CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT

1.1 Overview of the Resident Assessment Instrument (RAI)

Providing care to residents with post-acute and long-term care needs is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from all disciplines to develop individualized care plans. The Resident Assessment Instrument (RAI) helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being.

The RAI helps facility staff to look at residents holistically - as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this very emphasis on quality of care and quality of life. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication.

Persons generally enter a nursing facility due to functional status problems caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. The individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment and/or rehabilitation is needed for residents to maintain and/or restore function or to live safely from day to day. While we recognize that there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (Quality of Care) and maintain their sense of individuality (Quality of Life). This is true for long-term residents, as well as the resident in a rehabilitative program anticipating return to a less restrictive environment.

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI simply provides a structured, standardized approach for applying a problem identification process in long-term care facilities. **The RAI should not be, nor was it ever meant to be, an additional burden for nursing facility staff**.

All good problem identification models have similar steps:

a. **Assessment** - Taking stock of all observations, information and knowledge about a resident; understanding the resident's limitations and strengths; finding out who the resident is.

b. **Decision-making** - Determining the severity, functional impact, and scope of a resident's problems; understanding the causes and relationships between a resident's problems; discovering the "what's" and "whys" of resident problems.

c. **Care Planning** - Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

d. **Implementation** - Putting that course of action (specific interventions on the care plan) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the "how" and "when" of resident care.

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

This is how the problem identification process would look as a pathway. This manual will feature this pathway throughout the chapter discussions.

Assessment (MDS/other) → Decision-Making (RAPs/other) → Care Plan Development → Care Plan Implementation → Evaluation

If you look at the RAI process as solution oriented and dynamic, it becomes a richly practical means of helping facility staff to gather and analyze information in order to improve a resident's quality of care and quality of life. In an already overburdened structure, the RAI offers a clear path toward utilizing all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to understanding the RAI process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff, across all shifts, are involved in its "hands on" approach. The result is a process that flows smoothly from one component to the next and allows for good communication and uncomplicated tracking of resident care. In short, it works!

Since the RAI has been implemented, facilities that have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

Residents Respond to Individualized Care. While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, linked with appropriate resident specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or deteriorated at a slower rate. Facilities report that as individualized attention increases, resident satisfaction with quality of life is also increased.

Staff Communication Has Become More Effective. When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using the Resident Assessment Protocols (RAPs)) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

Resident and Family Involvement in Care Has Increased. There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.

Increased Clarity of Documentation. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

It is the intent of this manual to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help facilities achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 that made recommendations to improve the quality of care in nursing facilities, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

With the consistent application of item definitions, the RAI ensures standardized communication both within the facility and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.2 Content of the RAI for Nursing Facilities

The RAI consists of three basic components:

1. **Minimum Data Set (MDS) Version 2.0**,

2. **Resident Assessment Protocols (RAPs)**, and

3. **Utilization Guidelines** specified in State Operations Manual (SOM) Transmittal #272.

Utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS)**. A core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. **A copy of the MDS Version 2.0 can be found at the end of this chapter.**

- **Resident Assessment Protocols (RAPs)**. The RAPs are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. RAPs help identify social, medical and psychological problems and form the basis for individualized care planning. The 18 RAPs are explained in detail in Appendix C. There are four components in the RAPs protocols:

  - ***Triggers*** 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 evaluation.

  - The ***Trigger Legend*** is a two-page form that summarizes all of the triggers for the 18 RAPs. It is not a required form that must be maintained in the resident's clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS assessment.

  - The ***RAPs*** analysis is performed in accordance with the Utilization Guidelines. The indepth review assists the staff members to draw a conclusion to proceed or not to proceed to the plan of care.

  - The ***RAPs Summary Sheet*** documents the decisions made during this evaluation process on whether or not to proceed to care planning.

- **Utilization Guidelines**. Instructions concerning when and how to use the RAI. Application of the RAPs and the Utilization Guidelines is discussed in detail in Chapter 4.

1.3 Additional Uses of the Minimum Data Set

Over the course of time, the role of the MDS has expanded beyond its primary purpose as an assessment tool used to identify resident care problems that are addressed in an individualized care plan. Data collected from MDS assessments is used for the Medicare reimbursement system, many State Medicaid reimbursement systems, and to monitor the quality of care provided to nursing

facility residents. The MDS instrument has also been adapted for the hospital swing bed program. Swing bed providers are required to complete a unique 2-page MDS for the Medicare Prospective Payment System (PPS).

Medicare and Medicaid Payment Systems

The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. Chapters 2 and 6 provide more detailed information on the Medicare Prospective Payment System, assessment requirements, and payment requirements.

