CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING
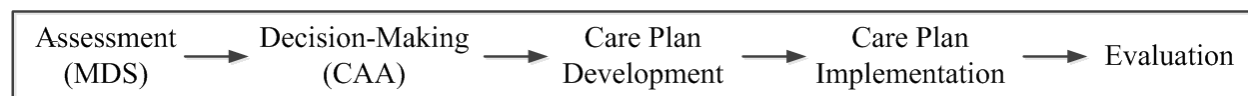
4.1　Background and Rationale

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.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

4.2　Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)

| Assessment (MDS) | → | Decision-Making (CAA) | → | Care Plan Development | → | Care Plan Implementation | → | Evaluation |

As discussed in Chapter 1, the updated Resident Assessment Instrument (RAI) consists of three basic components: 1) the Minimum Data Set (MDS) Version 3.0, 2) the Care Area Assessment (CAA) process, and 3) the RAI Utilization Guidelines. The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.

The MDS is a starting point. The Minimum Data Set (MDS) is a standardized instrument used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. For example, assessing a resident's orientation and recall helps staff complete portions of the MDS that relate to cognition (Section C), and weighing a resident and identifying his or her food intake helps staff complete portions

of the MDS related to nutritional status (Section K). When it is completed, the MDS provides a foundation for a more thorough assessment and the development of an individualized care plan. The MDS 3.0 manual explains in detail how to complete the MDS.

The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident.

The CAA process framework. The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

When implemented properly, the CAA process should help staff:

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her 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.

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 triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths. 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.

Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0

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

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.

By statute, the RAI must be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed and documented within the same time frame. While a workup cannot always be completed within 14 days, it is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.

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 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.

4.4   What Does the CAA Process Involve?

Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying

effective problem solving and decision making approaches to all of the information available for each resident.

Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be connected.

CATs provide a "flag" for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines.

A risk factor increases the chances of having a negative outcome or complication. For example, impaired bed mobility may increase the risk of getting a pressure ulcer/*injury*. In this example, impaired bed mobility is the risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the potential pressure ulcer is the complication.

A care area issue/condition (e.g., falls) may result from a single underlying cause (e.g., administration of a new medication that causes dizziness) or from a combination of multiple factors (e.g., new medication, resident forgot walker, bed too high or too low, etc.). There can also be a single cause of multiple triggers and impairments. For example, hypothyroidism is an example of a common, potentially reversible medical condition that can have diverse physical, functional, and psychosocial complications. Thus, if a resident has hypothyroidism, it is possible that the MDS might trigger any or several of the following CAAs depending on whether or not the hypothyroidism is controlled, there is an acute exacerbation, etc.: Delirium (#1), Cognitive Loss/Dementia (#2), Visual Function (#3), Communication (#4), ADL Functional/Rehabilitation (#5), Urinary Incontinence (#6), Psychosocial Well-Being (#7), Mood State (#8), Behavior Symptoms (#9), Activities (#10), Falls (#11), Nutritional Status (#12), Dehydration (#14), Psychotropic Medication Use (#17), and Pain (#19). Even if the MDS does not trigger a particular care area, the facility can use the CAA process and resources at any time to further assess the resident.

Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome. Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.

For example, it is necessary to assess a resident's orientation and recall in order to complete portions of the MDS that relate to cognitive patterns (Section C) and to obtain a resident's weight and identify his or her food intake in order to complete MDS items related to nutritional status (Section K). A positive finding in Section C may trigger one or several CAAs, including Delirium (#1), Cognitive Loss/Dementia (#2), and ADL Functional/Rehabilitation Potential (#5).

Additional evaluation is then required to identify whether the resident has delirium, dementia, or both; how current symptoms and patterns compare to their usual or previous baseline, whether potentially reversible causes are present, what else might be needed to identify underlying causes (including medical diagnoses and history), and what symptomatic and cause-specific interventions are appropriate for the resident. If the Nutritional Status (#12) CAA also triggered, due to weight loss and the resident being found to have delirium, then it is possible that both findings could have a common cause (e.g., an infection or medication side effects), that delirium resulted in impaired nutritional status, or that impaired nutritional status led to delirium, or still other possibilities. Thus, identifying the sequence of events is essential to understanding causes and choosing appropriate interventions.

The RAI is not intended to provide diagnostic advice, nor is it intended to specify which triggered areas may be related to one another or and how those problems relate to underlying causes. It is up to the IDT, including the resident's physician, to determine these connections and underlying causes as they assess the triggered care areas and any other areas pertinent to the individual resident.

Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident's functioning or minimize decline. For example, MDS item responses indicate the "resident believes he or she is capable of increased independence in at least some ADLs" (Item G0900A) may focus the assessment and care plan on functional areas most important to the resident or on the area with the greatest potential for improvement.

In addition to identifying causes and risk factors that contribute to the resident's care area issues or conditions, the CAA process may help the IDT:

- Identify and address associated causes and effects;

- Determine whether and how multiple triggered conditions are related;

- Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests;

- Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions;

- Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions;

- Determine whether a resident could potentially benefit from rehabilitative interventions;

- Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.

4.5   Other Considerations Regarding Use of the CAAs

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 (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.

Identifying policies and practices related to the assessment and care planning processes. Under the OBRA regulations, 42 CFR 483.70(h)(1) identifies the medical director as being responsible for overseeing the "implementation of resident care policies" in each facility, "and the coordination of medical care in the facility." Therefore, it is recommended that the facility's IDT members collaborate with the medical director to identify current evidence-based or expert-endorsed resources and standards of practice that they will use for the expanded assessments and analyses that may be needed to adequately address triggered areas. The facility should be able to provide surveyors the resources that they have used upon request as part of the survey review process.[1]

CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan.

