COMPREHENSIVE RESIDENT CENTERED CARE PLANS AND RESIDENT ASSESSMENTS SURVEY TAGS

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F655
BASELINE CARE PLANS AND BASELINE SUMMARY
INTENT

 Promote continuity of care
 Communication among nursing home staff
 Increase resident safety
 Safeguard against adverse events that are most likely to occur right after admission
 Ensure the resident and representative (if applicable) are informed of the initial plan for delivery of care and services by written summary of the baseline care plan

GUIDANCE

The baseline care plan should strike a BALANCE between conditions and risks affecting the resident's health and safety, and what is important to him or her, within the limitations of the baseline care plan timeframe.
The facility focuses on the resident as the center of control, and supports each resident in making his or her own choices.

This includes making an effort to understand:
• what each resident is communicating, verbally and nonverbally
• identifying what is important to each resident with regard to daily routines and preferred activities
• having an understanding of the resident’s life before coming to reside in the nursing home.

WHAT IS PERSON-CENTERED CARE?

DOCUMENTATION

Goals, objectives and include interventions that address his or her current needs.

It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.
The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

The baseline care plan must...

(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to...
   (A) Initial goals based on admission orders.
   (B) Physician orders.
   (C) Dietary orders.
   (D) Therapy services.
   (E) Social services.
   (F) PASARR recommendation, if applicable.

The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan...

(i) Is developed within 48 hours of the resident's admission.
(ii) Must meet all the guidelines in the previous slide.

In this circumstance, the completion of the comprehensive care plan will not override the RAI process, and must be completed and implemented within 48 hours of admission and comply with the requirements for a comprehensive care plan with the exception of the requirement requiring the completion of the comprehensive care plan within 7 days of completion of the comprehensive assessment. If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/representative can understand.
**Baseline Care Plans Summary**

The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(i) The initial goals of the resident.
(ii) A summary of the resident’s (current) medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

The summary must be in a language and conveyed in a manner the resident and/or representative can understand.

The format and location of the summary is at the facility’s discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.

In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident’s goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.

Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the baseline care plan. Rather, each resident will remain actively engaged in his or her care planning process through the resident’s rights to participate in the development of, and be informed in advance of changes to the care plan; see the care plan; and sign the care plan after significant changes.
SURVEYOR QUESTIONS

➢ Was the baseline care plan developed and implemented within 48 hours of admission to the facility?

➢ Does the resident’s baseline care plan include:
  - Initial goals for care
  - The instructions needed to provide effective and person-centered care that meets professional standards of quality care
  - The resident’s immediate health and safety needs;
  - Physician and dietary orders;
  - PASARR recommendations, if applicable;
  - Therapy and social services.

➢ Was the baseline care plan revised and updated as needed to meet the resident’s needs until the comprehensive care plan was developed?

SURVEYOR QUESTIONS

If the resident experienced an injury or adverse event prior to the development of the comprehensive care plan, should the baseline care plan have identified the risk for the injury/event (i.e., if risk factors were known or obvious)?

Did the facility provide the resident and his or her representative, if applicable, with a written summary of the baseline care plan that contained at least, without limitation:

• Initial goals of the resident;
• A summary of current medications and dietary instructions;
• Services and treatments to be provided or arranged by the facility and personnel acting on behalf of the facility;
• Any updated information based on details of the admission comprehensive assessment.

**IMPACT IN OTHER AREAS**

If the resident has been in the facility for less than 14 days (before completion of all the Resident Assessment Instrument (RAI) is required), the baseline care plan (will be reviewed) which must be completed within 48 hours to determine if the facility is providing appropriate care and services based on information available at the time of admission.

Could impact:

- Quality of Care (tag F684)  |  Vision and Hearing (tag F685)
- Skin Integrity (tag F686)  |  Falls (tag F689)
- Parenteral Fluids (F694)  |  Dialysis (tag F698)
- Hospice (tag F849)  |  Infection Control (tag F880)


Pages 254, 258, 274, 300, 340, 373, 609, 637.

