. Comin, RN, BSN, MPA

Margaret A. Comin, R.N.
Facility Services Manager

North Carolina Division of Medical Assistance
MDS Validation Documentation Review Standards
RUG-III, Version 5.12, 34-Grouper

Effective for assessments with an ARD date (A3a) on or after 10/1/2008, FINAL Version 8

<i>MDS 2.0 Location, Field Description, Observation Period, RAI Page Location</i>	<i>RUG-III Categories Impacted</i>	<i>Minimum Documentation and Review Standards</i>
B1 Comatose (7-day look back) (pages 3-42 to 3-43)	~Clinically Complex ~Impaired Cognition ~Contributes to ES count	Requires active Dx of coma or persistent vegetative state, signed by the physician within the past 15 months.
B2a Short-Term Memory (7-day look back) (pages 3-43 to 3-45)	~Impaired Cognition ~Contributes to ES count	Documentation demonstrating short-term memory problem for this specific resident within the observation period. If there is no positive indication of memory ability, the correct response is “1”, memory problem, and documentation must be cited in the medical record.
B4 Cognitive Skills for Daily Decision Making (7-day look back) (pages 3-46 to 3-47)	~Impaired Cognition ~Contributes to ES count	Documentation demonstrating degree of compromised daily decision-making that reflects level of cognitive impairment within the observation period. The intent of this item is to record the resident’s actual performance in making everyday decisions about tasks or activities of daily living.
C4 Making Self Understood (7-day look back) (page 3-54)	~Impaired Cognition ~Contributes to ES count	Documentation demonstrating resident’s degree of ability to make self-understood that reflects level of impairment within the observation period. Documentation by example of the resident’s ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.
E1a-p Indicators of Depression, Anxiety, Sad Mood (Coded 1 or 2) (30-day look back) (pages 3-61 to 3-64)	~Clinically Complex	Documentation demonstrating resident’s specific sad mood, anxiety or depression indicator(s) and frequency must be documented within the observation period. Frequency may be determined by either a tracking tool or log, or by specific narrative notes. A resident specific example must be identified that corresponds with the entry on the tool or log. If using narrative notes, would require a note for each occurrence.
E4a-e Col. A only Behavioral Symptoms (Coded 2 or 3) (7-day look back) (pages 3-66 to 3-69)	~Behavior Problems	Documentation demonstrating resident’s specific behavior symptoms and frequency must be documented within the observation period. Frequency may be determined by either a tracking tool or log, or by specific narrative notes. A resident specific example must be identified that corresponds with the entry on the tool or log. If using narrative notes, would require a note for each occurrence.

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<p>G1aA, B Bed Mobility G1bA, B Transfers G1iA, B Toilet Use G1hA Eating</p> <p><i>(7-day look back)</i> (pages 3-76 to 3-100)</p>	<p>~Extensive Services ~Rehabilitation ~Special Care ~Clinically Complex ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions</p>	<p>Documentation requires 24 hours/7 days within the observation period <u>while in the facility</u>.</p> <p>Must have initials and dates to authenticate the services provided. Must have signatures to authenticate initials. One signature/initial to authenticate an ADL grid is <u>not</u> sufficient for the review.</p> <p>ADL Keys: For either ADL grids, or electronic data collection tools, the key for self-performance and support provided must be equivalent to the intent and definition of the MDS key. ADLs Not supported: ~If there is no ADL key associated with the values, the ADL values will be considered unsupported. ~ADL keys with words for self-performance such as limited, extensive assist, etc., without the full definitions will be considered unsupported. ~ADL tools that lack codes for all possible MDS coding options will be considered unsupported.</p> <p>If using narrative notes to support ADLs, one note is considered one occurrence and must include the specific ADL(s) and degree of self-performance and support provided. Wording must be equivalent to MDS key definitions such as “extensive (weight-bearing) assist of one for transfers”.</p> <p>Providers with two different ADL tools per assessment will be asked to designate the one to be used for the review. ADL documentation must be maintained as part of the legal medical record.</p>