- Relevant documentation for each triggered CAA describes: causes and contributing factors;
- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;

---

[1]   In Appendix C, CMS has provided CAA resources that facilities may choose to use but that are neither mandatory nor endorsed by the government. Please note that Appendix C does not provide an all-inclusive list.

- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

Written documentation of the CAA findings and 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" whether the triggered care area is addressed in the care plan.

4.6   When Is the RAI Not Enough?

Federal requirements support a nursing home's ongoing responsibility to assess residents. The Quality of Care regulation requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (42 CFR 483.25).

Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.70(b), 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., 42 CFR 483.25(b)(1) Pressure Ulcers and 42 CFR 483.45(d) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

Therefore, facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.

Limitations of the RAI-related instruments. The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs are triggered, and a framework for the CAA process. However, the process of completing the MDS and related portions of the

RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.

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.

- The MDS may not trigger every relevant issue

- Not all triggers are clinically significant

- The MDS is not a diagnostic tool or treatment selection guide

- The MDS does not identify causation or history of problems

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 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.

4.7   The RAI and Care Planning

As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR 483.20(b)(1) and (2) and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html.

Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see 42 CFR 483.21(b), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.

Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives

Process Step / Objectives *	Key Tasks **
Recognition / Assessment *Gather essential information about the individual*	− 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 − Obtain a personal and medical history − Perform a physical assessment
Problem definition *Define the individual's problems, risks, and issues*	− Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc. − Clearly state the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns − Define significant risk factors
Diagnosis / Cause-and-effect analysis *Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences*	− Identify causes of, and factors contributing to, the individual's current dysfunctions, disabilities, impairments, and risks − Identify pertinent evaluations and diagnostic tests − Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another − Identify how addressing those causes is likely to affect consequences
Identifying goals and objectives of care *Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met*	− Clarify prognosis − Define overall goals for the individual − Identify criteria for meeting goals
Selecting interventions / planning care *Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks*	− Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial) − Identify how current and proposed treatments and services are expected to address causes, consequences, and risk factors, and help attain overall goals for the individual − Define anticipated benefits and risks of various interventions − Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences
Monitoring of progress *Review individual's progress towards goals and modify approaches as needed*	− Identify the individual's response to interventions and treatments − Identify factors that are affecting progress towards achieving goals − Define or refine the prognosis − Define or refine when to stop or modify interventions − Review effectiveness and adverse consequences related to treatments − Adjust interventions as needed − Identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care

* Refers to key steps in the care delivery process, related to clinical problem solving and decision making
** Refers to key tasks at each step in the care delivery process

The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs. A care plan that is based on a thorough

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 and executed assessment and care plan:

- Looks at each resident as a whole human being with unique characteristics and strengths;
- Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS);
- Gives the IDT a common understanding of the resident;
- Re-groups the information gathered to identify possible issues and/or conditions that the resident may have (i.e., triggers);
- Provides additional clarity of potential issues and/or conditions by looking at possible causes and risks (CAA process);
- Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up;
- Reflects the resident's/resident representative's input, goals, and desired outcomes;
- Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning);
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the individualized care plan as appropriate and necessary.

Following the decision to address a triggered condition on the care plan, key staff or the IDT should subsequently:

- Review and revise the current care plan, as needed; and
- Communicate with the resident or his/her family or representative regarding the resident, care plans, and their wishes.

The overall care plan should be oriented towards:

1. Assisting the resident in achieving his/her goals.
2. Individualized interventions that honor the resident's preferences.
3. Addressing ways to try to preserve and build upon resident strengths.
4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation).
5. Managing risk factors to the extent possible or indicating the limits of such interventions.
6. Applying current standards of practice in the care planning process.
7. Evaluating treatment of measurable objectives, timetables and outcomes of care.
8. Respecting the resident's right to decline treatment.
9. Offering alternative treatments, as applicable.

10. Using an interdisciplinary approach to care plan development to improve the resident's abilities.

11. Involving resident, resident's family and other resident representatives as appropriate.

12. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs.

13. Involving direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes.

4.8   CAA Tips and Clarifications

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 goals, preferences, 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)**.

Example:

Subject	*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

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 Care Area Assessment (CAA) Summary 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).

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.

6) The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

7) Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

8) 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.

9) 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.

10) 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.

11) 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 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.

12) 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.

4.9   Using the Care Area Assessment (CAA) Resources

Based on the preceding discussions in this Chapter, the following summarizes the steps involved in the CAA process, for those facilities that choose to use the CAA resources in this manual.

Please note: Because MDS 3.0 trigger logic is complex, please refer to the CAT Logic tables within each CAA description (Section 4.10) for detailed information on triggers.

Step 1: Identification of Triggered CAAs. After completing the MDS, identify triggered care areas. Many facilities will use automated systems to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified. CMS has developed test files for facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but the nursing home is responsible for ensuring that the software is triggering correctly.

It is prudent to consider whether or not the software has triggered relevant CAAs for individual residents. For example, did the software miss some CAAs you thought should have been triggered? Do some of the CAAs seem to be missing and are there other CAAs triggered that you did not expect?

