Welcome to MDS 3.0 Training 2026 Session #1

JANET BROOKS, RN

RAI EDUCATION COORDINATOR

NORTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH SERVICE REGULATION

Disclaimer:

This presentation is not a substitute for reading and reviewing the

Long-Term Care Resident Assessment Instrument 3.0 User's Manual

Version 1.20.1, October 2025

or

State Operations Manual Appendix PP

Revised 7/23/25

Objectives:

- Review the importance of accuracy
- Review the different RAI sections
- Technical Information
- Review Interviews and help in Appendix D
- Review Use of Dashes in the MDS
- Review Section A completion and assessment timing
- Associated Regulations

Problem Identification Using the RAI, section 1.4

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, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes.

The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

Problem Identification Using the RAI continued

The completion of the RAI can be conceptualized using the nursing process as follows:

Assessment—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian).

Decision Making—Determining with the resident, family and/or guardian, the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs.

*Decision making includes review of the assessment information, in-depth understanding of diagnoses and co-morbidities, careful consideration of triggered areas in the CAA process and finding out who the resident is and consideration of their needs, interests, and lifestyle choices.

Identification of Outcomes—Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals.

Care Planning—Establishing a course of action with input from the resident, family and/or guardian, resident's physician and interdisciplinary team; crafting the "how" of resident care.

Implementation—Putting that course of action (specific interventions) into motion; carrying out the "how" and "when" of resident care.

Evaluation—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes and assessing the need to modify the care plan.

The Importance of Accuracy

The importance of accurately completing and submitting the MDS cannot be over- emphasized. The MDS is the basis for:

- The development of an individualized care plan
- The Medicare Prospective Payment System
- Medicaid reimbursement programs
- Quality monitoring activities, such as the quality measure reports
- The data-driven survey and certification process
- The quality measures used for public reporting
- Research and policy development
- F641 Accuracy of Assessments

Layout of the RAI Manual

The layout of the RAI manual:

Chapter 1: Resident Assessment Instrument (RAI)

Chapter 2: Assessments for the Resident Assessment Instrument (RAI)

Chapter 3: Coding Conventions, Overview to the Item-by-Item Guide to the MDS 3.0

Chapter 4: Care Area Assessment (CAA) Process and Care Planning

Chapter 5: Submission and Correction of the MDS Assessments

Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

Layout of the RAI Manual Appendices

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 (When Administered In Writing)

Appendix F: MDS Item Matrix

Appendix G: References

Appendix H: MDS 3.0 Item Sets

MDS RAI Manual Version 1.20.1 effective October 2025

MDS RAI Manual version 1.20.1, Matrix and Item Sets version 1.20.4 available: https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

Final Rule: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/administrative-information-memos-states-and-regions/fiscal-year-fy-2025-mission-priorities-document-mpd-action

Check the MDS 3.0 Web site regularly for updates at: https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

Find the MDS 3.0 Item Details

SNF QRP Information webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

MDS 3.0 Technical Information, Data Submission Specifications: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

APPENDIX D: INTERVIEWING TO INCREASE RESIDENT VOICE IN MDS ASSESSMENTS

All residents capable of any communication should be asked what they consider most important to them and their care.

Self-report is the single most reliable indicator of these topics. Staff should actively seek information from the resident.

In addition, a simple performance-based assessment of cognitive function can quickly clarify a resident’s cognitive status.

- Most residents, even those with moderate to severe cognitive impairment, can answer some simple questions about these topics.

Helpful Interview Tips

- Explain the purpose of the questions to the resident.

You can tell the resident that these questions are designed to be asked of everyone to make sure that nothing is missed.

End by explaining that *their* answers will help the care team develop a care plan that is appropriate for the resident.

- Say and show the item responses. It is helpful to many older adults to both hear and read the response options.

Residents may respond to questions verbally, by pointing to their answers on the visual aid or by writing out their answers.

Interviews (continued)

Use the resident's preferred language or method of communication.

All residents capable of any communication should be asked about what is important in their care.

DO NOT complete the staff interview if the resident interview should have been attempted and was not.

