

## MEDICARE CHARTING GUIDELINES

**Resident Name:** \_\_\_\_\_ **Date of Admission:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Admitting Dx (Main):** \_\_\_\_\_

**Other Dx:** \_\_\_\_\_

**Guidelines:**

1. Chart Q Day.
2. Use this guideline to focus your charting.
3. Guideline to be completed by Medicare Nurse, Unit Manager, or other Nursing Supervisor.

**REASON FOR SKILLING ON MEDICARE:**

• Physical Therapy • Occupational Therapy • Speech Therapy • Respiratory Therapy • Unstable IDDM • Injections (IM only) • New G-Tube Feeding  
 • Decubitus/Ulceration [• Stage III • Stage IV • Multi-Stage II] • Other Wounds (i.e. v/p Surgical w/complications) • I.V. Therapy • Straight Catheterization  
 • Colostomy/Ileostomy Care • Medication Adjustment • Dehydration/Malnutrition • Isolation • Patient Teaching/Nursing Rationale  
 • Medically Unstable Condition • Cardiovascular Compromise • Gastrointestinal Complications • Circulation Problems • Hemodialysis (w/ complications)  
 •

TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE
<p>• <b>Physical, Occupational Therapy</b></p> <ul style="list-style-type: none"> <li>Describe exactly how the resident performs ADLS.</li> <li>Describe the amount of assistance provided.</li> <li>Describe how the resident accomplishes the following:               <ul style="list-style-type: none"> <li><b>Bed Mobility</b> **</li> <li><b>Transferring</b> **</li> <li>Ambulates</li> <li>Dresses Self</li> <li><b>Eats (Including G-Tubes)**</b></li> <li><b>Toilet Use (Including Post-Use Hygiene)**</b></li> <li>Personal Hygiene and Bathing</li> </ul> </li> <li>DESCRIBE SKILLED NURSING INTERVENTIONS USED TO COMPENSATE FOR ADL DEFICITS.</li> </ul> <p>** Indicates one of the 4 LATE LOSS ADLS which assign an ADL Index Score for RUG calculation.</p> <p>• <b>IM, or I.V. Medication Administration</b></p> <ul style="list-style-type: none"> <li>Describe nature of medication used (include reason for use) and nursing skills and observations used in administration of medication.</li> <li>Describe effectiveness of medication and any side effects observed.</li> <li>Describe how resident tolerated such therapy (i.e. IV infiltration, fluid volume overload, pain, phlebitis, etc)</li> </ul> <p>• <b>Surgical Wounds or Open Lesions (does not include rashes, ulcers and cuts)</b></p> <ul style="list-style-type: none"> <li>Describe location and nature of wound.</li> <li>Describe any pain rt to surgical wound and interventions used to combat pain.</li> <li>Describe nursing interventions and observations rt surgical wound healing process.</li> <li>Describe any drainage, areas of increased erythema, or warmth.</li> <li>Describe response to any treatments ordered.</li> <li>At least q week describe in detail wound healing process and response to tx.</li> </ul>	<p>• <b>Speech Therapy</b></p> <ul style="list-style-type: none"> <li>Describe Exactly how the resident communicates and makes needs known.</li> <li>Describe skilled nursing interventions used to compensate for speech deficits.</li> <li>Describe residents ability to swallow foods and skilled nursing interventions used to compensate for impaired swallowing abilities.</li> </ul> <p>• <b>Unstable IDDM</b></p> <ul style="list-style-type: none"> <li>Describe amount of order changes and physician visits (Requires in the past 14 days 2 order changes and 2 MD visits OR 4 order changes)</li> <li>Describe any skilled nursing interventions used to teach resident self administration.</li> <li>Describe outcome of resident teachings.</li> <li>Describe any signs and symptoms associated with fluctuating blood sugar levels.</li> </ul> <p>• <b>New Gastrostomy Tube Feeding</b></p> <ul style="list-style-type: none"> <li>Describe amount of fluids/feedings delivered</li> <li>Describe resident's ability to communicate and make needs known to staff</li> <li>Describe how resident tolerated tube feeding -- specifically any adverse effects to feeding such as diarrhea, abdominal distension, Cardiac symptoms, abnormal lung sounds.</li> <li>Describe type of ostomy care rendered around G-Tube site and condition of site.</li> <li>Describe clinical necessity for G-Tube/J-Tube</li> </ul> <p>• <b>Straight Catheterization / GU Complications</b></p> <ul style="list-style-type: none"> <li>Describe nature of resident's condition that warrants the use of straight catheterization techniques.</li> <li>Describe use of sterile technique during catheter administration.</li> <li>Describe any resident teaching rt catheter use.</li> <li>Describe any clinical conditions present that require skilled nursing observation (such as frequency, dysuria, indicators of UTI, etc)</li> </ul>	<p>• <b>Respiratory Therapy / Impaired Respiratory Status</b></p> <ul style="list-style-type: none"> <li>Describe skilled trach care rendered</li> <li>Describe accurately breath sounds over all lung aspects (i.e. wheezes, rales, ronchi).</li> <li>Describe respiratory rate, rhythm and quality.</li> <li>Describe the effectiveness of any respiratory treatments given (i.e. Nebulizers, Chest PT, Other Respiratory Medications, Oxygen, etc)</li> <li>Describe residents comfort level as rt respiratory status.</li> <li>Describe any changes in LOC, anxiety or other mental status changes.</li> <li>Describe each incident of suctioning and any other invasive techniques.</li> <li>Describe resident's overall condition as rt respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status.</li> </ul> <p>• <b>Decubitus Ulceration (Stage III or IV or Multi- II's)</b></p> <ul style="list-style-type: none"> <li>Describe condition of wound</li> <li>Describe response to current treatments</li> <li>Describe nursing interventions used to prevent further ulcer development</li> <li>Describe skilled nursing interventions used to aid in wound healing</li> <li>Describe consumption amounts of meals and fluids provided.</li> <li>Describe overall skin condition including poor skin turgor, bruises, rashes, cyanosis, redness, edema or other abnormality.</li> <li>Document any interventions implemented rt abnormal lab values (i.e. low H&amp;H, low serum albumin, low Fe+ levels, etc)</li> <li>Describe dietary interventions implemented such as increased vitamin C and protein foods offered.</li> <li>At least q week, describe in detail wound measurements, locations and response to treatments.</li> </ul>

# Medicare Skilled Nursing Documentation Guidelines

**J Ma**



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