§483.20(a) Admission Orders
At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care.

Intent §483.20(a)
To ensure the resident receives necessary care and services.

Interpretive Guidelines §483.20(a)
“Physician orders for immediate care” are those written orders facility staff need to provide essential care to the resident, consistent with the resident’s mental and physical status upon admission. These orders should, at a minimum, include dietary, drugs (if necessary) and routine care to maintain or improve the resident’s functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.

§483.20 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity.

Intent §483.20

To provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident’s status. The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to direct observation and communication with the resident, the facility should use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident’s physician, family members, or outside consultants and review of the resident’s record.

§483.20(b) Comprehensive Assessments

§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident’s needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

(i) Indentification and demographic information

(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge potential.

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

(xviii) Documentation of participation in assessment.

§483.20(b) Intent
To ensure that the RAI is used in conducting comprehensive assessments as part of an ongoing process through which the facility identifies the resident’s functional capacity and health status.

§483.20(b) Guidelines
The information required in §483.20(b)(i-xvi) is incorporated into the MDS, which forms the core of each State’s approved RAI. Additional assessment information is also gathered using triggered CAAs.

Each facility must use its State-specified RAI (which includes the MDS, utilization guidelines and the CAAs) to assess newly admitted residents, conduct an annual reassessment and assess
those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility’s responsibility to assess and address all care needed by the resident. Furthermore:

(i) **Identification and demographic information**
“Identification and demographic information” refers to information that uniquely identifies each resident and the facility in which he/she resides, date of entry into the facility and residential history.

(ii) **Customary routine**
“Customary routine” refers to information regarding the resident’s usual community lifestyle and daily routine.

(iii) **Cognitive patterns**
“Cognitive patterns” is defined as the resident’s ability to problem solve, decide, remember, and be aware of and respond to safety hazards.

(iv) **Communication**
“Communication” refers to the resident’s ability to hear, understand others, make him or herself understood (with assistive devices if they are used).

(v) **Vision**
“Vision” refers to the resident’s visual acuity, limitations and difficulties, and appliances used to enhance vision.

(vi) **Mood and behavior patterns**
“Mood and behavior patterns” refers to the resident’s patterns of mood and behavioral symptoms.

(vii) **Psychosocial well-being**
“Psychosocial well-being” refers to the resident’s positive or negative feelings about him or herself or his/her social relationships.

(viii) **Physical functioning and structural problems**
“Physical functioning and structural problems” refers to the resident’s physical functional status, ability to perform activities of daily living, and the resident’s need for staff assistance and assistive devices or equipment to maintain or improve functional abilities.

(ix) **Continence**
“Continence” refers to the resident’s patterns of bladder and bowel continence (control), pattern of elimination, and appliances used.

(x) **Disease diagnosis and health conditions**
“Disease diagnoses and health conditions”
(xi) Dental and nutritional status

“Dental and nutritional status”.

“Dental condition status” refers to the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident’s nutritional status, communication abilities, or quality of life. The assessment should include the need for, and use of, dentures or other dental appliances.

“Nutritional status” refers to weight, height, hematologic and biochemical assessments, clinical observations of nutrition, nutritional intake, resident’s eating habits and preferences, dietary restrictions, supplements, and use of appliances.

(xii) Skin conditions

“Skin conditions” refers to the resident’s development, or risk of development of a pressure sore.

(xiii) Activity pursuit

“Activity pursuit” refers to the resident’s ability and desire to take part in activities which maintain or improve, physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of activities of daily living (ADLs) which a person pursues in order to obtain a sense of well-being. Also, includes activities which provide benefits in self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence. The assessment should consider the resident’s normal everyday routines and lifetime preferences.

(xiv) Medications

“Medications” refers to all prescription and over-the-counter medications taken by the resident, including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident. This information must be in the resident’s clinical record.

(xv) Special treatments and procedures

“Special treatments and procedures” refers to treatments and procedures that are not part of basic services provided. For example, treatment for pressure sores, naso-gastric feedings, specialized rehabilitation services, respiratory care, or devices and restraints.

(xvi) Discharge potential

“Discharge potential” refers to the facility’s expectation of discharging the resident from the facility within the next 3 months.