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**QUESTIONS**

**BASELINE CARE PLAN AND BASELINE SUMMARY**
**F656 - DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN**

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights (per regulations) that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

**COMPREHENSIVE CARE PLAN MUST DESCRIBE...**

i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under (Quality of life and care and behavioral health)

ii. Any services that would otherwise be required under (Quality of life and care and behavioral health) but are not provided due to the resident's exercise of rights under (Resident rights), including the right to refuse treatment.

iii. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

iv. In consultation with the resident and the resident's representative(s)—
   a) The resident's goals for admission and desired outcomes.
   b) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
   c) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
**INTENT**

Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident’s medical, physical, mental and psychosocial needs.

**DEFINITION**

“Resident’s Goal”: The resident’s desired outcomes and preferences for admission, which guide decision making during care planning.

“Interventions”: Actions, treatments, procedures, or activities designed to meet an objective.

“Measurable”: The ability to be evaluated or quantified.

“Objective”: A statement describing the results to be achieved to meet the resident’s goals.

“Person-centered care”: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

**GUIDANCE**

Through the care planning process it is important to understand and meet the resident’s preferences, choices and goals.

Establish, document and implement the care and services to assist in attaining or maintaining his/her highest practicable quality of life.

Care planning drives the type of care and services that the resident receives. Consequences of inadequate or incomplete care planning may impact negatively on the quality of life/care/services.

Care plans should describe the resident’s medical, nursing, physical, mental and psychosocial needs and preferences and how the home will meet these needs and preferences.

Care plans must include person-specific, measurable objective and timeframes (in order to evaluate the resident’s progress towards his/her goals.

Care plans must be person-centered and reflect the resident’s goals for admission and desired outcomes.
GUIDANCE

Care plan should assist caregivers in understanding how the resident is communicating, verbally/non-verbally, identifying what is important to the resident with regards to daily routines and preferred activities and understanding the resident's life before coming to the nursing home.

Residents' goals set the expectation for care and services.

At a minimum, use the MDS to assess the resident's clinical condition, cognitive and functional status and services.

Care Area Assessment (CAA) is triggered- determines how the risk, weakness or need affects the residents.

CAA rationale for deciding whether or not to proceed to care plan for each triggered area and must be documented in the medical record. Even if it does not trigger on the CAA, if a risk, weakness or need is identified- it should be determined if the need is to care plan it.

The RAI assessment should be fluid and on-going not just to meet the guidelines set forth by the RAI process. Preferences and goals may change throughout their stay, facilities should have on-going discussions and update the care plan as needed.

In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain autonomy, etc.) poses a risk to the resident's health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.
GUIDANCE

The comprehensive care plan must coordinate with and address any specialized services or specialized rehabilitation services the facility will provide or arrange as a result of PASARR recommendations.

If the IDT disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. The rationale should include an explanation of why the resident's current assessed needs are inconsistent with the PASARR recommendations and how the resident would benefit from alternative interventions.

The facility should also document the resident's preference for a different approach to achieve goals or refusal of recommended services.

GUIDANCE

The comprehensive care plan must address a resident's preference for future discharge, as early as upon admission, to ensure that each resident is given every opportunity to attain his/her highest quality of life. This encourages facilities to operate in a person-centered fashion that addresses resident choice and preferences.
INVESTIGATIVE SUMMARY AND PROBES

- Does the care plan address the goals, preferences, needs and strengths of the resident, including those identified in the comprehensive resident assessment, to assist the resident to attain or maintain his or her highest practicable well-being and prevent avoidable decline?
- Are objectives and interventions person-centered, measurable, and do they include time frames to achieve the desired outcomes?
- Is there evidence of resident and, if applicable resident representative participation (or attempts made by the facility to encourage participation) in developing person-centered, measurable objectives and interventions?
- Does the care plan describe specialized services and interventions to address PASARR recommendations, as appropriate?
- Is there evidence that the care plan interventions were implemented consistently across all shifts?
- Is there evidence that the care plan interventions were implemented consistently across all shifts?
- Determine whether the facility has provided adequate information to the resident and, if applicable resident representative so that he/she was able to make informed choices regarding treatment and services.
- Evaluate whether the care plan reflects the facility’s efforts to find alternative means to address care of the resident if he or she has refused treatment.

