SUBJECT: TIME FRAMES FOR DOCUMENTATION	REFERENCE #9002
DEPARTMENT: REHABILITATION SERVICES	PAGE: 1 OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Certain time-specific documentation is required from Rehabilitation Services, when providing care within a skilled nursing facility. Rehabilitation services are provided under a written plan of patient care, initiated by the attending physician and developed in consultation with appropriate Rehabilitation Services staff, based on initial and continuing assessment of the patient.
- **Remember that timeliness and accuracy of documentation is very important.**
- Check State rules and regulations.

Documentation	Time Frame
Initial Assessment and Evaluation	Completed within 24 hours of receipt of physician's order.
Physician's Orders/Telephone Orders	Completed within 24 hours of receipt of physician's order, including frequency and duration.
Plan of Patient Care	Completed within 24 hours of receipt of physician's order, including frequency and duration.
Daily Treatment Notes	Completed on the day of each treatment.
Weekly Progress Reports	Completed at least every seven (7) days, beginning the seventh day after the initial assessment.
30-Day Reassessment and Notification to the Physician	Completed within 30 days after the initial assessment.
60-Day Reassessment and Notification to the Physician	Completed within 60 days after the initial assessment.
Discharge Summary and Notification to the Physician	Completed the last day of service.
Discharge Orders	Required if services are discontinued prior to discharge from the facility.

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