



# Commonwealth of Kentucky Department for Medicaid Services Documentation Guidelines

## Addendum #9

Related to RUG-III, Version 5.12, 34-Group

**\*Revised September 2005 to Include CMS Revisions to the RAI Manual  
CMS Revisions Effective June 15, 2005**

1. Hospital documentation present in the clinical record shall validate any response(s) on the MDS 2.0 that reflect the resident's hospital stay prior to admission, if the dates are within the observation period that ends on the A3a date.
2. The A3a date is the last day of the MDS observation period. This date refers to a specific end-point in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period, most frequently the 7-day period ending on this date. The date sets the designated endpoint of the common observation period, and all MDS items refer back in time from this point.

CMS revised clarification: "For example, for a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7<sup>th</sup> day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD (Item A3a).

3. For validation purposes, number codes that are "written over" will not be considered. Only legal corrections will be considered as a valid number code.
4. For validation purposes, electronic signatures/initials are acceptable. NHS shall be required to verify training on a staff person that has changed their name (due to marriage, divorce, etc.) by checking their Social Security number per Task Force.
5. The Resident Assessment Protocols (RAPs) documentation occurs after the A3a date and, therefore, will NOT be utilized to validate the Minimum Data Set (MDS). The focus is on documentation during the observation period that ends on the A3a date.
6. CMS – It is important to observe, interview and physically assess the resident, and to interview staff. The MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

## ADDENDUM (Continued)

7. CMS – “Assessors must capture the resident’s ACTUAL status and performance, and what care was ACTUALLY provided during the entire observation period. This includes gathering information from a variety of staff and/or gathering information across shifts, when indicated by the MDS Item coding instructions. Not every nuance will be documented in the clinical record. Therefore, it’s important to obtain information from the residents and direct care givers. To code the MDS accurately, multiple sources of information must be used, such as: interview, observation and assessment of the resident, communication with direct care staff and other disciplines working with the resident, contact with family, and clinical records review. It is not necessary that one assessor must do all of this him/herself. It’s up to the facility to establish systems, policies and procedures to facilitate the RAI processes, and accurate MDS coding.”
8. CMS – Not every facility prints computer generated resident assessment records. In some facilities, the records are manually completed. There is no requirement to maintain two copies of the form in the resident’s record. Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed and dated within the regulatory time frames, and maintained for 15 months in the resident’s active record. If changes are made after completion, those changes must be made to the electronic record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident’s care plan, based on the revised assessment. Resident assessment forms must accurately reflect the resident’s status, and agree with the record that is submitted to the CMS standard system at the State.  
  
**\*Task Force – Any nursing facility that only has computerized documentation to support RUG elements on the MDS for reimbursement shall provide print outs of those notes to the review nurse for validation purposes only. DMS will NOT allow the review nurse to access any computerized documentation electronically while in the facility.**
9. CMS – Facilities exhibiting a pattern of multiple corrections may be subject to stringent MDS review during survey. If the surveyor identifies an error pattern impacting Medicare or Medicaid reimbursement, we would expect the survey agency to alert the FI or state Medicaid agency of the problem.
10. It is acceptable to OIG surveyors for 15 months worth of MDS information to be kept at the nurse’s station in a binder. This is acceptable for PRO review nurses too.
11. **DMS – Hospice residents should not be included for RUG validation purposes. If a Hospice resident is included on the resident roster during the look back period, the field review nurse will be required to choose an alternate resident to review and contact Myers & Stauffer.**

### MDS SECTION B (Cognitive Patterns)

12. Section B2 (Memory) – When a resident is cognitively impaired and/or uncooperative with the assessment process/interview, supporting documentation shall demonstrate how the resident’s memory ability was determined (i.e., examples on p. 3-44) during the observation period that ends on the A3a date.

## **MDS SECTION B (Continued)**

13. Section B4 (Cognitive Skills) - The Review Nurse(s) must see documentation of the resident's ACTUAL performance in making "everyday" decisions during the observation period that ends on the A3a date. It is NOT a requirement to have "daily" documentation of the decision-making but it is necessary to document the resident's ACTUAL performance (i.e., examples on p. 3-46-47 of the MDS User's Manual). A check off sheet would be acceptable (for validation purposes) IF examples were included using MDS language.

A statement that says, "Cognition is severely impaired" is NOT acceptable because it does not give examples per Task Force.