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

If the surveyor identifies concerns about the resident’s care plan being individualized and person-centered, the surveyor should also review requirements at:

- Resident assessment
- Activities
- Nursing services
- Food and nutrition services
- Facility assessment
A Comprehensive care plan must be...
1) Developed within 7 days after completion of the comprehensive assessment.
2) Prepared by an interdisciplinary team, that includes but is not limited to--
   a) The attending physician.
   b) A registered nurse with responsibility for the resident.
   c) A nurse aide with responsibility for the resident.
   d) A member of food and nutrition services staff.
   e) To the extent practicable, the participation of the resident and the resident’s representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
   f) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
3) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
**INTENT**

To ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.

Facility staff must develop the comprehensive care plan within 7 days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment (except discharge assessments).

For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.

The IDT can meet its responsibility in development of the interdisciplinary care plan by face to face meetings, teleconference, written communication etc. it is at the discretion of the facility.

In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record must reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.
GUIDANCE

The IDT team must consist of the attending physician, a RN, nurses aide responsible for the resident, a member of the food and nutritional service staff, resident and resident representative to the extent as possible.

Other professionals should participate based on the physical, mental and psychosocial condition of the resident.

If the attending physician is unable to participate in the development of the care plan, he/she may delegate participation to an NPP who is involved in the resident's care, to the extent permitted by state law, or arrange alternative methods of providing input in the development and revision of the care plan, such as one-on-one discussions, videoconferencing and conference calls with the IDT.

Each resident has the right to participate in choosing treatment options and must be given the opportunity to participate in the development, review and revision of his/her care plan. Residents also have the right to refuse treatment.

GUIDANCE

Facility staff have a responsibility to assist residents to engage in the care planning process, e.g., helping residents and resident representatives, if applicable understand the assessment and care planning process; holding care planning meetings at the time of day when the resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's representative to participate in care planning and attend care planning conferences.

The facility must provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing.

The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.
GUIDANCE

If the facility determines that the inclusion of the resident and/or resident representative is not practicable, documentation of the reasons, including the steps the facility took to include the resident and/or resident representative, must be included in the medical record.

While Federal regulations affirm the resident's right to participate in care planning, request and/or refuse treatment, the regulations do not create the right for a resident or resident representative, if applicable, to demand that the facility use specific medical interventions or treatments that the facility deems not medically necessary and/or reasonable.

INVESTIGATIVE SUMMARY/PROBE

• Was a comprehensive plan of care developed within seven days of completion of the resident's comprehensive assessment?

• Is there evidence of participation in the care planning process by required IDT members?

• Ask required members of the IDT how they participate in the development, review and revision of care plans.

• Based on the resident's goals and needs, were other appropriate staff or professionals' expertise utilized to develop a plan to improve the resident's functional abilities?

FOR EXAMPLE:

• Did an occupational therapist recommend needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?

• Did the dietitian and speech therapist determine the optimum textures and consistency for the resident's food that is nutritionally adequate and compatible with the resident's oropharyngeal capabilities and food preferences?
INVESTIGATIVE SUMMARY/PROBE

• Is there evidence of attending physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls, written communication)?

• How do staff make an effort to schedule care plan meetings at the best time of the day for residents and if applicable, the resident representatives?

• How do staff make the care plan process understandable to the resident and resident representative, if applicable?

INVESTIGATIVE SUMMARY/PROBE

• Ask the resident and resident representative, if applicable if he or she actively participates in the care planning process? If not, what have been the barriers to participation?

• Ask the resident and if applicable, the resident representative if he or she has requested the participation of additional individuals care planning process. If so, was the request respected?

• In what ways does staff involve the resident and if applicable, the resident representative in care planning? If staff determine that the resident and/or resident representative involvement in care planning is not practicable, is the reason and the steps the facility took to include the resident and/or resident representative documented in the medical record?

• Is there evidence that the care plan is evaluated for effectiveness and revised following each required assessment, except discharge assessments, and as needed?
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must...

(i) Meet professional standards of quality.

