

Judy Wilhide Brandt, RN, BA, RAC-MT,  
 QCP, CPC, DNS-CT  
 judy@judywilhide.com  
 909-800-9124  
 www.JudyWilhide.com

## Care Area Assessments and Care Planning Chapter 4 RAI Manual

June 2019



### F636 Comprehensive Assessment Definitions

- **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.



## F636 Probes

## §483.20(b)(1)-(2)(i) &amp; (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?



## F656 Comprehensive Care Plan

## Guidance

- If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident.
- Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record.

## F691 Colostomy, urostomy, or ileostomy care

**PROCEDURES AND PROBES §483.25(f)**

Refer to appropriate sections of the MDS, as applicable.

Identify if the resident triggers any Care Area Assessments for urinary incontinence, nutritional status, and/or pressure injuries (skin care).

- If appropriate, is the resident provided with self-care instructions?
- Does the staff member observe and respond to any signs of the resident's discomfort about the ostomy or its care?
- Is skin surrounding the ostomy free of excoriation (abrasion, breakdown)?
- If excoriation is present, does the clinical record indicate an onset and a plan to treat the excoriation?



**F742: Treatment/services for Mental/Psychosocial Concert**

• **Record Review**

- Identify if the resident triggers Care Area Assessments (CAA) for activities, mood state, psychosocial well-being, and psychotropic drug use.
  - Consider whether the CAA process was used to assess the causal factors for decline, potential for decline, or lack of improvement.
  - Review the resident’s care plan for interventions to address the assessed problem.

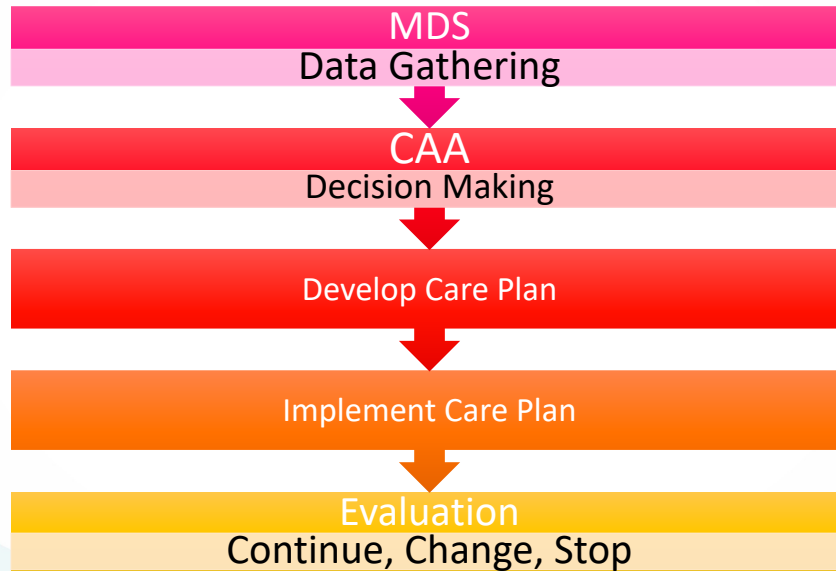
**F743: No pattern of behavioral difficulties unless unavoidable**

*Review the Resident Assessment Instrument (RAI) and identify if the Minimum Data Set (MDS) captures and was used to assess the resident’s conditions. Look to see that the resident Care Area Assessments (CAA) for activities, mood state, psychosocial well- being, and psychotropic drug use trigger for any reason in the absence of related diagnoses or difficulties, or history of trauma and/or PTSD.*

- *Consider whether the CAA process was used to identify and assess the reason and causal factors for decline, potential for decline, or lack of improvement.*
- *Is there an assessment of the resident’s usual and customary routines and preferences?*
- *Are accommodations made by the facility to support the resident by incorporating these routines and preferences in the care plan?*
- *Review the resident’s care plan to determine if interventions are in place to alleviate the assessed distress.*



The RAI is a **problem identification process**:



#### 4.1 Background and Rationale

- The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated that nursing facilities ***provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.***

Fundamental promise made to all residents upon admission.

