

MDS 3.0 Care Area Assessment (Pre-Care Plan) Development Process

Carol Eastburg, RN, HFI II
RAI/MDS/OASIS Education Coordinator

May 15, 2024



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

ALL IN GOOD HEALTH.

AGENDA

9:00 – 11:30* Carol Eastburg

11:30 – 12:00* Post-test/Answers/Eval

*approximate

OBJECTIVES

Attendees will:

Be familiar with all components of the CAAs and CATs

Understand the requirements for each step in the process

Know where to find needed supportive documentation

Be confident in their ability to develop appropriate care plans

DISCLAIMER



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

Information in this training is NOT intended to be all inclusive and is not a substitute for current regulations, CMS publications, updates, or instructions outlined in the RAI/MDS User Manual.

Attendees are encouraged to review the specific statutes, regulations, and other interpretive materials on a regular basis to ensure a full and accurate, up-to-date understanding of CMS requirements.

LAST SESSION

- Sections O, P and Q
- Trained/competent clinicians and administrative staff may complete sections of the RAI
- Documented evidence required to code active diagnosis (Physician query)
- RN Assessment Coordinator must document MDS-related assignments given to LPNs; facility policy.

FOLLOW-UP QUESTION #1



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

Is Hydroxyzine* considered/coded as anti-anxiety medication in Section N?

*Brand name Vistaril

FOLLOW-UP RESPONSE #1



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

N0415: High-Risk Drug Classes: Use and Indication

Check if the resident is taking any medications by pharmacological classification, not how it is used...

FOLLOW-UP QUESTION #2



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

Does an RN have to oversee and sign off on MDS sections completed by an LPN?



FOLLOW-UP RESPONSE #2

- Per the RAI Manual, a registered nurse must conduct or coordinate each assessment and sign off (at Z0500).
- A registered nurse Coordinator has assigned completion of the MDS/RAI Assessment to the LPN consistent with NAC 632.230 (Effective 1/19/22)

FOLLOW-UP QUESTION #3

Can you provide some GG functional, selfcare and mobility care planning templates and/or examples?

FOLLOW-UP RESPONSE #3

No “templates” per se, but we have excellent tools and examples to assist with the process.

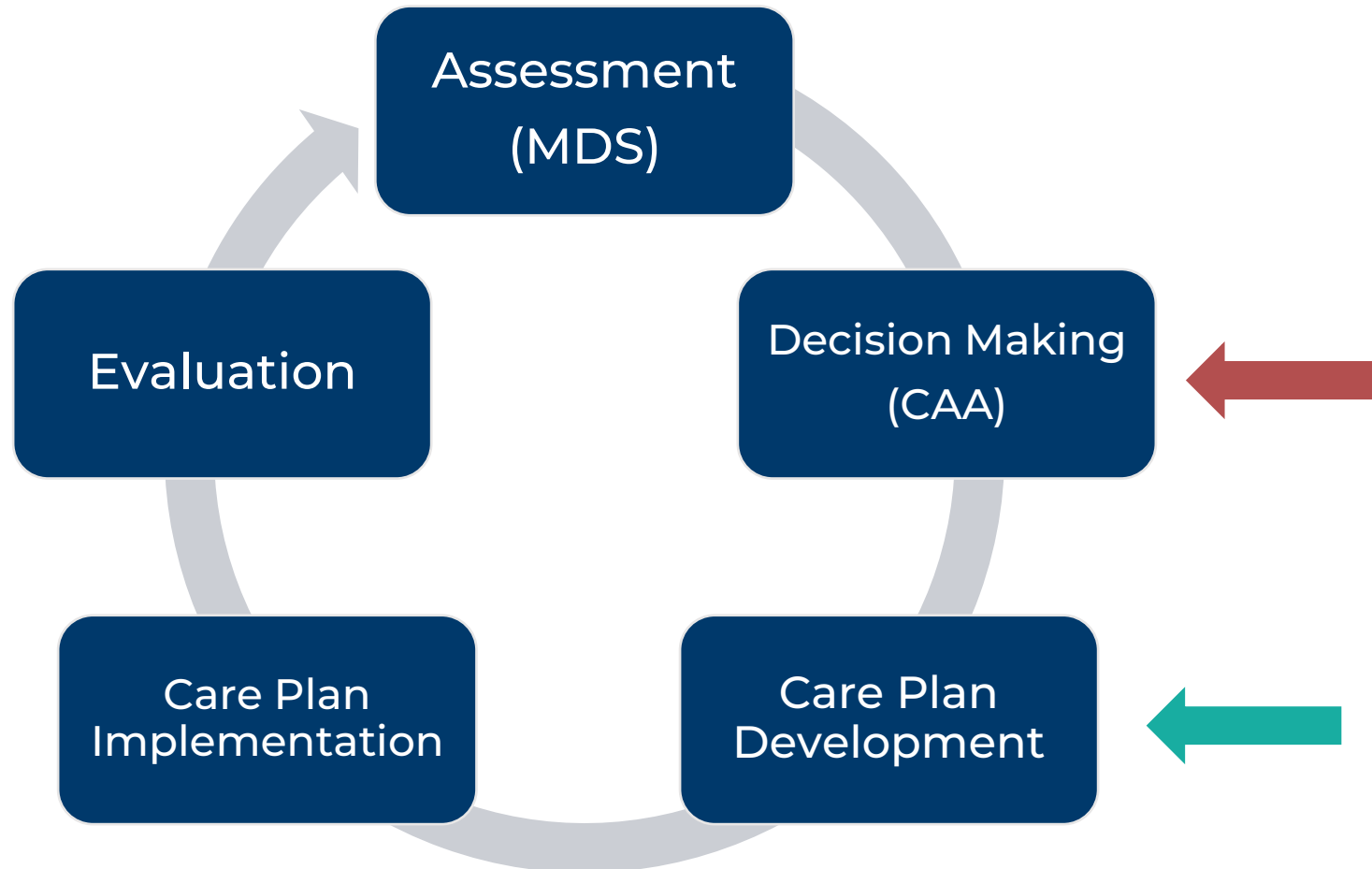
OBRA 1987

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987 or simply, OBRA) mandates 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.

RAI/CAA PROCESS OVERVIEW



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH





ASSESSMENTS REQUIRED

Comprehensive (NC) – Admission, Annual, Significant Change in Status Assessment (SCSA) and Significant Correction in Prior Comprehensive Assessment (SCPA)

Quarterly (NQ) – OBRA Quarterly, includes Significant Correction of Prior Quarterly Assessment (SCQA)

PPS (NP) – 5-Day Medicare Part A

Interim Payment Assessment (IPA) – Optional, Unscheduled, only for Medicare Part A beneficiaries

WHAT IS THE RAI?

The Resident Assessment Instrument (RAI) consists of three basic components:

- 1) the Minimum Data Set (MDS 3.0)
- 2) the Care Area Assessment (CAA) process
- 3) the RAI Utilization Guidelines (User Manual)

WHAT IS A CAA?

Care Area Assessment (CAA) Process:

Focused investigation of triggered areas to determine if they require interventions and care planning.



PURPOSE OF THE CAAs

When implemented properly, the CAA process should help staff:

- Consider each resident as an individual with unique characteristics and strengths that affect that individual's capacity to function;
- Identify areas of concern that may warrant interventions;
- Develop, to the extent possible, 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.

CARE AREA TRIGGERS (CATs)



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

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.

THE 20 CARE AREAS



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

Care Area Assessments in the Resident Assessment Instrument, Version 3.0

- | | |
|---|-----------------------------------|
| 1. Delirium | 11. Falls |
| 2. Cognitive Loss/Dementia | 12. Nutritional Status |
| 3. Visual Function | 13. Feeding Tube |
| 4. Communication | 14. Dehydration/Fluid Maintenance |
| 5. ADLs, Functional/Rehab Potential | 15. Dental Care |
| 6. Urinary Incontinence/Indwelling Catheter | 16. Pressure Ulcer/Injury |
| 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 |

CARE AREA SPECIFIC RESOURCES

The specific resources or tools contained on the next several pages are provided by care area. The general instructions for using them include:

Step 1: After completing the MDS, review all MDS items and responses to determine if any care areas have been triggered.

Step 2: For any triggered care area(s), conduct a thorough assessment of the resident using the care area-specific resources.

Step 3: Check the box in the left column if the item is present for this resident. *Some of this information will be on the MDS - some will not.*

Step 4: In the right column the facility can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor(s) for item(s) checked, etc.

Step 5: Obtain and consider input from resident and/or family/resident's representative regarding the care area.

Step 6: Analyze the findings in the context of their relationship to the care area and standards of practice. This should include a review of indicators and supporting documentation, including symptoms and causal and contributing factors, related to this care area. Draw conclusions about the causal/contributing factors and effect(s) on the resident, and document these conclusions in the Analysis of Findings section.

Step 7: Decide whether referral to other disciplines is warranted and document this decision.

Step 8: In the Care Plan Considerations section, document whether a care plan for the triggered care area will be developed and the reason(s) why or why not.

Step 9: Information in the *Supporting Documentation* column can be used to populate the *Location and Date of CAA Documentation* column in Section V, Item V0200A (CAA Results) – for e.g. “See Delirium CAA 4/30/11, H&P dated 4/18/11.”

NOTE: An optional Signature/Date line has been added to each checklist. This was added if the facility wants to document the staff member who completed the checklist and date completed.

DISCLAIMER: The checklists of care area specific resources in this appendix are not mandated, prescriptive, or all-inclusive and are provided as a service to facilities. They do not constitute or imply endorsement by CMS or HHS.

See Page C-3 in
Appendix C of
the Manual



STEP 1:

After completing the MDS, review all MDS items and responses to determine if any care areas have been 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 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!



STEP 2:

Check the box in the left column if the item is present for this resident. **Some of this information will be in the MDS – some will not.**

| 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"/> | |
| 06. Urinary Incontinence and Indwelling Catheter | <input type="checkbox"/> | <input type="checkbox"/> | |
| 07. Psychosocial Well-Being | <input type="checkbox"/> | <input type="checkbox"/> | |
| 08. Mood State | <input type="checkbox"/> | <input type="checkbox"/> | |
| 09. Behavioral Symptoms | <input type="checkbox"/> | <input type="checkbox"/> | |

STEP 2: INFO SOURCES

- ❖ SNF Admission orders
- ❖ History & Physical, physician notes, surgical reports, discharge summary from previous setting
- ❖ Nursing, therapies, social services, and dietary notes, ADL flow sheets, activity department notes, etc.
- ❖ Lab results and other diagnostic test reports (Radiological, EKG, MRI, CT scan, etc.)
- ❖ The resident and/or the resident's representative (spouse, other family member, friend, fiancé, Power of Attorney, court assigned advocate, etc.), attending provider.

STEP 3:

For each triggered care area, conduct a thorough assessment of the resident using the care area-specific resources. (Pages C-5 thru C-84)

APPENDIX C CARE AREA ASSESSMENT (CAA) RESOURCES



STEP 4:

In the right column, the facility provides a summary of supporting documentation regarding the basis or reason for checking certain items. This could include the location and date of documentation, symptoms, possible causal and contributing factor(s) for item(s) checked, etc.

| | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|-------------------------------------|---|--|
| <input checked="" type="checkbox"/> | Reversible causes of cognitive loss | |
| <input type="checkbox"/> | <ul style="list-style-type: none">Delirium (C1310) CAA triggered (Immediate follow-up required. Perform the Delirium CAA to determine possible causes, contributing factors, etc., and go directly to care planning for those issues. Then continue below.) | |
| <input checked="" type="checkbox"/> | Neurological factors | Supporting Documentation |
| <input type="checkbox"/> | <ul style="list-style-type: none">Intellectual disability/Developmental Disability (A11550) | |



STEP 5:

Obtain and consider input from the resident and/or family/
resident's representative regarding each specific triggered
care area.

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



STEP 6:

Step 6: Analyze the findings in the context of their relationship to the care area and standards of practice. This should include a review of indicators and supporting documentation, including symptoms and causes and contributing factors, related to this care area. Draw conclusions about the causal/contributing factors and effect(s) on the resident and document these conclusions in the Analysis of Findings section.

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



STEP 7:

Decide whether referrals to other disciplines are warranted and document this decision.

Referral(s) to another discipline(s) is warranted (to whom and why): N/A

STEP 8:

In the Care Plan Considerations section, document whether a care plan for the triggered area will be developed and the reason(s) why or why not.

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



STEP 9:

Information in the *Supporting Documentation* column can be used to populate the *Location and Date of CAA Documentation* column in Section V, Item V0200A (CAA Results) - For example:

| Supporting Documentation |
|---|
| See Delirium CAA 4/30/11, H&P dated 4/18/11 |



NOTE

An optional Signature/Date line has been added to each checklist in case the facility wants to document the staff member who completed the checklist and the date it was completed.

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

Yes No

Signature/Title: _____ Date: _____

DISCLAIMER ON PAGE C-3

The checklists of care area specific resources in this appendix are not mandated, prescriptive, or all-inclusive and are provided as a service to facilities. They do not constitute or imply endorsement by CMS or HHS.



MR. R. - EXAMPLE RESIDENT

72-year-old male admitted from acute care last night 10 days s/p ischemic CVA, with new onset expressive aphasia, impaired short-term memory, moderate right (dominant)-sided weakness, unable to transfer independently, impaired ambulation, and deep tissue injury right heel.

The hospital discharge summary reveals Mr. R. has a history of hypertension, atherosclerosis, O2 dependent COPD, and arthritis bilateral hands.

Orders are for skilled speech, occupational, and physical therapy to evaluate and treat; skilled nursing for close monitoring of vital signs and reactions to medication adjustments, prevent worsening of DTI, and development of additional skin issues.

A social service note indicates Mr. R., a retired architect, lives in a one-story house with his very supportive wife of 50 years, along with their adult daughter and her 12-year-old son. Mr. R. would like to return home.

EXAMPLE STEP 1:



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

Review entire completed MDS
and indicate which care areas
are triggered in Section V0200

MDS RESPONSES-SECTION A



A0310. Type of Assessment

Enter Code **01**

A. Federal OBRA Reason for 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 **01**

B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay

- 01. 5-day scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

- 08. IPA - Interim Payment Assessment

Not PPS Assessment

- 99. None of the above

Enter Code **1**

E. Is this assessment the first assessment (OBRA, Scheduled, PPS, or PPSA)?

- 0. No
- 1. Yes

Enter Code **99**

F. Entry/discharge reporting

- 01. Entry tracking record
- 10. Discharge assessment-return not anticipated
- 11. Discharge assessment-return anticipated
- 12. Death in facility tracking record
- 99. None of the above

“Bonus Slide”

MDS RESPONSES-SECTION B



Section B - Hearing, Speech, and Vision

B0100. Comatose

Enter Code **0** Persistent vegetative state/no discernible consciousness
0. No → Continue to B0200, Hearing
1. Yes → Skip to GG0100, Prior Functioning: Everyday Act

B0200. Hearing

Enter Code **0** Ability to hear (with hearing aid or hearing appliances if normally used)
0. Adequate - no difficulty in normal conversation, social interaction
1. Minimal difficulty - difficulty in some environments (e.g., noisy places)
2. Moderate difficulty - speaker has to increase volume and/or repeat words
3. Highly impaired - absence of useful hearing

B0300. Hearing Aid

Enter Code **0** Hearing aid or other hearing appliance used in completing B0200
0. No
1. Yes

B0600. Speech Clarity

Enter Code **2** Select best description of speech pattern
0. Clear speech - distinct intelligible words
1. Unclear speech - slurred or mumbled words
2. No speech - absence of spoken words

B0700. Makes Self Understood

Enter Code **2** Ability to express ideas and wants, consider both verbal and non-verbal
0. Understood
1. Usually understood - difficulty communicating some words
2. Sometimes understood - ability is limited to making concrete requests
3. Rarely/never understood

B0800. Ability To Understand Others

Enter Code **0** Understanding verbal content, however able (with hearing aid or other hearing appliance)
0. Understands - clear comprehension
1. Usually understands - misses some part/intent of message
2. Sometimes understands - responds adequately to simple requests
3. Rarely/never understands

B1000. Vision

Enter Code **0** Ability to see in adequate light (with glasses or other visual appliances)
0. Adequate - sees fine detail, such as regular print in newspaper
1. Impaired - sees large print, but not regular print in newspaper
2. Moderately impaired - limited vision; not able to see newspaper
3. Highly impaired - object identification in question, but eyes open
4. Severely impaired - no vision or sees only light, colors or shapes

B1200. Corrective Lenses

Enter Code **1** Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000
0. No
1. Yes

B1300. Health Literacy

Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1

Enter Code **7** How often do you need to have someone help you when you read in a pharmacy?
0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

MDS RESPONSES-SECTION GGO130

- 06. Independent - Resident completes the activity by themselves with no assistance from a helper.
- 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

| 1. Admission Performance | 2. Discharge Goal | |
|--------------------------------|-------------------------|---|
| Enter Codes in Boxes | | |
| 04 | 06 | A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and meal is placed before the resident. |
| 04 | 06 | B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| 03 | 06 | C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| 02 | 04 | E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing). Does not include transferring in/out of tub/shower. |
| 02 | 04 | F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| 02 | 04 | G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include shoes. |
| 01 | 06 | H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that provides safe mobility; including fasteners, if applicable. |
| 03 | | I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying lotion, and drying face and hands (excludes baths, showers, and oral hygiene). |

MDS RESPONSES-SECTION GGO170

- 06. Independent - Resident completes the activity by themselves with no assistance from a helper.
- 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

| 1. Admission Performance | 2. Discharge Goal | |
|--------------------------------|-------------------------|--|
| Enter Codes in Boxes | | |
| 04 | 06 | A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. |
| 03 | 06 | B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| 03 | 06 | C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no bed support. |
| 03 | 06 | D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| 03 | 06 | E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). |
| 03 | 06 | F. Toilet transfer: The ability to get on and off a toilet or commode. |
| 03 | | FF. Tub/shower transfer: The ability to get in and out of a tub/shower. |
| 02 | 06 | G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/c door or fasten seat belt. |
| 02 | 06 | I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GGO170M, 1 step (curb) |
| 03 | 06 | J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. |
| 88 | 06 | K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. |

MDS RESPONSES-GG0170, CONT.

If activity was not attempted, code reason:

07. Resident refused

09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)

88. Not attempted due to medical condition or safety concerns

| 1. Admission Performance | 2. Discharge Goal | |
|--|----------------------------------|--|
| Enter Codes in Boxes | | |
| <input type="text" value="1"/> <input type="text" value="0"/> | <input type="text" value="..."/> | L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| <input type="text" value="1"/> <input type="text" value="0"/> | <input type="text"/> | M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object |
| <input type="text"/> | <input type="text"/> | N. 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object |
| <input type="text"/> | <input type="text"/> | O. 12 steps: The ability to go up and down 12 steps with or without a rail. |
| <input type="text" value="8"/> <input type="text" value="8"/> | <input type="text"/> | P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| Q1. Does the resident use a wheelchair and/or scooter? | | |
| <input type="text" value="1"/> 0. No → Skip to GG0130, Self Care (Discharge) 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns | | |
| <input type="text" value="0"/> <input type="text" value="7"/> | <input type="text"/> | R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| RR1. Indicate the type of wheelchair or scooter used. | | |
| <input type="text" value="1"/> 1. Manual 2. Motorized | | |
| <input type="text" value="0"/> <input type="text" value="7"/> | <input type="text"/> | S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| SS1. Indicate the type of wheelchair or scooter used. | | |
| <input type="text" value="1"/> 1. Manual 2. Motorized | | |

EXAMPLE STEP 2:



Current Problems:

Expressive aphasia
Impaired memory
Weakness right side
Transfer dependent
Impaired ambulation
DTI right heel

Hx:

HTN
Atherosclerosis
O2 dependent COPD
RA bilateral hands

| 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 checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 03. Visual Function | <input type="checkbox"/> | <input type="checkbox"/> | |
| 04. Communication | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 05. ADL Functional/Rehabilitation Potential | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 06. Urinary Incontinence and Indwelling Catheter | <input type="checkbox"/> | <input type="checkbox"/> | |
| 07. Psychosocial Well-Being | <input type="checkbox"/> | <input type="checkbox"/> | |
| 08. Mood State | <input type="checkbox"/> | <input type="checkbox"/> | |
| 09. Behavioral Symptoms | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Activities | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 11. Falls | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 12. Nutritional Status | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 13. Feeding Tube | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Dehydration/Fluid Maintenance | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 15. Dental Care | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16. Pressure Ulcer | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 17. Psychotropic Drug Use | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18. Physical Restraints | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19. Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| 20. Return to Community Referral | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |



EXAMPLE STEP 3:

Care Area Assessments in the Resident Assessment Instrument, Version 3.0

- | | |
|---|-----------------------------------|
| 1. Delirium | 11. Falls |
| 2. Cognitive Loss/Dementia | 12. Nutritional Status |
| 3. Visual Function | 13. Feeding Tube |
| 4. Communication | 14. Dehydration/Fluid Maintenance |
| 5. ADLs, Functional/Rehab Potential | 15. Dental Care |
| 6. Urinary Incontinence/Indwelling Catheter | 16. Pressure Ulcer/Injury |
| 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 |

STEP 3 COMMUNICATION



4. COMMUNICATION

Review of Indicators of Communication

| Diseases and conditions that may be related to communication problems | | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) | | | Confounding problems that may need to be resolved before communication will improve | |
|---|--|---|--|---|---|---|
| <input checked="" type="checkbox"/> | Alzheimer's Disease or other dementias (I4200, I4800, I8000) | | Characteristics of the communication impairment <input type="checkbox"/> Expressive communication (B0700) <input type="checkbox"/> — Speaks different language (A1110A–B) <input type="checkbox"/> — Disruption in ability to speak (B0600) <input type="checkbox"/> — Problem with voice production, low volume (B0600) <input type="checkbox"/> — Word-finding problems <input type="checkbox"/> — Difficulty putting sentence together (B0700, C1310C) <input type="checkbox"/> — Problem describing objects and events (B0700) <input type="checkbox"/> — Pronouncing words incorrectly (B0600) <input type="checkbox"/> — Stuttering (B0700) <input type="checkbox"/> — Hoarse or distorted voice <input type="checkbox"/> Receptive communication (B0800) <input type="checkbox"/> — Does not understand English (A1110A–B) <input type="checkbox"/> — Hearing impairment (B0200, B0300, B0800) <input type="checkbox"/> — Speech discrimination problems <input type="checkbox"/> — Decreased vocabulary comprehension (A1110B) <input type="checkbox"/> — Difficulty reading and interpreting facial expressions <input type="checkbox"/> Communication is more successful with some individuals than with others. Identify and build on the successful approaches <input type="checkbox"/> Limited opportunities for communication due to social isolation or need for communication devices <input type="checkbox"/> Communication problem may be mistaken as cognitive impairment | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) | <input type="checkbox"/> | Decline in cognitive status and BIMS decline (C0500, V0100D) |
| <input type="checkbox"/> | Aphasia (I4300) following a cerebrovascular accident (I4500) | | | | <input type="checkbox"/> | Mood problem, increase in PHQ-2 to 9 [®] or PHQ-9-OV [®] score (D0160, D0600, V0100E) |
| <input type="checkbox"/> | Parkinson's disease (I5300) | | | | <input type="checkbox"/> | Increased dependence in <i>functional abilities</i> (changes in GG0130, GG0170) |
| <input type="checkbox"/> | Mental health problems (I5700–I6100) | | | | <input type="checkbox"/> | Deterioration in respiratory status |
| <input type="checkbox"/> | Conditions that can cause voice production deficits, such as | | | | <input type="checkbox"/> | Oral motor function problems, such as swallowing, clarity of voice production (B0600, K0100) |
| <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) | | | | | |
| <input type="checkbox"/> | — Infection (I1700–I2500, M1040A) | | | | | |
| <input type="checkbox"/> | — Acute illness (I8000) | | | | | |
| <input type="checkbox"/> | Other (I8000, clinical record) | | | | | |
| <input checked="" type="checkbox"/> | Medications (consultant pharmacist review of medication regimen can be very helpful) | | | | Supporting Documentation | |
| <input type="checkbox"/> | Opioids (N0415H) | | | | <input type="checkbox"/> | Hearing aid (B0300) |
| <input type="checkbox"/> | Antipsychotics (N0415A) | | | | <input type="checkbox"/> | Written communication |
| <input type="checkbox"/> | Antianxiety (N0415B) | | | | <input type="checkbox"/> | Sign language (A1100A) |
| <input type="checkbox"/> | Antidepressants (N0415C) | | | | <input type="checkbox"/> | Braille (A1100A) |
| <input type="checkbox"/> | Parkinson's medications | | | | <input type="checkbox"/> | Signs, gestures, sounds |
| <input type="checkbox"/> | Hypnotics (N0415D) | | | | <input type="checkbox"/> | Communication board |
| <input type="checkbox"/> | Gentamycin (N0415F) | | | | <input type="checkbox"/> | Electronic assistive devices |
| <input type="checkbox"/> | Tobramycin (N0415F) | | | | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | Aspirin | | | | | |
| <input type="checkbox"/> | Other | | | | | |



STEP 4: SUPPORTIVE DOCUMENTATION

Review of Indicators of Communication

| | Confounding problems that may need to be resolved before communication will improve | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|-------------------------------------|---|---|
| <input checked="" type="checkbox"/> | | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Decline in cognitive status and BIMS decline (C0500, V0100D) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Mood problem, increase in PHQ-2 to 9^o or PHQ-9-OV^o score (D0160, D0600, V0100E) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Increased dependence in <i>functional abilities</i> (changes in GG0130, GG0170) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Deterioration in respiratory status | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Oral motor function problems, such as swallowing, clarity of voice production (B0600, K0100) | |
| <input checked="" type="checkbox"/> | Use of communication devices | Supporting Documentation |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Hearing aid (B0300) | <i>4/19/24 Acute SLP evaluation; 4/30/24 Acute DC Summary; 5/2/24 SNF Admission H&P; 5/3/24 SNF SLP evaluation; 5/5/24 MDS Communication CAA; 5/1/24 wife's input</i> |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Written communication | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Sign language (A1100A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Braille (A1100A) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> Signs, gestures, sounds | |
| <input checked="" 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 | |

Section Z - Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

| | Signature | Title | Sections | Date Section Completed |
|----|-----------------|------------|-------------|------------------------|
| A. | | | | |
| B. | | | | |
| C. | | | | |
| D. | | | | |
| E. | <i>STherapy</i> | <i>SLP</i> | <i>B, F</i> | <i>5/3/24</i> |
| F. | | | | |
| G. | | | | |
| H. | | | | |
| I. | | | | |
| J. | | | | |
| K. | | | | |
| L. | | | | |

STEP 5: RESIDENT/FAM INPUT



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

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

5/1/24 during admission: Per spouse, before CVA, Mr. R. was a very articulate/open communicator; now reliant on communication board; becomes extremely frustrated/angry if not always accessible; anger is new - normally very low-key, upbeat, go with the flow attitude.

Indicate if this section is continued and where the continuation may be found.



STEP 6: ANALYSIS OF FINDINGS

Analysis of Findings

Review indicators and supporting documentation, and draw conclusions.

Document:

- Description of the problem;
- Causes and contributing factors; and
- Risk factors related to the care area.

*New onset expressive aphasia s/p CVA;
Pre-CVA, articulate and very
communicative; inability to communicate
triggers instant frustration/anger; risks
include exacerbation of HTN, CVA*

Enter all pertinent details affecting this care area.



STEP 7: REFERRAL DECISIONS



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

N/A



STEP 8: TO CARE PLAN OR NOT?

| | Care Plan Considerations |
|--|---|
| Care Plan <input checked="" type="radio"/> Y/ <input type="radio"/> N | Document reason(s) care plan will/will not be developed. |
| | <i>Need to avoid increased risk of uncontrolled HTN, additional CVA</i> |

Enter reason why care plan will (or won't) be developed.



STEPS 6 & 8 COMBINED:



| 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> |
| <p><i>New onset expressive aphasia s/p CVA; Pre-CVA, resident articulate and very communicative; inability to communicate triggers instant frustration/anger; risks include exacerbation of HTN, CVA</i></p> | | <p><i>To avoid increased risk of uncontrolled HTN, additional CVA, <u>ensure comm board is always available.</u></i></p> |

STEP 9: SUPPORTING DOCUMENTATION



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH

Supporting Documentation

4/19/24 Acute care SLP evaluation; 4/30/24 Acute DC Summary; 5/2/24 SNF Admission H&P; 5/3/24 SNF SLP evaluation; 5/5/24 RAI Communication CAA; 5/1/24 Spouse input



NOTE: YOU HAVE OPTIONS

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

Yes No

Signature/Title: _____ Date: _____

STEP 3 ADLS FUNCT REHAB



Review of Indicators of ADLs – Functional/Rehabilitation Potential

| | Possible underlying problems that may affect function. Some may be reversible. | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|-------------------------------------|---|--|
| <input checked="" type="checkbox"/> | • Delirium (C1310) (Delirium CAA) | |
| <input type="checkbox"/> | • Acute episode or flare-up of chronic condition | |
| <input type="checkbox"/> | • Changing cognitive status (C0100) (see Cognitive Loss CAA) | |
| <input type="checkbox"/> | • Mood decline (D0160, D0600) (see Mood State CAA) | |
| <input type="checkbox"/> | • Daily behavioral symptoms/decline in behavior (E0200) (see Behavioral Symptoms CAA) | |
| <input type="checkbox"/> | • Use of physical restraints (P0100) (see Physical Restraints CAA) | |
| <input type="checkbox"/> | • Pneumonia (I2000) | |
| <input type="checkbox"/> | • Fall (J1700–J1900) (see Falls CAA) | |
| <input type="checkbox"/> | • Hip fracture (I3900) | |
| <input checked="" type="checkbox"/> | • Recent hospitalization (A1700, A1805) | |
| <input type="checkbox"/> | • Fluctuating functional abilities (GG0130, GG0170) | |
| <input type="checkbox"/> | • Nutritional problems (K0520A, K0520B) (see Nutrition CAA) | |
| <input type="checkbox"/> | • Pain (J0300, J0800) (see Pain CAA) | |
| <input type="checkbox"/> | • Dizziness | |
| <input checked="" type="checkbox"/> | • Communication problems (B0200, B0700, B0800) (see Communication CAA) | |
| <input type="checkbox"/> | • Vision problems (B1000) (see Vision CAA) | |
| <input checked="" type="checkbox"/> | Abnormal laboratory values | Supporting Documentation |
| <input type="checkbox"/> | • Electrolytes | |
| <input type="checkbox"/> | • Complete blood count | |
| <input type="checkbox"/> | • Blood sugar | |
| <input type="checkbox"/> | • Thyroid function | |
| <input type="checkbox"/> | • Arterial blood gases | |
| <input type="checkbox"/> | • Other | |

| | Medications that can contribute to functional decline | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|-------------------------------------|--|--|
| <input checked="" type="checkbox"/> | • Psychoactive medications (N0415A–D) | |
| <input type="checkbox"/> | • Opioids (N0415H) | |
| <input type="checkbox"/> | • Other medications – ask consultant pharmacist to review medication regimen to identify these medications | |
| <input checked="" type="checkbox"/> | Limiting factors resulting in need for assistance with self-care or mobility | Supporting Documentation |
| <input type="checkbox"/> | • Mental errors such as sequencing problems, incomplete performance, or anxiety limitations | |
| <input checked="" type="checkbox"/> | • Physical limitations such as weakness (GG0130, GG0170), limited range of motion (GG0115), poor coordination, poor balance, visual impairment (B1000), or pain (J0300, J0800) | |
| <input type="checkbox"/> | • Facility conditions such as policies, rules, or physical layout | |
| <input checked="" type="checkbox"/> | Problems resident is at risk for because of functional decline | Supporting Documentation |
| <input checked="" type="checkbox"/> | • Falls (J1700–J1900) | |
| <input type="checkbox"/> | • Weight loss (K0300) | |
| <input type="checkbox"/> | • Unidentified pain (J0800) | |
| <input type="checkbox"/> | • Social isolation | |
| <input type="checkbox"/> | • Restraint use (P0100) | |
| <input type="checkbox"/> | • Depression (D0150, D0160, D0500, D0600) | |
| <input checked="" type="checkbox"/> | • Complications of immobility, such as <input checked="" type="checkbox"/> Pressure ulcer/injury (M0210, M0300) — Muscular atrophy — Contractures (GG0115) — Incontinence (H0300, H0400) — Urinary (I2300) and respiratory (I2000, I2200, I8000) infections | |

EXAMPLE STEP 3 ADLS FUNCT REHAB



| ADL SUPPLEMENT (Attaining maximum possible independence) | | | | | | |
|---|-----------------------------------|-------------------------------------|---|--|--|---|
| PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered - In areas physical help provided, indicate reason(s) for this help. | | | | | | |
| | DRESSING | BATHING | TOILETING | LOCOMOTION | TRANSFER | EATING |
| Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. Physical Limitations: Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. Facility Conditions: Policies, rules, physical layout, etc. | | | | | | |
| PART 2: Possible ADL Goals INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment - | | | | If wheelchair, check: <input type="checkbox"/> | | |
| Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in). | Locates/ selects/ obtains clothes | Goes to tub/ shower | Goes to toilet (include commode/ urinal at night) | Walks in room/ nearby <input type="checkbox"/> | Positions self in preparation | Opens/ pours/ unwraps/ cuts etc. |
| | Grasps/puts on upper lower body | Turns on water/ adjusts temperature | Removes/ opens clothes in preparation | Walks on unit <input type="checkbox"/> | Approaches chair/bed | Grasps utensils and cups |
| | Manages snaps, zippers, etc. | Lathers body (except back) | Transfers/ positions self | Walks throughout building (uses elevator) <input type="checkbox"/> | Prepares chair/bed (locks pad, moves covers) | Scoops/ spears food (uses fingers when necessary) |
| | Puts on in correct order | Rinses body | Eliminates into toilet | Walks outdoors <input type="checkbox"/> | Transfers (stands/sits/ lifts/turns) | Chews, drinks, swallows |
| | Grasps, removes each item | Dries with towel | Tears/uses paper to clean self | Walks on uneven surfaces <input type="checkbox"/> | Repositions/ arranges self | Repeats until food consumed |
| | Replaces clothes properly | Other | Flushes | Other <input type="checkbox"/> | Other | Uses napkins, cleans self |
| | Other | | Adjusts clothes, washes hands | | | Other |

Where rehabilitation goals are envisioned, use of the ADL Supplement will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the supplement can assist in the evaluation of all residents that trigger this care area. Part 2 of the supplement can be helpful for residents with rehabilitation potential (ADL Triggers A), to help plan a treatment program.



EXAMPLE STEP 4: SUPPORTIVE DOCUMENTATION

Review of Indicators of ADLs – Functional/Rehabilitation Potential

| | Possible underlying problems that may affect function. Some may be reversible. | Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information) |
|---|---|--|
| ✓ | | |
| ☐ | • Delirium (C1310) (Delirium CAA) | |
| ☐ | • Acute episode or flare-up of chronic condition | |
| ☐ | • Changing cognitive status (C0100) (see Cognitive Loss CAA) | |
| ☐ | • Mood decline (D0160, D0600) (see Mood State CAA) | |
| ☐ | • Daily behavioral symptoms/decline in behavior (E0200) (see Behavioral Symptoms CAA) | |
| ☐ | • Use of physical restraints (P0100) (see Physical Restraints CAA) | |
| ☐ | • Pneumonia (I2000) | |
| ☐ | • Fall (J1700–J1900) (see Falls CAA) | |
| ☐ | • Hip fracture (I3900) | |
| ☑ | • Recent hospitalization (A1700, A1805) | |
| ☐ | • Fluctuating functional abilities (GG0130, GG0170) | |
| ☐ | • Nutritional problems (K0520A, K0520B) (see Nutrition CAA) | |
| ☐ | • Pain (J0300, J0800) (see Pain CAA) | |
| ☐ | • Dizziness | |
| ☑ | • Communication problems (B0200, B0700, B0800) (see Communication CAA) | |
| ☐ | • Vision problems (B1000) (see Vision CAA) | |

4/26/24 Acute P7

Progress Note:

4/30/24 Acute DC

Summary

5/2/24 SNF Admission

H&P; 5/3/24 SNF SLP

evaluation; 5/5/24 MDS

Communication CAA



EXAMPLE STEP 4: SUPPORTIVE DOCUMENTATION, CONT.

