**Section 147.325 Resident Reimbursement Classifications and Requirements**

a) Resident reimbursement classification shall be based on the Minimum Data Set (MDS), Version 3.0 assessment instrument mandated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (federal CMS) that nursing facilities are required to complete for all residents. When later guidance or clarifications are released by federal CMS that contradicts or augments guidance provided in this Section, the more current information becomes the accepted standard and shall become effective as of the date required by federal CMS. The Department shall establish resident classification according to the 48-group, Version IV or RUG-IV model. Resident classification shall be established based on the individual items identified on the MDS and shall be completed according to the RAI Manual.

b) Each resident shall be classified based on the information from the MDS submitted according to the categories as identified in Section 147.330 and as defined in the RAI Manual.

c) General Documentation Requirements

1) A facility shall maintain resident records on each resident in accordance with acceptable professional standards and practices.

2) Supportive documentation in the clinical record used to validate the MDS item responses shall be dated during the specified look-back period or other timeframe as identified in the RAI Manual. Records shall be retained for at least three years from the date of discharge.

3) Supportive documentation entries shall be dated and their authors identified by signature or initials. Signatures are required to authenticate all documentation utilized to support MDS item responses. At a minimum, the signature shall include the first initial, last name, and title/credentials. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there shall also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS). When electronic signatures are used, the facility shall have policies in place to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures.

4) Each page or individual document in the clinical record shall contain the resident's identification information.

5) A multi-page supportive documentation form completed by one staff member may be signed and dated at the end of the form, provided that each page is identified with the resident's identification information and the dates are clearly indentified on the form.

6) Corrections/Obliterations/Errors/Mistaken Entries. At a minimum, there shall be one line through the incorrect information, the staff's initial, the date of correction was made, and the corrected information. Information that is deemed illegible by Department reviews will not be considered for validation purposes.

7) An error correction in the electronic record applies the same principles as for the paper clinical record. Some indication that a previous version of the entry exists shall be evident to the caregiver or other person viewing the entry.

8) Late entries shall be clearly labeled as a late entry and contain the current date, time and authorized signature. Amendments are a form of late entry. Amendments shall be clearly labeled as an addendum or amendment and include the current date, time and authorized signature.

9) Facilities shall have a written policy and procedures that states who is authorized to make amendments, late entries, and correct errors in the electronic health records (EHRs) and clearly dictate how these changes to the EHR are made.

10) Resident records shall be complete, accurately documented, readily accessible to Department staff, and systematically organized. At a minimum, the record shall contain sufficient information to identify the resident, a record of the resident's assessments, care plan, record of services provided, and progress notes.

11) Documentation from all disciplines and all portions of the resident's clinical record may be used to validate an MDS item response. All supporting documentation shall be produced by a facility during an onsite visit.

12) Documentation shall support all conditions or treatments were present or occurred within the look-back period ending on, and including the ARD period. The look-back period shall include observations and events through the end of the day (midnight) of the ARD. Documentation shall apply to the appropriate look-back period and reflect the resident's status on all shifts.

13) Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom or problem. Documentation shall reflect the resident's status on all shifts.

14) Problems that are identified by the MDS item responses that affect the resident's status shall be addressed on the care plan when deemed appropriate by the interdisciplinary team (IDT) as identified in the RAI Manual.

15) Insufficient or inaccurate documentation may result in a determination that the MDS item submitted was not validated.

16) Documentation shall support that the services delivered were medically necessary.

17) Documentation shall support an individualized care plan was developed based on the MDS and other assessments and addressed the resident's strengths and needs. In addition, documentation, observation and/or interview shall support services were delivered as identified by the care plan.

18) Clinical documentation that contributes to identification and communication of a resident's problems, needs and strengths that monitors his or her condition on an ongoing basis and that records treatments and response to treatment is a matter of clinical practice and is an expectation of trained and licensed health care professional.

19) When there is a significant change in status assessment done, documentation shall include the identification of the significant change in status in the clinical record.

d) Disease Diagnosis Requirements

1) The disease condition shall require a physician-documented diagnosis in the clinical record during the 60 days prior to and including the ARD.

2) The diagnosis shall be determined to be active as defined in the RAI Manual during the 7-day look-back period. Conditions that have been resolved or no longer affect the resident's current functioning or care plan during the 7-day look-back period shall not be included.

3) Documentation shall support that the active diagnoses have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.

4) There shall be specific documentation in the record by a physician stating the disease is active. Including a disease/diagnosis on the resident's clinical record problem list is not sufficient for determining active or inactive status. In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease.

A) Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy during the 7-day look-back period.

B) Symptoms and abnormal signs indicating ongoing or decompensating disease in the last 7-day look-back period.

C) Ongoing therapy with medication or other interventions to mange a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the 7-day look-back period. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition.

D) When documentation of conditions that are generally short term in nature (i.e., fever, septicemia, pneumonia, etc.) are noted over a long period of time by the facility staff, the physician may be interviewed to determine accuracy of the diagnosis. In addition, when questions regarding the validity of the diagnosis are found during review of the documentation the physician may be interviewed.

(Source: Old Section 147.325 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.325 added at 38 Ill. Reg. 12173, effective May 30, 2014)