

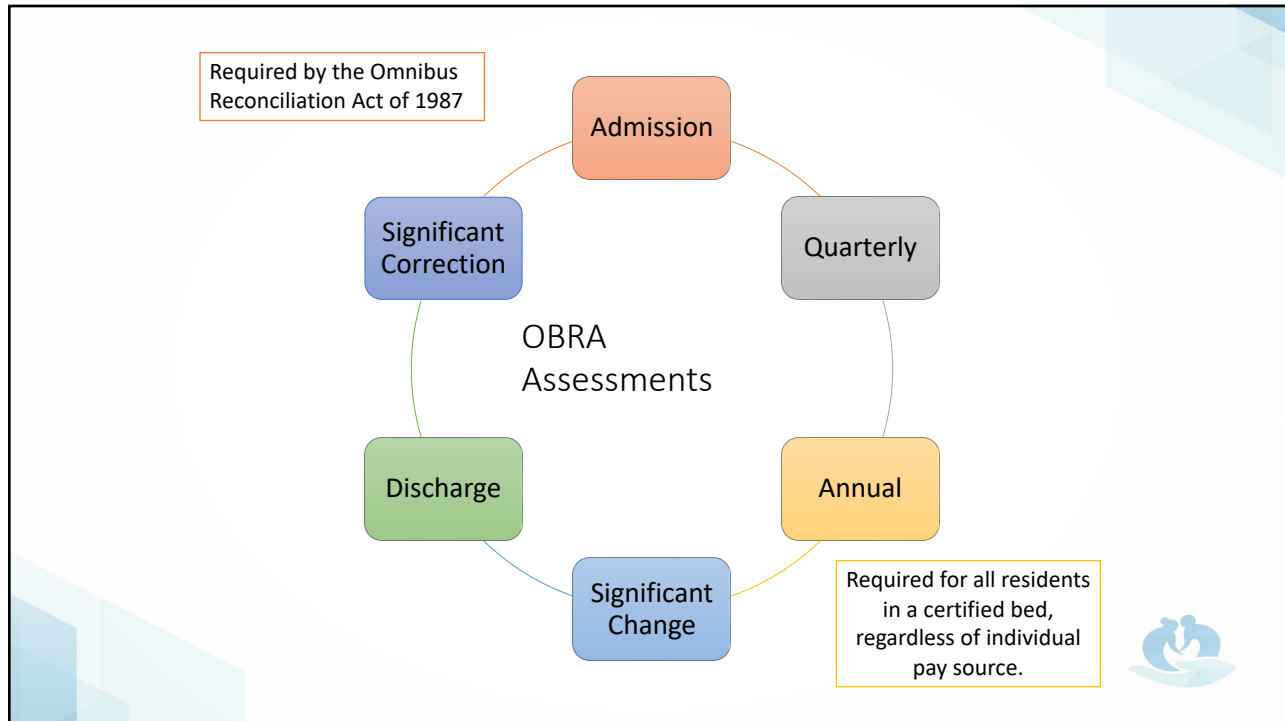
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OBRA Scheduling