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS.

“Documentation of summary information (xvii) regarding the additional assessment performed through the CAAs refers to documentation concerning which CAAs have been triggered, documentation of assessment information in support of clinical decision making relevant to the CAAs, documentation regarding where, in the clinical record, information related to the CAAs
can be found, and for each triggered CAA, whether the identified problem was included in the care plan.

(xviii) **Documentation of participation in assessment**
“Documentation of participation in the assessment” refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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**F273**  
§483.20(b)(2)

§483.20(b)(2) When required, a facility must conduct a comprehensive assessment of a resident as follows:

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for hospitalization for therapeutic leave.)

**Intent** §483.20(b)(2)
To assess residents in a timely manner.

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**F274**  
(Rev. 70, Issued: 01-07-11, Effective: 10-01-10 Implementation: 10-01-10)

§483.20(b)(2)(ii)

(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purpose of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.)

§483.20(b)(2)(ii) Guidelines
The following are the criteria for significant changes:

A significant change reassessment is generally indicated *when a resident elects, and revokes, the hospice benefit, and if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement:*
Decline:

- Any decline in activities of daily living (ADL) assistance where a resident is newly coded as 3, 4 or 8 Extensive Assistance, Total Dependence, activity did not occur (note that even if coding in both columns 1 and 2 of an ADL category changes, this is considered 1 ADL change);

  - Change in behavior or other symptoms is coded as “worse”;

  - Resident’s decision-making changes from 0 or 1, to 2 or 3;

  - Resident’s incontinence pattern changes from 0 or 1 to 2 or 3, or placement of an indwelling catheter;

- Emergence of sad or anxious mood as a problem as indicated by symptom presence and frequency, or total severity score, on the MDS (NOTE: For information on the coding of the MDS Mood Section, see Chapter 3 of the Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website (http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage);

  - Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

  - Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before;

  - Emergence of a condition/disease in which a resident is judged to be unstable;

  - Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or

  - Overall deterioration of resident’s condition; resident receives more support (e.g., in ADLs or decision making).

Improvement:

- Any improvement in ADL assistance where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8;

  - Change in behavior or other symptoms is coded as “improved”;

  - Decrease in the areas indicating sad or anxious mood as a problem as indicated by symptom presence and frequency, or total severity score, on the MDS (NOTE: For information on the coding of the MDS Mood Section see Chapter 3 of the Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website (http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage);
• Resident’s decision making changes from 2 or 3, to 0 or 1;

• Resident’s incontinence pattern changes from 2 or 3 to 0 or 1; or

• Overall improvement of resident’s condition; resident receives fewer supports.

• If the resident experiences a significant change in status, the next annual assessment is not due until 366 days after the ARD of the significant change reassessment (NOTE: For information on assessment scheduling for the MDS, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website (http://www.cms.gov/NursingHomeQualityInitiatives/45_NHQIMDS30TrainingMaterials.asp#TopOfPage).

§483.20(b)(2)(iii)

(iii) Not less than once every 12 months.

Interpretive Guidelines §483.20(b)(2)(iii): The annual resident assessment must be completed within 366 days after the ARD of the most recent comprehensive resident assessment. (NOTE: For information on assessment scheduling for the MDS, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website (http://www.cms.gov/NursingHomeQualityInitiatives/45_NHQIMDS30TrainingMaterials.asp#TopOfPage).

Probes §483.20(b)(2):

• Has each resident in the sample been comprehensively assessed using the State-specified RAI within the regulatory timeframes (i.e., within 14 days after admission, on significant change in status, and at least annually)?

• Has the facility identified, in a timely manner, those residents who have experienced a change?

• Has the facility reassessed residents using the State-specific RAI who had a significant change in status within 14 days after determining the change was significant?

• Has the facility gathered supplemental assessment information based on triggered CAAs prior to establishing the care plan?

• Does information in the RAI correspond with information obtained during observations of and interviews with the resident, facility staff and resident’s family?
§483.20(c) Quarterly Review Assessment
A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

Intent §483.20(c):
To assure that the resident’s assessment is updated on at least a quarterly basis.

