

DEFINITIONS §483.20(c)

“**Quarterly Review Assessment**” is an OBRA ‘87-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.

GUIDANCE §483.20(c)

At least every 92 days, the facility shall review each resident with respect to those MDS items specified in the CMS quarterly assessment (MDS).

A Quarterly assessment is considered timely if:

- The Assessment Reference Date (ARD) of the Quarterly MDS is **within 92 days** (ARD of most recent OBRA assessment +92 days) after the ARD of the previous OBRA assessment (Quarterly, Admission, Annual, Significant Change in Status, Significant Correction to Prior Comprehensive or Quarterly assessment) **AND**
- The MDS completion date (Item Z0500B) must be **no later than** 14 days after the ARD (ARD + 14 calendar days).

If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the ARD of the Significant Change in Status Assessment.

For information on assessment scheduling for the MDS, 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>.

NOTE: The Quarterly MDS does not require the completion of Care Area Assessments (CAAs). However, the resident’s care plan must be reviewed and revised by the interdisciplinary team after each assessment as required at §483.21(b)(2)(iii).

PROBES §483.20(c)

- Does the facility assess residents, using the CMS-specified quarterly review assessment, no less than once every 3 months, between comprehensive assessments?
- Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews and providing information about preferences or discharge goals.

F639

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§483.20(d) Use

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

INTENT §483.20(d)

Facilities are required to maintain 15 months of assessment data in each resident's active clinical record.

GUIDANCE §483.20(d)

The requirement to maintain 15 months of data in the resident's active clinical record applies regardless of form of storage to all Minimum Data Set (MDS) records, including the Care Area Assessment (CAA) Summary, Quarterly Assessment records, Identification Information and Entry, Discharge and Reentry Tracking Records and MDS Correction Requests (including signed attestation). MDS assessments must be kept in the resident's active clinical record for 15 months following the final completion date for all assessments and correction requests. Other assessment types require maintaining them in the resident's active clinical record for 15 months following:

- The entry date for tracking records including re-entry; and
- The date of discharge or death for discharge and death in facility records.

Facilities may maintain MDS data electronically regardless of whether the entire clinical record is maintained electronically and regardless of whether the facility has an electronic signature process in place. This is in accordance with state and local law, and when this is authorized by the long-term care facility's policy.

Facilities that maintain their MDS data electronically and do not utilize an electronic signature process must ensure that hard copies of the MDS assessment signature pages are maintained for every MDS assessment conducted in the resident's active clinical record for 15 months. (This includes enough information to identify the resident and type and date of assessment linked with the particular assessment's signature pages),

The information, regardless of form of storage (i.e., hard copy or electronic), must be kept in a centralized location and must be readily and easily accessible. This information must be available to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. (This information must also be made readily and easily accessible for review by the State Survey agency and CMS.) Resident specific information must also be available to the individual resident; if there are concerns, please refer to F573.

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, the State agency, or CMS. **NOTE:** States may have more stringent requirements for this process.

If there are concerns about how the results of the resident assessment are used to develop, review and revise the resident's comprehensive care plan - See §483.21(b)(2)(iii), F657.