## **MDS SECTION C (Communication/Hearing Patterns)**

14. Section C4 (Making Self Understood) – "A check off sheet would be acceptable IF it includes the MDS User's Manual definition of each area OR an example that fits the definition AND occurs during the 7-day observation period that ends on the A3a date."

## **MDS SECTION E (Mood & Behavior Patterns)**

15. Section E1 & E4 (Mood & Behavior) - A check form or flow sheet indicating the frequency and type of behavior is acceptable during the observation period that ends on the A3a date. An entry in the clinical record on a per occurrence basis is also acceptable for consideration of validation. However, a summary alone is NOT acceptable because they are too general and do not capture the information needed. Supporting documentation for behavior (E4) shall identify specific dates of occurrences in order to determine how many times a specific behavior occurred during the 7-day observation period that ends on the A3a date.

## **MDS SECTION G (Physical Functioning & Structural Problems – ADLs)**

16. Section G1a, b, h, i (ADLs) - It is acceptable that the documentation for the four (4) late-loss activities of daily living (ADLs): Bed Mobility, Transfer, Eating, and Toilet Use can be EITHER per shift OR on a daily basis, at the Provider's option during the observation period that ends on the A3a date.
17. Section G1h (A) - A resident is NOT coded a "2" in self-performance in eating due to food being prepared by the dietary staff and nursing carrying trays to the room or table in the dining room. The self-performance coding for eating should be specific to what the resident can do for himself.
18. Section G1i (A) – A resident who is totally dependent for staff to manage their Foley catheter but does their own care for managing bowel movements should be coded at "0". The issue of the catheter, which is continence status, will be coded at Section H (per CMS).

## MDS SECTION G (Continued)

19. Task Force – All ADL Tracking forms must meet the “Minimum Criteria Required for ADL Documentation” that was presented by the Department for Medicaid Services on 4/1/2001. (See attached document on the last page of this Addendum) Please pay particular attention to the following:

“The responsibility of the person completing the documentation for self-performance/support is to capture the total picture of the resident over the ‘entire shift’ (if the information is captured every shift) OR ‘entire 24 hours a day’ (if the information is captured daily) over the last 7 days.”

The review nurse shall NOT accept one signature/initial with a line drawn through the other 6 days of the observation period as meeting the “Minimum Criteria Required for ADL Documentation”.

20. Nurse Aide Care Plans are acceptable to support turning/repositioning and scheduled toileting plans for audit/review purposes. Nurse Aide Care Plans are NOT acceptable for supporting the 4 late-loss ADLs UNLESS they meet the “DMS Minimum Criteria Required for ADL Documentation”.
21. Interpretation for ADLs when code “8” is reviewed for validation purposes:

- Example #1: When the FRN can clearly determine that the ADL did not occur for the entire 7-day observation period, a code “8” will be accepted. If the ADL did occur, the Self-Performance Tree on p. 3-90 of the MDS User’s Manual will be utilized.

For example: The ADL was captured on a flow sheet or ADL tracking form and coded “8” on days 1-4, blanks were observed on days 5 & 6, and day 7 was coded “4” (total dependence).

In the above scenario, the FRN would be unable to determine what happened on days 5 & 6. She cannot “assume” that the resident was totally dependent for care on the blank days, if no supporting documentation was found elsewhere in the chart. When looking at the Self-Performance Tree (p. 3-90), the only appropriate code, for validation purposes only, would be “0”.

8 / 8 / 8 / 8 / blank / blank / 4 = 0 (For Validation Purposes Only)
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The FRN must review supporting documentation (either on a flow sheet, ADL tracking form or narrative notes) in the clinical record to validate a “4” response (full staff performance every occurrence during the entire 7-day observation period). Therefore, for validation purposes only, the audit worksheet would be marked a “No” (documentation does NOT support transmitted value) and a comment shall be documented in the comment section for your review.

- Example #2: If an ADL was coded “8” for days 1-4, a “1” for day 5, a “2” for day 6, and a “3” for day 7, the appropriate response, for validation purposes only, would be a “1”. In order to respond greater than a “1”, according to the Self-Performance Tree on p. 3-90, the resident must have required some type of physical assistance at least 3 or more times during the 7-day observation period. Since day 5 was a “1” (supervision), the resident did not receive physical assistance 3 or more times in the scenario described.

