Welcome to MDS 3.0 Training 2024 Session #6

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Disclaimer:

This presentation is not a substitute for reading and reviewing the

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

Version 1.18.11, October 2023

Item Sets Version 1.18.11 v6 October 2023

or

State Operations Manual Appendix PP

Revised 2/3/23

Objectives Participants will:

- Review the Care Area Assessment Summary
- Understand the Importance of Good Care Planning
- Review Related Federal Regulations

Section V:
Care Area Assessments (CAA)

- Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences.
- Care Areas are triggered by MDS item responses which form a critical link between the MDS and decisions about care planning.
- Documentation supports your decision.

Section V | Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date — Month / Day / Year

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date — Month / Day / Year

CAAs

- A risk factor increases the chances of having a negative outcome or complication. Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.
- Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with complex or mixed causes of impaired behavior, cognition and mood.
- Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and possible approaches to improve function or minimize decline.

The CAA Process Should…

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function
- Identify areas that may warrant interventions
- Help develop interventions to improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, choices, and preferences for interventions

CAAs

For each triggered CAA describe:

1. Identified nature of the condition and why it's a problem
2. Complications caused by the care area for this person
3. Risk factors related to the condition that affect the decision to care plan/or not to care plan
4. Factors to consider in developing *individualized* care plan interventions, including decision to care plan or not to care plan
5. The need for additional evaluation by the physician and other health professionals, as appropriate;
6. The resource(s), or assessment tool(s) used for decision-making

See Appendix C for CAA triggers, Chapter 4 CAA Process and Care Planning

Care Area Triggered

Step 1: For any care area triggered (CAT), assess the resident using the care area-specific resources.

Step 2: Check the box in the left column if the item is present for this resident. ***Some of this information will be on the MDS - some will not.***

Step 3: In the right column, Care Planning Decision, you can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor for item checked, etc.

CAAs

- Step 4: Get input from resident and/or family regarding the care area.
- Step 5: Analyze the findings for this care area in the context of this resident as an individual. Draw conclusions about the causal/contributing factors and effect(s) on the resident and document these conclusions in the Analysis of Findings section.

CAAs

Step 6: Decide whether referral to other disciplines is warranted and document this decision.

Step 7: Document the Care Planning Decision

Step 8: Use the “Location and Date of CAA Documentation” (at V0200 A) to note where the CAA summary can be found

Summary: Decision Making / Documentation

- Formulate clear picture of the resident
- Create a resident-centered care plan
  - Based on conclusions from clinical problem solving and decision-making process AND
  - Resident preferences, personal goals
- Document basis for conclusions
  - Not just conclusions

A Smooth Transition to the Care Plan

A good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan.

The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.

RAI Chapter 4

Care Planning

- No required format or structure
- Must have measurable goals and timetables
  - Goals should have a subject, verb, modifier, time frame and goal
- Approaches should identify what staff are to do and when to do it and when it will be evaluated by the nurse for possible changes

Subject	*Verb*	*Modifiers*	*Time frame*	*Goal*
Mr. Jones **OR** I	will walk	fifty feet daily with the help of one nursing assistant	the next 30 days	in order to maintain continence and eat in the dining area

The Overall CP Should Be Oriented Toward:

1. Preventing avoidable declines in functioning or clarifying why another goal takes precedence (e.g. palliative care for end of life).
2. Managing risk factors or indicating the limits of such interventions.
3. Ways to try to preserve and build upon resident strengths.
4. Applying current standards of practice in care planning.
5. Evaluating measurable objectives, timetables and outcomes.
6. Respecting the resident's right to decline treatment.
7. Offering alternative treatments, as applicable.

(cont.) CP Should Be Oriented Toward:

8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities.

9. Involving resident, resident's family and other resident representatives as appropriate.

10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs.

11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes.

12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.

Code of Federal Regulations (CFR)

- State Operations Manual Appendix PP revised 2/3/23: https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

- Comprehensive Resident Centered Care Plans
  - Regulations F655-F661

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
- F659 Qualified Persons
- F660 Discharge Planning Process
- F661 Discharge Summary

Regulation F655 Baseline Care Plans

- The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
- The baseline care plan must be developed within 48 hours of admission and include the minimum information necessary to properly care for a resident including, but not limited to:
  - (A) Initial goals based on admission orders. (B) Physician orders.
  - (C) Dietary orders. (D) Therapy services.
  - (E) Social services. (F) PASARR recommendation, if applicable.

F655 Intent

- Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to
- promote continuity of care
- communication among nursing home staff
- increase resident safety
- safeguard against adverse events that are most likely to occur right after admission
- and to ensure the resident and representative, are informed

Regulation F656 Develop/Implement Comprehensive Care Plan

- *Comprehensive Care Plans: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.*
- *The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.*
- *Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment.*

Regulation F656 (continued)

- *Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations.*
- *In consultation with the resident and the resident's representative(s)— (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate.*

F656 Intent

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

F656 Guidance

- GUIDANCE: Through the care planning process, facility staff must work with the resident and his/her representative, to understand and meet the resident's preferences, choices and goals.
- The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life.
- Care planning drives the type of care and services that a resident receives. If care planning is not complete, or is inadequate, the consequences may negatively impact the resident's quality of life, as well as the quality of care and services received.

Regulation F657 Care Plan Timing and Revision

- *A comprehensive care plan must be—*
- *Developed within 7 days after completion of the comprehensive assessment/CAA.*
- *Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.*
- *Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.*

F657 Intent

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

F657 Guidance

- GUIDANCE: Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment and review and revise the care plan after each assessment. “After each assessment” means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS), except discharge assessments.
- For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.

F658 Services Provided Meet Professional Standards

- **The services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality.**
- **GUIDANCE**
- "Professional standards of quality" means that care and services are provided
  - According to accepted standards of clinical practice.
  - Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting.
  - Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency.

- ***NOTE:*** *CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure.*
- *For these situations, determine if non-compliance exists related to the practitioner not adhering to professional standards of quality for assessing and diagnosing a resident.*
- *This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.*

F659 Qualified Persons

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must be provided by qualified persons in accordance with each resident's written plan of care.

GUIDANCE

The facility must ensure that services provided or arranged *in accordance with the resident's plan of care* are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required.

INVESTIGATIVE PROCEDURES AND PROBES

• Do staff assigned to the resident have the skills, experience and knowledge to provide care and services that meet the resident's needs?

DEFICIENCY CATEGORIZATION

An example of Level 4, immediate jeopardy to resident health or safety includes, but is not limited to:

• The facility had no qualified staff on duty knowledgeable or competent in how to care for a resident with a tracheostomy, posing a risk for serious injury, harm, impairment or death for the resident.

F660 Discharge Planning Process

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

Discharge Planning Collaboration

- Nursing home staff are expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.
- Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based, long-term care supports and services.
- Nursing home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services.

Contact Information

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Thank you!

- Thank you for all the work you do to ensure the care, comfort and safety of our most vulnerable in society. This is not an easy job you do, and it must come from the heart. Weariness and frustration can easily become your best friends, but don’t let them take over! Know that you are not alone in your work. Reach out, make friends and contacts who will encourage your soul.
  Please know that you are welcome to call or email me anytime.

Sincerely, Janet