**INTENT**

The intent of this regulation is to assure that services being provided meet professional standards of quality.
GUIDANCE

“Professional standards of quality” means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include:

- Current manuals or textbooks on nursing, social work, physical therapy, etc.
- Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.
- Clinical practice guidelines published by the Agency for Healthcare Research and Quality.
- Current professional journal articles.

There is no requirement for the surveyor to cite a reference or source (e.g. current textbooks, professional organizations or clinical practice guidelines) for the standard of practice.

However, in cases where the facility provides a reference supporting a particular standard of practice for which the surveyor has concerns, the surveyor must provide evidence that the standard of practice the facility is using is not up-to-date, widely accepted, or supported by recent clinical literature.
KEY ELEMENTS OF Noncompliance

The surveyor’s investigation will generally show that the facility did one or more of the following:

• Provided or arranged for services or care that did not adhere to accepted standards of quality;
• Provided a service or care when the accepted standards of quality dictate that the service or care should not have been provided;
• Failed to provide or arrange for services or care that accepted standards of quality dictate should have been provided.

F659 - Qualified Person

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must...

Be provided by qualified persons in accordance with each resident’s written plan of care.

Be culturally-competent and trauma-informed (will be implemented beginning November 28, 2019 (Phase 3).
GUIDANCE

The facility must ensure that services provided or arranged are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required.

PROCEDURES AND PROBES

NOTE: Provision of services by qualified individuals would be cited here, but implementation of the care plan would be cited in F656.

- Are the services identified in the comprehensive care plan being provided by qualified persons?
- Do staff assigned to the resident have the skills, experience?

F636 - COMPREHENSIVE ASSESSMENT AND TIMING

RESIDENT ASSESSMENT

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity.
Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.

**The assessment must include at least the following:**
- Identification and demographic information
- Cognitive patterns
- Vision
- Psychological well-being
- Continence
- Dental and nutritional status
- Activity pursuit
- Special treatments and procedures
- Customary routine
- Communication
- Mood and behavior patterns
- Physical functioning and structural problems
- Disease diagnosis and health conditions
- Skin Conditions
- Medications
- Discharge planning

Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

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A facility must conduct a comprehensive assessment of a resident in accordance with the timeframes, within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition.

(For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)

Not less than once every 12 months.
**INTENT**

To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an on-going process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.

**DEFINITIONS**

"Minimum Data Set": The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment.

"Comprehensive Assessment" includes the completion of the MDS as well as the CAA process, followed by the development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment.

"Resident Assessment Instrument (RAI)" consists of three basic components: the Minimum Data Set (MDS) version 3.0, the Care Area Assessment (CAA) process and the RAI utilization guidelines. The utilization of these components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.
“Care Area Assessment (CAA) Process” is a process outlined in Chapter 4 of the MDS manual designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. This process has three components:

- Care Area Triggers (CATs) are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
- Care Area Assessment (CAA) is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning.
- CAA Summary (Section V of the MDS) provides a location for documentation of the care area(s) that have triggered from the MDS, the decisions made during the CAA process regarding whether or not to proceed to care planning, and the location and date of the CAA documentation.

DEFINITIONS

The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAA. The scope of the RAI does not limit the facility’s responsibility to assess and address all care needed by the resident.

The information required is incorporated into the MDS, which forms the core of the RAI process. Additional assessment information is also gathered using triggered Care Area Assessments (CAAs) after the completion of the comprehensive MDS.

The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to record review, direct observation and communication with the resident, the facility must use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident’s physician, the resident’s representative, family members, or outside consultants.

At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident’s status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.

GUIDANCE
GUIDANCE

If a comprehensive assessment was completed, any time prior to a temporary absence for hospitalization or a leave of absence, and upon return to the facility, the resident does not meet the criteria for a Significant Change in Status Assessment (SCSA), a comprehensive assessment is not required.

PROBES

Did the facility complete a comprehensive assessment, using the CMS-specified RAI process, within the regulatory timeframes (i.e. within 14 days after admission and at least annually) for each resident in the sample?

Is there evidence in the clinical record that the facility gathered and analyzed supplemental information based on the triggered CAAs prior to developing the comprehensive care plan? For reference a list of CAAs is found in Section V of the MDS (Care Area Assessment Summary).

Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews, providing information about preferences or discharge goals.

