

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.

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

- Did the facility complete a comprehensive assessment, using the CMS-specified RAI process, within the regulatory timeframes (i.e. within 14 days after admission and at least annually) for each resident in the sample?
- Is there evidence in the clinical record that the facility gathered and analyzed supplemental information based on the triggered CAAs prior to developing the comprehensive care plan? For reference a list of CAAs is found in Section V of the MDS (Care Area Assessment Summary).
- Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews, providing information about preferences or discharge goals.
- Ask licensed and non-licensed direct-care staff if they participate in the resident assessment process.
- Does the facility have a system in place to assure assessments are conducted in accordance with the specified timeframes for each resident?

### **F637**

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**§483.20(b)(2)(ii) 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. (For purpose of this section, 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, and requires interdisciplinary review or revision of the care plan, or both.)**

### **INTENT**

To ensure that each resident who experiences a significant change in status is comprehensively assessed using the CMS-specified Resident Assessment Instrument (RAI) process.

### **DEFINITIONS**

**"Significant Change"** *refers to* a major decline or improvement in a resident's status that 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered "self-limiting" (**NOTE:** Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.); 2) impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan. This does not change the facility's requirement to immediately consult with a

resident's physician of changes as required under 42 CFR §483.10(i)(14), F580.

**“Significant Change in Status Assessment (SCSA)”** *refers to* a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline.

**“Assessment Reference Date (ARD)”** *refers to* the specific end point for the look-back periods in the Minimum Data Set (MDS) assessment process. This look-back period is also called the observation or assessment period.

## GUIDANCE

A SCSA including Care Area Assessments (CAAs) must be completed within 14 days after a determination has been made that a significant change in the resident's status from baseline occurred. This may be determined by comparison of the resident's current status to the most recent comprehensive assessment and most recent Quarterly assessment, and the resident's condition is not expected to return to baseline within 2 weeks. A SCSA is appropriate if there are either two or more MDS areas of decline or two or more MDS areas of improvement or if the IDT determines that the resident would benefit from the SCSA assessment and subsequent care plan revision. The facility should document in the medical record when the determination is made that the resident meets the criteria for a Significant Change in Status Assessment.

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).

Examples of Decline include, but are not limited to:

- Resident's decision-making ability has changed;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency, e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E Behavior;
- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since last assessment;

- Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as *partial/moderate assist, substantial/maximal assistance, dependent, resident refused, or not attempted* since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days).
- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type, when it was not used before;
- Emergence of a condition/disease in which a resident is judged to be unstable.

Examples of Improvement include, but are not limited to:

- Any improvement in ADL physical functioning area (at least 1) where a resident is newly coded as *Independent, Setup or clean-up assistance, or Supervision or touching assistance* since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Decrease in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- Resident's decision making ability improves;
- Resident's incontinence pattern improves;

If there is only one change, the resident may still benefit from a SCSA as determined by the IDT or as initiated by the resident based on changes in the care plan. It is important to remember that each resident's situation is unique. The facility must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion.

The facility may not complete a SCSA until after a Comprehensive Admission assessment has been completed.

A Significant Change in Status MDS is considered timely when:

- The RN Assessment Coordinator signs the MDS as complete at section Z0500B & V0200B2 by the 14<sup>th</sup> calendar day **after the determination** that a significant change has occurred (determination date + 14 calendar days).