Interviews continued

Basic approaches to make the interviews effective:

- Introduce yourself and find a quiet, private area
- Be sure the resident can hear you.
  - If they use an assistive device, make sure it’s working.
- Is an interpreter needed?
- Sit where the resident can see you clearly.
  - If they wear glasses, make sure they’re clean.
- Break the question apart if necessary
- Clarify

Ending the Interview

If the resident becomes agitated or overly emotional and does not want to continue, respond to *their* needs.

- This is more important than finishing the interview at that moment.

When a resident is unable to communicate information about *their* preferences, a family member, close friend, or other representative must be used to complete preference questions.

- In this case, it is important to emphasize that this person should try to answer based on <u>what the resident would prefer</u>.

Interviews

Interview status should not be based on B0700, Makes Self Understood, rather, B0700 should be evaluated after all interviews have been attempted and coded.

B0700 cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews as the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make self understood during the entire 7-day look-back.

While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

Interview Items

A1005 Ethnicity

A1010 Race

A1110 Language

A1255 Transportation

Section B- Items for Hearing, Speech Clarity, Makes Self Understood, Vision

B1300 Health Literacy

C0200 Brief Interview for Mental Status

D0150 Resident Mood Interview

Section F Interview for Preferences for Customary Routine and Activities

More Interview Items

GG0100-GG0110 Prior Functional Abilities

J0300-J0600 Pain Assessment Interview

J1100 Shortness of Breath

J1300 Current Tobacco Use

J1700 Fall History

K0300-K0400 Weight Loss or Gain

O0250-O0350 Influenza, Pneumococcal, and COVID Vaccines

Section Q- Participation in Assessment and Goal Setting

Use of Dashes

Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS iQIES system.

A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.

Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.

There is one date item (A2400C) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.

QMs cannot be calculated, for example, when the use of a dash (-) indicates the SNF was unable to perform a pressure ulcer assessment. Left blank, it also means no assessment was done for that item.

Coding Conventions RAI Page 3-4

Section A: Identification Information continued

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which they reside, and the reasons for assessment.

Section A: Identification Information

Remember:

The CMS Database matching process includes:

First Name

Last Name

Social Security Number

Sex

Date of Birth

Please communicate regarding any changes regarding the resident's demographic information

A0310: OBRA Required Assessments

Certified beds (Title 18 and/or Title 19): OBRA schedule is required and transmitted regardless of the payer source.

Licensed only beds are *not* transmitted.

If you accidently transmit a record for a licensed only bed, you need to call me.

- A manual Correction/Deletion Request Form will need to be completed.

This form will be phased out in the near future in lieu of the e-form.

- An e-form is also available in iQIES and requires the same information.

OBRA Required Assessments

Coding Instructions for A0310A, Federal OBRA Reason for Assessment

Document the reason for completing the assessment. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.

Enter the number corresponding to the OBRA reason for assessment.

- 01. Admission assessment (required by day 14)
- 02. Quarterly review assessment
- 03. Annual assessment
- 04. Significant change in status assessment
- 05. Significant correction to prior comprehensive assessment
- 06. Significant correction to prior quarterly assessment
- 99. None of the above

Significant Change in Status Assessment

A SCSA is appropriate when:

***** It is determined there has been a significant change (improvement or decline) in a resident’s condition from his/her baseline has occurred

and

***** The resident’s condition is not expected to return to baseline within two weeks.

Hospice Services

Electing Hospice or palliative care from an outside agency requires a SCSA to coordinate care and care plans.

In-house palliative care services are not indicated on the MDS, a SCSA is not required but the resident should be evaluated for a SCSA, and the care plans need to be updated to reflect palliative care.

CMS does not differentiate between levels of Hospice services, only that they are received.

O0110K indicates Hospice services for terminally ill persons. If a resident is receiving outside palliative services through a Hospice provider and is terminally ill, it should be counted here.

J1400 should be marked when a resident has a life expectancy of 6 months or less and/or is receiving Hospice services marked at O0110K.

Residents with non-terminal conditions receiving palliation services from a Hospice provider should not be marked.

A0310B PPS Assessments

A0310B: PPS Scheduled Assessments include:

- 01. 5-day scheduled assessment

PPS Unscheduled Assessment include:

- 08. IPA- Interim payment Assessment

A0310H: PPS Part A Discharge

Interim Payment Assessment (IPA)

Optional

Sets payment for remainder of the stay beginning on the ARD

Too many IPAs may appear to CMS as you trying to manipulate the system

Should have a plan to help determine when an IPA should be completed

IPA

Look back period is 7 days unless otherwise indicated.