Ask licensed and non-licensed direct-care staff if they participate in the resident assessment process.

Does the facility have a system in place to assure assessments are conducted in accordance with the specified timeframes for each resident?
COMPREHENSIVE ASSESSMENT

Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition.

(For purpose of this section, a “SIGNIFICANT CHANGE” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.)
INTENT

To ensure that each resident who experiences a SIGNIFICANT CHANGE in status is comprehensively assessed using the CMS-specified Resident Assessment Instrument (RAI) process.

DEFINITIONS OF SIGNIFICANT CHANGE

“SIGNIFICANT CHANGE” is a major decline or improvement in a resident’s status that:

1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered “self-limiting” (NOTE: self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition);

2) impacts more than one area of the resident’s health status; and

3) requires interdisciplinary review and/or revision of the care plan. This does not change the facility’s requirement to immediately consult with a resident’s physician of changes.
DEFINITIONS OF SIGNIFICANT CHANGE

“Significant Change in Status Assessment (SCSA)” is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline.

“Assessment Reference Date (ARD)” is the specific end point for the look-back periods in the Minimum Data Set (MDS) assessment process. This look-back period is also called the observation or assessment period.

GUIDANCE

An SCSA including Care Area Assessments (CAAs) must be completed within 14 days after a determination has been made that a significant change in the resident’s status from baseline occurred.

This may be determined by comparison of the resident’s current status to the most recent comprehensive assessment and most recent Quarterly assessment, and the resident’s condition is not expected to return to baseline within 2 weeks.

A SCSA is appropriate if there are either two or more MDS areas of decline or two or more MDS areas of improvement or if the IDT determines that the resident would benefit from the SCSA assessment and subsequent care plan revision.

The facility should document in the medical record when the determination is made that the resident meets the criteria for a Significant Change in Status Assessment.
A **Significant Change in Status MDS** is required when a resident:

- enrolls in a hospice program; or
- changes hospice providers and remains in the facility; or
- receiving hospice services discontinues those services; or
- experiences a consistent pattern of changes, with either **two or more** areas of decline or **two or more** areas of improvement, from baseline (as indicated by comparison of the resident’s current status to the most recent CMS-required MDS).

**Guidance**

**Significant Change Decline: Examples**

- Resident’s decision-making ability has changed;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E Behavior;
- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since last assessment;
- Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual’s functioning;
- Resident’s incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days).
- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type, when it was not used before;
- Emergence of a condition/disease in which a resident is judged to be unstable.
SIGNIFICANT CHANGE IMPROVEMENT: EXAMPLES

Any improvement in ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;

Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;

Resident's decision making ability improves;

Resident's incontinence pattern improves;

GUIDANCE

- If there is only one change, the resident may still benefit from a significant change. The facility must document a rationale, in the resident’s medical record, for completing a SCSA that does not meet the criteria for completion.

- The facility may not complete a SCSA until after a Comprehensive Admission assessment has been completed.

- A SIGNIFICANT CHANGE IN STATUS MDS is considered timely when:
  - The RN Assessment Coordinator signs the MDS as complete at section Z0500B & V0200B2 by the 14th calendar day after the determination that a significant change has occurred (determination date + 14 calendar days).

- If a SCSA MDS is completed, the next annual assessment is not due until 366 days after the ARD of the significant change in status assessment.
**Examples of Significant Change Not Needed**

- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change Assessment).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

**Probes**

Did the facility identify, in a timely manner, those residents who experienced a significant change in status?

Is there documentation in the medical record when the determination was made that the resident met the criteria for a Significant Change in Status Assessment?

Did the facility reassess residents who had a Significant Change in Status, using the CMS-specified RAI, within 14 days after determining the change was significant?
A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

**INTENT**

To assure each resident is assessed using the standardized Quarterly Review assessment tool no less than once every 3 months between comprehensive assessments.

**DEFINITIONS**

"Quarterly Review Assessment" is an OBRA ‘87-required, non-comprehensive assessment that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident’s status between comprehensive assessments to ensure critical indicators of gradual change in a resident’s status are monitored. As such, not all Minimum Data Set (MDS) items appear on the Quarterly assessment.
At least every 92 days, the facility shall review each resident with respect to those MDS items specified in the CMS quarterly assessment (MDS).

