

**RAI**

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# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

What is the proper procedure for completing Resident Assessment (RAP) summary sheets?

The purpose of the RAP Summary Form is to provide documentation of the information obtained by using the RAP Guidelines for assessment. Instructions for use are listed at the top of the form which consists of four columns. More detailed instructions are listed below.

## Column 1

The first column on the left lists the 18 RAPs.

## Column 2

This column contains a series of blocks. Check the box (or boxes) in this column that corresponds to the RAP (or RAPs) triggered by the Minimum Data Set.

## Column 3

Following the RAP process outlined in Chapter 4 and the Resident Assessment Protocols located in Appendix C of the Resident Assessment Instrument (RAI) manual, an individualized summary is written for the triggered concern(s). Use the "Location and Date of RAP Assessment Documentation" column to indicate where the RAP summary can be found in the resident's record and date of the summary.

## Column 4

This column consists of a series of blocks. It is completed at the time of the development of the care plan. Check the block which corresponds to the RAP (or RAPs) which contains the identified individual problem (or problems) that is addressed on the current care plan. This does not mean that every triggered RAP must be addressed on the care plan. Remember that the summary documentation is going to support the decision regarding proceeding to the care plan or not proceeding to the care plan.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can nurse aides fill out the Minimum Data Set (MDS) form instead of the Registered Nurse Coordinator? The Resident Assessment Instrument (RAI) manual indicates the health professionals who can participate in its completion and several examples of health professionals are listed, but not nurse aides.

A facility has flexibility in determining who should participate in the assessment provided it is accurately conducted. It is the responsibility of the facility to ensure that all participants in the assessment process have the knowledge required to complete an accurate and comprehensive assessment, so in most cases participants are licensed health professionals.

The North Carolina Board of Nursing also defines levels of practice. Nurse aides are not allowed to assess residents.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does each discipline that participates in the completion of a Minimum Data Set (MDS) have to indicate the sections for which they provided or entered information? What is the regulation (tag number) if a deficiency is cited?

Yes. Federal regulations at 42 CFR §483.20(c)(2), tag F278, require each individual who completes a portion of the assessment to sign and certify its accuracy at AA9.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

My Resident Assessment Instrument (RAI) manual states that heights and weights should be rounded to the nearest whole inch or pound, yet state surveyors tell me I should use the actual height and weight. Which is correct?

The RAI 2.0 manual instructions state: "round height to the nearest whole inch"; "round weight to the nearest whole pound" (page 3-128).

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Must facilities use a specific, designated printed version of the Resident Assessment Instrument (RAI) Version 2.0?

No. Please refer to Chapter 1 in the Resident Assessment Instrument (RAI) User's Manual for Version 2.0. "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 form in the resident's record accurately and completely represents the State's RAI as approved by CMS in accordance with 42 CFR §483.20(b). This applies to either pre-printed forms or computer generated printouts. 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 RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions)." North Carolina allows this flexibility.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

If a newly admitted resident must return for a temporary stay in the hospital during the first fourteen days of residence, must the completed Resident Assessment Instrument (RAI) information be discarded and a new RAI begun? If a new RAI does not have to be initiated, do you add the remainder of the 14 days to establish the date by which the RAI must be completed? For example, the resident is admitted on January 1 and returns to the hospital on January 10. For purposes of RAI, the resident was assessed for 9 days; therefore there are 5 days after return from the hospital to complete the assessment.

Refer to 2.2 and 2.4 of the RAI Manual

A completed RAI is required by the end of the fourteenth day from admission.

In this example, the assessment was not complete when the resident was sent out and admitted to the hospital. The facility can choose to:

- a) If the resident is admitted to the hospital, a discharge tracking form should be sent (AA8a=8 discharged prior to completion of the admission assessment). If the resident returns to the facility, then the admission assessment should be reinitiated, counting the 14-day period from the new admission date. The portion of the assessment that was previously completed should be stored on the resident's record with documentation indicating the assessment was reinitiated because the resident was hospitalized prior to completion of the admission assessment.
- b) If most of the admission assessment was completed prior to the hospitalization and the resident returns during the 14-day assessment period, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in condition. The ARD (Assessment Reference Date) remains the same in this case, and the comprehensive assessment must be completed by the 14<sup>th</sup> day from the original date of admission.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

If data has been collected for specific sections of the MDS to the extent required to review (work) a particular RAP, is the facility in compliance if this RAP is completed prior to the assessment date, Section A, Item 3 of the MDS? For example, some RAPs are reviewed and completed at the end of seven days and some are completed at the end of fourteen. The fourteenth day is the day the facility enters in A3 as the assessment reference date.

No. The RAI manual states that the assessment reference date is the “designated endpoint of the common observation period.”

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Do facilities have to complete a new face sheet for each Resident Assessment Instrument (RAI) done on an annual basis or due to significant change in condition?