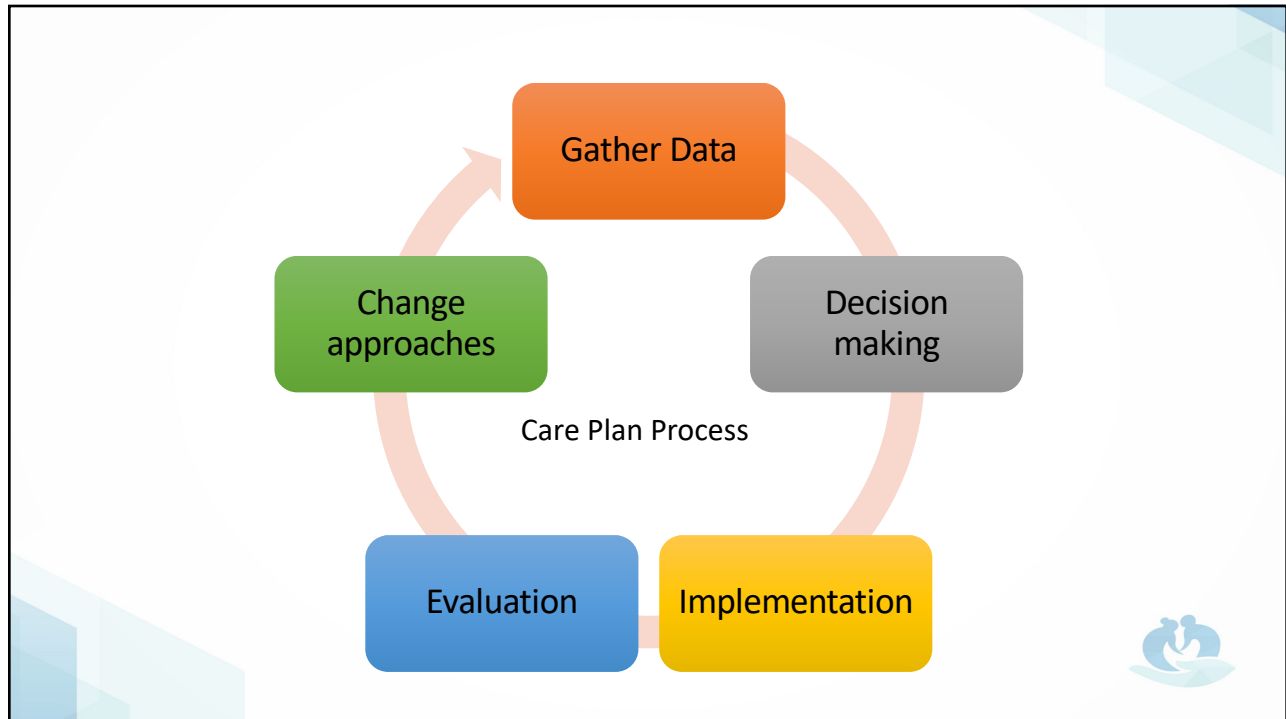


- Based on assessing the resident, the MDS identifies actual or potential areas of concern.
- The remainder of the RAI process (CAAs and Care Plan) supports efforts of the IDT to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment.
- These conclusions then provide the basis for developing an individualized care plan for each resident.

CAAs and Care Planning are required for a certified facility



4-1



## CAA Process Framework

**The CAA process framework.** The CAA process provides a framework for:


- guiding the review of triggered areas, and
- clarification of a resident's functional status and related causes of impairments
- providing basis for additional assessment of potential issues, including related risk factors.


The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.



20 Care Area Assessments	
1. Delirium	11. Falls
2. Cognitive Loss/Dementia	12. Nutritional Status
3. Visual Function.	13. Feeding Tubes
4. Communication	14. Dehydration/Fluid Maintenance
5. ADL Functional / Rehabilitation Potential	15. Dental Care
6. Urinary Incontinence and Indwelling Catheter	16. Pressure Ulcer
7. Psychosocial Well-Being	17. Psychotropic Medication Use
8. Mood State	18. Physical Restraints
9. Behavioral Symptoms	19. Pain
10. Activities	20. Return to Community Referral

4-3



- When implemented properly, the CAA process should help staff:
    - Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
    - Identify areas of concern that may warrant interventions;
    - Develop interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and
    - Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.
- 4-2
- 

- CAAs are required with all *comprehensive* assessments:

- Admission
- Annual
- Significant Change
- Significant Correction to Prior Comprehensive



## End Result of CAA Process:

- The care plan, the working action plan developed from the findings that result from the CAAs
  - Development of an individualized, **interdisciplinary care plan** designed to address the resident's specific problems, risk factors, and complications is the **primary purpose** of the RAI process

1-6

- The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas.
- Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources.
- When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (often called "critical thinking") skills is imperative.

4-3



## CATs

- Care Area Trigger (CAT) - MDS response indicating that clinical factors exist that may or may not represent a condition that should be care planned
- Triggers flag conditions that warrant further investigation
- Examples:
  - Any “Weight Loss” in Section K will **trigger** the Nutrition CAA
  - Any “Wandering” in Section E will **trigger** the Falls CAA

4-4



## How to Know if CAA Triggered:

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 <u>Addressed in Care Plan</u> 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 <u>Location and Date of CAA Information</u> 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. Addressed In Care Plan	Location and Date of CAA Information
	↓ Check all that apply ↓		
01. Delirium	<input checked="" type="checkbox"/>	<input type="checkbox"/>	See CAA Review of Indicators 8/7/16
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

If box is checked, the area triggered, and Care Area Assessment (CAA) must be completed.  
 If there is no Section V, no CAAs required.

Once CAA is worked, put where required documentation can be found and the date of that information.





**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 Addressed in Care Plan column must be completed within 7 days of completing the RAI (MDS and CAAs). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Information 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. Addressed in Care Plan	Location and Date of CAA Information
↓ Check all that apply ↓			
01. Delirium	<input type="checkbox"/>	<input type="checkbox"/>	See CAA Review of Indicators 8/7/16
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	

See Dietary Assessment 8/7/16

See CAA Analysis 8/7/16

Once CAA is worked, put where required documentation can be found and the date of that information.

## How to know what triggers each CAA

Section 4.10 (begins on page 4-16) lists all “logic tables” for each CAA  
 Logic table = what made it trigger

**Urinary Incontinence and Indwelling Catheter CAT Logic Table**

**Triggering Conditions (any of the following):**

1. ADL assistance for toileting was needed as indicated by:  
 (G0110I1 >= 2 AND G0110I1 <= 4)
2. Resident requires a indwelling catheter as indicated by:  
**H0100A = 1**
3. Resident requires an external catheter as indicated by:  
**H0100B = 1**
4. Resident requires intermittent catheterization as indicated by:  
**H0100D = 1**
5. Urinary incontinence has a value of 1 through 3 as indicated by:  
**H0300 >= 1 AND H0300 <= 3**
6. Resident has moisture associated skin damage as indicated by:  
**M1040H = 1**

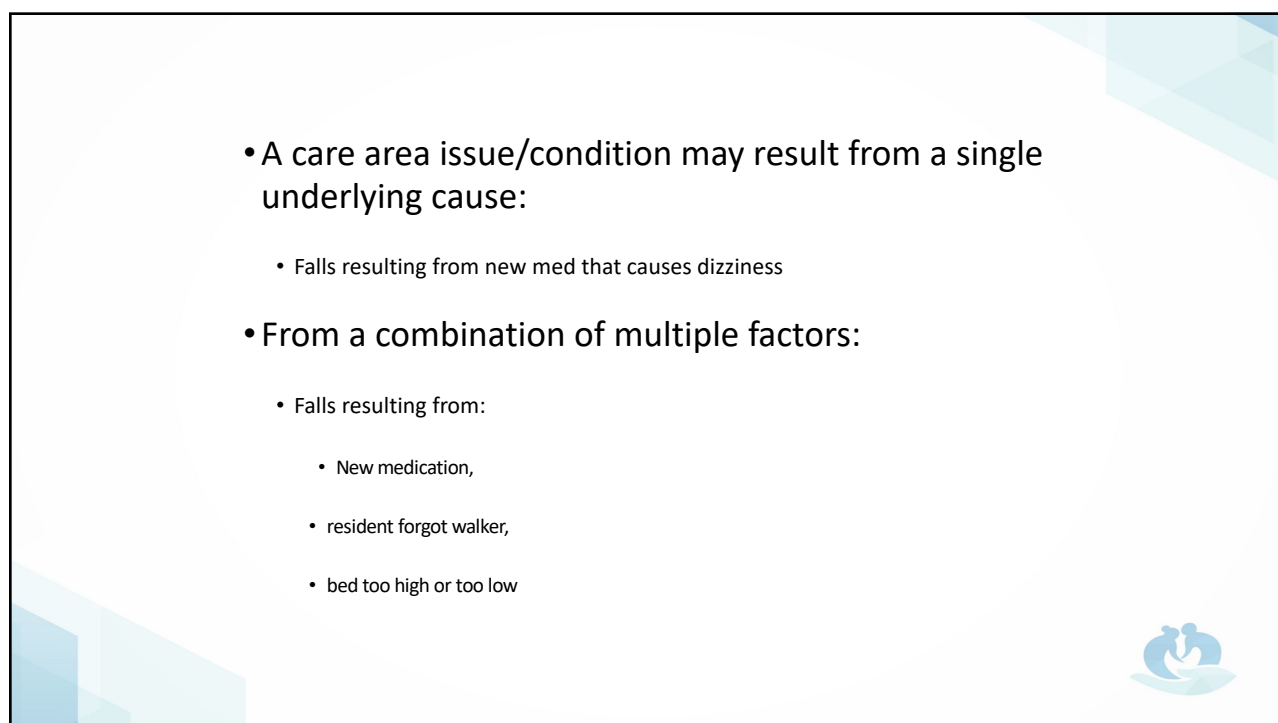
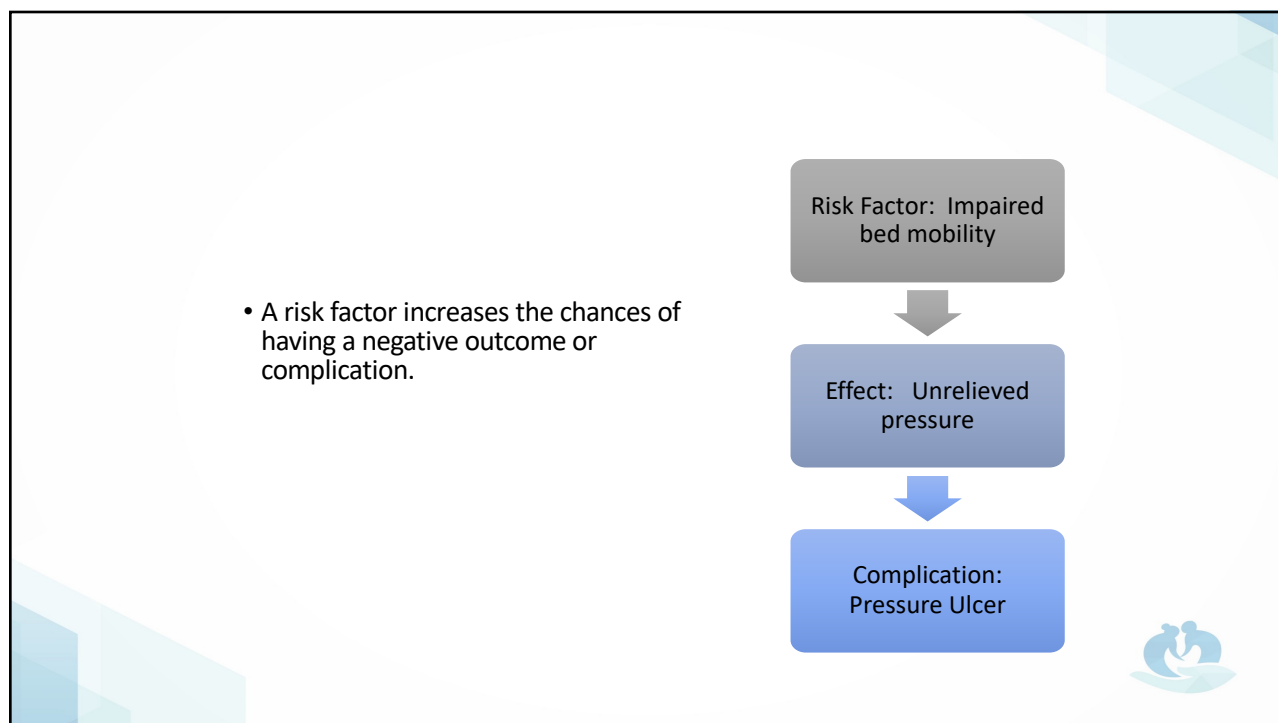
- CATs provide a “flag” for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions.
- Further assessment of a triggered care area may identify:
  - Causes,
  - Risk factors, and
  - Complications associated with the care area condition.
- The plan of care then addresses these factors with the goal of promoting the resident’s highest practicable level of functioning:
  - (1) improvement where possible or
  - (2) maintenance and prevention of avoidable declines.
    - [Includes support when decline is imminent]

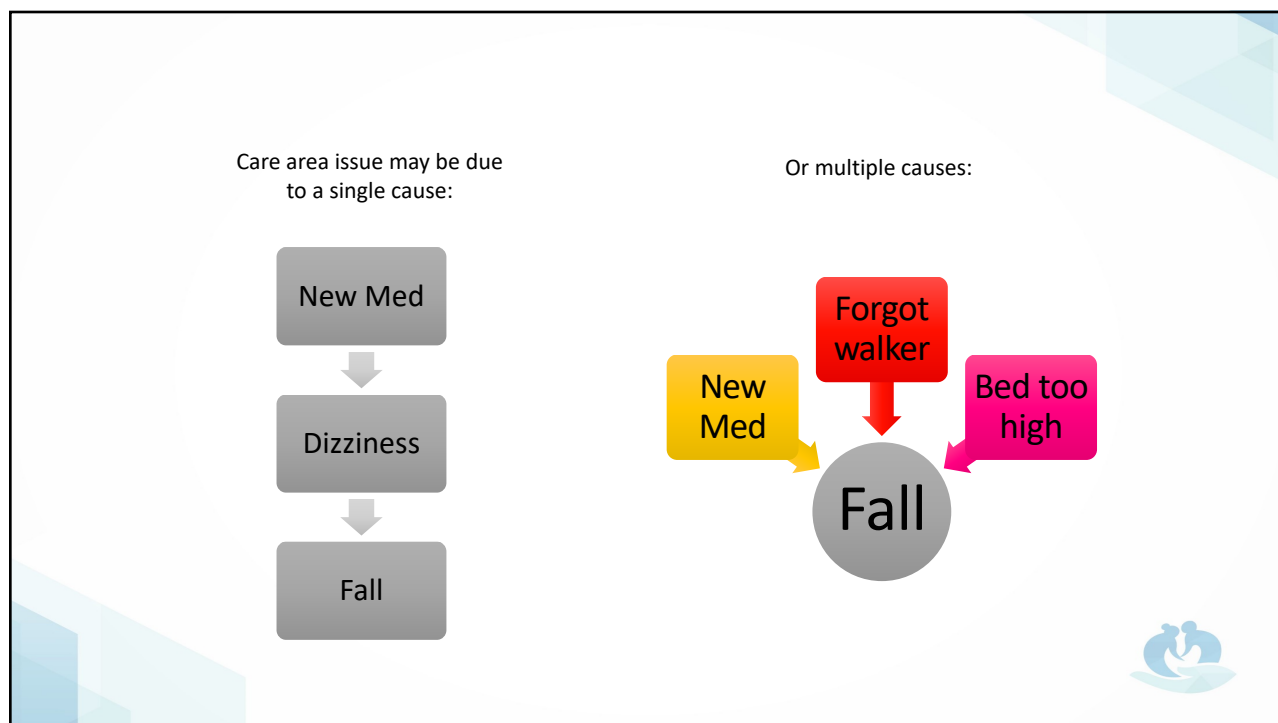
Page 4-4



- Each triggered item must be assessed further to facilitate care plan decision making, but it *may or may not* represent a condition that should or will be addressed in the care plan.
- The significance and causes of any given trigger may vary for different residents or in different situations for the same resident.
- Different CATs may have common causes, or various items associated with several CATs may be connected.







There can also be a single cause of multiple triggers and impairments.

- Hypothyroidism can have diverse physical, functional, and psychosocial complications. May be very stable, may not.
- MDS for resident with Hypothyroidism may trigger:
  - Delirium, Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehabilitation, Urinary Incontinence, Psychosocial Well-Being, Mood State, Behavior Symptoms, Activities, Falls, Nutritional Status, Dehydration, Psychotropic Medication Use, and Pain

- Diagnosis “hypothyroidism” in Section I did not alone trigger all these CAAs,

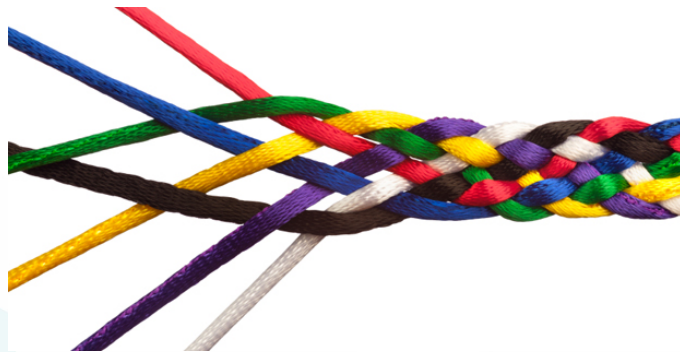
- **Functional assessment revealed issues in each of the areas above.**

- IDT is responsible for determining if the triggered events are
  - due to Hypothyroidism,
  - are related, or
  - are unrelated and due to different things.



- Recognizing the connection among various symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.

- Sequence is important!
  - Which came first, the delirium or the dehydration?



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 hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.



## Types of CATs

### Potential Problems:

- Suggest a problem that warrants additional assessment

### Broad Screening Triggers:

- Assist in identifying hard-to-diagnose problems, e.g. delirium, dehydration

### Prevention of Problems:

- Assist in identifying residents at risk of developing particular problems

### Rehabilitation Potential:

- Aimed at identifying candidates with rehabilitation potential



## Working A CAA

Step 1: Identify the Trigger:

- Ex: Stage 3 Pressure Ulcer triggers: Nutrition and Pressure Ulcer CAA

Step 2: Conduct thorough assessment of triggered CAAs using “Review of Indicators” or facility designated tool.

Step 3: Determine whether issue should/should not be care planned.

Step 4: Document findings.



- A separate care plan is not necessarily required for each area that triggers a CAA.
- If a single trigger has multiple causes, contributing factors and risk factors, it is acceptable and may sometimes be more appropriate to address multiple issues within a single care plan segment or to cross-reference related interventions from several care plan segments.
  - Example: If impaired ADL function, mood state, falls and altered nutritional status are all determined to be caused by an infection and medication-related adverse consequences, it may be appropriate to have a single care plan that addresses these issues in relation to the common causes.



- Usually, illnesses and impairments happen in sequence. The symptom or trigger often represents only the most recent or most apparent finding in a series of complications or related impairments.
- Detailed history is often essential to identifying causes and select the most beneficial interventions; e.g., the sequence over time of how the resident developed incontinence, pain, or anorexia.
- While the MDS presents diverse information about residents, and the CAAs cover various implications and complications, neither one is designed to give a detailed or chronological medical, psychosocial, or personal history.



- For example, knowing that the Behavioral Symptoms CAA is triggered and that the resident also has a diagnosis of UTI is not enough information to know whether the diagnosis of UTI is old or new, whether there is any link between the behavioral issue and the UTI, and whether there are other conditions such as kidney stones or bladder obstruction that might be causing or predisposing the resident to a UTI.





#### 4.5 Other Considerations Regarding Use of the CAAs

##### **Assigning responsibility for completing the MDS and CAAs.**

- Facilities may assign specific MDS items and CAAs to various disciplines
  - e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs,
- Proper decision making through the CAA process may involve consulting other disciplines to come to the right conclusion.
  - Ex: identifying specific medical conditions or medication side effects that cause anorexia leading to a resident's weight loss
- **It is the facility's responsibility to obtain the input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice.**
  - For example, a physician may need to get a more detailed history or perform a physical examination in order to establish or confirm a diagnosis and/or related complications.



##### **Identifying policies and practices related to the assessment and care planning processes.**

- The medical director is responsible for overseeing the implementation of resident care policies in each facility, and the coordination of medical care in the facility.
- It is recommended that the facility's IDT members collaborate with the medical director to identify current evidence-based or expert-endorsed resources and standards of practice that they will use for the expanded assessments and analyses that may be needed to adequately address triggered areas.



## CAA Documentation: Page 4-6



- Description of causes and contributing factors;
- Nature of the issue/condition: what exactly the issue/problem for this resident and why is it a problem
- Complications affecting or caused by the care area for this resident
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning
- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident
- The need for additional evaluation by the attending physician and other health professionals, as appropriate
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.



- Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record. For example:
  - discipline-specific flow sheets,
  - progress notes,
  - care plan summary notes,
  - a CAA summary narrative, etc.
- Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM). If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence.
- Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan.

4-7



### Sample Narrative Note: Urinary Incontinence CAA

CAA triggered because Mrs. Jones is frequently incontinent (see continence tracking 4/7 – 4/13/18) and requires assistance with toileting (CNA ADL tracking 4/7 – 4/13/18) secondary to her multi-infarct dementia (see CAA 2 for details). At times she is aware of her need to void but cannot communicate that need for assistance and has an incontinent void (See nursing notes 4/7, 4/10/18). She is aware that she has voided in her brief, and will sometimes communicate her desire for toileting or being changed with verbal or physical behaviors (See nursing note 4/9/18). She is at risk for declining ability to be aware of need to void, and risk of skin breakdown and infection related to incontinence. Will refer to restorative nursing for scheduled toileting plan. Will proceed to care plan for restorative toileting, incontinence care, and mitigation of risks of incontinence.



## Thoughts

Developing care plan interventions was never intended to be the 'job' of the MDS nurse or any other ONE person.

- It's not the 'dietary' care plan...it's the resident's care plan.

The person who 'works' the CAA is the "project manager" to ensure all necessary disciplines are consulted for appropriate interventions, based on evidence and current standards of practice.

How/where to write CAA documentation is up to the facility. Different survey agencies have different opinions on how/where to document and on what constitutes "appropriate documentation."

- Become well grounded in what the RAI Manual says about CAA documentation and the CAA process
- Go to state RAI Coordinator training and ask about these issues. Be as prepared as possible for your unique survey issues.
- Email your state RAI coordinator and ask if certain examples are correct.
- Tell your DON/Administrator and let them approve how/where your team documents CAA results.
- NC RAI Coordinator posts copies of handouts for her CAA training on NC agency website. Va RAI Coordinator trains on this frequently. Ask for handouts. Use them!





## CAAs to Person Centered Comprehensive Care Plans



F655

**§483.21 Comprehensive Person-Centered Care Planning**

**§483.21(a) Baseline Care Plans**

**Guidance**

**Person-centered care** means the facility focuses on the resident as the center of control, and supports each resident in making his or her own choices. Includes:

- Making effort to understand what each resident is communicating, **verbally and nonverbally**
- Identifying what is important to each resident with regard to **daily routines** and **preferred activities**, and
- Having an understanding of the **resident's life before coming to reside in the nursing home.**



## F552: Resident Rights for Planning & Implementing Care

The resident has the right to be informed of, and participate in, his or her treatment, including the right to be:

- Fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
- Informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
- Informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or options and to choose the alternative or option he or she prefers.



## F552: Definitions

- “Total health status” functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.
- “Treatment” refers to medical care, nursing care, and interventions provided to maintain or well-being, improve functional level, or relieve symptoms.



## F553: Resident Rights for Planning & Implementing Care

- Resident has right to participate in the development and implementation of the person-centered plan of care, including but not limited to the right to:
- Participate in the planning process, including the right to:
  - Identify individuals or roles to be included in the planning process,
  - Request meetings
  - Request revisions to the person-centered plan of care.
- Participate in establishing:
  - Expected goals and outcomes of care
  - Type, amount, frequency, and duration of care
  - Any other factors related to the effectiveness of the plan of care.
- Be informed, in advance, of changes to the plan of care.
- Receive the services and/or items included in the plan of care.
- See the care plan, including the right to sign after significant changes to plan of care.



## F553: Resident Rights for Planning & Implementing Care

- The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must—
- Facilitate the inclusion of the resident and/or resident representative.
- Include an assessment of the resident's strengths and needs.
- Incorporate the resident's personal and cultural preferences in developing goals of care.



## Interpretative Guidelines Definition

## Resident representative:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
3. Legal representative, as used in section 712 of the Older Americans Act; or
4. The court-appointed guardian or conservator of a resident.
5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

[www.JudyWilhide.com](http://www.JudyWilhide.com)



## F655

Comprehensive person-centered care plan  
Baseline Care Plan

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—

- (i) Be developed within 48 hours of a resident's admission.
- (ii) Include the minimum healthcare 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.



## Baseline Care Plan

1. *Must reflect **resident's stated goals and objectives***
2. Must be developed and implemented within 48 hours of admission.
3. Must be revised as needed until the comprehensive care plan has been developed.
4. A written summary must be delivered to the resident/representative by the time of comprehensive care plan completion.
5. Format/location of written summary at facility discretion
  - Clinical record must contain evidence the summary was done and given to the resident/representative by the time of comprehensive care plan completion. Copy of the baseline care plan can meet this requirement
6. Comprehensive care plan may be developed instead of the baseline care plan but all requirements for content and delivery of both baseline and comprehensive care plan must be met.
7. If the baseline care plan requires revision, each time it is revised a written summary of the revised care plan must be given to resident/representative.
8. Specific content is required for both the baseline care plan and written summary.

F655, §483.21(a)

www.JudyWilhide.com



## Written Summary must include:

***GUIDANCE §483.21(a)***

- Initial goals **of the resident**.
- Summary of medications and dietary instructions.
- Any services and treatments to be administered
- Any updated information based on the details of the comprehensive care plan, as necessary.

*The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.*

www.JudyWilhide.com





Baseline Care Plan references: 22 of 41 pathways

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Preadmission Screening and Resident Review</li> <li>• Hydration</li> <li>• Accidents</li> <li>• Tube Feeding Status</li> <li>• Positioning, Mobility &amp; Range of Motion (ROM)</li> <li>• Hospitalization</li> <li>• Bladder or Bowel Incontinence</li> <li>• Respiratory Care</li> <li>• Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review</li> <li>• Dementia Care</li> <li>• ADL</li> <li>• Behavioral and Emotional Status</li> </ul> | <ul style="list-style-type: none"> <li>• Urinary Catheter</li> <li>• Communication and Sensory Problems</li> <li>• Dental Status and Services</li> <li>• Dialysis</li> <li>• General</li> <li>• Hospice and End of Life Care and Services</li> <li>• Nutrition</li> <li>• Pain recognition and management</li> <li>• Physical restraints</li> <li>• Pressure Ulcer/Injury</li> <li>• Specialized Rehabilitative or Restorative Services</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

[www.JudyWilhide.com](http://www.JudyWilhide.com)



### Baseline Care Plan Summary

- The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
  - The initial goals of the resident.
  - A summary of the resident's medications and dietary instructions.
  - Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
  - Any updated information based on the details of the comprehensive care plan, as necessary.



### Baseline Care Plan Summary Components

- **Initial Goals of Resident: (examples)**

- Will walk 150 feet independently by 7/6/16
- Will maintain ability to walk 50' with rolling walker and assist of one person by 7/6/16
- Will participate in Rehab therapy services (PT/OT/ST) per therapy plans of treatment though next review on 7/6/16
- Will have no pressure ulcers by 7/6/16
- Will enjoy regular diet and maintain current weight by 7/6/16
- Pain level will be 6 or less by 7/6/16
- Infection (site) will resolve by 7/6/16
- Will participate in one community activity weekly by 7/6/16

Guidance F656: Residents' goals set the expectations for the care and services he or she wishes to receive. For example, a resident admitted for rehabilitation may have the following goal – "Receive the necessary care and services so that I may return to independent living." Another resident may have a goal of receiving the necessary care and services to meet needs they cannot independently achieve, while maintaining as much independence as possible. And yet another resident or his or her representative, if applicable, may have a goal of receiving the necessary care and services to keep the resident comfortable and pain-free at the end of their life. Each of these examples would be supported by measurable objectives, interventions and timeframes designed to meet each specific resident goal.



### Baseline Care Plan Summary Components

- **Summary of Medications:**

- Drug/reason for use/dose

- **Dietary Instructions:**

- Regular diet with no concentrated sweets, etc.

- **Services & treatments to be administered by the facility**

- Physical therapy 5 days/week
- Oxygen therapy
- Monitoring:
  - Labs to regular blood thinners (PT/INR twice weekly)
  - Blood glucose monitoring
- Daily dressing with medication for wound healing for Stage 2 pressure ulcer to right heel

- **Additional information:**

- Resident prefers therapy in the am and wound treatments after lunch

- **Signature of resident or representative**

- **Signatures of staff member(s) completing form**



## F656 Comprehensive Person Centered Plan of Care

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 that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —

- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and
- (ii) 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.
- (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
- (iv) 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



### GUIDANCE §483.21(b)

- Through the care planning process, facility staff must work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility.
- 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.



## Guidance: Continued

- Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified.
- For example:
  - Mrs. Jones, who underwent hip replacement, will report adequate pain control (as evidenced by pain at 1-3, on a scale of 1-10) throughout her SNF stay.
- The comprehensive care plan must reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. Interventions for the example above, related to pain, may include, but are not limited to:
  - Evaluate pain level using pain scale (0-10) 45 minutes after administering pain medication;
  - Administer pain medication 45-60 minutes prior to physical therapy.



## F657: Care Plan Timing and Revision

- A comprehensive care plan must be—
  - (i) Developed within 7 days after completion of the comprehensive assessment.
  - (ii) 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.
  - (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.



## Selected Guidance:

- *“Interdisciplinary” means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident.*
- *The mechanics of how the interdisciplinary team (IDT) meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility.*
- *In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record must reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.*
- *The determination of other appropriate staff or professionals participation in the IDT should be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, social workers, and other professionals, such as developmental disabilities specialists or spiritual advisor. Involvement of other individuals is dependent upon resident request and/or needs.*



## Selected Guidance

- Facilities are expected to facilitate the residents’ and if applicable, the resident representatives’ participation in the care planning process. There are limited circumstances in which the inclusion of the resident and/or resident representative may not be practicable (or feasible).
- An example may be the case of a severely cognitively impaired resident who is unable to understand or participate in care plan development, and the resident’s representative does not respond to facility attempts to make contact. If the facility determines that the inclusion of the resident and/or resident representative is not practicable, documentation of the reasons, including the steps the facility took to include the resident and/or resident representative, must be included in the medical record.
- While Federal regulations affirm the resident’s right to participate in care planning, request and/or refuse treatment, the regulations do not create the right for a resident or resident representative, if applicable, to demand that the facility use specific medical interventions or treatments that the facility deems not medically necessary and/or reasonable.



## Care Planning goes beyond the MDS

- The RAI does not include everything needed for clinical problem solving and decision making for the care of nursing home residents
- MDS/CAA process does not provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes.
- RAI was not designed to capture a history of a resident's symptoms and impairments. Thus, it can potentially be ***misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation.***



## Clarification for general care plan completion

- Care plan completion **based on the CAA process** is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records.
- **However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.**
  - Assessments required by 483.20 = OBRA assessments in A0310A.



## Chapter 4 Care Planning

**The overall care plan should be oriented towards:**

1. **Assisting the resident in achieving his/her goals.**
2. **Individualized interventions that honor the resident's preferences.**
3. **Addressing ways to try to preserve and build upon resident strengths.**
4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation).
5. Managing risk factors to the extent possible or indicating the limits of such interventions.
6. Applying current standards of practice in the care planning process.

www.JudyWilhide.com

4-10 &amp; 11



## Chapter 4 Care Planning

7. Evaluating treatment of measurable objectives, timetables and outcomes of care.
8. Respecting the resident's right to decline treatment.
9. Offering alternative treatments, as applicable.
10. Using an ~~appropriate~~ interdisciplinary approach to care plan development to improve the resident's ~~functional~~ abilities.
11. Involving resident, resident's family and other resident representatives as appropriate.
12. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs.
13. Involving ~~the~~ direct care staff with the care planning process relating to the

www.JudyWilhide.com

4-11



Care plan goal statements should include: The **subject (first or third person)**, the **verb**, the **modifiers**, the **time frame**, and the **goal(s)**.

**EXAMPLE:**

<i>Subject</i>	<i>Verb</i>	<i>Modifiers</i>	<i>Time frame</i>	<i>Goal</i>
Mr. Jones <b>OR I</b>	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



## Interventions:

- Specific and responsive to assessment & identified issue or problem
- Explains what staff are to do when caring for resident
- Consistent with current standards of practice
- Categories:
  - improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions





### Care Plan Tips

- A separate care plan is not required for each area that triggers a CAA.
- Since a single trigger can have multiple causes and contributing factors and multiple items can have a common cause or related risk factors, it is acceptable and may sometimes be more appropriate to address multiple issues within a single care plan segment or to cross reference related interventions from several care plan segments.



- The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and Annual RAI assessments.
- A new care plan does not need to be developed after each SCSA, SCPA, or Annual reassessment.
  - Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment.
- Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed.



Key components of the care plan may include, but are not limited to the following:

- Specific interventions, including those that address common causes of multiple issues
- Additional follow-up and clarification
- Items needing additional assessment, testing, and review with the practitioner
- Items that may require additional monitoring but do not require other interventions



[www.JudyWilhide.com](http://www.JudyWilhide.com) [www.Chileshealthcare.com](http://www.Chileshealthcare.com)

Questions/Discussion



**Judy W. Brandt**

 2005 Edmonds Rd.  
Virginia Beach, VA 23451

 [judy@judywilhide.com](mailto:judy@judywilhide.com)

 909-800-9124

 757-428-0462

 @WilhideMDS

 Wilhide Consulting

