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2	2.1	2-1	The OBRA regulations require nursing homes that are Medicare certified, ~~or~~ Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA required assessments will be described in detail in Section 2.6.
2	2.2	2-1	While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S ~~I~~items. As such, each ~~state~~ State must have CMS approval of the State's Comprehensive and Quarterly assessments.
2	2.2	2-2	• CMS's approval of a ~~state's~~ State's RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI. • CMS's approval of a ~~state's~~ State's RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). • All comprehensive RAIs authorized by ~~states~~ States must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including CATs and the CAA Summary (Section V)). • If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the ~~state~~State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-approved State's RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts. • Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of

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			items as is found on the State RAI). Additional information about State specification of the RAI, variations in format and CMS approval of a ~~state's~~ State's RAI can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual (SOM). For more information about your ~~state's~~ State's assessment requirements, contact your ~~state~~ State RAI coordinator (see Appendix B).
2	2.3	2-2	The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a ~~state~~ State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.
2	2.3	2-2 & 2-3	• **Hospice Residents:** When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation ~~between, and participation~~ of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident. • **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required~~,~~; however, a Discharge assessment is required:
2	2.3	2-4	— The OBRA assessments are a requirement for long-term

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			care facilities~~,~~; therefore resident assessments are conducted prior to certification as if the beds were already certified. — For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. If a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. ~~–t~~The facility simply continues the OBRA schedule using the actual admission date as Day 1.
2	2.3	2-4 & 2-5	o There are no links to the prior provider, including sanctions, deficiencies, resident assessments, ~~Quality Indicators,~~ Quality Measures, debts, provider number, etc. o The previous owner would complete ~~discharge~~ a Discharge assessment - return not anticipated, thus code A0310F=10, A2000=date of ownership change, and A2100=02 for those residents who will remain in the facility. o The new owner would complete an ~~admission entry tracking records~~Admission assessment and Entry tracking record for all residents, thus code A0310F=01, A1600=date of ownership change, A1700=1 (admission), and A1800=02.
2	2.3	2-5	— When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their ~~State agency and their~~ Regional Office, State agency, and Medicare contractor for guidance.
2	2.4	2-6	• After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items

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			A0500-A1600) from the most recent ~~admission~~ Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated. • Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by ~~state~~ State and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
2	2.4	2-7	• Nursing homes that are not capable of ~~maintaining MDSs~~maintenance of the MDS electronically must adhere to the current requirement that either ~~(not both)~~ a hand written **or** a computer-generated copy be maintained in the clinical record. E~~—e~~ither is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period. • All ~~state~~ State licensure and ~~state~~ State practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where ~~state~~ State law is more restrictive than ~~federal~~ Federal requirements, the provider needs to apply the ~~state~~ State law standard.
2	2.5	2-8	**Assessment Reference Date (ARD)** refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS ~~form~~ Item Set ~~itself~~ or in the facility software within the appropriate timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.
2	2.5	2-9	• OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments

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			may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, ~~states~~ States may have more stringent restrictions. **Death ~~in~~ In ~~facility~~ Facility** refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. A Discharge assessment is not required.
2	2.5	2-10	**Entry and Discharge ~~reporting~~ Reporting** MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter or leave a nursing home. Entry/Discharge reporting includes Entry tracking record, Discharge assessments, and Death in Facility tracking record.
2	2.5	2-10	**Interdisciplinary Team (IDT[1])** is a group of clinicians from several medical fields that combines knowledge, skills, and resources to provide care to the resident. [1] 42 CFR 483.20(k)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative;"
2	2.5	2-10	• **Nursing Home** — **Comprehensive (NC[~~1~~2]) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone or combined with any other assessment (PPS assessment and/or Discharge assessment). [~~1~~2] The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.
2	2.5	2-12	**Leave of Absence (LOA)**, which does not require completion of either a D~~d~~ischarge assessment or an E~~e~~ntry tracking record, occurs when a resident has a:
2	2.5	2-12	Upon return, providers should make appropriate

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			documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record.
2	2.5	2-12	**MDS ~~assessment~~Assessment ~~codes~~Codes** are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, and A0310F of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter. **Medicare- ~~required~~Required PPS ~~assessments~~ Assessments** provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment) and A0310C (PPS Other Medicare Required Assessment – OMRA) ~~– they~~. They include:
2	2.5	2-13	**Non-~~comprehensive~~Comprehensive** MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly and Significant Correction to Prior Quarterly (SCQA) assessments.
2	2.5	2-13	**OBRA-~~required~~Required ~~tracking~~Tracking ~~records~~Records and ~~assessments~~Assessments** are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting) ~~– they~~. They include:
2	2.5	2-14	**Respite** refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry ~~Tracking~~tracking record and a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA admission.