8 / 8 / 8 / 8 / 1 / 2 / 3 = 1 (For Validation Purposes Only)
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## MDS SECTION G (Continued)

- Example #3: If an ADL was coded “8” for days 1-6 and a “4” on day 7, the appropriate response, for validation purposes only, would be “4”. This would be because the only time the ADL occurred, the resident required total assistance (“4”) and it would fall under the Self-Performance Tree scoring on p. 3-90 as “4” (full staff performance every occurrence during the entire 7-day observation period).

8 / 8 / 8 / 8 / 8 / 8 / 8 / 4 = 4 (For Validation Purposes Only)

22. Section G (ADLs) – Task Force, “The physical therapy documentation must meet the DMS Minimum Criteria Required for ADL Documentation dated 4/1/2001 (i.e., A “key” descriptor must be available and correspond with the MDS/ADL definitions in the MDS User’s Manual.)”

## MDS SECTION H (Continence in Last 14 Days)

23. \*Section H3a (Any scheduled toileting plan) – A bowel program would NOT be acceptable for H3a. This section is ONLY for bladder programs.

**\*Task Force – Any scheduled toileting plan “refers to a specific approach that is organized, planned, documented, monitored and evaluated. Documentation in the clinical record should evaluate the resident’s response to the toileting program.” (Refer to clarification in the MDS 2.0 User’s Manual, p. 3-125.)**

## MDS SECTION I (Disease Diagnoses)

24. Section I1 and I2 (Diseases/Infections) – Supporting documentation for diseases/infections would need to: 1) demonstrate that the disease/infection was being treated OR 2) has an impact on their daily care during the 7-day observation period that ends on the A3a date.

## MDS SECTION J (Health Conditions)

25. Section Jh (Fever) – Supporting documentation for fever must: 1) clearly identify a “baseline temperature” OR 2) state how the baseline temperature was determined. Documentation shall support that the resident’s temperature (Fahrenheit) is 2.4 degrees greater than the baseline temperature during the 7-day observation period that ends on the A3a date.

## **MDS SECTION K (Oral/Nutritional Status)**

26. Section K6a (Total Calories) - A resident receiving intake by mouth and tube feeding **MUST** have a calorie count for **BOTH** the intake by mouth **AND** the tube feeding in order to determine the proportion ratio of total calorie intake during the observation period that ends on the A3a date. (i.e., example on p. 3.155.)

When a resident is receiving IV fluids of D 51/2 solution for dehydration, the glucose provided in the IV would **NOT** be coded under Medications. Since the glucose is most likely being given for caloric value, the facility should code K6a for total calories received during the observation period that ends on the A3a date. However, if the glucose were being given to maintain sugar levels for a diabetic, it would be coded under IV medications.

## **MDS SECTION M (Skin Condition)**

27. Section M (Skin Treatments) – A weekly skin assessment recorded on a log, along with other residents which does not become part of the individual resident’s clinical record will not be considered as supporting documentation for validation purposes. A weekly skin assessment must be part of the individual resident’s clinical record during the observation period that ends on the A3a date to be considered for validation purposes.
28. Section M1 a-d and M2a (Ulcers) - The Office of Inspector General is responsible for determining the effectiveness of a pressure ulcer treatment. The review nurse(s) may observe a pressure ulcer, at his/her discretion, if the pressure ulcer was documented as present during the MDS observation period and remains under treatment at the time of the review. (The review nurse(s) shall take into consideration that the pressure ulcer may have improved or deteriorated since the time of the MDS observation period.)
29. CMS – Section M4 (Skin Tears) – CMS has indicated that “Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.
30. Section M4c (Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) – “A cyst, not otherwise described, would not be coded as an open lesion. Documentation of a cyst does **NOT** meet the first criteria of ‘open’ in Section M4c.”
31. CMS – Section M4g (Surgical Wounds) – “Cataract surgery would be coded at M4g as a surgical wound because the definition includes “any part of the body” (p. 3-166). A surgical wound that has healed but reopened, and remained open, during the 7-day observation period could be coded again as a surgical wound at M4g. (Refer to p. 3-166....”includes healing and non-healing, open or closed....”)
32. Section M5a (Skin Treatments – Chair) – Documentation for a pressure relieving device to chair must include the type of device (i.e., gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do **NOT** include egg crate cushions in this category (p. 3-167). A bed pillow in a wheelchair does **NOT** meet the criteria for a pressure-relieving device for a chair.