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<p>H3a Any Scheduled Toileting Plan</p> <p>Nursing Restorative Score</p> <p><i>(14-day look back)</i> (pages 3-124 to 3-125)</p>	<p>~Rehabilitation ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions</p>	<p>Documentation in the medical chart to support a plan for bowel and/or bladder elimination whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes bowel habit training and/or prompted voiding.</p> <p>“Program” is defined as “a specific approach that is organized, planned, documented, monitored, and evaluated”.</p> <p>Review Requirements: 1) Program to be care planned 2) Provide documentation that toileting plan occurred daily within the observation period and 3) Provide documentation by licensed nurse describing an evaluation of the resident’s response to the program within the observation period.</p> <p>Minutes are <u>not</u> required for a scheduled toileting program.</p> <p>Changing wet garments is <u>not</u> included in H3a.</p>
<p>H3b Bladder Retraining Program</p> <p>Nursing Restorative Score</p> <p><i>(14-day look back)</i> (pages 3-124 to 3-125)</p>	<p>~Rehabilitation ~Impaired Cognition ~Behavior Problems ~Reduced Physical Functions</p>	<p>Documentation in the medical chart to support a retraining program where the resident is taught to delay urinating or resist the urgency to void.</p> <p>“Program” is defined as “a specific approach that is organized, planned, documented, monitored, and evaluated”.</p> <p>Requirements: 1) Program to be care planned 2) Provide documentation that a retraining program occurred daily within the observation period and 3) Provide documentation by licensed nurse describing an evaluation of the resident’s response to the program within the observation period.</p> <p>Minutes are <u>not</u> required for a bladder-retraining program.</p>
<p>I1a Diabetes Mellitus</p> <p><i>(7-day look back)</i> (page 3-127)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Active Dx. signed by the physician within the past 15 months.</p> <p>A cumulative diagnosis list signed and dated by the physician within the past 15 months will be sufficient for the review.</p>
<p>I1r Aphasia</p> <p><i>(7-day look back)</i> (page 3-128)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Active Dx. signed by the physician within the past 15 months.</p> <p>A cumulative diagnosis list signed and dated by the physician within the past 15 months will be sufficient for the review.</p>

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I1s Cerebral Palsy (7-day look back) (page 3-128)	~Special Care ~Contributes to ES count	Active Dx. signed by the physician within the past 15 months. Includes spastic quadriplegia secondary to cerebral palsy. A cumulative diagnosis list signed and dated by the physician within the past 15 months will be sufficient for the review.
I1v Hemiplegia/ Hemiparesis (7-day look back) (page 3-129)	~Clinically Complex ~Contributes to ES count	Active Dx. signed by the physician within the past 15 months. Left or right-sided paralysis is acceptable as a diagnosis. Left or right -sided weakness <u>not</u> acceptable as a diagnosis. A cumulative diagnosis list signed and dated by the physician within the past 15 months will be sufficient for the review.
I1w Multiple Sclerosis (7-day look back) (page 3-129)	~Special Care ~Contributes to ES count	Active Dx. signed by the physician within the past 15 months. A cumulative diagnosis list signed and dated by the physician within the past 15 months will be sufficient for the review.
I1z Quadriplegia (7-day look back) (page 3-129)	~Special Care ~Contributes to ES count	Active Dx. signed by the physician within the past 15 months. Paralysis of all four limbs cited in the medical record. <u>Does not include:</u> ~Quadriparesis ~Quadriplegia secondary to severe organic syndrome of Alzheimer's type ~Spastic Quad secondary to CP A cumulative diagnosis list signed and dated by the physician within the past 15 months will be sufficient for the review.
I2e Pneumonia (7-day look back) (page 3-135)	~Special Care ~Clinically Complex ~Contributes to ES count	Active Dx. signed by the physician. Documentation demonstrating active inflammation of the lungs. A hospital discharge note referencing pneumonia during hospitalization is <u>not</u> sufficient <u>unless</u> condition was present within the observation period.
I2g Septicemia (7-day look back) (page 3-135)	~Clinically Complex ~Contributes to ES count	Active Dx. signed by the physician. May be coded when blood cultures have been drawn but "results" are not yet confirmed. A hospital discharge note referencing septicemia during hospitalization is <u>not</u> sufficient unless condition was present within the observation period. Urosepsis may <u>not</u> be coded as septicemia.

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<p>K3a Weight Loss</p> <p><i>(30 and 180-day look back)</i> (pages 3-150 to 3-152)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Documentation in the medical chart of the resident's weight loss of 5% or more in last 30 days OR 10% or more in last 180 days.</p> <p>When calculating weight loss, obtain the actual weights for the 30-day and 180-day time periods from the clinical record.</p> <p>Calculate percentage based on the actual weight. Do not round the actual weight.</p>
<p>K5a Parenteral / IV</p> <p><i>(7-day look back)</i> (pages 3-153 to 3-154)</p>	<p>~Extensive Services ~ADL Score</p>	<p>Documentation of fluid being administered for nutrition or hydration. An active Dx of dehydration, signed by MD and current within the observation period will suffice as evidence of fluid being administered for nutrition or hydration.</p> <p>Administration records required for IV administration in the facility or outside of facility and must be administered within the observation period.</p> <p><u>Does not include:</u> ~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 ~IV fluids administered during chemotherapy or dialysis</p>
<p>K5b Feeding Tube</p> <p><i>(7-day look back)</i> (pages 3-153 to 3-154)</p>	<p>~Special Care ~Clinically Complex ~Contributes to ES count ~ADL Score</p>	<p>Documentation of any type of feeding tube that can deliver food/nutritional substances/ fluids/ medications directly into the gastrointestinal system.</p>
<p>K6a Calorie Intake</p> <p><i>(7-day look back)</i> (pages 3-154 to 3-156)</p>	<p>~Special Care ~Clinically Complex ~Contributes to ES count ~ADL Score</p>	<p>Documentation must support the proportion of all calories actually received within the observation period through parenteral or tube feeding.</p> <p>For residents receiving P.O. nutrition and tube feeding documentation to include:</p> <ol style="list-style-type: none"> 1) Calories tube feeding provides during observation period 2) Calories oral feeding provides during observation period 3) Percent of total calories provided by tube feeding. <p>* Documentation must demonstrate how the facility derived at the % of calories intake the tube feeding provided within the observation period.</p>
<p>K6b Average Fluid Intake</p> <p><i>(7-day look back)</i> (pages 3-156 to 3-157)</p>	<p>~Special Care ~Clinically Complex ~Contributes to ES count ~ADL Score</p>	<p>Documentation supports average fluid intake per day by IV and/or tube feeding.</p> <p>This is calculated by reviewing the intake records, adding the total amount of fluid received each day by IV and/or tube feedings <u>only</u>. Divide the week's total fluid intake by the number of days in the observation period. This will provide the average fluid intake per day.</p>

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<i>INFORMATIONAL ONLY</i>		
<p>Section: M Introduction Skin Conditions</p> <p>SKIN DOES NOT INCLUDE EYES OR ORAL MUCOSA</p> <p>Documentation on a weekly skin report or log with multiple residents listed will <u>not</u> be accepted for the review unless that document is a part of the individual resident’s medical record.</p>		
<p>M1a-d Ulcers/Staging</p> <p><i>(7-day look back)</i> (pages 3-159 to 3-161)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Skin ulcers that develop because of circulatory problems or pressure are coded in item M1.</p> <p>Documentation must include staging by a licensed nurse (or other professional whose scope of practice includes staging of ulcers) of skin ulcer(s) in terms of what is seen within the observation period (commonly referred to as reverse staged).</p> <p>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.</p> <p>If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage “4” until the eschar has been debrided (surgically or mechanically) to allow staging.</p> <p>A skin ulcer repaired with a flap graft is <u>not</u> coded here.</p>
<p>M2a Pressure Ulcer</p> <p><i>(7-day look back)</i> (pages 3-161 to 3-164)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Documentation must include staging of pressure ulcer(s) by a licensed nurse (or other professional whose scope of practice includes staging of ulcers) of skin in terms of what is seen (i.e., visible tissue) within the observation period (commonly referred to as reverse staged).</p> <p>Each wound should be documented separately noting observation date, location, stage, and measurements.</p> <p>If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage “4” until the eschar has been debrided (surgically or mechanically) to allow staging.</p>
<p>M4b Burns</p> <p><i>(7-day look back)</i> (page 3-165)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Documentation must include a description of what is seen within the observation period such as location and appearance of second or third degree burns.</p> <p>Includes burns from any cause (e.g., heat, chemicals) in any stage of healing.</p> <p>This category does <u>not</u> include first-degree burns (changes in skin color only).</p>

