



CARE AREA TRIGGERS, CARE AREA ASSESSMENTS AND CARE PLANNING

Presenter

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OBJECTIVES

- Summarize the CAA process
- Identify what care area triggers (CATs) are
- Identify the 20 care area assessments (CAA)
- Analyze other considerations regarding the use of the CAAs
- Develop a care plan



OBJECTIVES

- Review section V of the MDS data set
- Discuss the regulations behind the CATs, CAA, and care planning
- Locate resources for the CAA





TERMS

- ARD: Assessment reference date; the last day of the observation or look back period
- CAA: Care area assessment
- CAT: Care area trigger
- CP: Care plan(ing)
- DCRA: Discharge return anticipated
- IPA: Interim payment assessment



TERMS

- PPS: Prospective payment system
- OBRA: Omnibus Budget Reconciliation Act
- SCQA: Significant correction to prior quarterly
- Observation period: Time period over which the resident's condition or status is captured by the MDS
- SCSA: Significant change in status
- SCPA: Significant correction to prior comprehensive
- SNF: Skilled nursing facility



REVIEW

Last Session

- Understand the coding requirements for sections H-Z
- Reviewed common definitions
- Accessed external resources
- Identified what sections are not required

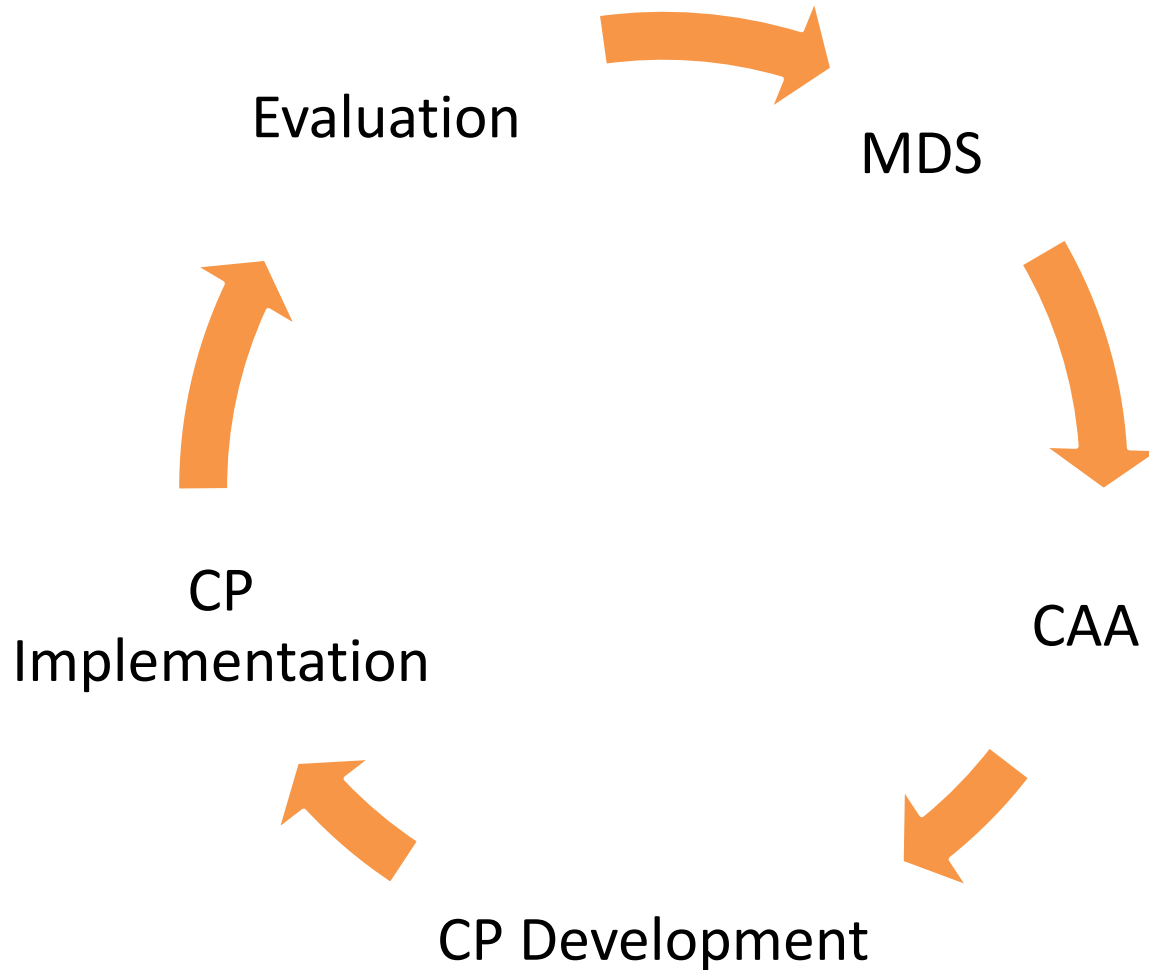


PROCESS





PROCESS





CAA PROCESS MAY HELP

- Identify and address associated causes and effects;
- Determine whether and how multiple triggered conditions are related;
- Identify a need to obtain additional medical; functional, psychosocial, financial, or other info;
- Identify whether and how a triggered condition affects the resident's function and quality of life;



CAA PROCESS MAY HELP

- Review the situation with a health care practitioner to try to identify links among causes and between causes and consequences;
- Identify pertinent tests, consultations, and interventions;
- Benefit from rehab intervention; and
- Develop an individualized CP.



CARE AREAS

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



VISUAL FUNCTION

The aging process leads to a decline in visual acuity, for example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities.



VISUAL FUNCTION

Visual Function CAT Logic Table

Triggering Conditions (any of the following):

1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:

I6500 = 1

2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:

B1000 >= 1 AND B1000 <= 4



VISUAL FUNCTION

- Information should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identify treatable conditions that place them at risk of permanent blindness and those who have impaired vision.
- Develop an individualized care plan based on these conclusions.



CARE AREA TRIGGER/PROCESS

- No specific tool for completing the further assessment of the CAT(s)
- Doesn't specify guidance on how to understand or interpret the triggered areas
- Identify and use tools that are current and grounded in current clinical standards or practice
- Utilize critical thinking



DOES AND DOES NOT

- Not intended to
 - Provide diagnostic advice
 - Specify which CAT(s) may be related to one another
 - How those problems relate to underlying causes
- Triggers
 - Not all identify deficits or problems
 - May be resident's strengths or to improve a functional or minimize decline
 - Not all are clinically significant
 - MDS may not trigger every relevant issue



CAT AND CAA PROCESS

3. VISUAL FUNCTION

Review of Indicators of Visual Function

	Diseases and conditions of the eye (diagnosis OR signs/symptoms present)	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
✓		
<input type="checkbox"/>	• Cataracts, Glaucoma, or Macular Degeneration (I6500)	
<input type="checkbox"/>	• Diabetic retinopathy (I2900)	
<input type="checkbox"/>	• Blindness (B1000 = 3 or 4)	
<input type="checkbox"/>	• Decreased visual acuity (B1000, B1200 = 1)	
<input type="checkbox"/>	• Visual field deficit (B1200 = 1)	
<input type="checkbox"/>	• Eye pain (J0800)	
<input type="checkbox"/>	• Blurred vision	
<input type="checkbox"/>	• Double vision	
<input type="checkbox"/>	• Sudden loss of vision	
<input type="checkbox"/>	• Itching/burning eye	
<input type="checkbox"/>	• Indications of eye infection (I8000)	



CAT AND CAA PROCESS

✓	Diseases and conditions that can cause visual disturbances	Supporting Documentation
<input type="checkbox"/>	• Cerebrovascular accident or transient ischemic attack (I4500)	
<input type="checkbox"/>	• Alzheimer’s Disease and other dementias (I4200, I4800)	
<input type="checkbox"/>	• Myasthenia gravis (I8000, clinical record)	
<input type="checkbox"/>	• Multiple sclerosis (I5200)	
<input type="checkbox"/>	• Cerebral palsy (I4400)	
<input type="checkbox"/>	• Mood ((I5800, I5900, I5950, I6000, I6100, D0300 or D0600) or anxiety disorder (I5700)	
<input type="checkbox"/>	• Traumatic brain injury (I5500)	
<input type="checkbox"/>	• Other (I8000)	



CAT AND CAA PROCESS

Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

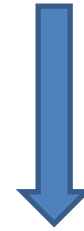


CAT AND CAA PROCESS

Analysis of Findings		Care Plan Considerations
<p>Review indicators and supporting documentation, and draw conclusions. Document:</p> <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. 	<p>Care Plan Y/N</p>	<p>Document reason(s) care plan will/ will not be developed.</p>



CAT AND CAA PROCESS



Referral(s) to another discipline(s) is warranted (to whom and why): _____

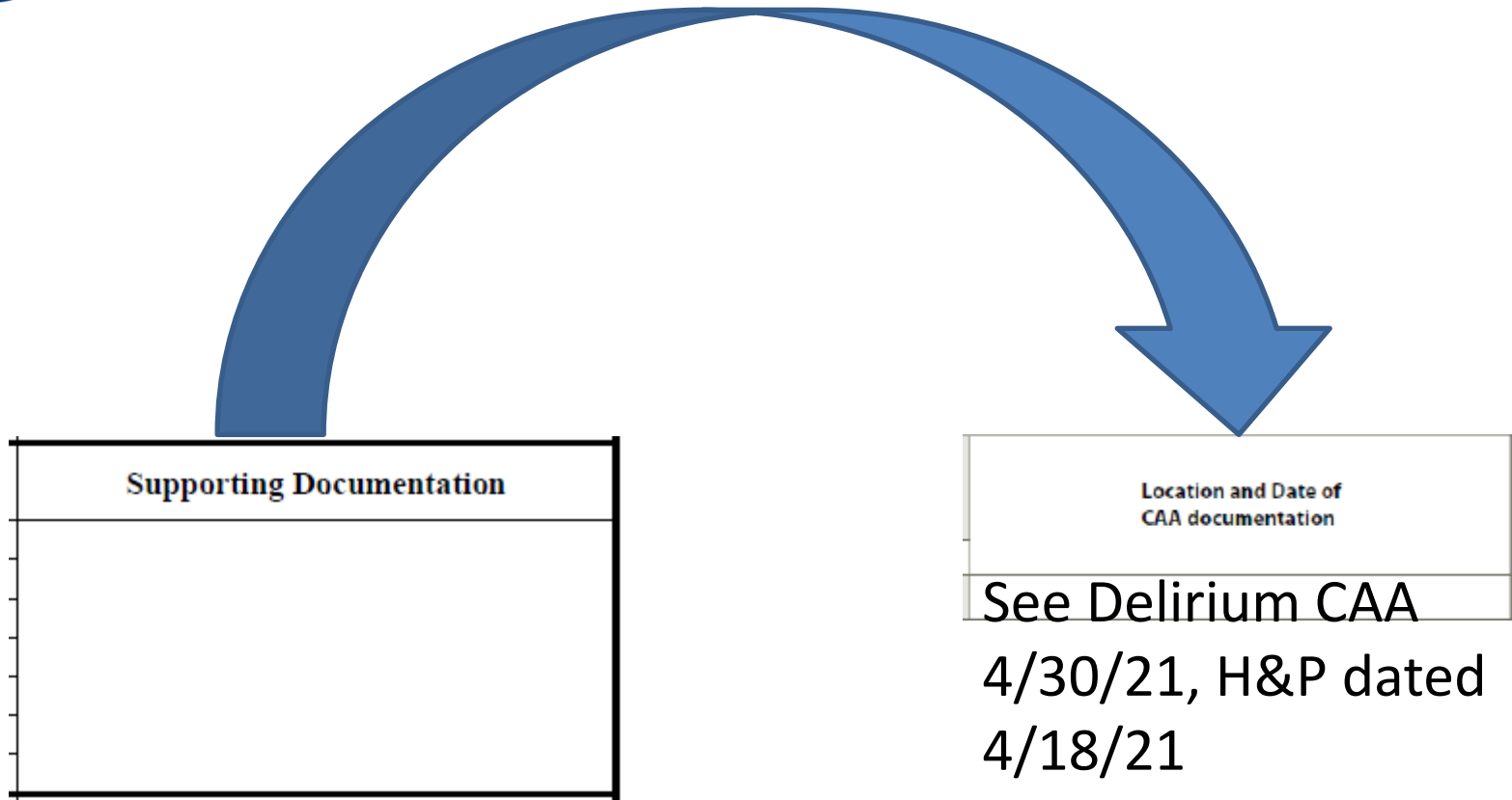
Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

Yes No

Signature/Title: _____ Date: _____



CAT AND CAA PROCESS





CARE PLANNING

- 42 C.F.R. § 483.21(b)
- Must develop a comprehensive CP
 - Measurable objectives and timetables
 - Include resident's refusal of treatment(s)





CARE PLANNING

- Goals and Objectives
 - Measurable
 - Pertinent to the resident's goals, preferences, condition, and situation
 - Time frame for completion or evaluation
- Statement
 - Subject (first or third person)
 - Verb
 - Modifiers
 - Time frame
 - Goal(s)





CARE PLANNING EXAMPLE

<i>Subject</i>	<i>Verb</i>	<i>Modifiers</i>	<i>Time frame</i>	<i>Goal</i>
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



CARE PLANNING

- Whole human being with unique characteristics and strengths;
- Views the resident in distinct functional areas;
- Common understanding of the resident;
- Identify possible issues and/or conditions that the resident may have (i.e., triggers);
- Clarity of potential issues and/or conditions by looking at possible causes and risks (CAA process);



CARE PLANNING

- Develops and implements an interdisciplinary care plan;
- Reflects the resident's/resident representative's input, goals, and desired outcomes;
- How the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being; and
- Re-evaluates the resident's status at prescribed intervals.



CARE PLANNING

- Separate CP is not necessary for each CAT/CAA
- RN coordinator signs and dates the CAA summary
- May revise an existing CP using the latest results
- CP must be reviewed after each assessment (except discharge)
- As preferences and goals change, so should the CP
- If annual assessment triggers same CAA(s) as prior comprehensive, CAA should be reviewed again



CARE PLANNING

- RN coordinator for the CAA process (V0200B1) doesn't need to be the same RN as the RN assessment coordinator who verifies completion of the MDS assessment (Z0500).
- Signature of person completing care plan decision (V0200C1) can be that of any person(s) who facilitates the care plan decision making.





CAA PROCESS AND CARE PLANNING

CAA process and care planning completed on all

- Comprehensive assessments
 - Admission
 - Annual
 - Significant change of status
 - Significant correction to a prior assessment



CAA PROCESS AND CARE PLANNING

CAA process and care planning is not completed on

- Non-comprehensive assessments
 - Quarterly
 - Significant correction to a prior quarterly assessment
- Tracking records
- Discharge assessments



SECTION V: CAA SUMMARY

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 that indicate the need for additional assessment based on problem identification, known as “triggered care areas,” which form a critical link between the MDS and decisions about care planning.



SECTION V

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment	
Complete only if A0310E = 0 and if the following is true for the prior assessment : A0310A = 01- 06 or A0310B = 01	
Enter Code <input type="text"/> <input type="text"/>	A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment) 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input type="text"/> <input type="text"/>	B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment) 01. 5-day scheduled assessment 08. IPA - Interim Payment Assessment 99. None of the above
	C. Prior Assessment Reference Date (A2300 value from prior assessment) <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"><input type="text"/><input type="text"/> Month</div> <div style="text-align: center;"><input type="text"/><input type="text"/> Day</div> <div style="text-align: center;"><input type="text"/><input type="text"/><input type="text"/><input type="text"/> Year</div> </div>
Enter Score <input type="text"/> <input type="text"/>	D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	E. Prior Assessment Resident Mood Interview (PHQ-9[®]) Total Severity Score (D0300 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)



SECTION V

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	<input type="checkbox"/>	<input type="checkbox"/>	
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"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	






CAA DOCUMENTATION

- Written documentation of the CAA findings and decision-making process may appear anywhere in a resident's record.
 - Discipline-specific flow sheets
 - Progress notes
 - Care plan summary notes
 - CAA summary narrative
- Utilize a format outlined in the RAI or the State Operations Manual (SOM).



SECTION V

B. Signature of RN Coordinator for CAA Process and Date Signed	
1. Signature  RN	2. Date  <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
C. Signature of Person Completing Care Plan Decision and Date Signed	
1. Signature 	2. Date  <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year



RESPONSIBILITY

- Per the OBRA statute, the resident's assessment must be conducted or coordinated by a RN with the appropriate participation of health professionals, 42 C.F.R. § 483.209(h).
- OBRA regulation, 42 C.F.R. § 483.70(h)(1) identifies the medical director as being responsible for overseeing the implementation of care policies and the coordination of medical care in the facility.



