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Chapter	Section	Page	Change
4	4.2	4-1	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.~~20(k)~~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.
4	4.2	4-2	The information in the MDS constitutes the core of the required ~~State~~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.
4	4.4	4-3	Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(~~b~~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.
4	4.5	4-6	**Identifying policies and practices related to the assessment and care planning processes.** Under the OBRA regulations, 42 CFR 483.~~75(i)~~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."

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4	4.6	4-7	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~~ [F 309]~~). Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.75~~0~~(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., ~~F314~~ 42 CFR 483.25~~(c)~~(b)(1) Pressure ~~Sores~~Ulcers and ~~F329~~ 42 CFR 483.~~25(l)~~45(d) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

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4	4.7	4-8	As required at 42 CFR 483.~~25~~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(~~k~~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.~~20(k)~~21(b), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.
4	4.7	4-10	• 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, ~~and~~ goals, and desired outcomes; ~~for health care;~~

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4	4.7	4-10–4-11	Revised the following bullets and updated numbering accordingly. **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. Addressing ways to try to preserve and build upon resident strengths.~~ 7. Applying current standards of practice in the care planning process. 8. Evaluating treatment of measurable objectives, timetables and outcomes of care. 9. Respecting the resident's right to decline treatment. 10. Offering alternative treatments, as applicable. 11. Using an ~~appropriate~~ interdisciplinary approach to care plan development to improve the resident's ~~functional~~ abilities. 12. Involving resident, resident's family and other resident representatives as appropriate. 13. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs. 14. Involving ~~the~~ direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes. ~~15. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.~~
4	4.7	4-10–4-11	Page length changed due to revised content on 4-10.

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4	4.8	4-11	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.
4	4.8	4-11–4-12	Revised the following bullets and updated numbering accordingly. 5) The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. ~~Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed.~~ 6) 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.
4	4.8–4.11	4-12–4-42	Page length changed due to revised content on 4-12.

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Chapter	Section	Page	Change
4	4.9	4-15	**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.
4	4.9	4-15–4-16	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