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4	4.3	4-2	**4.3 What Are the Care Area Assessments (CAAs)?** The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are ~~previous MDS versions provided Resident Assessment Protocols (RAPs) that were~~ triggered responses to items coded on the MDS~~by MDS item responses~~ specific to a resident's ~~that alerted the assessor to the resident's~~ possible problems, needs or strengths. ~~For the MDS 3.0, the RAPs have been replaced by Care Area Assessments (CAAs). CAAs are identified by responses to items coded on the MDS.~~ Specific "CAT logic" for each care area is identified under section 4.10 (The Twenty Care Areas). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan.
4	4.3	4-3	**CAAs are not required for Medicare PPS assessments. They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior ~~Full~~Comprehensive). However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.**

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4	4.5	4-6	Assigning responsibility for completing the MDS and CAAs. Per the OBRA statute, the resident's assessment must be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals. It is common practice for facilities to assign specific MDS items or portion(s) of items (and subsequently CAAs associated with those items) to those of various disciplines (e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs, if triggered). The proper assessment and management of CAAs that are triggered for a given resident may involve aspects of diagnosis and treatment selection that exceed the scope of training or practice of any one discipline involved in the care (for example, identifying specific medical conditions or medication side effects that cause anorexia leading to a resident's weight loss). It is the facility's responsibility to obtain the input that is needed for clinical ~~decision-making~~decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice. For example, a physician may need to get a more detailed history or perform a physical examination in order to establish or confirm a diagnosis and/or related complications.
4	4.5	4-7	Written documentation of the CAA findings and ~~decision-making~~decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM). If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence. Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision-making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision~~— Addressed in Care Plan~~" whether the triggered care area is addressed in the care plan.

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4	4.7	4-10	assessment, effective clinical decision making, and is compatible with current standards of clinical practice can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A ~~well-developed~~well developed and executed assessment and care plan: • Reflects the resident/resident representative input and goals for health care;
4	4.8	4-11	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~~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 Care Area Assessment (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).
4	4.8	4-12	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.
4	4.9	4-15	Usually, illnesses and impairments happen in sequence (i.e., one thing leads to another, which leads to another, and so on). The symptom or trigger often represents only the most recent or most

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			apparent finding in a series of complications or related impairments. Thus, a detailed history is often essential to identifying causes and selecting the most beneficial interventions~~;~~, e.g., the sequence over time of how the resident developed incontinence, pain, or anorexia. While the MDS presents diverse information about residents, and the CAAs cover various implications and complications, neither one is designed to give a detailed or chronological medical, psychosocial, or personal history. For example, knowing that the Behavioral Symptoms CAA (#9) is triggered and that the resident also has a diagnosis of UTI is not enough information to know whether the diagnosis of UTI is old or new, whether there is any link between the behavioral issue and the UTI, and whether there are other conditions such as kidney stones or bladder obstruction that might be causing or predisposing the resident to a UTI.
4	4.9	4-15	Key components of the care plan may include~~;~~, but are not limited to the following:
4	4.10	4-18	3. Visual Function The aging process leads to a decline in visual acuity~~; f~~. For example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self image, and participation in social, personal, self-care, and rehabilitation activities.
4	4.10	4-20	The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills~~; f~~. For example, touch, facial expressions, eye contact,

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			hand movements, tone of voice, and posture. 5. ADL Functional/Rehabilitation Potential The ADL Functional/Rehabilitation CAA addresses the resident's ~~selfsufficiency~~ self sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toileting, changing position in bed, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.
4	4.10	4-23	6. Urinary Incontinence and Indwelling Catheter Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence itself is not a normal part of aging. Urinary incontinence can be a risk factor for various complications, including skin rashes, falls, and social isolation. ~~It is often~~Often, it is at least partially correctable. Incontinence may affect a resident's psychological well-being and social interactions. Incontinence also may lead to the potentially troubling use of indwelling catheters, which can increase the risk of ~~lifethreatening~~life threatening infections
4	4.10	4-24	Change in table: 6. Resident has moisture associated skin damage as indicated by: **M1040H = 1**
4	4.10	4-24	Successful management will depend on accurately identifying the underlying cause(s) of the incontinence or the reason for the indwelling catheter. Some of the causes can be successfully treated to reduce or eliminate incontinence episodes or the reason for catheter use. Even when incontinence cannot be reduced or resolved, effective incontinence management strategies can prevent complications related to incontinence. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be used for appropriate indications and when no other viable options exist. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter~~;~~, the potential for removal of the catheter~~;~~, and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral

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			erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.
4	4.10	4-25	8. Mood State Sadness and anxiety are normal human emotions, and fluctuations in mood are also normal. But mood states (which reflect more enduring patterns of emotions) may ~~be~~ become as extreme or overwhelming as to impair personal and psychosocial function. Mood disorders such as depression reflect a problematic extreme and should not be confused with normal sadness or mood fluctuation.
4	4.10	4-26	Page length change.
4	4.10	4-27	The information gleaned from the assessment should be used as a starting point to assess further in order to confirm a mood disorder and get enough detail of the situation to consider whether treatment is warranted. If a mood disorder is confirmed, the individualized care plan should, in part, focus on identifying and addressing underlying causes, to the extent possible.
4	4.10	4-27	Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces,
4	4.10	4-30	Changes in table: 6. Resident received antianxiety medication on one or more of the ~~during the~~ last 7 days or since admission/entry or reentry ~~if less than 7 days~~ as indicated by: **~~N0400B~~N04010B> = 1 AND N0410B<=7** 7. Resident received antidepressant medication on one or more of ~~during~~ the last 7 days or since admission/entry or reentry ~~if less than 7 days~~ as indicated by: **~~N0400B~~N04010C> = 1 AND N0410C<7**