A Quarterly assessment is considered timely if:

- The Assessment Reference Date (ARD) of the Quarterly MDS is **within 92 days** (ARD of most recent OBRA assessment +92 days) after the ARD of the previous OBRA assessment (Quarterly, Admission, Annual, Significant Change in Status, Significant Correction to Prior Comprehensive or Quarterly assessment).

**AND**

- The MDS completion date (Item Z0500B) must be **no later than** 14 days after the ARD (ARD + 14 calendar days).

If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the ARD of the **Significant Change in Status Assessment**.

No CAA are due with a Quarterly Assessment

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**Guidance**

**Probes**

Does the facility assess residents, using the CMS-specified quarterly review assessment, no less than once every 3 months, between comprehensive assessments?

Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews and providing information about preferences or discharge goals.
**F639 - MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS**

A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.

**INTENT**

Facilities are required to maintain 15 months of assessment data in each resident’s active clinical record.

**GUIDANCE**

The requirement to maintain 15 months of data in the resident's active clinical record applies regardless of form of storage to all Minimum Data Set (MDS) records, including the Care Area Assessment (CAA) Summary, Quarterly Assessment records, Identification Information and Entry, Discharge and Reentry Tracking Records and MDS Correction Requests (including signed attestation).

MDS assessments must be kept in the resident's active clinical record for 15 months following the final completion date for all assessments and correction requests.

Other assessment types require maintaining them in the resident's active clinical record for 15 months following:

- The entry date for tracking records including re-entry; and
- The date of discharge or death for discharge and death in facility records.
GUIDANCE

Facilities may maintain MDS data electronically regardless of whether the entire clinical record is maintained electronically and regardless of whether the facility has an electronic signature process in place.

Facilities that maintain their MDS data electronically and do not utilize an electronic signature process must ensure that hard copies of the MDS assessment signature pages are maintained for every MDS assessment conducted in the resident's active clinical record for 15 months. (This includes enough information to identify the resident and type and date of assessment linked with the particular assessment's signature pages).

The information, regardless of form of storage (i.e., hard copy or electronic), must be kept in a centralized location and must be readily and easily accessible. This information must be available to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. (This information must also be made readily and easily accessible for review by the State Survey agency and CMS.) Resident specific information must also be available to the individual resident also.

F641 - ACCURACY OF ASSESSMENTS

THE ASSESSMENT MUST ACCURATELY REFLECT THE RESIDENT’S STATUS
"Accuracy of Assessment" means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).

Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.

**GUIDANCE**

The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.

When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

The initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.
**PROBE**

Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident’s status as of the Assessment Reference Date?

Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment? For example, has the resident’s nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?

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**F642 - COORDINATION/CERTIFICATION OF ASSESSMENT**

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

Certification: A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Penalty for Falsification. Under Medicare and Medicaid, an individual who willfully and knowingly—

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.
**INTENT**

Each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed.

**GUIDANCE**

Whether Minimum Data Set (MDS) assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the assessment.

**ELECTRONIC Signatures**

When MDS forms are completed directly on the facility's computer (i.e. no paper form has been manually completed), then each individual assessor signs and dates a computer-generated hard copy, or provides an electronic signature, after they review it for accuracy of the portion(s) they completed.

Facilities may use electronic signatures on the MDS when permitted to do so by state and local law and when this is authorized by the facility's policy. Additionally, the facility must have written policies in place to ensure proper security measures are in place to protect use of an electronic signature by anyone other than the person to which the electronic signature belongs. The policy must also ensure access to a hard copy of clinical records is made available to surveyors and others who are authorized access to clinical records by law, including the resident and/or resident representative.

Facilities that are not capable of maintaining the MDS signatures electronically must adhere to the current federal requirements at §483.20(d) addressing the need for either a hand-written copy or a computer-generated form.
**Electronic Signatures**

**Backdating Completion Dates** - Backdating completion dates is not acceptable – note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.

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**F644 - Coordination of PASARR and Assessments**

Appendix PP page 191-195

**F645 - PASARR Screening for MD and ID**

Appendix PP page 195-201
A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a **SIGNIFICANT CHANGE** in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.