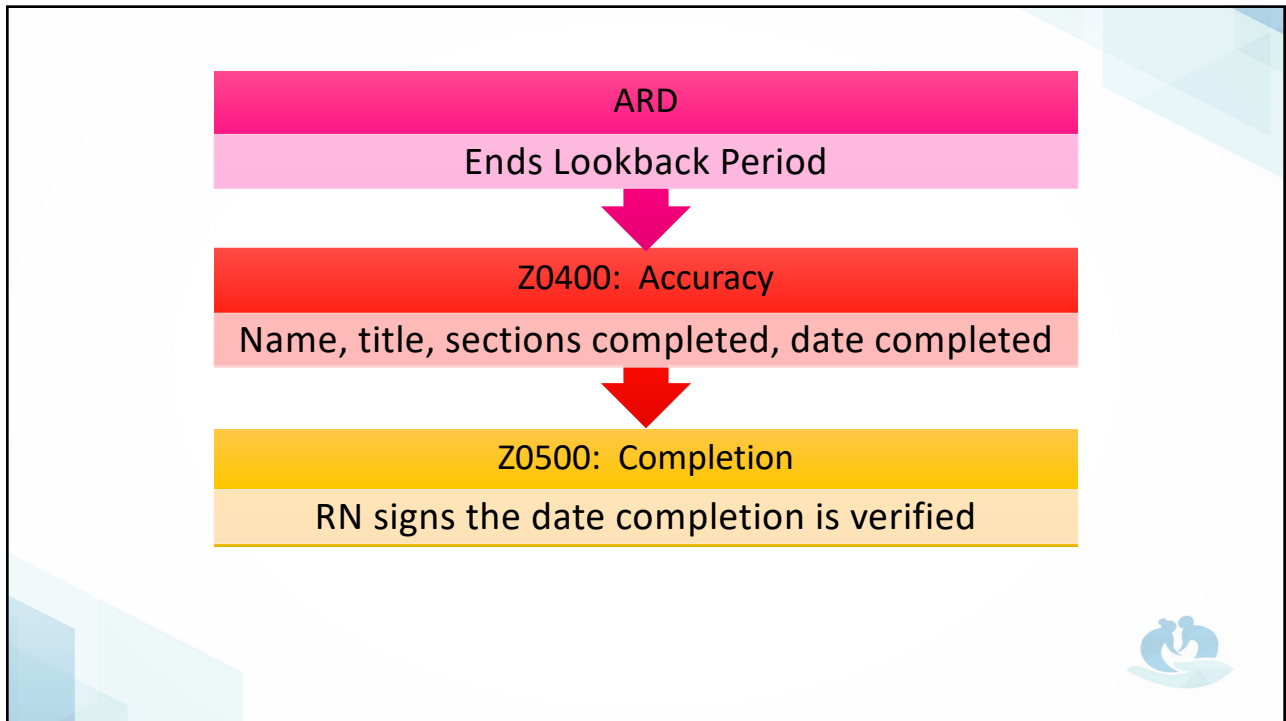
Does not include any State specific rules.
Contact state auditors, RAI manager, survey
agency or Medicaid agency.