For nursing homes that do not use an automated system, the CAT logic will provide the information necessary to manually identify triggered CAAs. The CAT logic is found within the CAT logic tables of each care area's description in section 4.10. These tables provide the MDS items that trigger the 20 (twenty) care areas. Facilities are not required to use this information or to maintain it in the resident's clinical record. Rather, the information is a resource that may be used by the IDT members to determine which CAAs are triggered from a completed MDS.

To identify the triggered CAAs manually using the CAT logic tables in section 4.10:

1. Compare the completed MDS with the CAT logic tables to determine which CAAs have been triggered for review.

2. The CAT logic table will list the MDS item numbers and specific codes that will trigger the particular CAA. To identify a triggered CAA, match the resident's MDS item responses with the MDS item number(s) and code(s) for each care area as listed in the CAT logic tables within section 4.10. If a particular item response matches a code in the CAT logic table for a particular care area, read through the logic statement and qualifiers (i.e., 'IF', 'AND', and 'OR') for that particular care area to determine if that care area is triggered. This means that further assessment using the CAA process is required for that particular care area.

3. Note which CAAs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.

4. Continue through the CAT logic tables for each of the 20 (twenty) care areas matching recorded MDS item responses with trigger indicators until all triggered CAAs have been identified.

5. When the CAT logic review is completed, document on the CAA Summary which CAAs were triggered by checking the boxes in the column titled "Care Area Triggered."

Step 2: Analysis of Triggered CAAs. Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps

staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.

Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:

- Warrant intervention;

- Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;

- Can help to minimize the onset or progression of impairments and disabilities; and

- Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

Use the information gathered thus far to make a clear issue or problem statement. An issue or problem is different from a finding (e.g., a single piece of information from the MDS or a test result). The chief complaint (e.g., the resident has a headache, is vomiting, or is not participating in activities) is not the same thing as an issue or problem statement that clearly identifies the situation. Trying to care plan a chief complaint may lead to inappropriate, irrelevant, or problematic interventions.

Example:

Chief Complaint: New onset of falls

Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most falls occurred after she stood up and started walking; a few falls occurred 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.

While the CAAs can help the IDT identify conditions or findings that could potentially be a problem or risk for the resident, additional thought is needed to define these issues and determine whether and to what extent the care area issue and/or condition is a problem or issue needing an intervention (assessment, testing, treatment, etc.) or simply a minor or inconsequential finding that does not need additional care planning. For example, a resident may exhibit sadness without being depressed or may appear to be underweight despite having a stable nutritional status consistent with their past history. The IDT should identify and document the functional and behavioral implications of identified problematic issues/conditions, limitations, improvement possibilities, and so forth (e.g., how the condition is a problem for the resident; how the condition limits or impairs the resident's ability to complete activities of daily living; or how the condition affects the resident's well-being in some way).

Identify links among triggers and their causes. CMS does not require that each care area triggered be care planned separately. The IDT may find during their discussions that several problematic issues and/or conditions have a related cause, or they might identify that those issues and/or conditions 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.

For example, behavior, mood, cognition, communication, and psychosocial well-being typically have common risk factors and common or closely related causes of related impairments. Thus, the following CATs naturally coexist and could be combined, assessed through the CAA process, and care planned together as a starting point for any resident: Delirium (CAA #1), Cognitive Loss/Dementia (CAA #2), Communication (CAA #4), Psychosocial Well-Being (CAA #7), Mood State (CAA #8) Behavioral Symptoms (CAA #9), and Psychotropic Drug Use (CAA #17).

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 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.

It is the facility's responsibility to refer to sources as needed to help with clinical problem solving and decision making that is consistent with professional standards of practice. It is often necessary to involve the attending physician to identify specific underlying causes of problems, including multiple causes of a single problem or multiple problems or complications related to one or more underlying causes.

Steps 3 and 4: Decision Making and CAA Documentation. The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, goals, preferences, strengths, and needs. The resident, family, or resident's representative should be an integral part of the team care planning process. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with professional standards of practice should support optimal approaches to addressing quality of care and quality of life needs of individual residents.

Key components of the care plan may include, but are not limited to the following:

- Resident goals and preferences

- Measureable objective with established timeframes

- Specific interventions, including those that address common causes of multiple issues

- Additional follow-up and clarification

- Items needing additional assessment, testing, and review with the practitioner

- Items that may require additional monitoring but do not require other interventions

- The resident's preference and potential for future discharge and discharge plan

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.**

Documentation related to CAAs should include the items previously discussed in Section 4.5.

4.10 The Twenty Care Areas

NOTE: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those MDS items that require a check mark response (e.g. H0100, J0800, K0510, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is not checked. Example: "I4800=0" means that a check mark has not been placed in the check box item I4800.

1. Delirium

Delirium is acute brain failure caused by medical conditions, which presents with psychiatric symptoms, acute confusion, and fluctuations in levels of consciousness. It is a serious condition that can be caused by medical issues/conditions such as medication-related adverse consequences, infections, or dehydration. It can easily be mistaken for the onset or progression of dementia, particularly in individuals with more advanced pre-existing dementia.

Unlike dementia, delirium typically has a rapid onset (hours to days). Typical signs include fluctuating states of consciousness; disorientation; decreased environmental awareness and behavioral changes; difficulty paying attention; fluctuating behavior or cognitive function throughout the day; restlessness; sleepiness periodically during the day; rambling, nonsensical speech; and altered perceptions, such as misinterpretations (illusions), seeing or feeling things that are not there (hallucinations), or a fixed false belief (delusions).