**INTENT**

To ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting, when a **SIGNIFICANT CHANGE** in their status occurs.

**DEFINITION**

“**Preadmission Screening and Resident Review (PASARR)**” is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that:

1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability;
2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.
GUIDANCE

Referral to the SMH/ID authority should be made as soon as the criteria indicative of a significant change are evident - the facility should not wait until the SCSA is complete.

Referral for Level II resident review evaluation is required for individuals previously identified by PASARR to have a mental disorder, intellectual disability, or a related condition who experience a significant change. Examples of such changes include, but are not limited to:

• A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
• A resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment.
• A resident who experiences an improved medical condition—such that the residents’ plan of care or placement recommendations may require modifications.
• A resident whose significant change is physical, but has behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
• A resident whose condition or treatment is or will be significantly different than described in the resident’s most recent PASARR Level II evaluation and determination.

(NOTE that a referral for a possible new Level II PASARR evaluation is required whenever such a disparity is discovered, whether or not associated with a SCSA.)

F660 - DISCHARGE PLANNING PROCESS

DISCHARGE PLANNING PROCESS

The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.

Appendix PP page 218-224
**F660 - DISCHARGE PLANNING PROCESS**

The facility’s discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and...

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team in the ongoing process of developing the discharge plan.

(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident’s goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

   (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

   (B) Facilities must update a resident’s comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

   (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
F660 - DISCHARGE PLANNING PROCESS

**INTENT**

This requirement intends to ensure that the facility has a discharge planning process in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

**GUIDANCE**

Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting.

Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged, and the resident's capacity for discharge.

It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions. A well-executed discharge planning process, without avoidable complications, maximizes each resident's potential to improve, to the extent possible, based on his or her clinical condition.

An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.
The discharge care plan is part of the comprehensive care plan and must:

- Be developed by the interdisciplinary team and involve direct communication with the resident and if applicable, the resident representative;
- Address the resident’s goals for care and treatment preferences;
- Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education;
- Be re-evaluated regularly and updated when the resident’s needs or goals change;
- Document the resident’s interest in, and any referrals made to the local contact agency;
- Identify post-discharge needs such as nursing and therapy services, medical equipment or modifications to the home, or ADL assistance.

The nursing home staff is responsible for making referrals to the LCA, if appropriate.

Discharge planning must identify the discharge destination, and ensure it meets the resident’s health and safety needs, as well as preferences.

If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility must treat this situation similarly to refusal of care, and must:

- Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location;
- Document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed;
- Document that despite being offered other options that could meet the resident’s needs, the resident refused those other more appropriate settings;
- Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.

Use the Discharge Critical Element Pathway as well as Appendix PP.
F661 - DISCHARGE SUMMARY

When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

i. A recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

ii. A final summary of the resident’s status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident’s representative.

iii. Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).

iv. A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident’s follow up care and any post-discharge medical and non-medical services.

CONTENT OF THE DISCHARGE SUMMARY

RECAPITULATION OF RESIDENT’S STAY

Recapitulation of the resident’s stay describes the resident’s course of treatment while residing in the facility. The recapitulation includes, but is not limited to, diagnoses, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including any pending lab results.
FINAL SUMMARY OF RESIDENT STATUS

In addition to the recapitulation of the resident’s stay, the discharge summary must include a final summary of the resident’s status which includes the items from the resident’s most recent comprehensive assessment identified at Comprehensive Assessment.

This is necessary to accurately describe the current clinical status of the resident. Items required to be in the final summary of the resident’s status are:

- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and Behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnoses and health conditions;
- Dental and nutritional status;
- Skin condition;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge planning (as evidenced by most recent discharge care plan);
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS; and
- Documentation of participation in assessment. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts.

NOTE: In addition to the above, the facility (transferring nursing home) must convey the following information to the receiving provider when a resident is discharged (or transferred) from that facility:

- Contact information of the practitioner (at the transferring nursing home) responsible for the care of the resident;
- Resident representative information, if applicable, including contact information;
- Advance directive information;
- All special instructions or precautions for ongoing care, as appropriate;
- Comprehensive care plan goals; and
- All other necessary information, including a copy of the resident’s discharge summary.