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<p>M5d Nutrition/hydration intervention to manage skin problems</p> <p><i>(7-day look back)</i> (pages 3-167 to 3-168)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Documentation of dietary intervention(s) to manage skin problems to be specified and purpose stated (i.e., to promote wound healing, to manage skin problems, etc.) at least once within the observation period.</p> <p>Includes vitamins and minerals, such as Vitamin C or Zinc, which are used to manage a potential or active skin problem.</p>
<p>M5e Ulcer Care</p> <p><i>(7-day look back)</i> (pages 3-167 to 3-168)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Treatment of ulcer documented at least once within the observation period.</p> <p>Includes any intervention for treating skin problems coded in M1, M2, and/or M4c.</p> <p>Example(s) may include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.</p>
<p>M5f Surgical Wound Care</p> <p><i>(7-day look back)</i> (pages 3-167 to 3-168)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Treatment of surgical wound documented at least once within the observation period.</p> <p>Includes any intervention for treating or protecting any type of surgical wound.</p> <p>Surgical wound care does <u>not</u> include observation of the surgical wound.</p>
<p>M5g Application of dressings; other than to feet</p> <p><i>(7-day look back)</i> (pages 3-167 to 3-168)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Documentation of any type of dressing application (with or without topical medications) to the body other than to the feet at least once within the observation period.</p>
<p>M5h Application of ointments/medications (other than to feet)</p> <p><i>(7-day look back)</i> (pages 3-167 to 3-168)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Documentation of application of ointments/medications (used to treat a skin condition) other than to feet at least once within the observation period.</p>
<p>M6b Infection of the foot</p> <p><i>(7-day look back)</i> (page 3-168 to 3-169)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Signs and symptoms of infection of the foot documented at least once within the observation period.</p> <p>Ankle problems are <u>not</u> considered foot problems.</p>

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M6c Open lesion on the foot (7-day look back) (pages 3-168 to 3-169)	~Clinically Complex ~Contributes to ES count	Documentation of cuts, ulcers or fissures at least once within the observation period. Documentation to include description of open lesion, such as location and appearance of lesion.
M6f Applications of Dressings (feet) (7-day look back) (pages 3-168 to 3-169)	~Clinically Complex ~Contributes to ES count	Documentation of dressing changes to the feet (with or without topical medication) at least once within the observation period.
N1a,b,c Time Awake (7-day look back) (pages 3-170 to 3-171)	~Clinically Complex ~Impaired Cognition ~Contributes to ES count	Documentation of time awake or nap frequency cited in the medical record. Flow charts are not expected for information such as sleep and awake times.
O3 Injections (7-day look back) (page 3-178 to 3-179)	~Clinically Complex ~Contributes to ES count	Documentation includes the number of days that the resident received any medication by subcutaneous, intramuscular, intradermal injection, antigen or vaccines. For subcutaneous pumps, includes only the number of days that the resident actually required a subcutaneous injection to restart the pump.
<u>INFORMATIONAL ONLY</u>		
Section: P1a Special Treatments, Procedures and Programs		
Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period. Surgical procedures include routine pre-and post-operative procedures.		
P1a,a Chemotherapy (14-day look back) (page 3-182)	~Clinically Complex ~Contributes to ES count	Documentation includes any type of chemotherapy (anticancer drug) given by any route during the observation period for the sole purpose of cancer treatment. If administered outside of facility, provide documentation of administration within the observation period. A nurse's note that resident went out for chemotherapy treatment will be sufficient if there is a corresponding physician order.

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<p>P1a,b Dialysis</p> <p><i>(14-day look back)</i> (page 3-182)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Documentation to include procedure occurred within the observation period.</p> <p>Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility.</p> <p>A nurse's note that resident went out for dialysis treatment will be sufficient if there is a corresponding physician order.</p>
<p>P1a,c IV Medication</p> <p><i>(14-day look back)</i> (page 3-182)</p>	<p>~Extensive Services</p>	<p>Documentation of administration of IV medication push or drip through a central or peripheral port at least once within the observation period.</p> <p>Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids, are included. Includes IV medications dissolved in a diluent as well as IV push medications.</p> <p><u>Does not include:</u> ~Biological (e.g., contrast material). ~Saline or heparin flush to keep a heparin lock patent ~IV fluids without medication ~IV medications administered only during chemotherapy or dialysis ~IV meds administered with procedure such as colonoscopy or endoscopy</p>
<p>P1a,g Oxygen Therapy</p> <p><i>(14-day look back)</i> (page 3-183 to 3-184)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Oxygen therapy shall be defined as the administration of oxygen continuously or intermittently via mask, cannula, etc.</p> <p>Documentation of administration of oxygen at least once within the observation period.</p> <p><u>Does not include:</u> ~Hyperbaric oxygen for wound therapy ~Oxygen Sats without documentation of administration of the oxygen</p>
<p>P1a,h Radiation</p> <p><i>(14-day look back)</i> (page 3-183)</p>	<p>~Special Care ~Contributes to ES count</p>	<p>Includes external radiation therapy or a radiation implant.</p> <p>If administered outside of facility, provide documentation of procedure occurring within the observation period.</p> <p>A nurse's note that resident went out for radiation treatment will be sufficient if there is a corresponding physician order.</p>
<p>P1a,i Suctioning</p> <p><i>(14-day look back)</i> (page 3-183)</p>	<p>~Extensive Services</p>	<p>Documentation of either nasopharyngeal or tracheal suctioning administered at least once within the observation period.</p> <p>Documentation must specify type of suctioning.</p> <p>Oral suctioning is <u>not</u> permitted to be coded in this field.</p>

