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Documentation

Essentials in Long-term

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Objectives 1. Provide basic Medicare coverage guidelines for skilled therapy services 2. Understand RehabCare's documentation policies and procedures 3. Describe the elements of therapy documentation that support Medical Necessity 4.

**Documentation
Essentials in Long-**

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The following are resources for documentation requirements for the LTC industry: [CLICK HERE](#) for AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines (PDF). [CLICK HERE](#) for AHIMA's Record Systems, Organization, and Maintenance. [CLICK HERE](#) for MO State Documentation

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Documentation
Tips
Guidelines (Jan 2011)

LTC Documentation Requirements | Nursing Home Help

20 Documentation Dos
and Don'ts. Nursing
documentation
includes any and all
forms of
documentation by a
nurse or midwife
recorded in a
professional capacity
and in relation to the
provision of nursing
care. This video

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collection explains
concisely what nursing
documentation is and
presents 20
fundamental principles
of sound nursing
documentation.

20 Dos and Don'ts for Documentation - Ausmed

Document the
circumstances
surrounding the
change in condition
that led to a transfer to
an acute care hospital.

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Documentation

Chart all interventions, the time EMS was called, and the exact time EMS removed the resident from the facility. Do not forget to obtain a physician's order to transfer the resident to the hospital.

LTC Charting: A Beginner's Guide - Geriatric / LTC - allnurses

DOCUMENTATION IN
THE LONG TERM CARE

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Documentation
RECORD - Updated

6/09 revised 10/2010

Federal Regulations
Pertaining to Clinical
Records Purpose of the
Documentation

Elimination of
Duplication/Redundant
Information when Evalu
ating/Implementing a
Documentation System
Documentation

Content in a Long Term
Care Record - Updated
6/09 revised 10/2010
Admission ...

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Documentation Tips **AHIMA's Long-Term Care Health Information Practice**

...

Provide nursing education regarding specific skilled nursing interventions. Provide sample documentation that reflects skilled nursing interventions. I hope that these tips and questions help to gauge the level of training and direction for our SNF nurses.

Now more than ever,

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Documentation
Tips
you deserve to be paid
for the great care you
provide.

Tips to Improve Skilled Nursing Documentation

Documentation don'ts:
Time blocks. Do not
chart time as a block
(e.g., 7-3), especially
for narrative notes.

Narrative
documentation should
reflect the actual time
the entry was made.

For certain types of

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flow sheets, such as a treatment record, recording time as a block could be acceptable.

Long-Term Care Pocket Guide to

Once the CNA has documented the ADL, whether through paper or electronic documentation, the nurse assessment coordinator (NAC) must look at all of the ADL information gathered

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Type

across all shifts for that seven-day look-back period in order to code the MDS. Section G on the MDS requires coding ADLs that have occurred three or more times.

Common Errors CNAs Make in Documenting ADLs—and How to ...

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common citations in Oregon's long term care environments.

The Expert Panel chose to work on falls management;

specifically, reducing falls with injury and repeat falls. Upon review of falls data, survey citation data, and incident reports, the Expert Panel

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concluded that

The Nursing Home Expert Panel's Falls Investigation Guide

...

Clinical Documentation
Quick Reference Guide
for Long-Term Care,
Second Edition.

Barbara Acello, MS, RN.

This handy resource
will help nurses
improve their efficiency
and quality of
documentation by
guiding them through

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150 of the most common conditions, procedures, and situations encountered in a long-term care facility.

Clinical Documentation Quick Reference Guide for Long-Term

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Documentation

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Documentation Tips

- Do not tamper with the medical record
- o Make entries in the medical record with the current date
- o All copies in a soft file and medical record should be marked COPY unless it is obvious it is a copy (NCR 2 part forms, for example)
- o Do not alter another person's documentation

Documentation

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Care

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Get To Know Your Facility. Take note of how many beds your facility has, types of rooms (shared, private), courtyards/visitor areas, employee breakrooms. Kitchen (s)-. Where your office and computer are located.

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The Long Term Care Dietitian's Quick Reference Guide ...

Documentation in the long-term setting is regulated by Federal regulation (FS14).

Documentation should be complete, accurate, readily accessible and systematically organized. The admission assessments are lengthy but are important as these assessments create a

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picture of the resident's overall condition.

Long-term Care Nursing: Admission and Medicare Documentation

As baby-boomers grow old and live longer, family physicians will be at the front line of caring for our aging population in long-term care, and the care of the elderly in a nursing facility is

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Tip **A Nursing Home Documentation Tool for More Efficient ...**

Spend a few minutes talking to your neighbors. As a group, determine what are the subtasks of the following ADLs: Bed Mobility – turn side to side, pull up, sit to lay day and vice versa. Personal Hygiene – washing up, shaving, teeth, hair, make up. Dressing – dressing,

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undressing, teds,
prosthetic application.

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A good practice is to
stay current with all

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policies that affect documentation of patient care to ensure that the documentation reflects the care provided. Document adverse events properly. Everyone's goal is to provide safe patient care without incident, but adverse events still occur.

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