TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Jon Weizenbaum

December 6, 2013

To: Nursing Facility Providers

Subject: Information Letter No. 13-76
Documentation Expectations for Activities of Daily Living

The purpose of this information letter is to clarify supporting documentation requirements for activities of daily living (ADL) coded in Section G of Minimum Data Set (MDS) 3.0 assessments for state surveys and utilization reviews.

The Centers for Medicare & Medicaid Services (CMS), the Department of Aging and Disability Services (DADS) and the Health and Human Services Commission (HHSC) rules and regulations do not require a nursing facility assign certain staff to complete ADL documentation. Therefore nursing facility management must determine which staff is assigned to complete ADL documentation. When making ADL documentation assignments, please keep in mind the MDS 3.0 Resident Assessment Instrument (RAI) Manual notes "Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician." (page 1-7)

Nursing facility management also must determine how ADL information is documented. CMS, DADS and HHSC rules and regulations do not mandate a specific form, format or template for ADL documentation. 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. As noted on page 1-8 of the MDS 3.0 RAI Manual, "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 completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident."

Furthermore, 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. Consider the following example:

Two months ago, Ms. Joplin's ADL flow sheet documented she was independent in bed mobility, transfer, eating and toilet use. She was not receiving any therapy. In Section G of the quarterly

MDS assessment completed at that time, her self-performance was coded as a “0” (Independent) and the ADL support provided was coded as a “0” (No setup or physical help from staff).

Then Mrs. Joplin fell and broke her hip. As required by DADS rules for documenting changes in condition [Texas Administrative Code Title 40, Section 19.1010(e) (2)], a detailed note describing the incident/accident was written in the clinical record. After surgical repair in the hospital, Mrs. Joplin was readmitted to the nursing facility. She was reassessed as requiring extensive assistance for bed mobility, transfer and toilet use. Her physician ordered physical therapy (PT) services. She was still able to eat independently. As a result, she was identified as experiencing a significant change in status that would not return to baseline within two weeks.

Ms. Joplin’s ADL flow sheet documented she required extensive assistance from two staff in bed mobility, transfer and toilet use. PT notes reflected that she required moderate assistance with transfer. Nursing staff met with therapy staff and determined that moderate assistance is the PT term that correlates to extensive assistance in MDS terms and this was documented in the clinical record. In Section G of the Significant Change in Status Assessment (SCSA) staff completed at that time, her self-performance in bed mobility, transfer and toilet use is now coded as a “3” (Extensive assistance). Eating remains a”0”. The ADL support provided for bed mobility, transfer and toilet use is now coded as a “3” (Two+ persons physical assist). The ADL support provided for eating remains a “0”. There was no conflicting documentation in the ADL flow sheets, the PT notes or anywhere else in the clinical record. Documentation in Ms. Joplin’s clinical record supports the coding in Section G of the MDS.

DADS nursing practices rule pertaining to documentation for nursing facility residents is found in Texas Administrative Code Title 40, Section 19.1010(e) (2). HHSC utilization review rules for nursing facilities are found in Texas Administrative Code Title 1, Section 371.212 and Section 371.214.

If you have questions about DADS Texas Administrative Code, call a policy specialist in Policy, Rules, & Curriculum Development at 512-438-3161. For MDS specific questions, please call the DADS MDS Clinical Coordinator at 210-619-8010.

Sincerely,

[Signature on file]

Donna Jessee
Director
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