Interpretive Guidelines §483.20(c):
At least each quarter, the facility shall review each resident with respect to those MDS items specified under the State’s quarterly review requirement. At a minimum, this would include all items contained in CMS’ standard quarterly review form. A Quarterly review assessment must be completed within 92 days of the ARD of the most recent, clinical assessment. If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the ARD of the significant change reassessment. (NOTE: For information on assessment scheduling for the MDS, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0, effective 10/1/2010, which is located on the CMS MDS 3.0 website (http://www.cms.gov/NursingHomeQualityInitiatives/45_NHQIMDS30TrainingMaterials.asp#TopOfPage).

Probes §483.20(c):
Is the facility assessing and acting, no less than once every 3 months, on the results of resident’s functional and cognitive status examinations?
Is the quarterly review of the resident’s condition consistent with information in the progress notes, the plan of care and your resident observations and interviews?

§483.20(d) Use
A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record.

Intent: §483.20(d):
Facilities are required to maintain 15 months of assessment data in the resident’s active clinical record.

Interpretive Guidelines §483.20(d):
The requirement to maintain 15 months of data in the resident’s active clinical record applies regardless of form of storage to all MDS records, including the CAA Summary, Quarterly
Assessment records, Identification Information and Entry, Discharge and Reentry Tracking Records and MDS Correction Requests (including signed attestation). MDS assessments must be kept in the resident’s active clinical record for 15 months following the final completion date for all assessments and correction requests. Other assessment types require maintaining them in the resident’s active clinical record for 15 months following:

• The entry date for tracking records including re-entry; and

• The date of discharge or death for discharge and death in facility records.

Facilities may maintain MDS data electronically regardless of whether the entire clinical record is maintained electronically and regardless of whether the facility has an electronic signature process in place.

Facilities that maintain their MDS data electronically and do not utilize an electronic signature process must ensure that hard copies of the MDS assessment signature pages are maintained for every MDS assessment conducted in the resident’s active clinical record for 15 months. (This includes enough information to identify the resident and type and date of assessment linked with the particular assessment’s signature pages).

The information, regardless of form of storage (i.e., hard copy or electronic), must be kept in a centralized location and must be readily and easily accessible. This information must be available to all professional staff members (including consultants) who need to review the information in order to provide care to the resident. (This information must also be made readily and easily accessible for review by the State Survey agency and CMS.)

After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, the State agency, or CMS.

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§483.20(f) Automated Data Processing Requirement
§483.20(f)(1) Encoding Data. Within 7 days after a facility completes a resident’s assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.

(ii) Annual assessment updates.

(iii) Significant change in status assessments.

(iv) Quarterly review assessments.
(v) A subset of items upon a resident’s transfer, reentry, discharge, and death.

(vi) Background (face-sheet) information, if there is no admission assessment.

**Intent: §483.20(f)(1):**
Facilities are required to encode MDS data for each resident in the facility.

**Interpretive Guidelines §483.20(f)(1):**
Background (face-sheet) information refers to the MDS Entry tracking record, while the discharge subset of items refers to the MDS Discharge assessment.

§483.20(f)(2) Transmitting data. *Within 7 days after a facility completes a resident’s assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.*

§483.20(f)(3) Transmittal requirements. *Within 14 days after a facility completes a resident’s assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:*

(i) Admission assessment.

(ii) Annual assessment.

(iii) Significant change in status assessment.

(iv) Significant correction of prior full assessment.

(v) Significant correction of prior quarterly assessment.

(vi) Quarterly review.

(vii) A subset of items upon a resident’s transfer, reentry, discharge, and death.

(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

**Intent: §483.20(f)(3):**
Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility. The CMS System for MDS data is named the QIES ASAP System.

**Interpretive Guidelines §483.20(f)(3):**
Background (face-sheet) information refers to the MDS Entry tracking record, while the discharge subset of items refers to the MDS Discharge assessment.
§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

Intent §483.20(f)(1-4):
The intent is to enable a facility to better monitor a resident’s decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data. The primary purpose of maintaining the assessment data is so a facility can monitor resident progress over time. The information should be readily available at all times.

Interpretive Guidelines §483.20(f)(1-4):
“Encoding” means entering MDS information into a computer.

“Transmitting data” refers to electronically sending encoded MDS information, from the facility to the QIES ASAP System, using a modem and communications software.