## MDS SECTION M (Continued)

“A facility may document the type of pressure relieving device (air, fluid, etc.) or the brand name for chair/bed. IF the facility only documents the brand name, the field review nurse would request to review the manufacturer’s literature on the device to verify that it meets the criteria defined on p. 3-167,” per Task Force.

33. Section M5b (Pressure Relieving Device(s) for Bed) – Documentation for a pressure relieving device to bed must include the type of device (i.e., air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed.) Do NOT include egg crate cushions in this category.

A foot cradle would not be coded under M5b because, clinically speaking, the mattress devices described on p. 3-167 are used to relieve the pressure of the body from the mattress. A foot cradle is used to relieve the weight of the bed linens from the feet and lower legs. They are different devices used for different reasons, per CMS.

34. CMS – Section M5f (Surgical Wound Care) – “Post-operative eye patch and eye drops would be coded at M5f for surgical wound care during the observation period that ends on the A3a date (p. 3-167).” The definition includes “any intervention for treating or protecting any type of surgical wound.”
35. Section M5g (Application of Dressings) – The application of a Band-Aid does meet CMS’ definition of a dressing IF applied for ulcer care or wound care. (p. 3-167.)
36. CMS – Section M5g (Application of Dressings (with or without topical medications) other than to feet) – “There would not be a need to code M5g for a post-operative cataract eye patch if you coded M5f for applying the eye patch as Surgical Wound Care. A “dressing” could be coded here for the eye, if you were using a patch for some non-surgical intervention to the eye.”
37. A Tegaderm dressing on a skin tear that was applied prior to the 7-day observation period and nurses were only checking to see that it was still intact would NOT meet the definition of application as outlined on p. 3-167 & 3-168. If the dressing was not “applied” during the 7-day observation period, do NOT code it.
38. CMS – Section M5h (Application of Ointments/Medications (other than to feet) – “Eye drops do NOT meet the criteria for application of ointments/medications.” The definition on p. 3-168 states “include ointments or medications used to treat a skin condition.” In addition, normal saline can NOT be counted as an ointment/medication in Section M5h.”

“Crisco should NOT be coded under M5h (Application of ointments/medications (other than to feet). Crisco is neither an ointment nor a medication” per Task Force.

39. Section M5g & M5h (Skin Treatments) – Curagel dressings are pre-treated and should be coded under M5g – Application of dressings (with or without topical medications) other than to feet. Curagel dressings should NOT be coded under M5h – Application of ointments /medications (other than to feet) since they are pre-treated dressings.

**MDS SECTION P**  
**(Special Treatments & Procedures)**

40. CMS – Section P1a. a. – When a resident with a cancer diagnosis is given a long-acting chemotherapy treatment once every 3 months, it should NOT be coded unless it was given within the 14-day observation period that ends on the A3a date.
41. Section P1a. b. – A physician’s progress note or nursing care plan dated during the 14-day observation period that states, “Resident out to dialysis \_\_\_ times a week” would be supporting documentation to transmit P1a. b. (Dialysis). If NOT found, the review nurse shall look for nurses notes or a statement from the Dialysis Center during the 14-day observation period per Task Force.
42. CMS – Section P1a. j. – Tracheostomy care includes cleansing of tracheostomy AND cannula. When a resident has a trach with a disposable cannula and there is no cleaning required (only replacement), it is possible, under this instance to NOT code the tracheostomy unless the cannula has been changed in the 14-day observation period.

If the resident has a stoma ONLY and the facility transmitted “tracheostomy care”, it would NOT be a valid response. However, if the resident has an inner OR outer cannula (disposable or non-disposable), the documentation shall indicate more than merely “changing the cannula” to be a valid response for trach care, if all other criteria were met per Task Force.

- 43. DMS - Section P1b. c. (Physical Therapy) – CMS has not approved Anodyne (Infrared) treatments because they are still considered “investigational/experimental” at this time. The field review nurse shall not give credit for these treatments if documented on the MDS. All such treatments will be referred to DMS until further clarification is received from CMS.**
44. Section P1b. d. (Respiratory Therapy) - A record of the number of days and total number of minutes of Respiratory Therapy is necessary to support coding the MDS. The Review Nurse(s) will look at the therapy documentation that occurred during the 7-day observation period that ends on the A3a date, verify the physician’s order, the therapist’s (qualified professional, i.e., trained nurse, respiratory therapist) assessment and treatment plan that is documented in the resident’s clinical record. \*The review nurse must see actual therapy minutes in order to give credit for respiratory therapy services per Task Force.