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2	2.6	2-17	## Comprehensive Assessments OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of:
2	2.6	2-17	• If a resident had an OBRA admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the ~~time frame~~timeframe in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
2	2.6	2-18	must be maintained in the resident's medical record.~~2~~3 In closing the record, the nursing home should note why the RAI was not completed. • If a resident dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.~~3~~4 In closing the record, the nursing home should note why the RAI was not completed. ~~2~~3 The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved. ~~3~~4 The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.
2	2.6	2-18	• In the process of completing any assessment except an

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			Admission and a SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into the MDS system, and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing a SCPA, and chapter 5 for detailed information on processing corrections. • In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in ~~chapter~~Chapter 5.
2	2.6	2-19	• For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status **requires** an Entry ~~Tracking~~tracking record **each time** the resident returns to the facility and a Discharge assessment **each time** the resident is discharged. The nursing home may combine the Admission assessment with the Discharge assessment when applicable.
2	2.6	2-20	*A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.* *A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, ~~mental retardation~~intellectual disability (ID), or related condition~~ related to mental retardation~~ is present or is suspected to be present.*
2	2.6	2-21	— For a resident who goes in and out of the facility on a relatively frequent basis and reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry ~~Tracking~~tracking record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from a Significant

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			Change in Status Assessment during the intervening period, the staff must complete a SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
2	2.6	2-21	• A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services~~, t~~. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.
2	2.6	2-22	• A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin a SCSA. This ~~time-frame~~timeframe may vary depending on clinical judgment and resident needs. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident’s status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a

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			comprehensive assessment would not be required.
2	2.6	2-23	— Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g.,~~;~~ ~~I~~ increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (B~~b~~ehavior);
2	2.6	2-24	— Resident's ~~decision-making~~decision making changes for the better;
2	2.6	2-25	*Examples (SCSA):* 1. Mr. M has been in this nursing home for two and one-half years. He has been a favorite of staff and other residents, and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia~~–~~, diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.
2	2.6	2-26	• If a SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability ("mental retardation" in the regulation), or ~~condition~~ related ~~to mental retardation~~condition (as defined by 42 CFR 483.102), a referral to the state mental health or ~~mental retardation~~ID/DD authority (SMH/MR/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act[45]. [45] The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

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2	2.6	2-26	*Referral for Level II Resident Review Evaluations are Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability~~Mental Retardation~~, or a ~~Condition~~ Related Condition ~~to Mental Retardation~~ in the Following Circumstances:*
2	2.6	2-27	2. Ms. K has intellectual disability~~mental retardation~~. She is normally cooperative, but after she had a fall and sustained a leg injury, she becomes agitated and combative with the physical therapist and with staff who try to assess her status. She does not understand why her normal routine has changed and why staff are touching a painful area of her body. *Referral for Level II Resident Review Evaluations are Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability~~Mental Retardation~~, or a Related Condition ~~Related to Mental Retardation~~ in the Following Circumstances: Note: this is not an exhaustive list* • A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis). • A resident whose intellectual disability ~~mental retardation~~ as defined under 42 CFR 483.100, or related condition ~~related to mental retardation~~ as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR. • A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.
2	2.6	2-29	If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. For example: — Resident A has a ~~quarterly~~ Quarterly assessment with

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			an ARD of March 20th. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23rd and returns on March 25th. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continue with the assessment that was not fully completed before discharge and complete the assessment by April 3rd (which is day 14 after the ARD). — Resident B also has a ~~quarterly~~ Quarterly assessment with an ARD of March 20th. She goes to the hospital on March 20thand returns March 30th. While there is no significant change the facility decides to start a new assessment and sets the ARD for April 2nd and completes the assessment.
2	2.6	2-29	• If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.~~56~~ In closing the record, the nursing home should note why the RAI was not completed. ~~56~~ The RAI is considered part of the resident's clinical record and is treated as such by the RAI utilization guidelines, e.g., portions of the RAI that are "started" must be saved.
2	2.6	2-31	• OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, ~~states~~States may have more stringent restrictions.
2	2.6	2-32	Tracking Records and Discharge Assessments (A0310F) OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility~~ – they~~. T~~t~~hey do not include completion of the CAA process and care planning. The Discharge assessments include items for

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			quality monitoring. Entry and discharge reporting **is** required for Swing Bed residents and respite residents.
2	2.6	2-32	**Admission (Item A1700=1)** • Entry ~~Tracking~~tracking record is coded an Admission every time a resident: — is admitted for the first time to this facility~~,~~ ; or
2	2.6	2-33	— is readmitted after a discharge return anticipated when return was not within 30 days of discharge. • For swing bed facilities, the Entry ~~Tracking~~tracking record will always be coded 1, Admission, since these providers do not complete an OBRA Admission assessment.
2	2.6	2-33	*Example (Admission):* 1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the ~~entry~~Entry tracking record for the August 27, 2011 return as follows: **Reentry (Item A1700=2)** • Entry ~~Tracking~~tracking record is coded Reentry every time a person is readmitted to a nursing home when the resident was previously admitted to this nursing home (i.e., an OBRA Admission was completed), **and** was discharged return anticipated from this nursing home, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail. *Example (Reentry):* 1. Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital. On May 18, 2011, Mr. W.