Delirium CAT Logic Table

Triggering Conditions (any of the following):

1. Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) as indicated by:

   (a)

   C1310A = 1

   AND

   C1310B = 1 or 2

   AND EITHER

   C1310C = 1 or 2 OR C1310D = 1 or 2

   (b)

   C1310B, C1310C or C1310D = 2

   AND

   C1310B = 1 or 2

   AND EITHER

   C1310C = 1 or 2 OR C1310D = 1 or 2

Delirium is never a part of normal aging, and it is associated with high mortality and morbidity unless it is recognized and treated appropriately. Staff who are closely involved with residents should report promptly any new onset or worsening of cognitive impairment and the other aforementioned symptoms in that resident.

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 if the resident is exhibiting an acute change in mental status and/or the presence of inattention, disorganized thinking or altered mental status.

The information gleaned from the assessment should be used to identify and address the underlying clinical issue(s) and/or condition(s), as well as to identify related underlying causes and 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 clinical issues/conditions identified through this assessment process (e.g., treating infections, addressing dehydration, identifying and treating hypo- or hyperthyroidism, relieving pain and depression, managing medications, and promoting adaptation and a comfortable environment for the resident to function. Other simple preventive measures that can be applied in all settings

include addressing hearing and visual impairments to the extent possible (e.g., with the use of glasses and hearing aids) and minimizing the use of indwelling urinary catheters.

2. Cognitive Loss/Dementia

Cognitive prerequisites for an independent life include the ability to remember recent events and the ability to make safe daily decisions. Although the aging process may be associated with mild impairment, decline in cognition is often the result of other factors such as delirium, another mental health issue and/or condition, a stroke, and/or dementia. Dementia is not a specific condition but a syndrome that may be linked to several causes. According to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue and/or condition and trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) and these troubles have an impact on the performance of activities of daily living. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.

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 evidence of cognitive loss.

Cognitive Loss/Dementia CAT Logic Table

Triggering Conditions (any of the following):

1. BIMS summary score is less than 13 as indicated by:

    C0500 >= 00 AND C0500 < 13

2. BIMS summary score has a missing value and there is a problem with short-term memory as indicated by:

    (C0500 = 99, -, OR ^) AND

    (C0700 = 1)

3. BIMS summary score has a missing value and there is a problem with long-term memory as indicated by:

    (C0500 = 99, -, OR ^) AND

    (C0800 = 1)

4. BIMS summary score has missing value of 99 or – and at least some difficulty making decisions regarding tasks of daily life as indicated by:

    (C0500 = 99, -, OR ^) AND

    (C1000 >= 1 AND C1000 <= 3)

5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking or altered level of consciousness as indicated by:

    (C1310B = 1 OR C1310B = 2) OR

Cognitive Loss/Dementia CAT Logic Table

(C1310C = 1 OR C1310C = 2) OR

(C1310D = 1 OR C1310D = 2)

6. Presence of any behavioral symptom (verbal, physical or other) as indicated by:

(E0200A >= 1 AND E0200A <= 3) OR

(E0200B >= 1 AND E0200B <= 3) OR

(E0200C >= 1 AND E0200C <= 3)

7. Rejection of care occurred at least 1 day in the past 7 days as indicated by:

E0800 >= 1 AND E0800 <= 3

8. Wandering occurred at least 1 day in the past 7 days as indicated by:

E0900 >= 1 AND E0900 <= 3

The information gleaned from the assessment should be used to evaluate the situation, to identify and address (where possible) the underlying cause(s) of cognitive loss/dementia, as well as 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. It is important to define the nature of the impairment, e.g., identify whether the cognitive issue and/or condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the issue and/or condition is apparently not related to reversible causes, assessment should focus on the details of the cognitive issue/condition (i.e., forgetfulness and/or impulsivity and/or behavior issues/conditions, etc.) and risk factors for the resident presented by the cognitive loss, to facilitate care planning specific to the resident's needs, issues and/or conditions, and strengths. The focus of the care plan should be to optimize remaining function by addressing underlying issues identified through this assessment process, such as relieving pain, optimizing medication use, ensuring optimal sensory input (e.g., with the use of glasses and hearing aids), and promoting as much social and functional independence as possible while maintaining health and safety.

3. Visual Function

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

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 a diagnosis of glaucoma, macular degeneration or cataracts or B1000 is coded 1-4.

Visual Function CAT Logic Table

Triggering Conditions (any of the following):

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

$$I6500 = 1$$

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

$$B1000 >= 1 \text{ AND } B1000 <= 4$$

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying residents who have treatable conditions that place them at risk of permanent blindness (e.g., glaucoma, diabetes, retinal hemorrhage) and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances, as well as to determine any possibly related 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 prevent decline when possible and to enhance vision to the extent possible when reversal of visual impairment is not possible, as well as to address any underlying clinical issues and/or conditions identified through the CAA or subsequent assessment process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

4. Communication

Normal communication involves related activities, including expressive communication (making oneself understood to others, both verbally and via non-verbal exchange) and receptive communication (comprehending or understanding the verbal, written, or visual communication of others). Typical expressive issues and/or conditions include disruptions in language, speech, and voice production. Typical receptive communication issues and/or conditions include changes or difficulties in hearing, speech discrimination, vocabulary comprehension, and reading and interpreting facial expressions. While many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.

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's ability to hear, to express ideas and wants, or to understand verbal content may be impaired.