- D0150 with a 14 day look back
- GG0130 and GG0170 with 3 day look back
- K0300 with 6 month look back
- O0110 with a 14 day look back

Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.

IPA (continued)

The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior).

It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.

The IPA does not affect the variable per diem schedule.

Entry/Discharge Reporting Required for all Residents A0310F/A0310G/A0310G1/A0310H

A0310F

- 01. Entry tracking record
- 10. Discharge assessment- return not anticipated
- 11. Discharge assessment- return anticipated
- 12. Death in facility tracking
- 99. None of the above

A0310G Type of Discharge

- 1. Planned, 2. Unplanned

A0310G1 Is this a SNF Part A Interrupted Stay?

- 0. No, 1. Yes

A0310H Is this a SNF Part A PPS Discharge Assessment?

- 0. No, 1. Yes

A0310H SNF PPS Part A Discharge (End of Stay) Assessment

A Part A PPS Discharge assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility

If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are **both required** and must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000)

Needs to be completed even if in the facility for a short period of time

A0310F: Entry/Discharge Reporting

Entry Record

Completed within 7 days every time a person is **admitted or readmitted** into a nursing home (or swing bed facility)

Submitted no later than the 14th calendar day after the entry (entry + 14 calendar days)

Submit before the next assessment

Required in addition to the initial Admission assessment or other OBRA or PPS assessments

Cannot be combined with an assessment

Needs to be completed even if in the facility for a short period of time

Discharge Assessment and Record

Not associated with the bed hold status or opening and closing of the medical record

Section A (continued) Interrupted Stay

A0310G1: Is this a SNF Part A Interrupted Stay? Yes or No

DEFINITIONS:

- Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.
- Interruption Window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services or return to the same SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

A0410 Unit Certification or Licensure Designation

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified

Should always be '3' unless it should not be transmitted then '1' would be coded

Required Assessment Summary

RAI pages 2-17 through 2-20

PPS Assessments

Section A (continued)

A0500: Legal Name of Resident: First and Last Names: needs to be what Medicare has on file, match the Medicare/Medicaid card, the common working file.

A0500 D: Suffix: *Please use!*

A0600A Social Security Number

A0700 Medicaid Number

A0800 Sex: What it says on the Medicare card.

A0900 Date of Birth

Used in the CMS Database Matching Process!

A2400 Medicare Stay: This is for traditional Medicare ONLY

A1005 Ethnicity Coding Instructions

If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.

- Code X, Resident unable to respond:

In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, *including* X. Resident unable to respond.

If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.

Code Y, Resident declines to respond:

When the resident declines to respond, code only Y. Resident declines to respond.

When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

RAI page A-16

A1010 Race

Race and Ethnicity will become Standardized Patient Assessment Data Elements (SPADEs) for SNF QRP starting 10/1/23.

To aid in completing a culturally competent and trauma-informed comprehensive care plan.

A1010 Race Coding Instructions

If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.

- **Code X**, Resident unable to respond:

In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, *including* X. Resident unable to respond.

If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1010 as X. Resident unable to respond.

Code Y, Resident declines to respond:

When the resident declines to respond, code only Y. Resident declines to respond.

When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Code Z, None of the above: if the resident reports or it is determined from other resources that none of the listed races apply.

A1110 Language

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.

2. If the resident is unable to respond, a family member or significant other should be asked.

3. If neither source is available, review record for evidence of a need for an interpreter.

4. If an interpreter is wanted or needed, ask for preferred language.

5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

A1255 Transportation

Only completed for PPS 5-day and A2300 (ARD) minus A1900 (admission date) is less than 366 days

*Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.

A1255 Transportation- Steps for Assessment

Ask the resident, "In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?"

Ask the resident to select the response that most closely corresponds to the resident's transportation status from the list in A1255.

If the resident declines to respond, code 7, Resident declines to respond, and do not code based on other resources (family, significant other, or legally authorized representative or medical records).

If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.

Only use medical record documentation to code A1255, Transportation if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.