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			returned to the facility. Code the Entry tracking ~~R~~record for the May 18, 2011 return, as follows: *Assessment Management Requirements and Tips for Entry Tracking ~~R~~Records:* • The Entry ~~Tracking~~tracking record is the first item set completed for all residents. • Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility). • Must be completed for a respite resident every time the resident enters the facility. • Must be completed within 7 days after the admission/reentry. • Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days).
2	2.6	2-34	• Is a ~~stand-alone~~stand-alone tracking record.
2	2.6	2-34	**08. Death in ~~f~~Facility ~~t~~Tracking R~~r~~ecord (A0310F=12)**
2	2.6	2-34	*Example (Death in Facility):* 1. Mr. W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. He passed away on November 13, 2011. Code the November 13, 2011 Death in Facility ~~Tracking~~tracking ~~Record~~record as follows:
2	2.6	2-34	**09. Discharge ~~assessment~~Assessment ~~return~~Return ~~not~~Not ~~anticipated~~Anticipated (A0310F=10)**
2	2.6	2-35	*Example (Discharge-return not anticipated):* 1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 Discharge ~~Assessment~~assessment as follows: **10. Discharge ~~assessment~~Assessment ~~return~~Return ~~anticipated~~Anticipated (A0310F=11)**
2	2.6	2-35	• For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be

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			expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return within 30 days. This status requires an Entry ~~Tracking~~tracking record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged. • When a resident had a prior Discharge ~~Assessment~~ assessment completed indicating that the resident was expected to return (A0310E=11) to the facility, but later learned that the resident will not be returning to the facility~~;~~, there is no Federal requirement to inactivate the resident's record nor to complete another Discharge assessment. Please contact your State RAI Coordinator for specific ~~state~~State requirements.
2	2.7	2-38	The RAI process, which includes the ~~federally~~Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.
2	2.7	2-38	**CAA(s) Completion** • Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or ~~t~~Tracking records.
2	2.7	2-39	**Care Plan Completion** • Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or ~~t~~Tracking records. • After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment

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			processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs (described in detail in ~~chapter~~ Chapter 4 of this manual). • Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly assessment and ~~on an on-going basis,~~ modify the care plan on an ongoing basis, ~~plan~~ if appropriate.
2	2.10	2-52	***PPS Scheduled Assessment and Start of Therapy OMRA*** • If the ARD for the SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
2	2.10	2-53	***PPS Scheduled Assessment and End of Therapy OMRA*** • If the ARD for the EOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined. ***PPS Scheduled Assessment and Start and End of Therapy OMRA*** • If the ARD for the EOT and SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
2	2.11	2-55	**2.11 Combining Medicare Assessments and OBRA Assessments[~~67~~ 67]** [~~67~~ 67] OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.
2	2.11	2-56	When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be

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			combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. ~~For Medicare, the ARD must be set between days 11 and 14, but the regulation allows grace days up to day 19. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD between days 11 and 14 would have to be chosen in this situation.~~For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (Item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.
2	2.12	2-58	***Medicare-required 14-Day and OBRA Admission Assessment*** • ARD (Item A2300) must be set on days ~~11 through 14~~ 13 or 14 of the Part A SNF stay. • ARD may not be extended from day 15 to day ~~19~~18

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			(i.e., grace days may not be used).
2	2.12	2-59	***Medicare-required Scheduled Assessment and Significant Correction to Prior Comprehensive Assessment*** • ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the determination that an uncorrected ~~major~~significant error in the prior comprehensive assessment has occurred. • Must be completed (Item Z0500B) within 14 days after the determination that an uncorrected ~~major~~significant error in the prior comprehensive assessment has occurred.
2	2.12	2-61	***Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment*** • ARD (Item A2300) must be set within 14 days after determination that an uncorrected ~~major~~significant error in a comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). • Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected ~~major~~significant error in a comprehensive assessment has occurred.
2	2.12	2-63	***End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment*** • ARD (Item A2300) must be set within 14 days after the determination that an uncorrected ~~major~~significant error in the prior comprehensive assessment has occurred **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). • Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected ~~major~~significant error in prior comprehensive assessment has occurred.
2	2.12	2-65	***Start and End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment*** • ARD (Item A2300) must be set within 14 days after the

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			determination that an uncorrected ~~major~~significant error in the prior comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). • Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected ~~major~~significant error in prior comprehensive assessment has occurred.
2	2.12	2-66 & 2-67	***Change of Therapy OMRA and OBRA Admission Assessment*** • Establishes a new RUG-IV classification and Medicare payment rate (Item ~~Z0150A~~Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment. ***Change of Therapy OMRA and OBRA Quarterly Assessment*** • Establishes a new RUG-IV classification and Medicare payment rate (Item ~~Z0150A~~Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
2	2.13	2-69	**2.13 Factors Impacting the SNF Medicare Assessment Schedule~~7~~8** ~~7~~8 These requirements/policies also apply to swing bed providers.
2	2.15	2-75	There is one additional item set for inactivation request records. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system. An inactivation request is indicated by A0050~~X0100~~ = 3. The item set for this type of record is "Inactivation" with an ISC code of XX.
2	2.15	2-75	The "Inactivation" (XX) item set is also used for swing beds when Item A0050~~X0100~~ = 3.