Monitoring the Quality of Care

MDS assessment data is also used to monitor the quality of care in the nation's nursing facilities. A set of 24 quality indicators (QIs) was developed by researchers to assist State staff to identify potential care problems in a nursing facility. CMS is currently evaluating the usefulness of these indicators and is considering additions and modifications to further enhance the effectiveness of the QI system. The QI data is available to providers to assist them in their ongoing quality improvement activities, to surveyors to assist in identifying potential problem areas that should be addressed during the survey process, and to CMS for long-term quality monitoring and program planning.

Consumers are also able to access information about every Medicare and Medicaid certified nursing facility in the country. The Nursing Home Compare tool available at **www.medicare.gov** provides the following sections of detailed information:

- **About the Nursing Facility:** Including the number of beds and type of ownership.
- **About the Nursing Facility Inspection:** Including health deficiencies found during the most recent State nursing facility survey and from recent substantiated complaint investigations.
- **About Nursing Facility Staff:** Including the average number of hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per resident per day.
- **About the Quality of Care Received at the Facility:** In 2002, CMS began a new program called the Nursing Home Quality Initiative (NHQI). The purpose of this program is to provide consumers with information on the quality of care delivered in nursing facilities to help them make informed decisions. CMS expanded the original quality indicators to a set of 39 quality measures. These quality measure domains include pain and measures for the short-stay and post-acute population. A subset of 10 quality measures are posted on the Nursing Home Compare web site, a CMS developed internet search tool to allow comparisons between nursing facilities. The public reporting initiative was successfully piloted in six states, and, beginning in November 2002, was expanded to all fifty states as well as to U.S. territories that have Medicare or Medicaid certified nursing facilities.

The Nursing Home Compare web site is:

http://www.medicare.gov/nhcompare/home.asp.

1.4 Suggestions for the Use of this Manual

This manual is designed to meet the needs of nursing facility staff who are both skilled in the use of the RAI process and staff who are just beginning to work with it.

This revised manual includes information about:

- MDS automation
- Reimbursement
- Quality monitoring applications

It also includes new case studies and expanded clarifications for the original item-by-item section information of the October 1995 Version 2.0 Long-Term Care Resident Assessment Instrument User's Manual and "how-to" directions for completing the RAP review process and documentation requirements.

The following fundamental concepts associated with the RAI are interwoven as themes throughout this manual:

- The resident is an individual with strengths, as well as functional limitations and health problems.
- The RAPs are utilized to identify possible causes for each problem area, and guidance for further assessment and resolution or intervention.
- An interdisciplinary approach to resident care is vital - both in assessment and in developing the resident's care plan.
- Good clinical practice requires solid, sound assessment.

In essence, this manual promotes a step-by-step system of assessing resident needs and functional status based on standardized definitions of items (the MDS). It then helps you think through possible reasons for and risk factors that contribute to a resident's clinical status (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that is based on specific, individual characteristics.

1.5 Clarifications and Revisions to the Manual

Since the publication of the MDS 2.0 manual in October 1995, a number of additional systems and monitoring protocols that use MDS data have been developed and implemented, such as SNF PPS, nursing facility quality of care monitoring, and the public reporting of nursing facility quality of care information.

In addition, CMS established a process for answering questions and clarifying MDS coding instructions for nursing facility staff. CMS posted responses to questions on their web site. These responses are now incorporated into this manual. The instructions in this revised manual incorporate and supercede previous Q&A documents.

CMS recognizes that the publication of this revised manual will not preclude future questions or the need for more clarification about MDS items. Therefore, CMS has developed a procedure to review, respond and distribute clarifications to the MDS coding process.

STEP 1: If clinicians have a question about a particular MDS item, they should first review the manual and then contact their State RAI Coordinator for a clarification. If necessary, the State RAI Coordinator will contact the appropriate CMS staff if he/she is not able to answer a specific question.

STEP 2: CMS will determine if a clarification about an item is needed and will post new clarifications on the CMS web site. If a clarification is posted on the official CMS web site, then it can be considered policy. CMS will develop a process to periodically update the manual and incorporate additional clarifications. Clinicians should monitor the CMS web site at: **http://www.cms.hhs.gov/medicaid/mds20** for these clarifications

1.6 Statutory and Regulatory Basis for the RAI in Nursing Facilities

Minimum Data Set (MDS): The statutory authority for the MDS Version 2.0 and the Resident Assessment Instrument (RAI) is found in Section 1819(f)(6)(A-B) for Medicare and 1919 (f)(6)(A-B) for Medicaid in the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the Social Security Act required the Secretary of the Department of Health and Human Services (the Secretary) to specify a minimum data set of core elements for use in conducting comprehensive assessments. It furthermore required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995. Revision #22, issued December 8, 2000, required nursing facilities to implement the September 2000 update of the Resident Assessment Instrument (RAI).

Federal requirements at 42 CFR 483.20(b)(1)(i) -- (F272) require that facilities use an RAI that has been specified by the State. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident's functional capabilities and helps staff to identify health problems. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data from the facility to the State MDS database. (Detailed submission requirements are located in Chapter 5.)

1.7 State Designation of the RAI for Nursing Facilities

All comprehensive RAIs authorized by states include at least the Centers for Medicare & Medicaid Services' (CMS's):

- **MDS Version 2.0 (with or without optional Sections S, T, U)**
- **Resident Assessment Protocols (RAPs), including**
  - **Triggers**
  - **Trigger Legend**
  - **RAPs Summary Sheet**
- **Utilization Guidelines**

Each state must have CMS approval for the State RAI. CMS's approval of a state's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. CMS's approval of the RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). States must use all Federally required MDS items (see Section 1.9) but have some flexibility in adding one or more optional sections (Sections S, T and U) and in selecting a Quarterly assessment instrument.

In addition to approving the State's RAI, CMS must also pre-approve the Quarterly assessment designated by each state. Effective July 1, 2002, CMS approved the Medicare Prospective Payment Assessment Form (MPAF) for use as a Quarterly assessment. States choosing to use the MPAF form as the State Quarterly assessment do not need prior CMS approval. The state is only required to notify CMS that the MPAF has been designated as the State Quarterly assessment.

If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the state can ensure that the facility's RAI form in the resident's record accurately and completely represents the State's RAI as approved by CMS in accordance with 42 CFR 483.20 (b). This applies to either pre-printed forms or computer generated printouts. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions).

Additional information about State specification of the RAI, variations in format and CMS approval of alternative State instruments can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual, Transmittal #272 issued April 1995. Revision #22 issued December 8, 2000 updated RAI requirements and mandated nursing facilities to implement the Version 2.0 September 2000 update of the RAI.

1.8 Protecting the Privacy of MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities under the Conditions of Participation (COP). By regulation at CFR 483.75(L)(2)(3) and 483.75(L)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. The Privacy Act can be found at **www.usbr.gov/laws/privacy.html.**

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the State MDS database. The notice shown on Page 1-11 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under OBRA or for Medicare payment purposes.

Contractual Agreements

Providers, who are part of a chain, may release data to their corporate office or parent company but not to other providers within their chain organization. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the CFR at 483.10(e)(3)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

NURSING FACILITIES
PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits the information to CMS.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators(TPA),employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

1.9 The Components of the Minimum Data Set (MDS)

Minimum Data Set

The MDS is completed on all residents in Medicare or Medicaid certified facilities. A mandated assessment schedule is discussed in Chapter 2. In addition, states may establish additional MDS requirements. For specific information on State requirements, contact your State RAI Coordinator (see Appendix B).

Since the requirements for Medicare PPS went into effect, assessments may be referred to as either a "comprehensive" or "full" assessment. To clarify this terminology, the comprehensive assessment is a clinical assessment that requires the full MDS, RAPs and Utilization Guidelines. Comprehensive assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines. Comprehensive assessments are required within 14 days of the admission, annually, when there has been a significant change in clinical status, and when the facility does a Significant Correction of a Prior Full assessment.

When the term "full assessment" is used, it includes the MDS required items A through R (plus any State-required items). A full assessment is distinguished from a comprehensive assessment (RAI) in that the RAPs and care planning are not completed when the full assessment is completed for a Medicare assessment.

Of course, the facility's right to care plan is not restricted to the RAI mandated requirements. Facilities may expand upon these requirements, when appropriate, to fully assess and care plan for an individual.

The required components of the MDS are as follows:

SECTION AA - The Basic Assessment Tracking Form

This form contains Identification Information Items 1-9, which consists of identifying information needed to uniquely identify each resident, the nursing facility in which he or she resides, the reason(s) for assessment; and Items AA9 a-l, Signatures of Persons Completing a Portion of the MDS or Tracking form. The information contained on this form must accompany each comprehensive, full, MPAF, or Quarterly assessment, as well as every Distcharge and Reentry Tracking form, submitted electronically to the State MDS database. This includes Federally required assessment records, (e.g., Admission, Annual, Significant Change in Status, and Quarterly assessments), as well as assessments required for Medicare or by the State. This section also contains the Attestation Statement that staff members must sign and date attesting to the accuracy of the portions of the MDS completed by each member of the interdisciplinary team.

