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Chapter	Section	Page	Change
2	2.1	2-1	The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each ~~nursing home~~ resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.
2	2.2	2-1	**2.2 CMS~~State~~ Designation of the RAI for Nursing Homes** Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by ~~the State and approved by~~ CMS. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data. (Detailed submission requirements are located in Chapter 5.) While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items. ~~As such, each State must have CMS approval of the State's Comprehensive and Quarterly assessments.~~

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2	2.2	2-2	• CMS' ~~approval of a State's~~ specified RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI. • CMS' ~~approval of a State's~~ specified RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). • All comprehensive RAIs ~~authorized by States~~specified by CMS must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including CATs and the CAA Summary (Section V)). • If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS ~~approved State's~~specified RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts. • Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates ~~the State's~~CMS' specified RAI (i.e., using the exact wording and sequencing of items as is found on the ~~State~~ RAI specified by CMS).
2	2.2	2-2	Additional information about ~~State~~CMS specification of the RAI and~~,~~ variations in format ~~and CMS approval of a State's RAI~~ can be found in Sections 4145.1–~~–~~4145.7 of the CMS State Operations Manual (SOM). For more information about your State's assessment requirements, contact your State RAI coordinator (see Appendix B).

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2	2.4	2-7	• Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the ~~long-term care~~ facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
2	2.4	2-8	• Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. Resident specific information must also be available to the individual resident. • Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a hand-written **or** a computer-generated copy be maintained in the active clinical record for 15 months following the final completion date for all assessments and correction requests. ~~Either is equally acceptable.~~ This includes all MDS records, including the CAA Summary, Quarterly assessment records, Identification Information, Entry and Death in Facility Tracking records and MDS Correction Requests (including signed attestation)~~(including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period~~. • All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified ~~long-term care~~ facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard. • In the future, ~~long-term care~~ facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

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Chapter	Section	Page	Change
2	2.4–2.6	2-8–2-15	Page length changed due to revised content on 2-8.
2	2.5	2-11	**Interdisciplinary Team (IDT[1])** is a group of professional disciplines ~~clinicians from several medical fields~~ that combine~~s~~ knowledge, skills, and resources to provide the greatest benefit ~~care~~ to the resident.
2	2.5	2-11	1. 42 CFR 483.~~20(k)(2)~~21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).~~, the resident's family or the resident's legal representative;"~~
2	2.6	2-22	The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.
2	2.6	2-22	A **"significant change"** is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered ~~is not~~ "self-limiting"~~;~~ ~~(for declines only);~~

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2	2.6	2-25–2-26	• **Decline in two or more of the following:** — Resident's decision-making ability has changed~~s~~; — Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); — Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; — Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning; — Resident's incontinence pattern changes or there was placement of an indwelling catheter; — Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); — Emergence of a new pressure ulcer at Stage 2~~II~~ or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status; — Resident begins to use ~~trunk~~ a restraint of any type ~~or a chair that prevents rising~~ when it was not used before; and/or — Emergence of a condition/disease in which a resident is judged to be unstable. ~~— Overall deterioration of resident's condition.~~

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2	2.6	2-26	• **Improvement in two or more of the following:** — Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning; — Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; — Resident's decision making improves; ~~changes for the better;~~ — Resident's incontinence pattern improves. ~~changes for the better;~~ ~~— Overall improvement of resident's condition.~~
2	2.6	2-30	A **"significant error"** is an error in an assessment where: 1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2	2.6	2-32	• While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan. ~~determine if a revision to the resident's care plan is necessary, and make the applicable revision.~~ • The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).

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2	2.7	2-41	• It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/ problems. Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline ~~preliminary~~ care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
2	2.7	2-42	• Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, 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. • After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs (described in detail in Chapter 4 of this manual).

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2	2.7	2-42	• 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. ~~Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly and SCQA assessment and modify the care plan on an ongoing basis, if appropriate.~~ • Detailed information regarding the care planning process appears in Chapter 4 of this manual.
2	2.7–2.15	2-42–2-88	Page length changed due to revised content on 2-42.
2	2.10	2-60	When combining assessments, the more stringent requirements must be met. For example, when a ~~nursing home~~ Start of Therapy OMRA is combined with a 14-Day Medicare-required Assessment, the PPS item set must be used. The PPS item set contains all the required items for the 14-Day Medicare-required assessment, whereas the Start of Therapy OMRA item set consists of fewer items, thus the provider would need to complete the PPS item set. The ARD window (including grace days) for the 14-day assessment is days 13-18, therefore, the ARD must be set no later than day 18 to ensure that all required time frames are met. For a swing bed provider, the swing bed PPS item set would need to be completed.
2	2.13	2-80	***Resident Takes a Leave of Absence from the SNF*** If a resident is out of the facility for a Leave of Absence (LOA) as defined on page ~~2-12~~2-13 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments.