Track Changes
from Chapter 4 V1.03
to Chapter 4 V1.07

Chapter	Section	Page	Change
4	4.1	4-1	~~Background.~~ 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.
4	4.3	4-3	~~Care Area Assessment.~~ 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	4.5	4-6	• Relevant documentation for each triggered CAA describes: ~~C~~causes and contributing factors;
4	4.6	4-7	Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.75(b), ~~T~~the facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Furthermore, surveyor guidance within OBRA (e.g., F314 42 CFR 483.25(c) Pressure Sores and F329 42 CFR 483.25(l) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

4	4.6	4-8	Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents. By themselves, neither the MDS nor the CAA process 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. Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) 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. Although facilities have the latitude to choose approaches to the CAA process, compliance with various OBRA requirements can be enhanced by using additional relevant clinical problem solving and decision making processes to analyze and address MDS findings and CAAs. Table ~~1~~2 provides a framework for a more complete approach to clinical problem solving and decision making essential to the appropriate care of individuals with multiple and/or complex illnesses and impairments.
4	4.7	4-9	– Identify and collect information that is needed to identify an individual's conditions that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis

Track Changes
from Chapter 4 V1.03
to Chapter 4 V1.07

Chapter	Section	Page	Change
4	4.7	4-11 & 4-12	~~Care planning is a process that has several steps that may occur at the same time or in sequence. The following key steps and considerations may help the IDT develop the care plan after completing the comprehensive assessment:~~ ~~1. The RAI process (MDS and CAAs) and any other additional assessments as required by the resident's condition are completed as the basis for care plan decision making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the IDT that will develop the resident's care plan.~~ ~~2. The IDT uses clinical problem solving and decision making steps (Table 2) to make decisions. The team may find during their discussions that several problematic issues and/or conditions have a related cause. Or, they might find that they stand alone and are unrelated. Goals and approaches for each problematic issue and/or condition may overlap, and consequently the IDT may decide to address the problematic issues and/or conditions collectively in the care plan.~~ ~~3. After assessing the resident, staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.~~ ~~4. The existence of a care planning issue (i.e., a problematic issue and/or condition, need, or strength) should be documented as part of the CAA review documentation. There are various options for documentation; for example, it may be done by individual staff members who have completed assessments or have participated in care planning, or as a summary note by members of the IDT.~~ ~~5. Every effort should be made to include the input of the resident, family, or resident's representative in creating the individualized care plan. They should also be invited to participate in team discussions in an ongoing manner, and be encouraged to share their perspectives on the delivery of care. . This can be accomplished by having individual team members discuss preliminary care plan ideas with the resident, family, or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.~~ ~~6. In some cases, a resident may decline particular services or treatments that the IDT believes may assist him or her to attain the highest practicable level of well-being. In such cases, the resident's wishes should be honored and documented in the clinical record and alternatives should be offered before the care plan is finalized.~~ ~~7. The IDT should identify and document the functional and behavioral implications of identified problematic issues and/or conditions, limitations, maintenance levels, improvement possibilities, and so forth (e.g., how the condition is a problem for the resident, how the condition limits or jeopardizes the resident's ability to complete activities of daily living, or how the condition somehow affects the resident's well-being).~~ ~~8. The IDT agrees on intermediate goal(s) that will lead to outcome objectives.~~

~~9. The intermediate goal(s) and objectives must be pertinent to the resident's condition and situation (i.e., not just automatically applied without regard for their individual relevance), measurable, and have a time frame for completion or evaluation.~~

~~10. The parts of the goal statement should include: The **subject (first or third person),** the **verb,** the **modifiers,** the **time frame, and the goal(s)**.~~

	Verb	***Modifiers***	***Time frame***	***Goal***
~~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~~

~~11. Depending upon the conclusions of the assessment, types of goals may include improvement, prevention, palliation, or maintenance of current status.~~

~~12. The IDT, with input from the resident, family and/or resident representative, identifies specific, individualized steps or approaches that will be taken to help the resident achieve his or her goal(s). These approaches serve as instructions for resident care and provide for continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions by consistently.~~

~~13. The resident has the right to participate in care planning and to refuse treatment, as found in 42 CFR 483.10(d)(3). Unless adjudged incompetent or otherwise found incapacitated under the laws of the State, the resident has the right to participate in planning and/or modifying care and treatment. The final care plan should be agreed to and discussed with the resident or the resident's representative.~~

~~14. The goals and their accompanying approaches should be communicated to other direct care staffs who were not directly involved in developing the care plan.~~

~~15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.~~

~~16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). IDT members should communicate as needed about care plan changes.~~

~~17. A separate care plan is not necessarily 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. For 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.~~

Track Changes
from Chapter 4 V1.03
to Chapter 4 V1.07

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>4</td><td>4.8</td><td>4-11
&
4-12</td><td>
Care planning is a process that has several steps that may occur at the same time or in sequence. The following key steps and considerations may help the IDT develop the care plan after completing the comprehensive assessment:
1) Care Plan goals should be measurable. The IDT may agree on intermediate goal(s) that will lead to outcome objectives. Intermediate goal(s) and objectives must be pertinent to the resident's condition and situation (i.e., not just automatically applied without regard for their individual relevance), measurable, and have a time frame for completion or evaluation.
2) Care plan goal statements should include: The subject (first or third person), the verb, the modifiers, the time frame, and the goal(s).
<u>EXAMPLE:</u>
<table>
<tr><th>Subject</th><th>Verb</th><th>Modifiers</th><th>Time frame</th><th>Goal</th></tr>
<tr><td>Mr. Jones
OR I</td><td>will walk</td><td>fifty feet daily with the help of one nursing assistant</td><td>the next 30 days</td><td>in order to maintain continence and eat in the dining area</td></tr>
</table>
3) A separate care plan is not necessarily 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. For 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.
4) The RN coordinator is required to sign and date the CAA Summary form after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days).
</td></tr>
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			5) The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or 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. 6) If the RAI (MDS and CAAs) is not completed until the last possible date (the end of calendar day 14 of the stay), many of the appropriate care area issues, risk factors, or conditions may have already been identified, causes may have been considered, and a preliminary care plan and related interventions may have been initiated. A complete care plan is required no later than 7 days after the RAI is completed. 7) Review of the CAAs after completing the MDS may raise questions about the need to modify or continue services. Conditions that originally triggered the CAA may no longer be present because they resolved, or consideration of alternative causes may be necessary because the initial approach to an issue, risk, or condition did not work or was not fully implemented. 8) On the Annual assessment, if a resident triggers the same CAA(s) that triggered on the last comprehensive assessment, the CAA should be reviewed again. Even if the CAA is triggered for the same reason (no difference in MDS responses), there may be a new or changed related event identified during CAA review that might call for a revision to the resident's plan of care. The IDT with the input of the resident, family or resident's representative determines when a problem or potential problem needs to be addressed in the care plan. 9) The RN Coordinator for the CAA process (V0200B1) does not need to be the same RN as the RN Assessment Coordinator who verifies completion of the MDS assessment (Z0500). The date entered in V0200B2 on the CAA Summary form is the date on which the RN Coordinator for the CAA process verified completion of the CAAs, which includes assessment of each triggered care area and completion of the location and date of the CAA assessment documentation section. See Chapter 2 for detailed instructions on the RAI completion schedule. 10) The Signature of Person Completing Care Plan Decision (V0200C1) can be that of any person(s) who facilitates the care plan decision making. It is an interdisciplinary process. The date entered in V0200C2 is the day the RN certifies that the CAAs have been completed and the day V0200C1 is signed.

Track Changes
from Chapter 4 V1.03
to Chapter 4 V1.07

Chapter	Section	Page	Change
4	4.9	4-14	Example: Chief Complaint: New onset of falls Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most occurred after she stood up and started walking; a few while attempting to stand up from a sitting or lying position. It is clear that the problem statement reflects assessment findings from which the investigation may continue and relevant conclusions drawn.
4	4.9	4-16	Staff who have participated in the assessment and who have provided pertinent information about the resident's status for triggered care areas should be a part of the IDT that develops the resident's care plan. In order to provide continuity of care for the resident and good communication with all persons involved in the resident's care, information from the assessment that led the team to their care planning decision should be clearly documented. **See Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives.**
4	4.10	4-34	1. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by: **((M0300B1 > 0 AND M0300B1 <= 9) OR**