SECTIONS AB, AC, AD - Background (Face Sheet) Information at Admission Form

This form contains Sections AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This information is to be completed at the

time of the resident's initial admission to the nursing facility. A new Face Sheet is also required to be completed, along with an Admission assessment, for an individual who returns to the facility after a discharge in which return was not anticipated. CMS's clinical policies, as well as data specifications, allow Face Sheet information to be updated and submitted after the Admission assessment is completed and transmitted. This means that Face Sheet information can be transmitted with any of the Federally required records (those indicated by the codes under AA8a) or the assessments required for Medicare (those indicated by the codes under AA8b). The only instance in which Face Sheet information cannot be updated is from those assessments required by the State (AA8a = "0" and AA8b = "6").

SECTIONS A-Q - Clinical Assessment

Sections A-Q contain the clinical data items used to assess residents in the nursing facility. Section A9 is where staff sign that they have completed portions of the assessment and agree to the Attestation Statement.

SECTION R – Signature and Completion Date

Section R contains the signature of the RN coordinating the assessment. This is the section that records participation of the resident, family and/or significant other in the assessment process.

SECTION S - State Section

Some states have added items to the core MDS that must be completed for each resident when a comprehensive assessment, full, MPAF, or Quarterly is required. Thus, while the basic MDS form is the standard foundation for states, you may find that other items have been added at the end of the form (in Section S) in your state. Contact your State RAI Coordinator for State-specific requirements. A list of State RAI Coordinators is found in the Appendix B.

SECTION T – Supplement

Required for all Medicare assessments. Optional at State discretion for all other types of assessments.

SECTION U – Medications

Not used by CMS. Can be required by the State.

SECTION V - Resident Assessment Protocol Summary

Section V contains the form used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether or not a care plan has been developed for each RAP area. Note that the RAP need not have triggered for a care plan to be developed for that particular area. A RAP Summary form must be completed each time a comprehensive RAI is required under the Federal schedule. If a care plan is written from a non-triggered RAP, it should be noted on the RAP Summary form.

Quarterly Assessments

Additionally, states must specify a Quarterly assessment form, for use by facilities that includes at least the items on the CMS-designated form. The Quarterly assessment contains the mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serves as the minimum requirement for Quarterly assessments within each State's RAI. Some states have mandated an expanded Optional Quarterly assessment form. CMS has published two optional versions that states may require. A state may also require a full assessment on a quarterly basis. Again, contact your State RAI Coordinator for State specifics. States have the following options for the Quarterly Assessment:

- **Minimum Required MDS Quarterly Assessment**
- **MDS Quarterly Assessment Form Optional Version for RUG-III or Optional Version for RUG-III 1997 Update**
- **Full MDS Assessment**
- **Medicare Prospective Payment Assessment Form (MPAF)**

Copies of the Quarterly assessment options available to the states are included at the end of this Chapter.

Discharge and Reentry Tracking Forms

Facilities are required to submit the information contained in two additional forms to notify the State if a resident is "discharged" or "reenters" the MDS system. Both the Discharge Tracking form and the Reentry Tracking form contain Section AA (Identification Information) Items 1-7, a subset of codes from Item 8 (Reason for Assessment), and Item 9. The Discharge Tracking form also contains items from Section R related to discharge status and date, along with two items from Section AB, that are required only for individuals whose stay is less than 14 days. The Reentry Tracking form contains items from Section A related to the date and point of reentry. States may opt to require Section S information to accompany Discharge and Reentry Tracking forms. A detailed discussion of the Discharge and Reentry Tracking process is in Chapter 2.

Medicare Assessments

Nursing facilities perform a comprehensive MDS assessment when the Medicare assessment is combined with any assessment required for clinical and/or care planning purposes, i.e., all OBRA assessments except the Quarterly. In 2002, a customized version of the MDS form was developed to minimize the facility's data collection requirements. This customized Medicare Prospective Payment System Assessment Form (MPAF) may be used when the assessment is performed solely for payment purposes (see Chapter 2 for details).

Resident Assessment Protocols (RAPs)

The **triggers** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who either have or are at risk for developing specific functional problems and require further evaluation using Resident Assessment Protocols (RAPs) designated within the

State specified RAI. MDS item responses that define triggers are specified in each RAP and on the trigger legend form. Not all items assessed on the MDS are automatic triggers, e.g., use of side rails at P4. However, the RAP may be used to evaluate those items that are not automatic triggers. Turn to the RAPs (in Appendix C) to review these items and the accompanying RAP Guidelines. Once you are familiar with the RAP triggers and guidelines, the trigger legend form serves as a useful summary of all RAP triggers. The **trigger legend** summarizes which MDS item responses trigger individual RAPs and has been designed as a helpful tool for facilities if they choose to use it. **It is a worksheet, not a required form**, and does not need to be maintained in each resident's clinical record.

The RAPs provide structured, problem-oriented frameworks for organizing MDS information, and additional clinically relevant information about an individual's health problems or functional status. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an unconventional manner for the RAP in question? Clinical staffs are responsible for answering questions such as these. The information from the MDS and RAPs forms the basis for individualized care planning. The RAPs Summary form documents the decisions made during this evaluation process whether or not to proceed to care planning.

Utilization Guidelines

The **Utilization Guidelines** are instructions concerning when and how to use the RAI. Once a RAP has been triggered, use the utilization guidelines to evaluate the problem and determine whether or not you continue to care plan for it. The Utilization Guidelines for Version 2.0 of the RAI were published by CMS in the State Operations Manual[1] Transmittal #272, and are discussed in detail in Chapter 4.

The individual resident's care plan must be evaluated and revised, if appropriate, each time a comprehensive or Quarterly assessment is completed. Facilities may either make changes to the original care plan or develop a new care plan.

Additional information relevant to a resident's status, but not necessarily included on the RAI, may be documented in the resident's active record. This documentation should include progress notes or facility specific flow sheets.

1.10 Applicability of RAI to Facility Residents

The clinical requirements for the resident assessment instrument are found at 42 CFR 483.20 and are applicable to all residents in certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, or payment category.

[1]The SOM is a reference only; it is not necessary for effective use of the RAI. The SOM can be ordered from the National Technical Information Service (NTIS); PB# 95-950007; (703) 487-4650.

An RAI must be completed for any resident residing in the facility **longer than 14 days**, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities or Medicaid (Title 19) nursing facilities. This includes a certified Skilled Nursing Facility (SNF) or Nursing Facility (NF) and certified SNFs or NFs in hospitals, regardless of payment source.

- **Hospice Residents.** When an SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between the hospice and long-term care facility staff with the consent of the resident. In these situations, the hospice team should participate in completing the RAI.

- **Short-term stay or respite residents.** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, you must follow the OBRA assessment schedule and tracking document requirements. If the respite resident is in the facility for fewer than 14 days, no assessment is due. Facilities that have short-term or respite residents should follow the instructions in Chapter 2 for completion of assessments and tracking forms.

  Given the nature of short stay or respite admissions, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge (e.g., the physician may not be available, or the family may not be able to provide information on the resident's Customary Routine). In that case, the "no-information" convention should be used ("-") (See Chapter 3 Section 3.2 for more information). For respite residents who come in and out of the facility on a relatively frequent basis and readmission can be expected, the resident may be discharged to "extended" leave status (Discharged-return anticipated). This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred in the intervening period.

  Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet the resident's needs upon or shortly after admission. In addition, if the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.

- **Special populations (e.g. pediatric or residents with a psychiatric diagnosis).** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.

- **Long-Term Care Facilities.** Additional assessments are required for Medicare beneficiaries in a SNF Part A stay. The MDS is used to determine the Resource Utilization Group (RUG-III) that is used to calculate payment under the SNF PPS. See Chapter 2 for detailed information on Medicare assessments.

- **Swing bed facilities.** Swing bed hospitals providing Part A skilled nursing facility-level services were phased into the skilled nursing facility prospective payment system (SNF PPS) starting July 1, 2002. Beginning on the first day of each hospital's cost reporting year on and after July 1, 2002, swing bed hospitals must complete a customized two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. A separate Swing Bed MDS Assessment Training Manual has been developed and can be found on the CMS website at:
  http://www.cms.hhs.gov/providers/snfpps/sbtraining.asp.

Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a state from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.

1.11 Facility Responsibilities for Completing Assessments

NEWLY CERTIFIED NURSING HOMES

Nursing homes must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed *as if the beds were already certified.* Then, assuming a survey where the SNF has been determined to be in substantial compliance, the facility will be certified effective on the last day of the survey. If the facility completed the Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.

Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 (of the covered Part A stay) when establishing the Assessment Reference Date for the 5-Day Medicare assessments. For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Assuming a survey where the SNF has been determined to be in substantial compliance, the SNF should implement the Medicare assessment schedule (for any resident in a bed that is pending certification) using the last day of the survey as Day 1.

If the SNF is already certified and is adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification. Medicare and Medicaid residents should not be placed in a bed until you are notified that the bed has been certified.

CHANGE IN OWNERSHIP

There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment schedule for existing residents continues, and the facility continues to use the existing provider number. For example, if the Admission assessment was done 10 days prior to the change in

ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.

There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases, the beds are no longer certified. Also, there are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Indicators, Quality Measures debts, etc. Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See page 1-16 for information regarding newly certified facilities.

TRANSFERS OF RESIDENTS

Any time a resident is admitted to a new facility (regardless of whether or not it is a transfer within the same chain), a new comprehensive assessment must be done within 14 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care. However, when the second facility admits the resident, the MDS schedule starts from the beginning with an Admission assessment, and if applicable, a 5-Day Medicare assessment. The admitting facility should of course look at the previous facility's assessment (in the same way they would review other incoming documentation about the resident) for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new assessment for the purpose of planning care within the facility to which the resident has been transferred. The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper--that is, the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff. States may have other requirements from a payment perspective. Therefore, facilities should contact their survey agency as well for clarification.