REPRODUCING AND MAINTAINING ASSESSMENTS

- Federal regulatory requirement at 42 C.F.R. § 483.20(d)
- 15 months in the resident's active clinical record
 - Electronic or hard copy
- After 15 months, RAI information may be thinned from the active clinical record and stored
 - Exception: Demographic information (A0500-A1600)



CLINICAL RECORD

- Electronic signatures
- Electronic clinical record or hard copy



CLINICAL RECORD

- Maintain electronically without the use of electronic signatures
 - Maintain, at a minimum, hard copies of signed and dated CAA(s) completion, correction completion, and assessment completion data in the active clinical record
- Ensure proper security measures are implemented



MAINTAINING RECORDS

Clinical records are maintained in a centralized location and easily and readily accessible to staff, state agencies, CMS, and others as well as resident specific information.





COMPLETION AND TIMING

Assessment Type	CAA(s) Completion V0200B2	CP Completion V0200C2
Admission	No later than the 14 th calendar day of the resident's admission	CAAs completion + 7 calendar days
Annual	ARD + 14 calendar days	CAAs completion date + 7 calendar days
Significant Change in Status (SCSA)	14 th calendar day after determination that SCSA occurred	CAAs completion date + 7 calendar days
Significant Correction to Prior Comprehensive (SCPA)	14 th calendar day after determination that significant error in prior comprehensive assessment occurred	CAAs completion date + 7 calendar days



REGULATIONS

Assessment Type	Regulatory Requirement
Admission – When required	42 CFR 483.20 (b)(2)(i) (by the 14th day)
Annual – When required	42 CFR 483.20 (b)(2)(iii) (every 12 months)
Significant Change in Status (SCSA)	42 CFR 483.20 (b)(2)(ii) (within 14 days)
Quarterly Review	42 CFR 483.20(c) (every 3 months)



REGULATIONS

Other Regulations	Regulatory Requirement
Resident Assessment – Conduct initially and periodically Including CAA, CAT, CAA summary	42 CFR 483.20
Comprehensive Assessment – Assessment of resident using RAI	42 CFR 483.20 (b)(1)
Maintaining Assessments (15 months)	42 CFR 483.20 (d)
Significant Correction to Prior Comprehensive (SCPA)	42 CFR 483.20(f)(3)(iv)



REGULATIONS

Other Regulations	Regulatory Requirement
Comprehensive Care Plans *Culturally-competent and trauma-informed *CAA/CAT	42 CFR 483.21(b) 42 CFR 483.21(b)(3)(iii)
Comprehensive Care Plans - Developed, prepared by IDT and reviewed	42 CFR 483.21(b)-(b)(iii)
Comprehensive Care Plans - Meet professional standards of quality	42 CFR 483.21 (b)(3)(i)
Comprehensive Care Plans - Services provided or arranged	42 CFR 483.21(b)(3)(ii)



SURVEY CITATIONS

CFR	Tag Number	Tag Title
483.20(b)(1)-(2)(i) & (iii)	F636	Comprehensive Assessments
483.20(d)	F639	Maintain 15 months
483.20(f)(1)-(4)	F640	Encoding/Transmitting
483.20(h)-(i)	F642	Coordination/Certification (RN)



SURVEY CITATIONS

CFR	Tag Number	Tag Title
483.21(b)(1)	F656	Comprehensive Care Plans
483.21(b)(2)(i)-(iii)	F657	Comprehensive Care Plan Revision
483.21(b)(3)(i)	F658	Services Provided Meet Professional Standards
483.21(b)(3)(ii)	F659	Qualified Persons



RESOURCES

- Chapter 3, RAI Manual
 - Page V-1 through V-6 is CAA summary
- Chapter 4, RAI Manual
 - Information on specific CAT and CAA process
- Appendix C, CAA Resource
 - Not mandated, nor does it endorse, the use of any resource(s)



RESOURCES

- RAI Manual, Page C-85
 - [Advancing Excellence in America's Nursing Homes Resources](#)
 - [Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice](#)
 - [Alzheimer's Association Resources](#)
 - [American Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities \(PDF Version\)](#)



PRACTICE

Communication CAT Logic Table

Triggering Conditions (any of the following):

1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:

$B0200 \geq 1 \text{ AND } B0200 \leq 3$

2. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

$B0700 \geq 1 \text{ AND } B0700 \leq 3$

3. Impaired ability to understand others through verbal content as indicated by:

$B0800 \geq 1 \text{ AND } B0800 \leq 3$



PRACTICE

Communication CAT Logic

Triggering condition (any of the following)

- B0200 \geq 1 AND B0200 \leq 3
- B0700 \geq 1 AND B0700 \leq 3
- B0800 \geq 1 AND B0800 \leq 3

Resident's Coding

- B0100 – 0
- B0200 – 2
- B0300 – 1
- B0600 – 0
- B0700 – 1
- B0800 – 1



PRACTICE

Communication CAT Logic

Triggering condition (any of the following)

- B0200 \geq 1 AND B0200 \leq 3
- B0700 \geq 1 AND B0700 \leq 3
- B0800 \geq 1 AND B0800 \leq 3

Resident's Coding

- B0100 – 0
- B0200 – 2
- B0300 – 1
- B0600 – 0
- B0700 – 1
- B0800 – 1



PRACTICE

✓	Diseases and conditions that may be related to communication problems
<input type="checkbox"/>	• Alzheimer’s Disease or other dementias (I4200, I4800, I8000)
<input type="checkbox"/>	• Aphasia (I4300) following a cerebrovascular accident (I4500)
<input type="checkbox"/>	• Parkinson’s disease (I5300)
<input type="checkbox"/>	• Mental health problems (I5700 – I6100)
<input type="checkbox"/>	• Conditions that can cause voice production deficits, such as
<input type="checkbox"/>	— Asthma (I6200)
<input type="checkbox"/>	— Emphysema/COPD (I6200)
<input type="checkbox"/>	— Cancer (I0100)
<input type="checkbox"/>	— Poor-fitting dentures (L0200)
<input type="checkbox"/>	• Transitory conditions, such as
<input type="checkbox"/>	— Delirium (C1310, I8000, clinical record)
<input type="checkbox"/>	— Infection (I1700 – I2500)
<input type="checkbox"/>	— Acute illness (I8000, clinical record)
<input type="checkbox"/>	• Other (I8000, clinical record)



PRACTICE

✓	Medications (consultant pharmacist review of medication regimen can be very helpful)
<input type="checkbox"/>	• Opioids (N0410H)
<input type="checkbox"/>	• Antipsychotics (N0410A)
<input type="checkbox"/>	• Antianxiety (N0410B)
<input type="checkbox"/>	• Antidepressants (N0410C)
<input type="checkbox"/>	• Parkinson's medications
<input type="checkbox"/>	• Hypnotics (N0410D)
<input type="checkbox"/>	• Gentamycin (N0410F)
<input type="checkbox"/>	• Tobramycin (N0410F)
<input type="checkbox"/>	• Aspirin
<input type="checkbox"/>	• Other (clinical record)



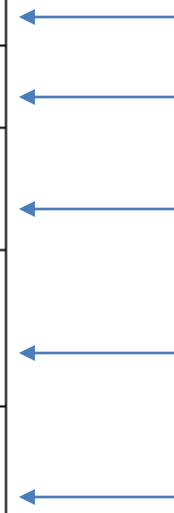
PRACTICE

✓	Characteristics of the communication impairment (from clinical record)	
<input type="checkbox"/>	• Expressive communication (B0700)	
<input type="checkbox"/>	— Speaks different language (A1100)	
<input type="checkbox"/>	— Disruption in ability to speak (B0600, clinical record)	←
<input type="checkbox"/>	— Problem with voice production, low volume (B0600, clinical record)	←
<input type="checkbox"/>	— Word-finding problems (clinical record)	←
<input type="checkbox"/>	— Difficulty putting sentence together (B0700, C1310C, clinical record)	←
<input type="checkbox"/>	— Problem describing objects and events (B0700, clinical record)	←
<input type="checkbox"/>	— Pronouncing words incorrectly (B0600, clinical record)	←
<input type="checkbox"/>	— Stuttering (B0700, clinical record)	←
<input type="checkbox"/>	— Hoarse or distorted voice (clinical record)	



PRACTICE

<input type="checkbox"/>	• Receptive communication (B0800)
<input type="checkbox"/>	— Does not understand English (A1100)
<input type="checkbox"/>	— Hearing impairment (B0200, B0300 = 1, B0800)
<input type="checkbox"/>	— Speech discrimination problems (clinical record)
<input type="checkbox"/>	— Decreased vocabulary comprehension (clinical record) (A1100A-B)
<input type="checkbox"/>	— Difficulty reading and interpreting facial expressions (clinical record, direct observation)
<input type="checkbox"/>	• Communication is more successful with some individuals than with others. Identify and build on the successful approaches (clinical record, interviews, observation)
<input type="checkbox"/>	• Limited opportunities for communication due to social isolation or need for communication devices (clinical record, interviews)
<input type="checkbox"/>	• Communication problem may be mistaken as cognitive impairment





PRACTICE

<input checked="" type="checkbox"/>	Confounding problems that may need to be resolved before communication will improve
<input type="checkbox"/>	<ul style="list-style-type: none"> Decline in cognitive status (clinical record) and BIMS decline (C0500, V0100D)
<input type="checkbox"/>	<ul style="list-style-type: none"> Mood problem, increase in PHQ-9 score (D0300, D0600, V0100E)
<input type="checkbox"/>	<ul style="list-style-type: none"> Increased dependence in Activities of Daily Living (ADLs) (clinical record, changes in G0110, G0120)
<input type="checkbox"/>	<ul style="list-style-type: none"> Deterioration in respiratory status (clinical record)
<input type="checkbox"/>	<ul style="list-style-type: none"> Oral motor function problems, such as swallowing, clarity of voice production (B0600, K0100, clinical record)
<input checked="" type="checkbox"/>	Use of communication devices (from clinical record, observation)
<input type="checkbox"/>	<ul style="list-style-type: none"> Hearing aid (B0300)
<input type="checkbox"/>	<ul style="list-style-type: none"> Written communication
<input type="checkbox"/>	<ul style="list-style-type: none"> Sign language
<input type="checkbox"/>	<ul style="list-style-type: none"> Braille
<input type="checkbox"/>	<ul style="list-style-type: none"> Signs, gestures, sounds
<input type="checkbox"/>	<ul style="list-style-type: none"> Communication board
<input type="checkbox"/>	<ul style="list-style-type: none"> Electronic assistive devices
<input type="checkbox"/>	<ul style="list-style-type: none"> Other



PRACTICE

✓	Diseases and conditions that may be related to communication problems
<input type="checkbox"/>	• Alzheimer's Disease or other dementias (I4200, I4800, I8000)
<input checked="" type="checkbox"/>	• Aphasia (I4300) following a cerebrovascular accident (I4500)
<input type="checkbox"/>	• Parkinson's disease (I5300)
<input type="checkbox"/>	• Mental health problems (I5700 – I6100)
<input type="checkbox"/>	• Conditions that can cause voice production deficits, such as
<input type="checkbox"/>	— Asthma (I6200)
<input type="checkbox"/>	— Emphysema/COPD (I6200)
<input type="checkbox"/>	— Cancer (I0100)
<input type="checkbox"/>	— Poor-fitting dentures (L0200)
<input type="checkbox"/>	• Transitory conditions, such as
<input type="checkbox"/>	— Delirium (C1310, I8000, clinical record)
<input type="checkbox"/>	— Infection (I1700 – I2500)
<input type="checkbox"/>	— Acute illness (I8000, clinical record)
<input type="checkbox"/>	• Other (I8000, clinical record)





PRACTICE

Things to consider

- What is the concern or description of the problem?
- What is the cause and contributing factors?
- Is there any input from the resident and/or representative?
- Would a referral to another discipline be warranted?
- What might that care plan look like for this resident?



SUMMARY

- Complete and submit a timely, accurate MDS assessment
- Review the CAT(s)
- Talk with the resident, resident rep, and the Interdisciplinary Team (IDT)
- Perform chart review, observations, and interviews with staff or others as applicable



SUMMARY

- Put on the thinking cap “critical thinking”
- Make referrals as necessary
- Care plan
- **DOCUMENT!**



QUESTIONS





MDS DHS WEBSITE

<http://www.dhs.wisconsin.gov/>

- Go to A-Z at the top of the page
- Go to M (minimum data set)

<https://www.dhs.wisconsin.gov/regulations/nh/rai-mds.htm>



THANK YOU!

Contact Information

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608-266-1718



REFERENCES

- [RAI Manual](#) v1.17.2
- [Appendix PP](#) State Operations Manual (SOM)