MDS ACCURACY AND COMPREHENSIVE CARE PLANS

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REGULATIONS

- F635 Admission Physician Orders for Immediate Care
- F636 Comprehensive Assessments& Timing
- F637 Comprehensive Assessment After Significant Change
- F638 Quarterly Assessment
- F639 Maintain 15 Months of Resident Assessments
- F640 Encoding/Transmitting Resident Assessment
- F641 Accuracy of Assessments
- F642 Coordination/Certification of Assessment
- F644 Coordination of PASARR and Assessments
- F645 PASARR Screening for MD& ID
- F646 MD/ID Significant Change Notification

- F655 Baseline Care Plan
- F656 Develop/Implement Comprehensive Care Plan
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards
- F659 Qualified Persons
- F660 Discharge Planning Process
- F661 Discharge Summary

RAI MANUAL

- Chapter 1: Introduction to the RAI Process, overview
- Chapter 2: Timing and Scheduling –OBRA and PPS assessments
- Chapter 3: Coding Instructions Item by Item
- Chapter 4: Care Area Assessments and Care Planning
- Chapter 5: Corrections Process
- Chapter 6: RUGS IV, PDPM
- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS
- Appendix F: MDS Item Matrix
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OBRA-Required Tracking Records and Assessments

Tracking records

- Entry
- Death in facility

Assessments

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated

RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days **AND** ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Entry tracking record	A0310F = 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F = 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment

RAI PROCESS

- The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

F641: Accuracy of Assessments

- The assessment must accurately reflect the resident's status.
- Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.
- 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.

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ACCURACY OF ASSESSMENTS: WHY?

- Resident Assessment and Care Planning
  - Reimbursement
  - Medicaid
  - Medicare
- Quality Indicators/Quality Measures
  - Impacts survey
  - 5-star rating/nursing home compare web site
  - Value Based Purchasing
- Proper care planning

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MDS Accuracy: How?

- Understand the terminologies
  - MDS manual contains
    - Definitions,
    - Instructions,
    - Clarifications and
    - Examples critical to accurate completion of the MDS
- Assessment Reference Date (ARD) is critical to accurate assessments
- Communication
  - Interview the resident
  - Interview to the family
  - Interview to staff
  - Review the medical record
- Observe resident's conditions care aspects

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Regulation F636 Comprehensive Assessments & Timing

- The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.
- 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.
- 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.
- Not less than once every 12 months.

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Care Plan Timing and Revision

A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment.

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.

Prepared by an interdisciplinary team, that includes but is not limited to:

- The attending physician; A registered nurse with responsibility for the resident; A nurse aide with responsibility for the resident;

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.

Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

CARE PLANS

F655 Baseline Care Plans

- The baseline care plan must be developed within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
  - Initial goals based on admission orders. (B) Physician orders.
  - Dietary orders. (D) Therapy services.
  - Social services. (F) PASARR recommendation, if applicable.

Regulation F656 Develop/Implement Comprehensive Care Plan

- Comprehensive Care Plans: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights 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.
- The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

CARE PLANS

- 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.
- **"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.
- **Evaluation**—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline

CARE PLAN

- 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.
- Care plan interventions were implemented consistently across all shifts

- **Problems**
- **Goals**
- **Approaches**
- **Implementations**
- **Evaluations**

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CARE PLAN

Care Plan Process

- Policy and process for successful care planning
- Base on MDS assessment and CAA analysis
- Identify the areas/problems/concerns for developing a plan of care
- Team communication/Team discussion
- Further assessment/investigation
- Approaches/interventions
- Implementation
- Evaluation

Care plan components

- Data Collection or Assessment. ...
- Data Analysis
- Formulating the Problems or concerns using Diagnoses and impacts of the problems
- Outcomes Identification
- Planning for formatting the plan of care
- Establishing Goals and Desired Outcomes. ...
- Selecting Interventions, approaches
- Planning for implementation
- Implementation: communication
- Evaluation: if the care plans work?. Make decision

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References:

- RAI manual 2017
- SOM- Appendix PP

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