A1500 –Preadmission Screening and Resident Review (PASRR)

PASRR is a preadmission screening process.

A positive screen indicates the resident has a mental illness, intellectual disability, or a related condition.

A1500 documents whether a PASRR Level II determination has been issued.

Reports on the results of the PASRR process.

Only completed on the OBRA comprehensive MDS assessments.

A1500: PASRR

Acentra Health (833) 522-5429, (919) 568-1717

Not everyone with MI has a Level II PASRR determination.

Everyone with ID/DD should have a Level II PASRR determination.

All known Level II PASRR residents need to have a referral completed for any significant change in status identified. Do not wait until the SCSA assessment has been completed to make this referral.

Level I residents who experience a psychiatric episode, have a new psychiatric diagnosis or have been placed on antipsychotic medications should have a Level II PASRR referral made (RAI page 2-30 through 2-31).

Halted PASRR

Old:

Halted – Level II Authorization No end date, no restrictions.

(*indicates Dementia primary or Does Not Meet Level II Target Population Criteria)*

New:

Halted – Level II authorizations halted due to dementia primary, terminal prognosis, or does not meet Level II Target Population. Criteria after further assessment. No restrictions, no end date unless a change in condition. 1/19/24

https://medicaid.ncdhhs.gov/documents/providers/programs-services/pasrr/pasrr-authorizations-quick-reference/download

Level II PASRR for Referral

§483.20(e)(2) Refer all level II residents and all residents with newly evident or possible serious mental disorder (MI), intellectual disability (ID), or a related condition for level II resident review upon a significant change in status assessment

F644, F645, F646

A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121 Completed only on SNF Part A PPS DC and A2105= 02-12

A2122 Completed only if A2121= Yes

A2123 Completed only on SNF Part A PPS DC

SNF QRP will begin collecting data on Transfer of Health (TOH) Information to the provider and to the resident. Documentation supports the MDS.

*Need a process for documentation and communication of the reconciled medication list.

How does this get coded if staying in the facility?

Reconciled Medication List

In the case of a standalone Medicare Part A PPS Discharge assessment with the resident staying on the same unit and with the same team of interdisciplinary professionals, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge as 1, Yes.

In the case of a standalone Medicare Part A PPS Discharge assessment and the resident is moving to a different unit and/or IDT, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge based on whether a member of the resident's IDT transferred the resident's current reconciled medication list to the subsequent unit and/or IDT.

RAI pages A-45 and A-46

A2124 Route of Current Reconciled Medication List Transmission to Resident Only completed if A2123=1 (Yes)

A2123 At the time of DC, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

1.= Yes- Current reconciled medication list provided to the resident, family and/or caregiver.

Completed only on SNF Part A PPS DC

Assessment Reference Date

Assessment Reference Date (ARD) refers to the *specific endpoint for* the observation (or "look-back") period*s in the MDS assessment process.*

The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed.

Most of the MDS 3.0 items have a 7-day look-back period. If a resident has an ARD of July 1, 2011, then all pertinent information starting at 12:00 a.m. on June 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding. RAI page 2-9

Code of Federal Regulations (CFR)

State Operations Manual Appendix PP revised 7/23/25 :

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Resident Assessment

- Regulations F635-F646

Comprehensive Resident Centered Care Plans

- Regulations F655-F659

CFR 483.20 Resident Assessments

F636 Comprehensive Assessments & Timing

F637 Comprehensive Assessment After Significant Change (examples updated)

F638 Quarterly Assessment At Least Every 3 Months

F640 Encoding/Transmitting Resident Assessment

F641 Accuracy of Assessments (F642 language incorporated)

~~F642 Coordination/Certification of Assessment~~

F644 Coordination of PASARR and Assessments

F645 PASARR Screening for MD & ID

F646 MD/ID Significant Change Notification

CFR 483.21 Comprehensive Resident Centered Care Plans

F655 Baseline Care Plan

F656 Develop/Implement Comprehensive Care Plan

F657 Care Plan Timing and Revision

F658 Services Provided Meet Professional Standards (guidance, probes and deficiency categorization updated to include new schizophrenia and psychiatric diagnoses)

F659 Qualified Persons

Regulation F636
Comprehensive Assessments & Timing

Resident Assessment: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

Comprehensive Assessments: Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's <u>needs, strengths, goals, life history and preferences</u>, using the resident assessment instrument (RAI) specified by CMS.