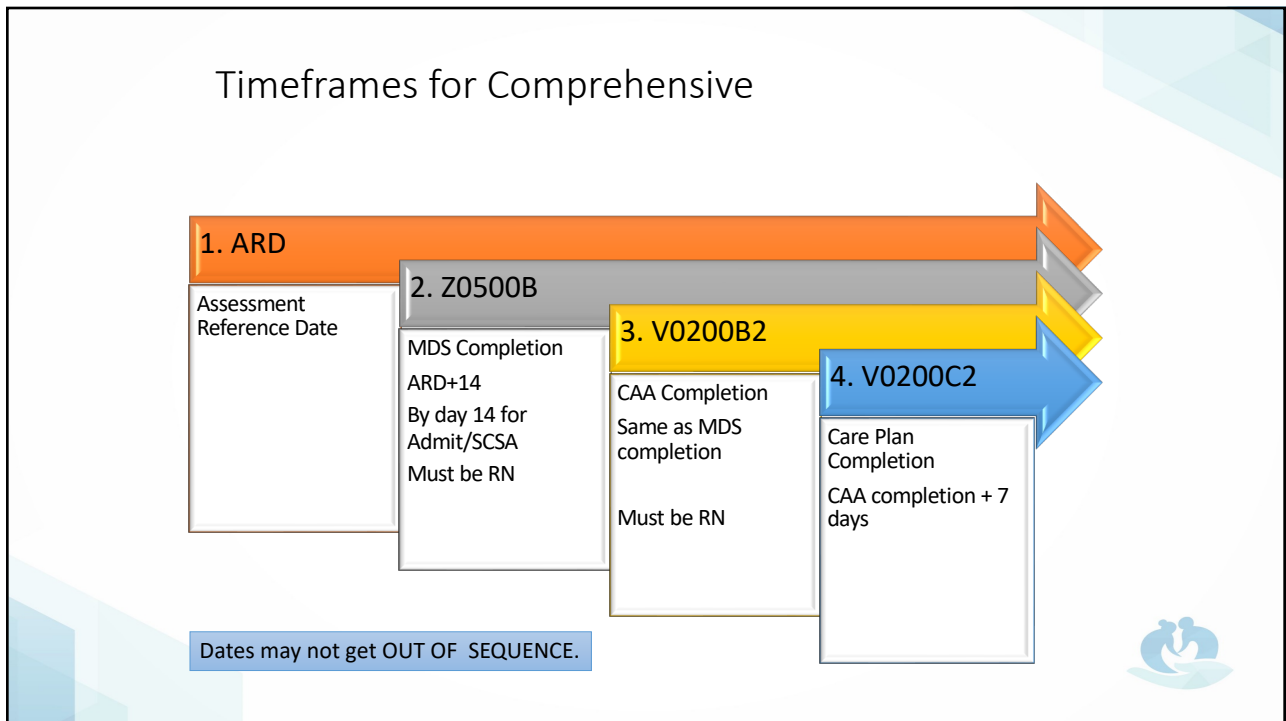
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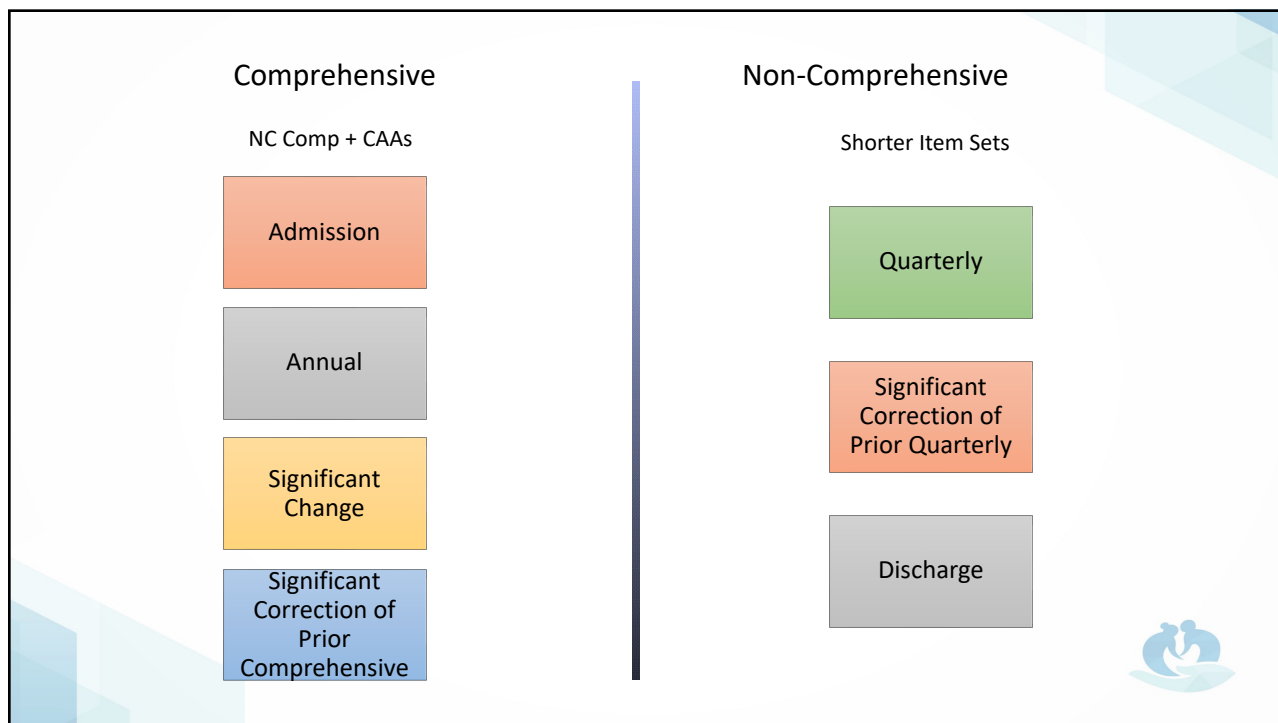
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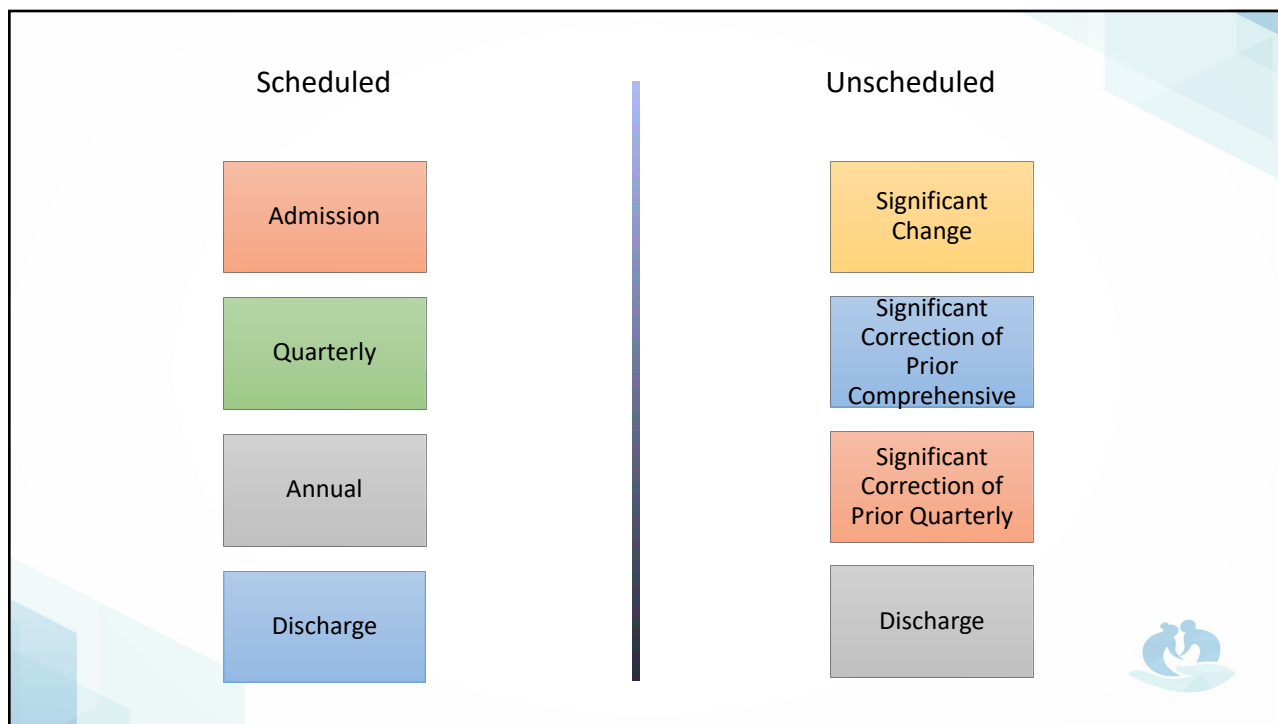
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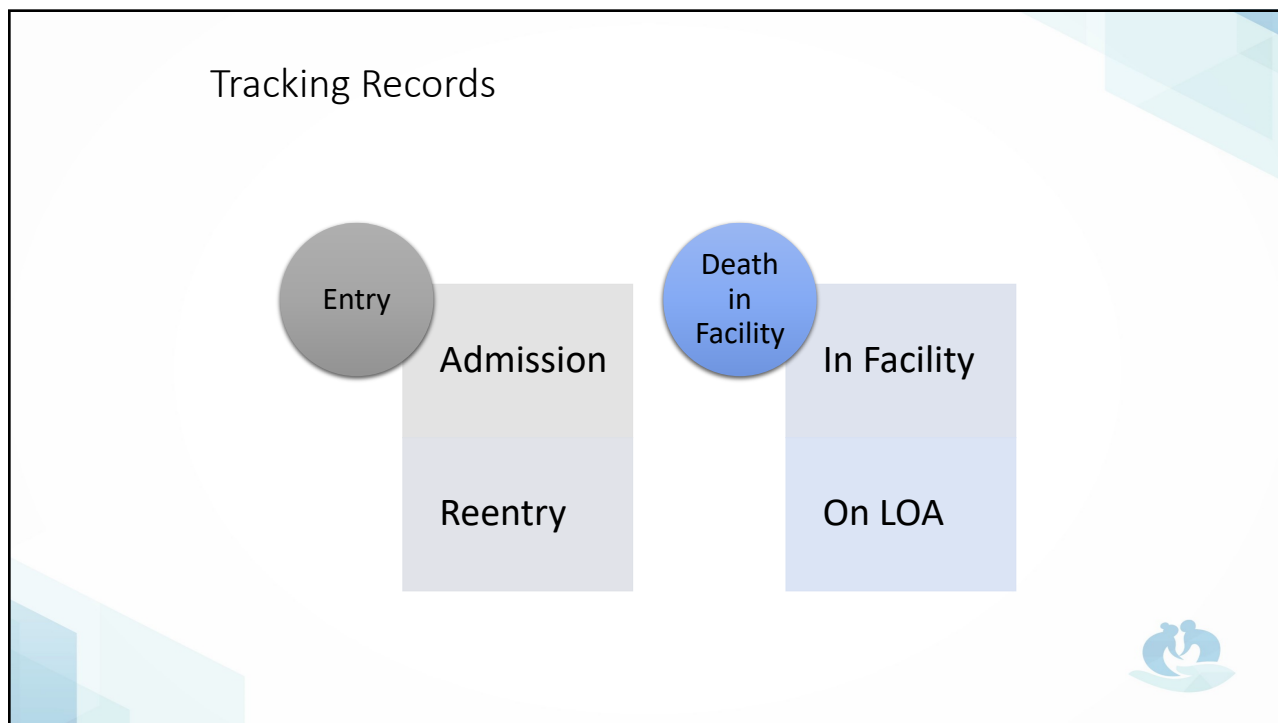
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Tracking Records