Communication CAT Logic Table

Triggering Conditions (any of the following):

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

   B0200 >= 1 AND B0200 <= 3

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

   B0700 >= 1 AND B0700 <= 3

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

   B0800 >= 1 AND B0800 <= 3

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, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toilet use, bed mobility, 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.

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 requires assistance to improve performance or to prevent avoidable functional decline.

The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. 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, improving or maintaining function when possible, and preventing

additional decline when improvement is not possible. An ongoing assessment is critical to identify and address risk factors that can lead to functional decline.

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by:

<center>

(G0110A1 >= 1 AND G0110A1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

</center>

2. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for transfer between surfaces (excluding to/from bath/toilets) was needed as indicated by:

<center>

(G0110B1 >= 1 AND G0110B1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

</center>

3. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in his/her room was needed as indicated by:

<center>

(G0110C1 >= 1 AND G0110C1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

</center>

4. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in corridor was needed as indicated by:

<center>

(G0110D1 >= 1 AND G0110D1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

</center>

5. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion on unit (including with wheel chair, if applicable) was needed as indicated by:

<center>

(G0110E1 >= 1 AND G0110E1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

</center>

6. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion off unit (including with wheel chair, if applicable) was needed as indicated by:

(G0110F1 >= 1 AND G0110F1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

7. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for dressing was needed as indicated by:

(G0110G1 >= 1 AND G0110G1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

8. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for eating was needed as indicated by:

(G0110H1 >= 1 AND G0110H1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

9. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for toilet use was needed as indicated by:

(G0110I1 >= 1 AND G0110I1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

10. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for grooming/personal hygiene was needed as indicated by:

(G0110J1 >= 1 AND G0110J1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

11. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for self-performance bathing (excluding washing of back and hair) has a value of 1 through 4 as indicated by:

(G0120A>= 1 AND G0120A<= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

12. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while balance during transition has a value of 1 or 2 for any item as indicated by:

$$((G0300A = 1 \text{ OR } G0300A = 2) \text{ OR}$$
$$(G0300B = 1 \text{ OR } G0300B = 2) \text{ OR}$$
$$(G0300C = 1 \text{ OR } G0300C = 2) \text{ OR}$$
$$(G0300D = 1 \text{ OR } G0300D = 2) \text{ OR}$$
$$(G0300E = 1 \text{ OR } G0300E = 2)) \text{ AND}$$
$$((C1000 >= 0 \text{ AND } C1000 <= 2) \text{ OR}$$
$$(C0500 >= 5 \text{ AND } C0500 <= 15))$$

13. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while resident believes he/she is capable of increased independence as indicated by:

$$G0900A = 1 \text{ AND}$$
$$((C1000 >= 0 \text{ AND } C1000 <= 2) \text{ OR}$$
$$(C0500 >= 5 \text{ AND } C0500 <= 15))$$

14. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while direct care staff believe resident is capable of increased independence as indicated by:

$$G0900B = 1 \text{ AND}$$
$$((C1000 >= 0 \text{ AND } C1000 <= 2) \text{ OR}$$
$$(C0500 >= 5 \text{ AND } C0500 <= 15))$$

6. Urinary Incontinence and Indwelling Catheter

Urinary incontinence is the involuntary loss or leakage of urine or the inability to urinate in a socially acceptable manner. There are several types of urinary incontinence (e.g., functional, overflow, stress, and urge) and the individual resident may experience more than one type at a time (mixed incontinence).

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. 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 life threatening infections.

This CAA is triggered if the resident is incontinent of urine or uses a urinary catheter. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Urinary Incontinence and Indwelling Catheter CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for toileting was needed as indicated by:

   (G0110I1 >= 2 AND G0110I1 <= 4)

2. Resident requires a indwelling catheter as indicated by:

   H0100A = 1

3. Resident requires an external catheter as indicated by:

   H0100B = 1

4. Resident requires intermittent catheterization as indicated by:

   H0100D = 1

5. Urinary incontinence has a value of 1 through 3 as indicated by:

   H0300 >= 1 AND H0300 <= 3

6. Resident has moisture associated skin damage as indicated by:

   M1040H = 1

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 erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.

7. Psychosocial Well-Being

Involvement in social relationships is a vital aspect of life, with most adults having meaningful relationships with family, friends, and neighbors. When these relationships are challenged, it can cloud other aspects of life. Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity. Similarly, declines in physical functioning or cognition or a new onset or worsening of pain or other health or mental health issues/conditions may affect both social relationships and mood. Psychosocial well-being may also be negatively impacted when a person has significant life changes such as the death of a loved one. Thus, other contributing factors also must be considered as a part of this assessment.

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 exhibits minimal interest in social involvement.

Psychosocial Well-Being CAT Logic Table

Triggering Conditions (any of the following):

1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:

$$D0200A1 = 1$$

2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:

$$D0500A1 = 1$$

3. Interview for activity preference item "How important is it to you to do your favorite activities?" has a value of 3 or 4 as indicated by:

$$F0500F = 3 \text{ OR } F0500F = 4$$

4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities:

$$F0800Q = 0$$

5. Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

$$(E0200A >= 1 \text{ AND } E0200A <= 3) \text{ AND}$$

$$(I4800 = 0 \text{ OR } I4800 = \text{-}) \text{ AND}$$

$$(I4200 = 0 \text{ OR } I4200 = \text{-})$$

6. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

$$(E0200B >=1 \text{ AND } E0200B <= 3) \text{ AND}$$

$$(I4800 = 0 \text{ OR } I4800 = \text{-}) \text{ AND}$$

$$(I4200 = 0 \text{ OR } I4200 = \text{-})$$

7. Any six items for interview for activity preferences has the value of 4 and resident is primary respondent for daily and activity preferences as indicated by:

$$(\text{Any 6 of F0500A through F0500H} = 4) \text{ AND}$$

$$(F0600 = 1)$$

The information gleaned from the assessment should be used to identify whether their minimal involvement is typical or customary for that person or a possible indication of a problem. If it is problematic, then address the underlying cause(s) of the resident's minimal social involvement and factors associated with reduced social relationships and engagement, as well as 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 the underlying cause or causes in order to stimulate and facilitate social engagement.