“Capable of transmitting” means that the facility has encoded and edited according to CMS specifications, the record accurately reflects the resident’s overall clinical status as of the assessment reference date, and the record is ready for transmission.

“Passing standard edits” means that the encoded responses to MDS items are consistent and within range, in accordance with CMS specified standards. In general, inconsistent responses are either not plausible or ignore a skip pattern on the MDS. An example of inconsistency would be if one or more MDS items on a list were checked as present, and the “None of the Above” response was also checked for the same list. Out of range responses are invalid responses, such as using a response code of 2 for an MDS item for which the valid responses are zero or 1.

“Transmitted” means electronically transmitting to the QIES ASAP System, an MDS record that passes CMS’ standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry, Discharge and Death in Facility situations, of the record.

“Accurate” means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at §483.20(g), and the information accurately reflects the resident’s status as of the Assessment Reference Date (ARD).

“Complete” means that all items required according to the record type, and in accordance with CMS’ record specifications and State required edits are in effect at the time the record is completed.

In accordance with the final rule, facilities will be responsible to edit the encoded MDS data to ensure that it meets the standard edit specifications.

We encourage facilities to use software that has a programmed capability to automatically edit MDS records according to CMS’ edit specifications.
For §483.20(f)(1)(v), the subset of items required upon a resident’s entry, transfer, discharge and death are contained in the Entry and Death in Facility Tracking records and Discharge assessments. Refer to Chapter 2 of Appendix R (the MDS manual) for further information about these records.

All nursing homes must computerize MDS information. The facility must edit MDS information using standard CMS-specified edits, revise the information to conform to the edits and to be accurate, and be capable of transmitting that data to the QIES ASAP system within 7 days of:

- Completing a comprehensive assessment (the care plan completion date);
- Completing an assessment that is not comprehensive (the MDS completion date);
- A discharge event (the date of death or discharge);
- An entry event (the date of entry (admission or reentry)); or
- Completing a correction request.

Submission must be according to State and Federal time frames. Therefore the facility must:

- Encode the MDS and CAA Summary (where applicable) in machine readable format; and
- Edit the MDS and CAA Summary (where applicable) according to edits specified by CMS. Within the 7 day time period specified above for editing, the facility must revise any information on the encoded MDS and CAA Summary (if applicable) that does not pass CMS-specified edits, revise any otherwise inaccurate information, and make the information ready for submission. The MDS Vendor software used at the facility should have an automated editing process that alerts the user to entries in an MDS record that do not conform with the CMS-specified edits and that prompts the facility to complete revisions within the 7-day editing and revision period. After editing and revision, MDS information and CAA summary information (if applicable) must always accurately reflect the resident’s overall clinical status as of the original ARD for an assessment or the original event date for a discharge or entry.

Electronically submit MDS information to the QIES ASAP system within 14 days of:

- Completing a comprehensive assessment (the care plan completion date);
- Completing an assessment that is not comprehensive (the MDS completion date);
- A discharge event (the date of death or discharge);
- An entry event (the date of entry (admission or reentry)); or
- Completing a correction request.

For a discussion of the process that a facility should follow in the event an error is discovered in an MDS record after editing and revision but before it is transmitted to the QIES ASAP system, refer to Appendix R of the State Operations Manual, Chapter 5.
Facilities are required to maintain 15 months of assessment data in the resident’s active clinical record. Refer to the interpretive guidelines at §483.20(d) for information regarding this requirement.

A facility must complete and submit to the QIES ASAP system a subset of items when a resident enters the facility (entry tracking record - admission or reentry), is discharged from the facility (discharge assessment – return anticipated or return not anticipated) or dies in the facility (death in facility tracking record).

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§483.20(g) Accuracy of Assessment
The assessment must accurately reflect the resident’s status.

Intent §483.20(g):
To assure that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident’s status, needs, strengths, and areas of decline.

Interpretive Guidelines §483.20(g):
“The accuracy of the assessment” means that the appropriate, qualified health professional correctly documents the resident’s medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. The initial comprehensive assessment provides baseline data for ongoing assessment of resident progress.