F661 - DISCHARGE SUMMARY

Timing of the Discharge Summary

The discharge summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility, to the receiving provider assuming responsibility for the resident’s care after discharge. The discharge summary may be furnished in either hard copy or electronic format, if the provider assuming responsibility for the resident’s care has the capacity to receive and use the discharge summary in electronic format. Delays in preparing and forwarding the discharge summary hinder the coordination required to provide optimal care to the resident. The medical record must contain the discharge summary information and identify the recipient of the summary.

NOTE: In situations where there is no continuing care provider (e.g. resident has no primary care physician in the community), the facility is expected to document in the medical record efforts to assist the resident in locating a continuing care provider.
INSTRUCTIONS TO RESIDENTS DISCHARGED TO HOME

For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident representative. These instructions must be discussed with the resident and resident representative and conveyed in a language and manner they will understand.

RESIDENT ASSESSMENTS RAI AND SURVEY TAGS

635 ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE
APPENDIX PP PAGE 176-177
**F635 ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE**

**ADMISSION ORDERS**

At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

**INTENT**

To ensure each resident receives necessary care and services upon admission.

**GUIDANCE**

“Physician orders for immediate care” are those written and/or verbal orders facility staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission to the facility. These orders should, at a minimum, include dietary, medications (if necessary) and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.

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**F640 - ENCODING/TRANSMITTING RESIDENT ASSESSMENT**

APPENDIX PP PAGE 185-188
F640 - ENCODING/TRANSMITTING RESIDENT ASSESSMENT

AUTOMATED DATA PROCESSING REQUIREMENT

Encoding data. Within 7 days after a facility completes a resident’s assessment, a facility must encode the following information for each resident in the facility:

i. Admission assessment
ii. Annual assessment updates
iii. Significant change in status assessments
iv. Quarterly review assessments
v. A subset of items upon a resident’s transfer, reentry, discharge, and death
vi. Background (face-sheet) information, if there is no admission assessment

TRANSMITTING DATA: Within 7 days after a facility completes a resident’s assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

TRANSMITTAL REQUIREMENTS: Within 14 days after a facility completes a resident’s assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

i. Admission assessment
ii. Annual assessment
iii. Significant change in status assessment
iv. Significant correction of prior full assessment
v. Significant correction of prior quarterly assessment
vi. Quarterly review
vii. A subset of items upon a resident’s transfer, reentry, discharge, and death
viii. Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment
**F640 - Encoding/Transmitting Resident Assessment**

**Intent**

- To ensure that facilities have provided resident specific information for payment and quality measure purposes.
- To enable a facility to better monitor each resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data.

**Definitions**

"Accurate" means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at §483.20(g), and the information accurately reflects the resident's status as of the Assessment Reference Date (ARD).

"Encoding" means entering information into the facility MDS software in the computer.

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**F640 - Encoding/Transmitting Resident Assessment**

All nursing homes must computerize MDS information. The facility must edit MDS information using standard CMS-specified edits, revise the information to conform to the edits and to be accurate, and be capable of transmitting that data to the QIES ASAP system within 7 days:

- For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
- For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).
- For a tracking record, encoding should occur within 7 days of the Event Date (A1600+ 7 days for Entry records and A2000 + 7 days for Death in Facility records).

Electronically submit MDS information to the QIES ASAP system within 14 days:

- Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
- Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).
F640 - ENCODING/TRANSMITTING RESIDENT ASSESSMENT

Only CMS-required MDS assessments (e.g., OBRA and Medicare Part A PPS) are permitted to be transmitted into the QIES ASAP System. Assessments completed to meet third party payer (i.e., private insurance or managed care) requirements cannot be transmitted to CMS. OBRA MDS assessments completed anytime a facility is NOT certified to participate in Medicare/Medicaid cannot be transmitted.

PROCEDURES
If the surveyor suspects the facility is not encoding and submitting assessments as required, the surveyor should review the facility’s MDS 3.0 NH Final Validation Report to verify assessment submission into the QIES ASAP System.