Comprehensive Assessments & Timing

The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychological well-being.

Comprehensive Assessments & Timing (cont.)

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnosis and health conditions.

(xi) Dental and nutritional status.

(xii) Skin Conditions.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

Regulation F636
Comprehensive Assessments & Timing (cont.)

(xvi) Discharge planning.

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

(xviii) 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.

Intent F636

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

F636 Guidance

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

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

F636 Guidance (continued)

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

The facility must use the RAI process to develop a comprehensive care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.

F637 Comprehensive Assessment After Significant Change

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

A “significant change” means a major decline or improvement in the resident’s status that:

- will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions
- that has an impact on more than one area of the resident’s health status
- requires interdisciplinary review or revision of the care plan, or both.

F637 SCSA

A Significant Change in Status MDS is required when:

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

F638 Quarterly Assessment at Least Every 3 Months

A facility must assess a resident using the quarterly review instrument (RAI Manual) specified by the State and approved by CMS not less frequently than once every 3 months.

"Quarterly Review Assessment" is an OBRA required, non-comprehensive assessment that must be completed at least every 92 days following the previous OBRA assessment of any type.

It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all Minimum Data Set (MDS) items appear on the Quarterly assessment.

F640
Encoding/Transmitting Resident Assessment

INTENT

To ensure that facilities have provided resident specific information for payment and quality measure purposes.

To enable a facility to better monitor each resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data.

F640 Definitions, in part

"Accurate" means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at F641, and the information accurately reflects the resident's status as of the Assessment Reference Date (ARD).

"Capable of transmitting" means that the facility has encoded and edited according to CMS specifications, the record accurately reflects the resident's overall clinical status as of the assessment reference date, and the record is ready for transmission.

"Complete" means that all items required according to the record type, and in accordance with CMS' record specifications and State required edits are in effect at the time the record is completed.

"Discharge subset of items" refers to the MDS Discharge assessment.

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

"Transmitted" means electronically transmitting to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, an MDS record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record.

F640 Guidance

Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility. The CMS System for MDS data is named the iQIES System.

For the subset of items required upon a resident's entry, transfer, discharge and death refer to Chapter 2 of the Long-Term Care Resident Assessment Instrument User's Manual for further information about these records.

- For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).

Submission must be according to State and Federal time frames. Electronically submit MDS information to the iQIES system within 14 days:

Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).

Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Regulation F641
Accuracy of Assessments

Accuracy of Assessments. The assessment must accurately reflect the resident's status.

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

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

Penalty for Falsification. Clinical disagreement does not constitute a material and false statement.

F641 Intent

INTENT: To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

F641 Guidance

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.

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

F641 Guidance (in part)

Inaccurate MDS Diagnosis Coding *CMS is aware of situations where residents are given a diagnosis of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia.*

For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment.

This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.

Inaccurate MDS Diagnosis Coding

If the facility is unable to provide documentation which supports the MDS coding of the new diagnosis in question, then noncompliance exists.

Supporting documentation should include, but is not limited to, evaluation(s) of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation

Certification of Accuracy and Completion *Whether Minimum Data Set (MDS) assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status.*

All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

F644 Coordination of PASRR and Assessments

A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid…

Coordination includes:

Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

F644 Related Conditions

Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions:

It is attributable to— Cerebral palsy or epilepsy; or any other condition, other than a mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

It is manifested before the person reaches age 22.

It is likely to continue indefinitely.

It results in substantial functional limitations in three or more of the following areas of major life activity:

Self-care, Understanding and use of language, Learning, Mobility, Self-direction, Capacity for independent living.

F645 PASRR Screening for MD & ID

Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. A nursing facility must not admit, on or after January 1, 1989, any new residents with:

Mental disorder as defined in this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

- That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
- If the individual requires such level of services, whether the individual requires specialized services; or

Intellectual disability, as defined in this section, unless the State intellectual disability or developmental disability authority has determined prior to admission—

- That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
- If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

F645 Intent

To ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs.

F646 MD/ID Significant Change Notification

A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.

INTENT

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