“There is not a specific requirement in the RAI manual as to what the assessment should include. The field review nurse will accept an assessment provided by a “trained nurse” (i.e., “Trained Nurse” refers to a nurse who received specific training on the administration of respiratory treatments and procedures”.) The trained nurse (“qualified professional”) can be any licensed nurse (i.e., RN or LPN).

The fact that the nurse is licensed is NOT sufficient. The review nurse must see documentation that either the “trained” nurse OR “trained” nurse in-service coordinator has received their training by a respiratory therapist per Task Force.

The documentation that would be acceptable for a nurse who obtained respiratory therapy training as part of her nurses training would be any type of documentation (i.e., orientation check list, inservice on respiratory therapy, continuing education attendance, on-the-job-training, etc.) presented by the Provider. The MDS User’s Manual does not address who is qualified to train nurses in respiratory therapy techniques.

## MDS SECTION P (Continued)

45. CMS – The beneficiary’s needs and goals during an acute care hospital stay are not necessarily the same as those that will be established during the SNF stay. Although the physician and therapist should review the hospital evaluation, if available, the therapist **MUST** perform a full evaluation of the beneficiary as he/she presents in the facility. The plan of treatment is then developed by the physician and the therapist to address the beneficiary’s needs and goals during the post-acute stay at the SNF.
46. Section P3 (Nursing Rehabilitation/Restorative Care) - There must be a plan of care specific to the resident’s restorative nursing care with measurable objectives and interventions. This plan may either be an interdisciplinary care plan or a separate restorative care plan. The care plan must meet the nursing rehabilitation/restorative care MDS User’s Manual Guidelines. A check form or flow sheet that demonstrates the completion of the restorative treatment as specified in the care plan **IS** acceptable. It is **NOT** required that actual minutes be recorded as the restorative measures are performed, as long as the plan of care details the minutes and frequency of the restorative measures.

**\*Task Force – The field review nurse is not required to look for nursing rehabilitation/restorative training IF the services are performed by licensed staff. The field review nurse must look for training IF a State Registered Nursing Assistant (SRNA) provides the services. It would NOT be appropriate for licensed staff to sign for this service IF the SRNA actually performed the services.**

47. **Section P3 a. & b. – \*CMS Update Effective June 15, 2005 – (Clarify coding on p. 3-192) P3b. Range of Motion (Active) – Exercises performed by a resident, with cueing, supervision **or physical assist** by staff, that are planned, scheduled, and documented in the clinical records. **Include active ROM and “active assisted” ROM. Any participation by the resident in the ROM activity should be coded here.****

**DMS - \*P3a. Range of Motion (Passive) was not changed by CMS; therefore, Assisted PROM (APROM) will NOT be accepted by the review nurse as supporting documentation for validation purposes.**

48. The Nursing Rehabilitation/Restorative Care may be provided by the nurse assistants/aides or other staff and volunteers during the 7-day observation period that ends on the A3a date. The Review Nurse(s) will be required to:

- Validate measurable objectives and interventions were documented in the care plan and in the clinical record. The use of “and” does not mean that objectives and interventions have to be in both places **IF** the documentation is considered a permanent part of the clinical record. When reviewing for restorative nursing care and the care plan states the number of minutes to be provided but, the actual flow sheet provided indicates a different number of minutes, the flow sheet shall “override” the care plan per Task Force.

**\*The nurse aide care plan is acceptable for coverage of minutes to validate nursing rehabilitation & restorative. A grid form is not necessary if the nurse aide staff sign the back of the nurse aide care plan daily.**

## MDS SECTION P (Continued)

- Validate evidence of “periodic evaluation” by licensed nurse was present in the clinical record. A “periodic evaluation” shall be defined in the NF’s Policy and Procedure Manual. The MDS User’s Manual does not define “periodic evaluation by licensed nurse”. A signature by a licensed nurse is sufficient for evidence of documentation for validation purposes, per task group.
- Validate documentation that the nurse assistants/aides were trained in the techniques that promote resident involvement in the activity. For validation purposes, if a nurse aide has NOT completed training classes, then additional documentation that reflects restorative care would be required (i.e., orientation checklist, inservice on restorative techniques, etc.). The review nurse shall ask to see the SRNA certification/training for aides providing restorative nursing care. This shall be done EVERY TIME the review is performed regardless of how well the review nurse may know the facility and staff members per Task Force.
- Validate documentation that the activities were carried out or supervised by members of the nursing staff. If other staff and volunteers were assigned to work with specific residents, validate documentation that they were under a licensed nurse’s supervision.
- Validate documentation that no more than four (4) residents were included in exercise groups per supervising helper or caregiver.

(Refer to p. 3-192)

49. Section P7 (Physician Visits) – “For validation purposes, evidence (i.e., progress note, etc.) that the physician ‘actually examined’ the resident would need to be observed in the supporting documentation during the 14-day observation period that ends on the A3a date. A nurse’s note stating, “MD here. New orders noted.” would not be sufficient. Refer to CMS clarification in the MDS User’s Manual, p. 3-204 & 3-205.

50. Section P8 (Physician Orders) – The key word is TREATMENT! Taber’s describes treatment as #1 Medical, surgical, dental or psychiatric management of a patient. #2 Any specific procedure used for the cure or the amelioration (improvement) of a disease or pathological condition. The following examples do NOT meet DMS definition nor CMS’ intent to mark as a physician’s order that has changed the resident’s treatment:

- PT Evaluation
- Change LOC from SNF to ICF
- Change MD to Dr. XYZ
- Move resident from Room 999 to Room 000
- D/C Skilled Level of Care
- Admit to NF Level of Care
- Set up eye exam with Dr. Z for treatment due to diabetic retinopathy
- **\*Send to ER**

## MDS SECTION P (Continued)

### Section P8 Exceptions:

A physician's DNR order shall be considered a valid changed order, if it is not included in the resident's admission orders, return admission orders or renewal orders without changes per DMS.

If additional physician's orders are received on the same day of admission/return admission that are NEW or CHANGE the admission/return admission orders, they shall be considered as a valid changed order. If the review nurse identifies a frequent pattern of additional orders being received on the admission/return admission days, the review nurse shall report this information to DMS.

A physician's order to discontinue (d/c) a treatment does count as a physician's order change.

A physician's order: "Clinical monitoring for problems due to antibiotic therapy for bronchitis" could be considered a physician's order change. Evidence of clinical monitoring must be observed in the resident's clinical record during the 14-day observation period to support the transmitted response for validation purposes.

A physician's order to "discontinue bedrails or bedrails up times one" during the 14-day observation period does count as a physician's order change per Task Force.

See additional CMS clarifications on p. 3-205 & 3-206 in the MDS User's Manual.

## MDS SECTION R (Signature of Persons Coordinating the Assessment)

51. Federal regulations at 42 CFR 483.20 (i) (1) and (2) require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b.

CMS Clarifications on p. 3-212 to 3-213: The use of signature stamps is allowed. The facility must have policies in place to ensure proper use and secure storage of the stamps. The State may have additional regulations that apply.

Therefore, if the review nurse observes a blank at R2a or R2b, she/he shall continue the RUG review, document on the resident's audit worksheet that Section R2a or R2b was blank, and forward a copy of the MDS (first page and Section R) to the Department for Medicaid Services.

**\*CMS Update effective June 15, 2005: Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is NOT acceptable.**

CABINET FOR HEALTH AND FAMILY SERVICES  
COMMONWEALTH OF KENTUCKY  
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES  
“An Equal Opportunity Employer M/F/D”

## Minimum Criteria Required for ADL Documentation

1. If an ADL tracking tool is used to code self-performance and support provided for coding bed mobility, transfer, toilet use and eating, the following must be clearly documented:
  - An observation period that ends on the assessment reference date (A3a).
  - If ADL documentation is not captured on a tracking tool, the observation period that ends on the assessment reference date (A3a) must be established and clearly documented.
  - A “key” descriptor must be available and correspond with the MDS/ADL definitions in the MDS User’s Manual.
  - A signature must identify any staff member’s initials completing the documentation (i.e., signature log is acceptable).
  - The month, day, year and resident’s name must be clearly identified on the document source used.
2. The responsibility of the person completing the documentation for self-performance is to capture the total picture of the resident’s ADL self-performance over the “entire shift” (if the information is captured every shift) or “entire 24 hours a day” (if the information is captured daily) over the last 7 days.
3. The responsibility of the person completing the documentation for support provided is to code the maximum amount of support the resident received over the “entire shift” (if the information is captured every shift) or “entire 24 hours a day” (if the information is captured daily) over the last 7 days, irrespective of frequency.

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