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P1a,j Tracheostomy Care <i>(14-day look back)</i> (page 3-183)	~ <i>Extensive Services</i>	Documentation must support either tracheostomy OR cannula care by staff at least once within the observation period. Changing a disposable cannula by staff is included.
P1a,k Transfusions <i>(14-day look back)</i> (page 3-183)	~ <i>Clinically Complex</i> ~ <i>Contributes to ES count</i>	Documentation of transfusions of blood or any blood products administered directly into the bloodstream at least once within the observation period. Does <u>not</u> include transfusions administered during dialysis or chemotherapy.
P1a,l Ventilator or Respirator <i>(14-day look back)</i> (pages 3-183 to 3-184)	~ <i>Extensive Services</i>	Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident in the process of being weaned off the ventilator or respirator in the last 14 days may be included. Does <u>not</u> include CPAP or BiPAP in this field.
P1b-a,b,c. Col. A,B Therapies <i>(7-day look back)</i> (pages 3-185 to 3-190)	~ <i>Rehabilitation</i>	Direct therapy days and minutes with associated initials/ signature(s) must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy reported on the MDS. Minutes for electrical stimulation of a wound may be counted providing there is documentation that supports therapist directly supervised (line of sight) treatment. The medical record must indicate that the wound being treated is a Stage III or higher to report these minutes on the MDS. At no time are “unattended” minutes supported for the MDS Validation documentation review. Must provide documentation of physician order, treatment plan and assessment.

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<p>P1b, d Column A Respiratory Therapy</p> <p><i>(7-day look back)</i> (pages 3-185 to 3-190)</p>	<p><i>~Special Care</i> <i>~Contributes to ES count</i></p>	<p>Direct respiratory therapy days and minutes with associated initials/ signature(s) must be cited in the medical chart on a daily basis to support the total days and minutes of direct respiratory therapy reported on the MDS</p> <p>Must provide documentation of physician order, treatment plan and assessment.</p> <p>A trained, licensed nurse may perform the assessment and the treatments when permitted by the state practice act.</p> <p>~In lieu of the Licensed Respiratory Therapist, a “Trained Nurse” may perform the initial respiratory assessments and subsequent assessments after being trained by a Licensed Respiratory Therapist.</p> <p>Requires an evaluation by a trained, licensed nurse or respiratory therapist of resident’s response to treatment at least once within the observation period.</p> <p>Resident response to treatment must include a clinical assessment of resident’s condition such as lung sounds, cough, sputum, etc.</p> <p>Must provide evidence of nurse training.</p>
<p>P3a-j Nursing Restorative</p> <p><i>(7-day look back)</i> (pages 3-191 to 3-195)</p>	<p><i>~Rehabilitation</i> <i>~Impaired Cognition</i> <i>~Behavior Problems</i> <i>~Reduced Physical Functions</i></p>	<p>Documentation must meet the five criteria of a nursing restorative program:</p> <ol style="list-style-type: none"> 1) Care plan with measurable objectives and interventions 2) Periodic evaluation* by a licensed nurse <p>*Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period.</p> <ol style="list-style-type: none"> 3) Staff trained in the proper techniques 4) Supervision by nursing 5) No more than 4 residents** per supervising staff personnel <p>**When residents are part of a group, provide documentation to identify the group participants, program, minutes and initials of person providing program.</p>