§483.20(h) Coordination

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

Intent §483.20(h):
The registered nurse will conduct and/or coordinate the assessment, as appropriate. Whether conducted or coordinated by the registered nurse, he or she is responsible for certifying that the assessment has been completed.

Interpretive Guidelines §483.20(h):
According to the Utilization Guidelines for each State’s RAI, the physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the
resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.

**Probes §483.20(g)(h):**

Have appropriate health professionals assessed the resident? For example, has the resident’s nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?

If the resident’s medical status, functional abilities, or psychosocial status declined and the decline was not clinically unavoidable, were the appropriate health professionals involved in assessing the resident?

Based on your total review of the resident, is each portion of the assessment accurate?

Are the appropriate certifications in place, including the RN Coordinator’s certification of completion of an assessment or Correction Request, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment or tracking record completed or corrected. On an assessment or correction request, the RN Assessment Coordinator is responsible for certifying overall completion once all individual assessors have completed and signed their portion(s) of the MDS. When MDS records are completed directly on the facility’s computer, (e.g., no paper form has been manually completed), the RN Coordinator signs and dates the computer generated hard copy, or provides an electronic signature, after reviewing it for completeness, including the signatures of all individual assessors. Backdating a completion date is not acceptable – note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.

**§483.20(i) Certification**

(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

**Interpretive Guidelines §483.20(i):**

Whether the MDS assessments are manually completed, or computer generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident’s condition and discharge or entry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the MDS record.

When MDS forms are completed directly on the facility’s computer (e.g., no paper form has been manually completed), then each individual assessor signs and dates a computer generated hard copy, or provides an electronic signature, after they review it for accuracy of the portion(s)
they completed. Backdating completion dates is not acceptable – note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.

§483.20(j) Penalty for Falsification

(1) Under Medicare and Medicaid, an individual who willfully and knowingly--

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

Interpretive Guidelines §483.20(j):

MDS information serves as the clinical basis for care planning and delivery. With the introduction of additional uses of MDS information such as for payment rate setting and quality monitoring, MDS information as it is reported impacts a nursing home’s payment rate and standing in terms of the quality monitoring process. A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher RUG scores, untriggering CAA(s), or unflagging QI(s), where the information does not accurately reflect the resident’s status, may be indicative of payment fraud or avoidance of the quality monitoring process. Such practices may include but are not limited to a pattern or high prevalence of the following:

• Submitting MDS Assessments (including any reason(s) for assessment, routine or non-routine) or tracking records, where the information does not accurately reflect the resident’s status as of the ARD, or the Discharge or Entry date, as applicable;

• Submitting correction(s) to information in the QIES ASAP system where the corrected information does not accurately reflect the resident’s status as of the original ARD, or the original Discharge or Entry date, as applicable, or where the record it claims to correct does not appear to have been in error;

• Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error;

• Submitting Significant Change in Status Assessments where the criteria for significant change in the resident’s status do not appear to be met;

• Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Entry Tracking information, or correction(s) to information in the QIES ASAP system.
When such patterns or practices are noticed, they should be reported by the State Agency to the proper authority.

§483.20(d) (A facility must..) use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

§483.20(k) Comprehensive Care Plans

(1) 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 care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25; and

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

Interpretive Guidelines §483.20(k):

An interdisciplinary team, in conjunction with the resident, resident’s family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the CAA summary or clinical record of the following:

• The resident’s status in triggered CAA areas;

• The facility’s rationale for deciding whether to proceed with care planning; and

• Evidence that the facility considered the development of care planning interventions for all CAAs triggered by the MDS.

The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident’s ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may, for some residents, need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan or care.

The requirements reflect the facility’s responsibilities to provide 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. However, in some cases, a
resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being.

Desires of the resident should be documented in the clinical record (see guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment).

**Probes§483.20(k)(1):**

- Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment?
- Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? How does the care plan attempt to manage risk factors? Does the care plan build on resident strengths?
- Does the care plan reflect standards of current professional practice?
- Do treatment objectives have measurable outcomes?
- Corroborate information regarding the resident’s goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment.
- Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.
- If the resident has refused treatment, does the care plan reflect the facility’s efforts to find alternative means to address the problem?
- For implementation of care plan, see §483.20(k)(3).