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4	4.10	4-30	The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other ~~persons~~ residents will be at risk of undernutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.
4	4.10	4-31	Changes in table: 2. Body mass index (BMI) is too low or too high as indicated by: **BMI < 18.5000 OR BMI > 24.9000** 3. Any weight loss as indicated by a value of 1 or 2 as follows: **K0300 = 1 OR K0300 = 2** 4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows: **K0310 = 1 OR K0310 = 2** ~~4.~~5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by: **~~K0500A~~K0510A1 = 1 OR K0510A2 = 1** ~~5.~~6. Mechanically altered diet while NOT a resident or while a resident is used as nutritional approach as indicated by: **~~K0500C~~K0510C1 = 1 OR K0510C2 = 1** ~~6.~~7. Therapeutic diet while NOT a resident or while a resident is used as nutritional approach as indicated by: **~~K0500D~~K0510D1 = 1 OR K0510D2 = 1** ~~7.~~8. 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:
4	4.10	4-31 & 4-32	13. Feeding Tubes This CAA focuses on the long-term (greater than 1 month) use of feeding tubes. It is important to balance the benefits and risks of feeding tubes in individual residents in deciding whether to

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			make such an intervention a part of the plan of care. In some acute and longer term situations, feeding tubes may provide adequate nutrition that cannot be obtained by other means. In other circumstances ~~(for example, in individuals with advanced dementia)~~, feeding tubes may not enhance survival or improve quality of life, e.g., in individuals with advanced dementia. Also, feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival. For example, tube feedings will not prevent aspiration of gastric contents or oral secretions and feeding tubes may irritate or perforate the stomach or intestines.
4	4.10	4-32	Changes in table: 1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by: **~~K0500B~~K0510B = 1 OR K0510B2 = 1**
4	4.10	4-33	Changes in table: 7. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by: **~~K0500A~~K0510A1 = 1 OR K0510A2 = 1** 8. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by: **~~K0500B~~K0510B1 = 1 OR K0510B2 = 1**
4	4.10	4-33 & 4-34	15. Dental Care When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has indicators of an oral/dental issue~~/~~ and/or condition. The information gleaned from the assessment should be used to identify the oral/dental issues and/or conditions and to identify any related possible causes and/or contributing ~~and/or~~ risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's issues and/or conditions.
4	4.10	4-35	The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure

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			ulcers(s) and to identify any related causes and/or contributing ~~and/or~~ risk factors. The next step is to develop an individualized care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent them by identifying the resident's risks and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it. 17. Psychotropic Medication Use Any medication, prescription or non-prescription, can have benefits and risks, depending on various factors (e.g., active medical conditions, coexisting medication regimen). However, psychotropic medications ~~(medications that are~~, prescribed primarily to affect cognition, mood, or behavior~~)~~, are among the most frequently prescribed agents for elderly nursing home residents. While these medications can often be beneficial, they can also cause significant complications such as
4	4.10	4-36	Changes in table: 1. Antipsychotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry ~~to resident in last 7 days or since admission~~ as indicated by: **~~N0400A~~N0410A> = 1 AND N0410A<=7** 2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry ~~to resident in last 7 days or since admission~~ as indicated by: **~~N0400B~~N0410B> = 1 AND N0410B<7** 3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry ~~in last 7 days or since admission~~ as indicated by: **~~N0400C~~N0410C> = 1 AND N0410C<7** 4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry ~~in last 7 days or since admission~~ as indicated by: **~~N0400D~~N0410D> = 1 AND N0410D<7**
4	4.10	4-36	The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's

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			medication, ~~(~~in consultation with the physician and the consultant pharmacist~~)~~, and to identify any adverse consequences, as well as any related possible causes and/or contributing ~~and/or~~ risk factors. The next step is to develop an individualized care plan based directly on these conclusions. Important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.
4	4.10	4-37	The physical restraint CAA identifies residents who are physically restrained during the look-back period. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. ~~This CAA is triggered when a resident used a physical restraint during the look-back period.~~
4	4.10	4-38	19. Pain Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." Pain can be affected by damage to various organ systems and tissues~~; e.g.,~~. For example, musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The presence of pain can also increase suffering in other areas, leading to an increased sense of helplessness, anxiety, depression, decreased activity, decreased appetite, and disrupted sleep.
4	4.10	4-39 & 4-40	20. Return to Community Referral All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. ~~The~~ This ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments (Federal and State) have a responsibility to enforce and support these choices. An individual in a nursing home with adequate ~~decision-making~~ decision making capacity can choose to leave the facility and/or request to talk to someone about returning to the community at any time. The return to community referral portion of MDS 3.0 uses a person-centered approach to ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long-term care in the last restrictive setting possible. The CAA associated with this

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			portion of MDS 3.0 ~~CAA~~ focuses on residents who want to talk to someone about returning to the community and promotes opening the discussion about the individual's preferences for ~~service~~ settings for receipt of services. Individual choices related to returning to ~~the~~ community living will vary~~;~~, e.g., returning to a former home or a different community home~~. O~~or, the individual may choose to stay in the nursing home. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care ~~interventions~~, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals.
4	4.10	4-40	Change to table: 1. Referral is or may be needed but has not been made to local contact agency as indicated by:
4	4.10	4-40	The goal of care planning is to initiate and maintain collaboration between the nursing facility and the local contact agency (LCA) to support the individual's expressed interest in being transitioned to community living. The nursing home staff is responsible for making referrals to the LCAs under the process that the State has established. The LCA is, in turn, responsible for contacting referred residents and assisting with transition services planning. This includes facility support for the individual in achieving his or her highest level of functioning and the involvement of the designated contact agency providing informed choices for community living. The LCA is the entity that does the necessary community support planning (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, arranging of care support, etc.) This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the individual (and his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.