When there has been a transfer of residents secondary to disasters (flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Fiscal Intermediary for guidance.

When the originating facility determines that the resident will not return to the evacuating facility, the provider will discharge the resident. The receiving facility will then admit the resident and the MDS cycle will begin as of the admission date. For questions related to this type of situation, providers should contact their State agency and their Regional Office.

1.12 Completion of the RAI

PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulations[2] require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI isbest accomplished by an interdisciplinary team that includes facility staff with varied clinical

[2] 42 CFR 483.20 (h)--(F 278)

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backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

The RAI must be conducted or coordinated by an RN who signs and certifies the completion of the assessment[3]. If a facility does not have an RN on its staff (i.e., has an RN waiver granted under 42 CFR 483.30 (c) or (d) -- F354) it must still provide an RN to complete the RAI. This requirement can be met by hiring an RN specifically for this purpose. In this situation, the LPN responsible for the care of the resident should participate in the resident assessment process and the development of the resident's care plan.

The attending physician is also an important participant in the RAI process. The facility needs the physician's evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the MDS and RAPs and is a member of the mandated interdisciplinary team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to integrate the RAI into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following:

- Train facility staff on the circumstances that require a comprehensive assessment and the staff that should be involved.

- Assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, attending physicians, social workers, activities specialists, physical, occupational, or speech therapists, dietitians, and pharmacists.

- Assure that residents and their families are actively involved in the information sharing and decision-making processes.

- Assure that the care planning component is developed with input from all staff.

- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the accuracy of this information or the need to perform a significant change reassessment.

[3] 42 CFR 483.20 (i)(1)--(F 278)

- Instruct staff on how to integrate MDS information with existing facility resident assessment and care planning practices.

1.13 Sources of Information for Completion of the MDS

The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, interacting with the resident and direct care staff validates information in the resident's record.

The following sources of information must be used in completing the MDS. Although not required, the review sequence for the assessment process generally follows the order below:

- **Review of the resident's record** - Depending on whether or not the assessment is an admission or follow-up assessment, the review could include: preadmission, admission, or transfer notes; current plan of care; recent physician notes or orders; documentation of services currently provided; results of recent diagnostic or other test procedures; monthly nursing summary notes and medical consultations for the previous 60-day period; and a record of medications administered for the prior 30-day period.

- **Communication with and observation of the resident.**

- **Communication with direct-care staff (e.g., nursing assistants, activity aides) from all shifts.**

- **Communication with licensed professionals** (from all disciplines) who have recently observed, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to document their impressions of the resident.

- **Communication with the resident's physician.**

- **Communication with the resident's family** - Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, the resident may request that someone else who is very close to him/her be contacted.

REVIEW OF THE RESIDENT'S RECORD

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

At admission, record review includes an examination of notes written in the first 2 weeks (assuming the full 14-day period is used to complete the assessment), documentation that came with the resident at admission, facility intake forms (e.g., social service notes), and any preadmission test results including copies of the MDS and RAPs from another nursing facility if the resident was transferred. Obviously, transcribing the previous facility's MDS is inappropriate.

Subsequent reassessments should focus on recorded information from earlier MDS assessments and Quarterly assessments, written information from the previous 3-month period, and notes made during the prior 30-day period.

The following are important considerations when reviewing the resident's record:

- **Review the information documented in the record, keeping in mind the required MDS definitions.** Make sure that assumptions based on the record are compatible with MDS definitions (e.g., resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly, according to the MDS, a resident, who stays "dry" with a catheter may be considered continent).

- **Make sure that the information taken from the record covers the same observation period as that specified by the MDS items.** The MDS refers to specific time frames for each item; for example ADL status is based on resident performance over a 7-day period. To ensure uniformity, the MDS has an Assessment Reference Date (A3a) that establishes a common reference end-point for all items. Consequently, it is necessary to pay careful attention to the notes regarding time frames for each section of the MDS and also to the Item-by-Item instructions in Chapter 3.

- **Be aware of discrepancies and view the record information as preliminary only.** Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets), where different types of information are maintained in the clinical record, and more importantly, what information is missing.

- **Where information in the record is sufficiently detailed and conforms to MDS descriptions and time periods, complete the MDS items.** A few MDS items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e., the resident, the resident's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a suggested work tool only.

- **As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.**

COMMUNICATION WITH AND OBSERVATION OF THE RESIDENT

The resident is a primary source of information and may be the only source of information for many items (e.g., customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many MDS items will not be documented elsewhere in the clinical record, and the completed MDS may ultimately be the single source of documentation about these issues.

Become familiar with the MDS items to make communication and observation of the resident an ongoing everyday activity in the facility. For example, an RN can observe and interact with a resident when medications are given, during meals, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in confirming staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other information obtained from the resident record and facility staff.

To be most efficient, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance as to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. For further information on "Interviewing Techniques" see Appendix D.

It is important to observe, interview and physically assess the resident, and to interview staff. In addition, the MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

Any person completing any MDS section is required to follow the Item-by-Item guidelines in Chapter 3 of this manual that specify sources of information necessary for accurate coding. The process of information gathering should include direct observation of the resident; communication with the resident's direct caregivers across all shifts; review of relevant information in the resident's clinical record; and if possible, consultation with family members who have direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not personally observe for example a behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the MDS form. In addition, the resident's clinical record should support their status as reported on the MDS.

COMMUNICATION WITH DIRECT CARE STAFF

Direct care staff (e.g., nursing assistants and activity aides) having daily, intimate contact with residents is often the most reliable source of information about the resident. Direct care staff talk with and listen to the residents. They observe and assist the resident's performance of ADLs and involvement in activities. They observe the resident's physical, cognitive and psychosocial status

daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- **Be sure to speak with a person who has first-hand knowledge of the resident.** Plan for sufficient time to talk with direct care staff person(s).

- **Start by asking about the resident's performance on ADLs and activities.** What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioral symptoms.

- **Talk with direct care staff across all shifts, if possible.** The information from other shifts may be obtained in other ways as well (e.g., from change-of-shift reports if direct care staff comments are included).

COMMUNICATION WITH LICENSED PROFESSIONALS

Licensed practical nurses (LPNs), RNs, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, dietitians, and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns, and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

COMMUNICATION WITH THE RESIDENT'S PHYSICIAN

The physician's role is central to the overall management and outcome of resident care. The MDS assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders. At the Quarterly assessments and Annual assessments, review the most recent physician orders and notes. Also, review the MDS with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment from the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

COMMUNICATION WITH THE RESIDENT'S FAMILY

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas, and customary routine prior to the first nursing facility admission. This information is particularly necessary when the resident is cognitively impaired or has a great deal of difficulty communicating. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. Facilities need to respect the cognitively intact resident's right to privacy, and should have permission from the individual for staff to ask questions of family members. In most instances, family will not be the sole source of information but will supplement

information from other sources. The assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

1.14 CMS Clarification Regarding Documentation Requirements

CMS has always accepted the MDS as a primary data source, and duplicative documentation is not required. However, clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. For this reason, it is always expected that information contained in the clinical record supports rather than conflicts with the MDS. Completion of the MDS does not remove the facility's responsibility to document a more detailed assessment of particular issues of relevance for the resident. In addition, for the Medicare prospective payment system, documentation must substantiate the resident's need for Part A SNF-level services and his/her response to those services.

Nursing facilities are required to document the resident's care and response to care during the course of the stay, and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment. Always keep in mind that government requirements are not the only or even the major reason for clinical documentation. The MDS has simply codified some documentation requirements into a standard format.

Clinical documentation that contributes to identification and communication of residents' problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals. Good clinical practice has always dictated documentation of certain treatments and conditions such as the amount of IV nutrient intake and the number of minutes of therapy actually provided to a SNF resident. For these types of services, the more detailed documentation needed for good resident care also provides all the data needed to code the MDS. The MDS does not require duplication of the more detailed treatment logs; the data are simply summarized on the MDS.

In addition, it is important to note that CMS does not impose specific documentation procedures to nursing facilities. Some facilities have developed tools to collect data across shifts or throughout an assessment period; e.g., ADL support needs, type and duration of restorative nursing services, etc. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility. These tools may provide more accurate data for MDS reporting and care planning, and may provide real value to the facilities utilizing them. However, these tools are not mandated by CMS or by Fiscal Intermediaries.

When available, State agency and Fiscal Intermediary staff will utilize these data collection tools as part of an MDS validation review. In the absence of this type of documentation, the MDS can still be verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the MDS.

Some states may have regulations that require supporting documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system. If your state requires the MDS to be completed for the Medicaid program, they may have additional documentation requirements. Contact your State agency's Resident Assessment Coordinator or your Medicaid program for State-specific requirements.

1.15 RAI Completion Time Frames

ASSESSMENT COMPLETION TIME FRAMES

Each individual team member who completes a portion of the MDS assessment must sign and certify its accuracy.[4] Each interdisciplinary team member who completes a portion of the MDS assessment signs, dates, and indicates the portion of the assessment he or she completed in AA9. This signature and date should reflect the date of the assessment and may be earlier than the date in R2b. The RN coordinator is required to sign R2b to certify that the MDS is complete.[5] The RN coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the MDS. If the RN does all of the MDS, then the nurse alone would sign and be responsible for certifying accuracy and completeness. An assessment that was signed and dated by all assessors, but not by the RN coordinator, because the RN coordinator is no longer at the facility, should be signed and dated (with the date it is actually signed) by the current RN assessment coordinator.