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§483.10(d)(3) – The resident has the right to -- unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

**Interpretive Guidelines §483.10(d)(3)**

“Participates in planning care and treatment” means that the resident is afforded the opportunity to select from alternative treatments. This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment. The resident’s right to participate in care planning and to refuse treatment are covered in §§483.20(d)(2) and 483.10(b)(4).

A resident whose ability to make decisions about care and treatment is impaired, or a resident who has been formally declared incompetent by a court, should, to the extent practicable, be kept informed and be consulted on personal preferences.
Whenever there appears to be a conflict between a resident’s right and the resident’s health or safety, determine if the facility attempted to accommodate both the exercise of the resident’s rights and the resident’s health, including exploration of care alternatives through a thorough care planning process in which the resident may participate.

**Procedures §483.10(d)(3)**
Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes (e.g., ask residents or their representatives during interviews).

**§483.20(k)(2) A comprehensive care plan must be—**

(i) Developed within 7 days after the completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

**Interpretive Guidelines §483.20(k)(2):**

As used in this requirement, “Interdisciplinary” means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility.

The physician must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-on-one discussions and conference calls.

The resident’s right to participate in choosing treatment options, decisions in care planning and the right to refuse treatment are addressed at §483.20(k)(2)(ii) and 483.10(b)(4), respectively, and include the right to accept or refuse treatment. The facility has a responsibility to assist residents to participate, e.g., helping residents, and families, legal surrogates or representatives understand the assessment and care planning process; when feasible, holding care planning meetings at the time of day when a resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident’s advocate to attend (e.g. family member, friend) if desired by a resident.

The resident has the right to refuse specific treatments and to select among treatment options before the care plan is instituted. (See §483.20(k)(2)(ii) and 483.10(b)(4).) The facility should
encourage residents, legal surrogates and representatives to participate in care planning, including attending care planning conferences if they so desire.

While Federal regulations affirm the resident’s right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical intervention or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident’s care and safety, including clinical decisions.

**Probes §483.20(k)(2):**

1. Was interdisciplinary expertise utilized to develop a plan to improve the resident’s functional abilities?

   a. For example, did an occupational therapist design needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?

   b. Do the dietitian and speech therapist determine, for example, the optimum textures and consistency for the resident’s food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident?

   c. Is there evidence of physician involvement in development of the care plan (e.g., presence at care plan meetings, conversations with team members concerning the care plan, conference calls)?

2. In what ways do staff involve residents and families, surrogates, and/or representatives in care planning?

3. Do staff make an effort to schedule care plan meetings at the best time of the day for residents and their families?

4. Ask the ombudsman if he/she has been involved in a care planning meeting as a resident advocate. If yes, ask how the process worked.

5. Do facility staff attempt to make the process understandable to the resident/family?

6. Ask residents whether they have brought questions or concerns about their care to the attention of facility’s staff. If so, what happened as a result?

**Interpretive Guidelines §483.20(k)(2)(iii):**

See §483.75(g)(2)(iii) for “Qualified Person,”

**Probes §483.20(k)(2)(iii):**

Is the care plan evaluated and revised as the resident’s status changes?
§483.20(k)(3)

(3) The services provided or arranged by the facility must--

(i) Meet professional standards of quality and;

Intent §483.20(k)(3)(i):
The intent of this regulation is to assure that services being provided meet professional standards of quality (in accordance with the definition provided below) and are provided by appropriate qualified persons (e.g., licensed, certified).

Interpretive Guidelines §483.20(k)(3)(i):
“Professional standards of quality” means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include:

• Current manuals or textbooks on nursing, social work, physical therapy, etc.

• Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.

• Clinical practice guidelines published by the Agency of Health Care Policy and Research.

• Current professional journal articles.

If a negative resident outcome is determined to be related to the facility’s failure to meet professional standards, and the team determines a deficiency has occurred, it should be cited under the appropriate quality of care or other relevant requirement.

Probes §483.20(k)(3):

Question only those practices which have a negative outcome or have a potential negative outcome. Ask the facility to produce references upon which the practice is based.

• Do nurses notify physicians, as appropriate, and show evidence of discussions of acute medical problems?