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 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.

The mood section of the MDS screens for—but is not intended to definitively diagnose—any mood disorder, including depression. Mood disorders may be expressed by sad mood, feelings of emptiness, anxiety, or uneasiness. They may also result in a wide range of bodily complaints and dysfunctions, including weight loss, tearfulness, agitation, aches, and pains. However, because none of these symptoms is specific for a mood disorder, diagnosis of mood disorders requires additional assessment and confirmation of findings. In addition, other problems (e.g., lethargy, fatigue, weakness, or apathy) with different causes, which require a very different approach, can be easily confused with depression.

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 if the Resident Mood Interview, Staff Assessment of Mood, or certain other specific issues indicate a mood issue and/or condition may be present.

Mood State CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has had thoughts he/she would be better off dead, or thoughts of hurting him/herself as indicated by:

    D0200I1 = 1

2. Staff assessment of resident mood suggests resident states life isn't worth living, wishes for death, or attempts to harm self as indicated by:

    D0500I1 = 1

3. The resident mood interview total severity score has a non-missing value (0 to 27) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the resident interview summary score on the current non-admission comprehensive assessment (D0300) is greater than the prior assessment (V0100E) as indicated by:

    ((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND

    ((D0300 >= 00) AND (D0300 <= 27)) AND

    ((V0100E >= 00) AND (V0100E <= 27)) AND

    (D0300 > V0100E)

4. The resident mood interview is not successfully completed (missing value on D0300), the staff assessment of resident mood has a non-missing value (0 to 30) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the staff assessment current total severity score on the current non-admission comprehensive assessment (D0600) is greater than the prior assessment (V0100F) as indicated by:

((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND

((D0300 < 00) OR (D0300 > 27)) AND

((D0600 >= 00) AND (D0600 <= 30)) AND

((V0100F >= 00) AND (V0100F <= 30)) AND

(D0600 > V0100F)

5. The resident mood interview is successfully completed and the current total severity score has a value of 10 through 27 as indicated by:

D0300 >= 10 AND D0300 <= 27

6. The staff assessment of resident mood is recorded and the current total severity score has a value of 10 through 30 as indicated by:

D0600 >= 10 AND D0600 <= 30

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.

9. Behavioral Symptoms

In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a symptom and not a disease. The MDS only identifies certain behaviors, but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention.

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, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature

of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts.

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 the resident is identified as exhibiting certain troubling behavioral symptoms.

Behavioral Symptoms CAT Logic Table

Triggering Conditions (any of the following):

1. Rejection of care has a value of 1 through 3 indicating resident has rejected evaluation or care necessary to achieve his/her goals for health and well-being as indicated by:

$$E0800 >= 1 \text{ AND } E0800 <= 3$$

2. Wandering has a value of 1 through 3 as indicated by:

$$E0900 >= 1 \text{ AND } E0900 <= 3$$

3. Change in behavior indicates behavior, care rejection or wandering has gotten worse since prior assessment as indicated by:

$$E1100 = 2$$

4. Presence of at least one behavioral symptom as indicated by:

$$E0300 = 1$$

The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related 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, reduce the frequency of truly problematic behaviors, and minimize any resultant harm.

10. Activities

The capabilities of residents vary, especially as abilities and expectations change, illness intervenes, opportunities become less frequent, and/or extended social relationships become less common. The purpose of the activities CAA is to identify strategies to help residents become more involved in relevant activities, including those that have interested and stimulated them in the past and/or new or modified ones that are consistent with their current functional and cognitive capabilities.

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 the resident may have evidence of decreased involvement in social activities.

Activities CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has little interest or pleasure in doing things as indicated by:

   D0200A1 = 1

2. Staff assessment of resident mood suggests resident states little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Any 6 items for interview for activity preferences has the value of 4 (not important at all) or 5 (important, but cannot do or no choice) as indicated by:

   Any 6 of F0500A through F0500H = 4 or 5

4. Any 6 items for staff assessment of activity preference item L through T are not checked as indicated by:

   Any 6 of F0800L through F0800T = 0

The information gleaned from the assessment should be used to identify residents who have either withdrawn from recreational activities or who are uneasy entering into activities and social relationships, to identify the resident's interests, and 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 care plan should focus on addressing the underlying cause(s) of activity limitations and the development or inclusion of activity programs tailored to the resident's interests and to his or her cognitive, physical/functional, and social abilities and improve quality of life.

11. Falls

A "fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost his/her balance and would have fallen without staff intervention.

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 the resident has had recent history of falls and balance problems.

