

## **F636**

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### **§483.20 Resident Assessment**

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

#### **§483.20(b) Comprehensive Assessments**

**§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:**

- (i) Identification and demographic information**
- (ii) Customary routine.**
- (iii) Cognitive patterns.**
- (iv) Communication.**
- (v) Vision.**
- (vi) Mood and behavior patterns.**
- (vii) Psychological well-being.**
- (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.**
- (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 nonlicensed direct care staff members on all shifts.**

**§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.**

- (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)**

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**(iii) Not less than once every 12 months.**

### **INTENT §483.20(b)(1)-(2)(i) & (iii)**

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.

### **DEFINITIONS §483.20(b)(1)-(2)(i) & (iii)**

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

**“Care Area Assessment (CAA) Process”** is a process outlined in Chapter 4 of the MDS manual designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. This process has three components:

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

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

**“Resident Assessment Instrument (RAI)”** consists of three basic components: the Minimum Data Set (MDS) version 3.0, the Care Area Assessment (CAA) process and the RAI utilization guidelines. The utilization of these components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.

**“Utilization Guidelines”** provide instructions for when and how to use the RAI. The Utilization Guidelines are also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual.

#### **GUIDANCE §483.20(b)(1)-(2(i) & (iii)**

Each facility must use the RAI specified by CMS (which includes the MDS, utilization guidelines and the CAAs) to assess each resident. 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 information required in §483.20(b)(1)(i-xviii) is incorporated into the MDS, which forms the core of the RAI process. Additional assessment information is also gathered using triggered Care Area Assessments (CAAs) after the completion of the comprehensive MDS.

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

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

For additional requirements regarding a Significant Change in Status Assessment, see §483.20(b)(2)(ii).

If a comprehensive assessment was completed, any time prior to a temporary absence for hospitalization or a leave of absence, and upon return to the facility, the resident does not meet the criteria for a Significant Change in Status Assessment (SCSA), as defined in §483.20(b)(2)(ii), a comprehensive assessment is not required. For example, a resident had a comprehensive assessment completed within 14 days of admission, four months later was hospitalized, then returned to the facility. Upon return to the facility, the resident’s status does not meet the criteria for a SCSA, therefore a comprehensive assessment is not required.

For additional information on assessment scheduling and completion requirements, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual. Link to the LTCF RAI User’s Manual: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html>.