• Are residents with acute conditions who require intensive monitoring and hospital-level treatments that the facility is unable to provide, promptly hospitalized?
• Are there errors in the techniques of medication administration? (Cite actual medication errors at §483.25(m).)

• Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan?

• Are physicians’ orders carried out, unless otherwise indicated by an advanced directive?

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§483.20(k)(3)(ii) Be provided by qualified persons in accordance with each resident’s written plan of care.

Interpretive Guidelines §483.20(k)(3)(ii):

If you find problems with quality of care, quality of life, or resident rights, are these problems attributable to the qualifications of the facility staff, or lack of, inadequate or incorrect implementation of the care plan?

Probes §483.20(k)(3)(ii):

• Can direct care-giving staff describe the care, services, and expected outcomes of the care they provide; have a general knowledge of the care and services being provided by other therapists; have an understanding of the expected outcomes of this care, and understand the relationship of these expected outcomes to the care they provide?

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§483.20(l) Discharge Summary
When the facility anticipates discharge a resident must have a discharge summary that includes:

(1) A recapitulation of the resident’s stay;

(2) A final summary of the resident’s status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

Intent §483.20(l):
To ensure appropriate discharge planning and communication of necessary information to the continuing care provider.
Interpretive Guidelines §483.20(l):

“Anticipates” means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident’s death.

“Adjust to his or her living environment” means that the post-discharge plan, as appropriate, should describe the resident’s and family’s preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple caregivers. It should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/caregiver education needs and ability to meet care needs after discharge.

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(Rev. 70, Issued: 01-07-11, Effective: 10-01-10 Implementation: 10-01-10)

§483.20(l)(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Interpretive Guidelines §483.20(l)(3):
A post-discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for individuals with mental retardation. Resident protection concerning transfer and discharge are found at §483.12. A “post-discharge plan of care” means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual’s needs will be met after discharge from the facility into the community.

Probes §483.20(l):

- Does the discharge summary have information pertinent to continuing care for the resident?

- Is there evidence of a discharge assessment that identifies the resident’s needs and is used to develop the discharge plan?

- Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)?

- Do discharge plans address necessary post-discharge care?

- Has the facility aided the resident and his/her family in locating and coordinating post-discharge services?

- What types of pre-discharge preparation and education has the facility provided the resident and his/her family?
• Does the discharge summary have information identifying if the resident triggered the CAA for return to community referral?

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§483.20(e) Coordination
A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

Interpretive Guidelines §483.20(e)
With respect to the responsibilities under the Pre-Admission Screening and Resident Review (PASRR) program, the State is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens. The State is required to provide a copy of the PASRR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide.

§483.20(m) Preadmission Screening for Mentally Ill Individuals and Individuals With Mental Retardation.

§483.20(m)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; and

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

§483.20(m)(2) Definitions. For purposes of this section:

(i) An individual is considered to have “mental illness” if the individual has a serious mental illness defined at 483.102(b)(1).

(ii) An individual is considered to be “mentally retarded” if the individual is mentally retarded as defined in 483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

Intent §483.20(m):

To ensure that individuals with mental illness and mental retardation receive the care and services they need in the most appropriate setting.

“Specialized services” are those services the State is required to provide or arrange for that raise the intensity of services to the level needed by the resident. That is, specialized services are an “add-on” to NF services--they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF.

The statute mandates preadmission screening for all individuals with mental illness (MI) or mental retardation (MR) who apply to NFs, regardless of the applicant’s source of payment, except as provided below. (See §1919(b)(3)(F).) Residents readmitted and individuals who initially apply to a nursing facility directly following a discharge from an acute care stay are exempt if:

• They are certified by a physician prior to admission to require a nursing facility stay of less than 30 days; and

• They require care at the nursing facility for the same condition for which they were hospitalized.

The State is responsible for providing specialized services to residents with MI/MR residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident’s condition. Therefore, if a facility has residents with MI/MR, do not survey for specialized services, but survey for all other requirements, including resident rights, quality of life, and quality of care.

If the resident’s PAS report indicates that he or she needs specialized services but the resident is not receiving them, notify the Medicaid agency. NF services ordinarily are not of the intensity to meet the needs of residents with MI or MR.

Probes §483.20(m):