This section is completed at the time of the resident's original admission to the facility and is kept on the active record until the resident is permanently discharged. The face sheet is also required if the resident is readmitted to the facility following a discharge - return not anticipated (AA8a=6).

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does the facility have to indicate on the Minimum Data Set (MDS) quarterly review that the care plan has been reviewed and revised? If so, where is this indicated on the 2.0 version?

No. The facility does not have to indicate care plan review and revision on the MDS quarterly review form. The accurately completed plan in and of itself is the documentation of the review and revision.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Does Division of Medical Assistance, Division of Health Service Regulation or the Centers for Medicare and Medicaid Services automatically require a new Minimum Data Set (MDS) when a Medicaid resident's level of care changes from Intermediate Care Facility (ICF) to Skilled Nursing Facility (SNF) or SNF to ICF?

No. Only when the resident's condition has changed to the degree of significant change (see definition in RAI 2.0 manual) must a new Resident Assessment be performed. If a resident's condition does not change significantly and it is the attempted treatment modalities that change, therefore resulting in a change in level of care, the care plan must be revised to reflect the change in treatment/therapies but a new Resident Assessment Instrument (RAI) is not indicated.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

The quarterly summary form for Resident Assessment Instrument (RAI) Version 2.0 now has the potential to elicit responses to items that would trigger a Resident Assessment Protocol (RAP) if entered as a part of an annual assessment. Computer software and certain forms printed by independent vendors will indicate a RAP has been triggered when entering data during a quarterly assessment. Are RAPs a part of every quarterly assessment?

Quarterly assessments do not require that RAPs be completed. If a significant change was discovered during the completion of a quarterly assessment, a full assessment would be required with the accompanying triggered RAPs.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can non-professional staff, e.g., admissions coordinators make entries on the Minimum Data Set (MDS)?

Yes, non-professional staff can input data, but an RN must sign that the MDS is complete.

# REGULATORY FOCUS BULLETIN

FILE TOPIC: RAI

Can nursing home staff provide palliative care or treatment designed to promote comfort for residents who are not appropriate for rehabilitative care, and do not qualify for the Medicare hospice benefit?

Persons with 6 months or less to live are generally acknowledged to be "terminally ill," and they qualify for the Medicare hospice benefit. Some nursing home residents will suffer the symptoms of incurable, end-stage chronic disease for more than 6 months at the end of their lives. For example, many nursing home residents eventually die from complications of dementing illnesses such as Alzheimer's or multiple strokes, and others suffer from end-stage heart or lung diseases. In the natural course of these illnesses, some residents will reach an end-stage of disease that is irreversible and incurable. Near the natural end of life, persons with these illnesses will typically be unable to walk or participate in self-care even with aggressive staff encouragement and rehabilitation. They often lose their appetite, reduce intake, and lose weight in the final stages of illness.

Nursing home residents and their families may elect an approach to care that maximizes comfort and minimizes suffering during the final phase of any severe chronic or terminal illness. Nursing home staff, together with residents and families, may create palliative care plans or treatment plans designed to promote comfort when rehabilitation is not possible or appropriate to the resident's wishes and needs. According to OBRA 1987, skilled nursing facilities must "...provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." This set of goals is met for residents who are progressively declining toward death by using care plans that differ from care plans for residents who are expected to improve with rehabilitation. A palliative plan of care is most appropriate when the primary goals of treatment are to ensure comfort, improve psychosocial well-being, and maximize quality of life. The critical steps in designing and implementing an appropriate palliative care plan is individualized resident assessment and careful communication and goal-setting with resident and family.

Facilities should document the following process to arrive at an appropriate palliative care plan for a resident with end-stage chronic or terminal illness, whether or not they are enrolled in hospice care.

- a) Physician documentation of the life-limiting disease diagnosis and end-stage prognosis.
- b) Nursing and therapy team assessment of resident's functional status decline, and the failure of rehabilitative measures to improve functional status.<sup>1</sup>
- c) Interdisciplinary care planning with resident and family, to discuss diagnosis, prognosis, and appropriate goals of care; resident and/or family should express the resident's desire for a natural death, and his or her wish to create a care plan focused on quality of life and comfort.
- d) Nursing and social work assessments of palliative care needs -- physical pain and other symptoms, emotional, social, and spiritual sources of suffering.
- e) Chart documentation of palliative care plan of treatment designed to improve comfort and quality of life.
- f) Chart documentation of a discussion of treatment preferences, and physician orders to respect preferences, including Do-Not-Resuscitate orders, Do-Not-Hospitalize orders, orders to forego other life-prolonging treatments such as tube-feeding or antibiotics, orders to give comfort treatments such as pain medication, and other supportive measures.

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<sup>1</sup> If the patient is in a Medicare/Medicaid bed, the Resident Assessment Instrument and protocols (RAPs) should be used accordingly. When working "RAPs" triggered by the required MDS, the assessor can note how rehabilitation and restorative measures would not be beneficial nor appropriate interventions for goals such as comfort and psychosocial well-being of the individual.