| ✓ | Limiting factors resulting in need for assistance with <i>self-care or mobility</i> | Supporting Documentation |
|-------------------------------------|---|---|
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Mental errors such as sequencing problems, incomplete performance, or anxiety limitations | 4/26/24 Acute PT Progress Note; 4/30/24 Acute DC Summary; 5/2/24 SNF PT Eval; 5/2/24 SNF OT Eval |
| <input checked="" type="checkbox"/> | <ul style="list-style-type: none"> • Physical limitations such as weakness (<i>GG0130, GG0170</i>), limited range of motion (<i>GG0115</i>), poor coordination, poor balance, visual impairment (B1000), or pain (J0300, <i>J0800</i>) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Facility conditions such as policies, rules, or physical layout | |
| ✓ | Problems resident is at risk for because of functional decline | Supporting Documentation |
| <input checked="" type="checkbox"/> | <ul style="list-style-type: none"> • Falls (<i>J1700–J1900</i>) | 5/2/24 SNF PT Eval; 4/30/24 Acute DC Summary; 5/1/24 Admission H&P 5/2/24 skilled nursing eval |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Weight loss (K0300) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Unidentified pain (J0800) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Social isolation | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Restraint use (P0100) | |
| <input type="checkbox"/> | <ul style="list-style-type: none"> • Depression (<i>D0150, D0160, D0500, D0600</i>) | |
| <input checked="" type="checkbox"/> | <ul style="list-style-type: none"> • Complications of immobility, such as <ul style="list-style-type: none"> — ✓ Pressure ulcer/injury (<i>M0210, M0300</i>) — Muscular atrophy — Contractures (<i>GG0115</i>) — Incontinence (H0300, H0400) — Urinary (I2300) and respiratory (<i>I2000, I2200, I8000</i>) infections | |



EXAMPLE STEP 5: RESIDENT/FAM INPUT

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

5/1/24 during admission: Per spouse, before CVA, Mr. R. was independent with activities of daily living and only occasionally needed assistance due to the pain and moderate deformity caused by RA in both hands, but especially the dominant right hand; afraid of being a burden to his family

Indicate if this section is continued and where the continuation may be found.



EXAMPLE STEP 6: ANALYSIS OF FINDINGS

| Analysis of Findings |
|--|
| <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><i>New onset right-sided upper and lower extremity (dominant side) s/p CVA. Now needs substantial assistance with ADLs; frustration r/t dependence on others for help results in risk for HTN exacerbation, subsequent CVA</i></p> |

Related details affecting this care area.





EXAMPLE STEP 8: TO CARE PLAN OR NOT?

| | Care Plan Considerations |
|--|--|
| Care Plan <input checked="" type="radio"/> Y/ <input type="radio"/> N | Document reason(s) care plan will/will not be developed. |
| | <i>Full therapeutic efforts to return to pre-acute care level of function will be care planned - resident very motivated and family is 100% supportive</i> |

Reason why care plan will (or won't) be developed.





EXAMPLE STEPS 6 & 8 COMBINED:

| 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. | Care Plan Y/N | Document reason(s) care plan will/will not be developed. |
| <i>At risk for HTN exac/subsequent CVA d/t frustration with being dependent for ADL assistance (formerly independent).</i> | | <i>Full therapeutic efforts to return to pre-CVA level of function to be care planned - resident very motivated and family 100% supportive</i> |

RECAP/SUMMARY

- ✓ Reviewed the three components of the RAI
- ✓ Described CAAs and their purpose
- ✓ Described CATs and their purpose
- ✓ Learned the steps of the CAA Process
- ✓ Practiced with an example resident

QUESTIONS?



**NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH**

THANK YOU!



POST TEST/EVALUATION

- Please follow the directions in the email with PT&E attached
- Both documents are required if you would like to receive CEUs
- All fields must have an entry to submit
- Your honest feedback is truly appreciated and considered for future use



CONTACT INFORMATION

Carol Eastburg, RN
Health Facilities Inspector II
RAI/MDS/OASIS Education Coordinator
ceastburg@health.nv.gov
(702) 622-9380 (Direct line)

ACRONYMS

- ADLs – Activities of Daily Living
- AKA – also known as
- ARD – Assessment Reference Date
- BIMS – Brief Interview for Mental Status
- CAAs – Care Area Assessments
- CATs – Care Area Triggers
- CCN – CMS Certification Number
- CMS – Centers for Medicare & Medicaid Services
- IADLs – Instrumental Activities of Daily Living
- IDT – Interdisciplinary Team (the Team)
- MDS – Minimum Data Set (aka RAI)
- RAI – Resident Assessment Instrument (aka MDS)



RESOURCES, 1

RAI Manual

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>

DHHS Official YouTube Channel

<https://www.youtube.com/channel/UC5Bfpf86CylhRm6vP5rjfRA>

State Operations Manual (SOM) Appendix PP

<https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>



RESOURCES, 2

State Operations Manual (SOM) Appendix PP

<https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

Section GG Assessment Tool

<https://www.aota.org/-/media/Corporate/Files/Practice/Manage/Documentation/Self-Care-Mobility-Section-GG-Items-Assessment-Template.pdf>

Care Plans and Examples

<https://www.nursetogether.com/nursing-care-plans/#care-plan-examples>

RESOURCES, 3

Care Plans

<https://nurselabs.com>

LPN Scope of Practice Decision Regarding MDS/RAI

<https://nevadanursingboard.org/wp-content/uploads/2022/03/LPN-MDS-RAI-final.pdf>

Nevada Official DHHS YouTube Channel

<https://www.youtube.com/@nevadadepartmentofhealthan3934/videos>