Falls CAT Logic Table

Triggering Conditions (any of the following):

1. Wandering occurs as indicated by a value of 1 through 3 as follows:

   E0900 >= 1 AND E0900 <= 3

2. Balance problems during transition indicated by a value of 1 or 2 for any item as follows:

   (G0300A = 1 OR G0300A = 2) OR

   (G0300B = 1 OR G0300B = 2) OR

   (G0300C = 1 OR G0300C = 2) OR

   (G0300D = 1 OR G0300D = 2) OR

   (G0300E = 1 OR G0300E = 2)

3. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by:

   If A0310A = 01 AND J1700A = 1

4. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:

   If A0310A = 01 AND J1700B = 1

5. Resident has fallen at least one time since admission or the prior assessment as indicated by:

   J1800 = 1

6. Resident received antianxiety medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410B>= 1 AND N0410B<=7

7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410C> = 1 AND N0410C<=7

8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:

   P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows:

   P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and 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(s) of the resident's fall(s), as well as the factors that place him or her at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging, but it can arise from many diverse causes, often acting together. It may cause or reflect acute or chronic illness, and it represents a risk factor for subsequent decline.

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 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.

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:

$$J1550C = 1$$

2. Body mass index (BMI) is too low or too high as indicated by:

$$BMI < 18.5000 \text{ OR } BMI > 24.9000$$

3. Any weight loss as indicated by a value of 1 or 2 as follows:

$$K0300 = 1 \text{ OR } K0300 = 2$$

4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:

$$K0310 = 1 \text{ OR } K0310 = 2$$

5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

$$K0510A1 = 1 \text{ OR } K0510A2 = 1$$

6. Mechanically altered diet while a resident is used as nutritional approach as indicated by:

$$K0510C2 = 1$$

7. Therapeutic diet while a resident is used as nutritional approach as indicated by:

$$K0510D2 = 1$$

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:

$$((M0300B1 > 0 \text{ AND } M0300B1 <= 9) \text{ OR}$$

$$(M0300C1 > 0 \text{ AND } M0300C1 <= 9) \text{ OR}$$

$$(M0300D1 > 0 \text{ AND } M0300D1 <= 9) \text{ OR}$$
$$(M0300E1 > 0 \text{ AND } M0300E1 <= 9) \text{ OR}$$
$$(M0300F1 > 0 \text{ AND } M0300F1 <= 9) \text{ OR}$$
$$(M0300G1 > 0 \text{ AND } M0300G1 <= 9))$$

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 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, 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.

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 the resident has a need for a feeding tube for nutrition.

Feeding Tubes CAT Logic Table

Triggering Conditions (any of the following):

1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

$$K0510B1 = 1 \text{ OR } K0510B2 = 1$$

The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related 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(s), including any reversible issues and conditions that led to using a feeding tube.

14. Dehydration/Fluid Maintenance

Dehydration is a condition in which there is an imbalance of water and related electrolytes in the body. As a result, the body may become less able to maintain adequate blood pressure and electrolyte balance, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. In older persons, diagnosing dehydration is accomplished primarily by a detailed history, laboratory testing (e.g., electrolytes, BUN, creatinine, serum osmolality, urinary sodium), and to a lesser degree by a physical examination. Abnormal vital signs, such as falling blood pressure and an increase in the pulse rate, may sometimes be meaningful symptoms of dehydration in the elderly.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Dehydration/Fluid Maintenance CAT Logic Table

Triggering Conditions (any of the following):

1. Fever is selected as a problem health condition as indicated by:

$$J1550A = 1$$

2. Vomiting is selected as a problem health condition as indicated by:

$$J1550B = 1$$

3. Dehydration is selected as a problem health condition as indicated by:

$$J1550C = 1$$

4. Internal bleeding is selected as a problem health condition as indicated by:

$$J1550D = 1$$

5. Infection present as indicated by:

$$(I1700 = 1) \text{ OR}$$
$$(I2000 = 1) \text{ OR}$$
$$(I2100 = 1) \text{ OR}$$
$$(I2200 = 1) \text{ OR}$$
$$(I2300 = 1) \text{ OR}$$
$$(I2400 = 1) \text{ OR}$$
$$(I2500 = 1) \text{ OR}$$
$$((M1040A = 1))$$

6. Constipation present as indicated by:

$$H0600 = 1$$

7. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

$$K0510A1 = 1 \text{ OR } K0510A2 = 1$$

8. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

$$K0510B1 = 1 \text{ OR } K0510B2 = 1$$

The information gleaned from the assessment should be used to identify whether the resident is dehydrated or at risk for dehydration, as well as to identify any related possible causes and 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 prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance, and to address the underlying cause or causes of any current dehydration.

15. Dental Care

The ability to chew food is important for adequate oral nutrition. Having clean and attractive teeth or dentures can promote a resident's positive self-image and personal appearance, thereby enhancing social interactions. Medical illnesses and medication-related adverse consequences may increase a resident's risk for related complications such as impaired nutrition and communication deficits. The dental care CAA addresses a resident's risk of oral disease, discomfort, and complications.

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.

Dental Care CAT Logic Table

Triggering Conditions (any of the following):

1. Any dental problem indicated by:

$$(L0200A = 1) \text{ OR}$$
$$(L0200B = 1) \text{ OR}$$
$$(L0200C = 1) \text{ OR}$$
$$(L0200D = 1) \text{ OR}$$
$$(L0200E = 1) \text{ OR}$$
$$(L0200F = 1)$$

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 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.