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<i>MDS 2.0 Location, Field Description, Observation Period, RAI Page Location</i>	<i>RUG-III Categories Impacted</i>	<i>Minimum Documentation and Review Standards</i>
<p>P3a-j Nursing Restorative (cont'd)</p> <p><i>(7-day look back)</i> (pages 3-191 to 3-195)</p>		<p>Direct nursing restorative days and minutes with associated initials/ signature(s) must be cited in the medical chart on a daily basis to support the total days and minutes of nursing restorative programs provided.</p> <p>“ROM” is <u>not</u> sufficient for the review; specify either Active or Passive ROM.</p> <p>Active or passive movements by a resident that are incidental to dressing, bathing, etc., do <u>not</u> count as part of a formal restorative program.</p> <p>A scheduled splint or brace program must include a daily assessment by a licensed nurse that documents an evaluation of the resident’s skin and circulation under the device.</p>
<p>P7 Physician visits</p> <p><i>(14-day look back)</i> (pages 3-204 to 3-205)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Documentation includes the number of days (NOT NUMBER OF VISITS) a physician examined the resident. Can occur in the facility or in the physician’s office.</p> <p>Provide documentation establishing an exam by the physician to be counted as a physician visit.</p> <p><u>Does not include:</u> ~Nurses’ notes that MD was in facility and examined resident ~Physician visits that occurred during a resident’s acute care stay</p>
<p>P8 Physician orders</p> <p><i>(14-day look back)</i> (pages 3-205 to 3-206)</p>	<p>~Clinically Complex ~Contributes to ES count</p>	<p>Documentation includes the number of days (NOT NUMBER OF ORDERS) a physician changed the resident’s orders. Includes written, telephone, fax, or consultation orders for new or altered treatment.</p> <p>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 may be counted as a day with order changes.</p> <p><u>Does not include:</u> ~Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes ~Nurse’s notes that MD wrote an order</p>

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Special Notes Regarding the MDS Validation Documentation Review

- 1) Information contained in the clinical record must be consistent and cannot be in conflict with the MDS. Inconsistencies will be deemed unsupported.
- 2) The entire medical record is subject to review.
- 3) Standard Medical Record Documentation Requirements
 - Each page or individual document in the medical record must contain the resident's identification information. At a minimum, each page must include resident's name and complete date (mm/dd/yy).
 - Initials and signatures rules
 - Supportive documentation entries must be dated with a complete date (mm/dd/yy) and their authors identified by an initial and or signature
 - When initials are used to identify the author, there must be a corresponding full signature to authenticate the initial
 - Full signatures should include first initial or name, last name and title/credential
 - Initials may never substitute when a full signature is required by law
 - Supportive documentation forms or tools that include entries completed by multiple staff members at different times must include complete dates and initials with signatures or complete signatures on the form or tool itself to clearly identify who completed each entry
 - When electronic signatures are used, there must be a policy to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures
 - A master signature legend is acceptable to authenticate initials for purposes of the review.
- 4) **A general quarterly note will not be used as supporting documentation unless the note includes an example that is dated within the observation period. At no time would a quarterly note suffice for supporting documentation for ADLs for the MDS Validation Documentation Review.**
- 5) **Supporting documentation for the MDS Validation Documentation Review must be provided within the observation period. For those infrequent circumstances a note dated after the observation period, stating, "this reflects the observation period ending 00/00/00" will be acceptable only on a case-by-case basis. This is intended to be used only when the discipline writing the note cannot complete the note within the observation period – such as illness, State Survey, ARD on Sunday, etc. In the event that all notes are dated after the observation period, all documentation contained in those notes may be deemed unsupported.**
- 6) A care plan should include: 1) a resident problem, need or strength, 2) a measurable goal and 3) specific interventions / approaches.

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Medical Record Corrections for the MDS Validation Documentation Review

The Division of Medical Assistance has adopted a new policy for medical record corrections related to acceptance of supporting documentation for MDS Validation reviews. This policy allows for minor changes or corrections to previously recorded documentation in the resident's status in accordance with standards of clinical practice and documentation. This policy was effective January 1, 2008.

- a) If an error is discovered on or after but within 7 days of the Assessment Reference Date (A3a) of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.
- b) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction.
- c) If a major error is discovered in a record in the State MDS database, modification or inactivation procedures must be implemented by the facility to assure that the database information is corrected.
- d) Clinical documentation corrections must also be made as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed.
- e) A quarterly or summary note will not substitute for an occurrence correction.
- f) A standard medical correction consists of drawing a line through the incorrect information, entering the correct information, dating and initialing the change. Improper or illegible corrections will not be accepted for the review.