RAPs COMPLETION TIME FRAMES

An RN coordinator must also sign and date the RAP Summary form at VB1 and VB2, the RAPs Completion Date, to signify completion of the RAI assessment. For the admission assessment, the RN coordinator must sign and date the RAP Summary form at VB1 and VB2 within 14 days of the resident's admission to the facility. There is no Federal requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the clinical record. However, if desired, individual team members may indicate which RAP(s) they completed, list their credentials, and the date it was completed by signing the form wherever there is room to do so in a legible manner. The RN completing the RAP Summary form does not have to be the same RN who completed and signed the MDS assessment.

It is never permissible to certify or backdate RAI forms for another individual on the interdisciplinary team. If an individual who completed a portion of the MDS is not available to sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the RAI when these situations occur.

[4] 42 CFR 483.20 (i)(2)--(F 278)

[5] 42 CFR 483.20 (i)(1)--(F 278)

CARE PLANNING COMPLETION TIME FRAMES

The facility has 7 days after completing the RAI (RAPs Completion Date (VB2)). The staff member entering the care planning decision information must also sign and date the RAP Summary form at VB3 and VB4, the Care Plan Completion Date.

1.16 Attestation Statement of Accuracy

The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS information is the basis for:

- The development of an individualized care plan for the resident occurs directly from responses entered on the MDS,
- Medicare Prospective Payment System,
- State Medicaid reimbursement programs,
- Quality monitoring activities such as the Quality Indicator (QI) Reports, the data driven survey and certification process, and the quality measures used for public reporting,
- Research, and
- Policy development.

Primary responsibility for accuracy lies with the person selecting the MDS item response. Each person completing a section of the MDS is required to sign the Attestation Statement (AA9, AD, and AT7) that reads:

> "I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from Federal funds. I further understand that payment of such Federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

In addition, the RN coordinating the assessment must sign and date the MDS. The signature of the RN attests to the completeness of the document. Each staff member who completes any portion of the MDS must sign and date the MDS and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN assessment coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN assessment coordinator is not certifying the accuracy of assessments that were completed by other health professionals.

1.17 Correcting The MDS

Once completed, edited, and accepted into the MDS data repository, facilities may not "change" a previously completed MDS form as the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. However, it is important to remember that the electronic record submitted to and accepted into the MDS database is the legal assessment. Changes made to the electronic record after data transmission or to the paper copy maintained in the medical record are not recognized as proper corrections. The MDS correction process is described in Chapter 5.

However, several additional processes have been put into place to assure that the MDS data is accurate both at the facility and in the State MDS database:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.

- Software used in the facility to encode the MDS must run all standard edits as defined in the data specifications released by CMS.

- Enhanced record rejection standards have been implemented in the State MDS database. If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent, e.g., a skip pattern is not observed, the record is rejected. Inaccurate data is not added to the State MDS database.

- If an error is discovered in a record in the State MDS database, Modification or Inactivation procedures must be implemented by the facility to assure that the database information is corrected.

- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed. A Significant Change in Status assessment or a Significant Correction of a Prior assessment may be needed as well as corrections to the information in the State MDS database.

1.18 Reproduction and Maintenance of the Assessments

Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs.

While use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically, the guidance language for Clinical Records found in Appendix PP [42 CFR 483.75(1)(1)] notes that facilities have the option for an individual's record to be maintained by computer rather than hard copy. In addition, proper security measures must be implemented via facility policy to ensure the privacy and integrity of the record and to ensure that access to clinical records is made available to surveyors and others who are authorized by law.

Long-term care facilities that are not capable of maintaining MDSs electronically must adhere to the current requirements that either a hand written copy or a computer-generated form must be maintained in the clinical record. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard. In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

Unless the provider has exercised the option to maintain electronic MDSs, facilities are required to maintain hard copies of 15 months of assessment data in the resident's active clinical record according to CMS policy. There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The **exception** is that face sheet information (Section AB,AC, andAD) must be maintained in the active record until the resident is permanently discharged. The information must be kept in a centralized location, assessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.

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The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, unless maintaining the MDSs electronically, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, including linking the prior electronic MDS to the new admission record, but the15-month requirement for maintenance of the RAI data does not restart with each new admission. In Cases where the resident returns to the facility after a long break in care (e.g., 14 ½ months), staff may want to review the older record to familiarize them with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirement.

For additional information, refer to Resident Assessment Requirements for Long-Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.