16. Pressure Ulcer/*Injury*

A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Pressure Ulcer/*Injury* CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for bed mobility was needed, or activity did not occur, or activity only occurred once or twice as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) OR

   (G0110A1 = 7 OR G0110A1 = 8)

2. Frequent urinary incontinence as indicated by:

   H0300 = 2 OR H0300 = 3

3. Frequent bowel incontinence as indicated by:

   H0400 = 2 OR H0400 = 3

4. Weight loss in the absence of physician-prescribed regimen as indicated by:

   K0300 = 2

5. Resident at risk for developing pressure ulcers as indicated by:

   M0150 = 1

6. 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

   (M0300C1 > 0 AND M0300C1 <= 9) OR

   (M0300D1 > 0 AND M0300D1 <= 9) OR

   (M0300E1 > 0 AND M0300E1 <= 9) OR

   (M0300F1 > 0 AND M0300F1 <= 9) OR

   (M0300G1 > 0 AND M0300G1 <= 9))

7. Resident has one or more unhealed pressure ulcer(s) at Stage 1 as indicated by:

   M0300A > 0 AND M0300A <= 9

8. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure ulcers(s) and to identify any related causes and/or contributing 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, 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 postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's 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 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.

Psychotropic Medication Use CAT Logic Table

Triggering Conditions (any of the following):

1. Antipsychotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   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 as indicated by:

   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 as indicated by:

   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 as indicated by:

   N0410D>= 1 AND N0410D<=7

18. Physical Restraints

A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. This category also includes the use of passive restraints such as chairs that prevent rising.

Physical restraints are only rarely indicated, and at most, should be used only as a short-term, temporary intervention to treat a resident's medical symptoms. They should not be used for purposes of discipline or convenience. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

Restraints are often associated with negative physical and psychosocial outcomes (e.g., loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence). Adverse psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation.

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.

Physical Restraints CAT Logic Table

Triggering Conditions (any of the following):

1. Bed rail restraint used in bed has value of 1 or 2 as indicated by:

P0100A = 1 OR P0100A = 2

2. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

3. Limb restraint used in bed has value of 1 or 2 as indicated by:

P0100C = 1 OR P0100C = 2

4. Other restraint used in bed has value of 1 or 2 as indicated by:

P0100D = 1 OR P0100D = 2

5. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

6. Limb restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100F = 1 OR P0100F = 2

7. Chair restraint that prevents rising used in chair or out of bed has value of 1 or 2 as indicated by:

P0100G = 1 OR P0100G = 2

8. Other restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100H = 1 OR P0100H = 2

The information gleaned from the assessment should be used to identify the specific reasons for and the appropriateness of the use of the restraint and any adverse consequences caused by or risks related to restraint use.

The focus of an individualized care plan based directly on these conclusions should be to address the underlying physical or psychological condition(s) that led to restraint use. By addressing underlying conditions and causes, the facility may eliminate the medical symptom that led to using restraints. In addition, a review of underlying needs, risks, or issues/conditions may help to identify other potential kinds of treatments. The ultimate goal is to eliminate restraint use by employing alternatives. When elimination of restraints is not possible, assessment must result in using the least restrictive device possible.

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, 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.

As with all symptoms, pain symptoms are subjective and require a detailed history and additional physical examination, and sometimes additional testing, in order to clarify pain characteristics and causes and identify appropriate interventions. This investigation typically requires coordination between nursing staff and a health care practitioner.

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 active symptoms of pain.

Pain CAT Logic Table

Triggering Conditions (any of the following):

1. Pain has made it hard for resident to sleep at night over the past 5 nights as indicated by:

   J0500A = 1

2. Resident has limited day-to-day activity because of pain over past 5 days as indicated by:

   J0500B = 1

3. Pain numeric intensity rating has a value from 7 to 10 as indicated by:

   J0600A >= 07 AND J0600A <=10

4. Verbal descriptor of pain is severe or very severe as indicated by a value of 3 or 4 as follows:

   J0600B = 3 OR J0600B = 4

5. Pain is frequent as indicated by a value of 1 or 2 and numeric pain intensity rating has a value of 4 through 10 or verbal descriptor of pain has a value of 2 through 4 as indicated by:

   (J0400 = 1 OR J0400 = 2) AND

   ((J0600A >= 04 AND J0600A <= 10) OR

   (J0600B >= 2 AND J0600B <= 4))

6. Staff assessment reports resident indicates pain or possible pain in body language as indicated by:

   (J0800A = 1) OR

   (J0800B = 1) OR

   (J0800C = 1) OR

   (J0800D = 1)

The information gleaned from the assessment should be used to identify the characteristics and possible causes, contributing factors, and risk factors related to the pain. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to alleviate symptoms and, to the extent possible, address the underlying condition(s) that cause the pain.

Management of pain may include various interventions, including medications and other treatments that focus on improving the person's quality of life and ability to function. Therefore, it is important to tailor an individualized care plan related to pain to the characteristics, causes, and consequences of pain in the context of a resident's whole picture, including medical conditions, cognitive capabilities, goals, wishes, and personal and psychosocial function.

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. 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 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 portion of MDS 3.0 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 settings for receipt of services.

Individual choices related to returning to community living will vary, e.g., returning to a former home or a different community home, 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, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals.

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 expresses interest in returning to the community.

Return to Community Referral CAT Logic Table

Triggering Conditions (any of the following):

1. Referral is or may be needed but has not been made to local contact agency as indicated by:

    Q0600 = 1

The information gleaned from the assessment should be used to assess the resident's situation and begin appropriate care planning, discharge planning, and other follow-up measures. The next step is to develop an individualized care plan based directly on these findings.

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.

4.11 Reserved