# Long-Term Care Survey Alert

## Documentation: Ensure No Conflicting Information in Clinical Record While Documenting ADLs

**Tip: Identifying patient's problems and needs is crucial when recording treatment and response.**

Completing the Activities of Daily Living (ADL) section of the MDS accurately is important. But even if your MDS responses are spot on, you'll need to make certain the data is backed up by documentation in the medical record.

**Importance:** "The ADL section of the MDS has an impact on all RUG payment categories for Medicare," stresses the **American Health Information Management Association** (AHIMA). "The documentation in the medical record should provide support for the scoring on the MDS along with observation and interviews." And the medical record documentation should also support the MDS answers within the time frame established by the assessment reference date (ARD).

**What Are Your ADL Documentation Requirements?**

The **Centers for Medicare & Medicaid Services** (CMS) has stated that the RAI/MDS is a "source document" and doesn't require supportive documentation, but it has "identified that some entities may require additional documentation requirements specific to supporting the MDS," AHIMA says.

**The RAI Manual states:**

"While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completing of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident."

**What to do:** Therefore, because CMS does not mandate a specific form, format, or template for ADL documentation, nursing facility management must determine how ADL information is documented, explained **Donna Jessee**, director of the **Texas Department of Aging and Disability Services** (DADS) **Center for Policy and Innovation**, in a Dec. 6, 2013 information letter to nursing facility providers.

"For example, use of ADL flow sheets, electronic or paper, completed by Certified Nurse Aides is acceptable supporting documentation for ADL coding in Section G, as long as there is no conflicting information in the rest of the clinical record," Jessee said.

**Use a Clarification Note for Discrepancies**

You may use ADL charting to collect information from all three shifts during the seven-day observation period," AHIMA says. But what can you do if the ADL assessment interviews and observations disagree with the clinical record?

**Best bet:** "Write a clarification note documenting the rationale for the ADL scoring on the MDS, if the staff member assessing the ADL status and completing the MDS disagrees with the supporting documentation based on observations and interviews," AHIMA instructs.

**What to Do When Resident's ADLs Change**

And further, "when the resident's level of self-performance or the level of support provided changes, supporting documentation in the clinical record must accurately describe the change," Jessee said. She provided the following scenario:

**Example:** Two months ago, Mrs. Brown's ADL flow sheet documented that she was independent in bed mobility, transfer, eating, and toilet use. In Section G, her self-performance was "0" (Independent) and the ADL support provided was "0" (No setup or physical help from staff). Mrs. Brown was not receiving any therapy.

Then, Mrs. Brown fell and broke her hip. Nursing home staff wrote a detailed note describing the incident in the clinical record. After surgical repair in the hospital, Mrs. Brown was readmitted to the nursing facility. Staff reassessed her as requiring extensive assistance for bed mobility, transfer, and toilet use, but she was still able to eat independently. Her physician ordered physical therapy.

As a result, staff identified Mrs. Brown as experiencing a significant change in status that would not return to baseline within two weeks. Here's how the nursing facility staff ensured that documentation in Mrs. Brown's clinical record supports the coding in Section G:

- Mrs. Brown's ADL flow sheet documented she required extensive assistance from two staff members in bed mobility, transfer, and toilet use.
- Physical therapy notes reflected that she required moderate assistance with transfer.
- Nursing staff met with therapy staff and determined that moderate assistance is the physical therapy term that correlates to extensive assistance in MDS terms, and staff documented this in the clinical record.
- Staff completed Section G of the Significant Change in Status Assessment (SCSA), scoring for Mrs Brown:
- "3" (Extensive assistance) for her self-performance in bed mobility, transfer, and toilet use;
- "0" (Independent) for eating;
- "3" (Two+ persons physical assist) for bed mobility, transfer, and toilet use in ADL support provided; and
- 0" (No setup or physical help from staff) for eating in ADL support provided.

**Bottom line:** Because there was no conflicting documentation in the ADL flow sheets, the physical therapy notes, or anywhere else in the clinical record, staff in this scenario properly described the change in ADL levels, Jessee explained. Therefore, the documentation in the resident's clinical record supported the coding in Section G of the MDS.

**Remember:** Your state may have its own unique documentation requirements, so be sure that you're following those. "Some case-mix states will stipulate [a] specific source document that is allowable in supporting the MDS data and/or additional state-specific documentation requirements," AHIMA notes.