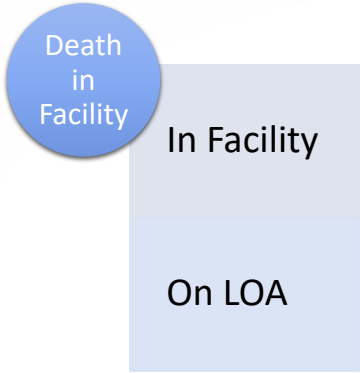
A1700. Type of Entry

Enter Code	1. Admission
<input type="checkbox"/>	2. Reentry

The diagram shows a grey bar for 'Admission' with 'Entry' in a grey circle above it, and a light grey bar for 'Reentry' below it.

- Contains:
 - Demographic information
 - Date entered
 - "Entered From"
 - Medicare Part A stay dates
- Must be:
 - Completed NLT 7 days from entry
 - Transmitted NLT 14 days from entry


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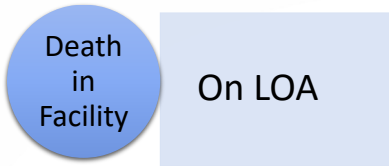
- Contains:
 - Demographic information
 - Date entered/type of entry
 - "Entered From"
 - Date of Death
 - Medicare Part A stay dates
- Must be:
 - Completed NLT 7 days from death
 - Transmitted NLT 14 days from death

Leave of Absence (LOA), (2-12)
 which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the patient.




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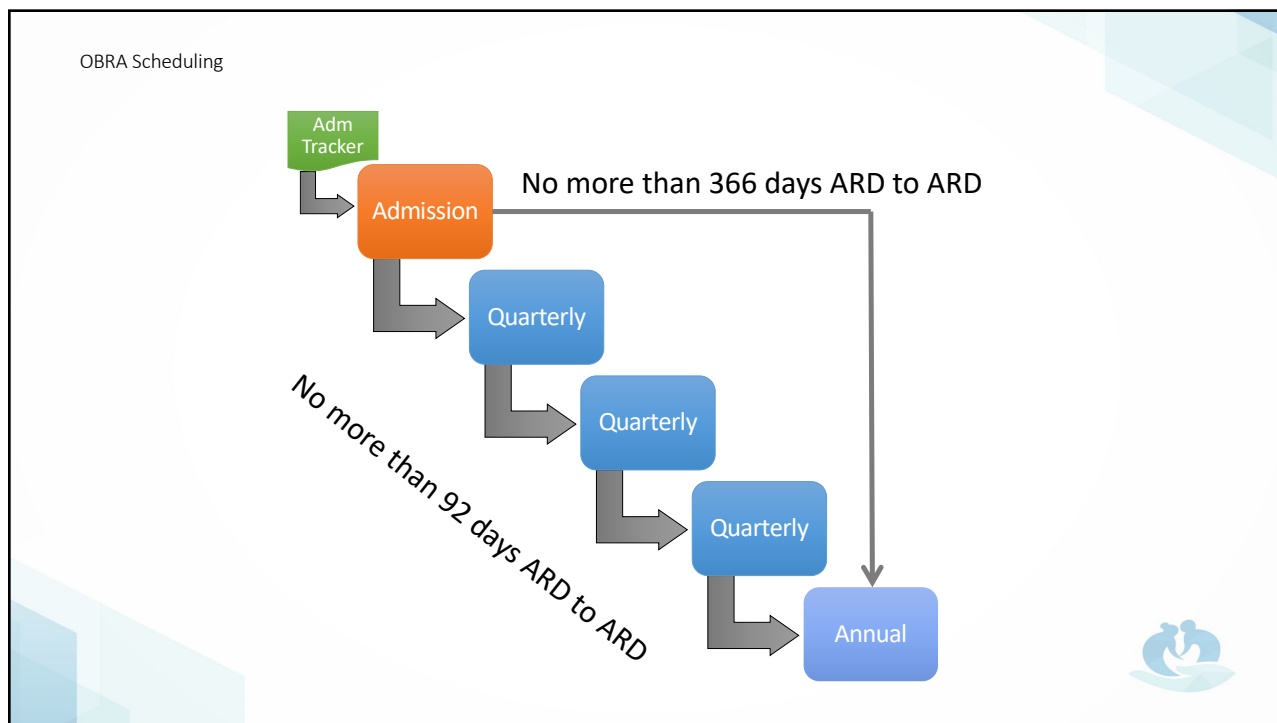
Examples when Death in Facility Tracking Record is appropriate:

- Resident dies in the facility
- Resident goes home on Wednesday afternoon before Thanksgiving on LOA and dies at home on Thanksgiving.
- Resident dies in ambulance on way to hospital
- Resident dies in emergency room, less than 24 hours and never admitted.

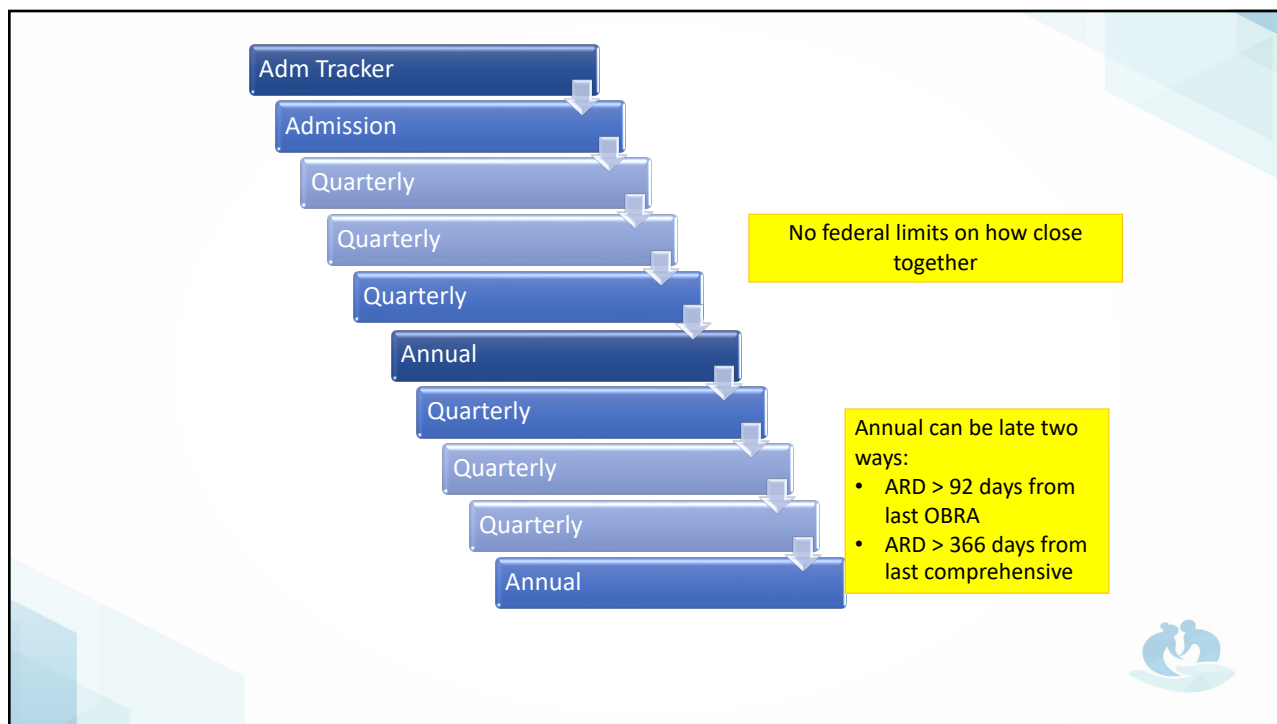
Always use the actual date of death, even if it occurs after they left the facility.



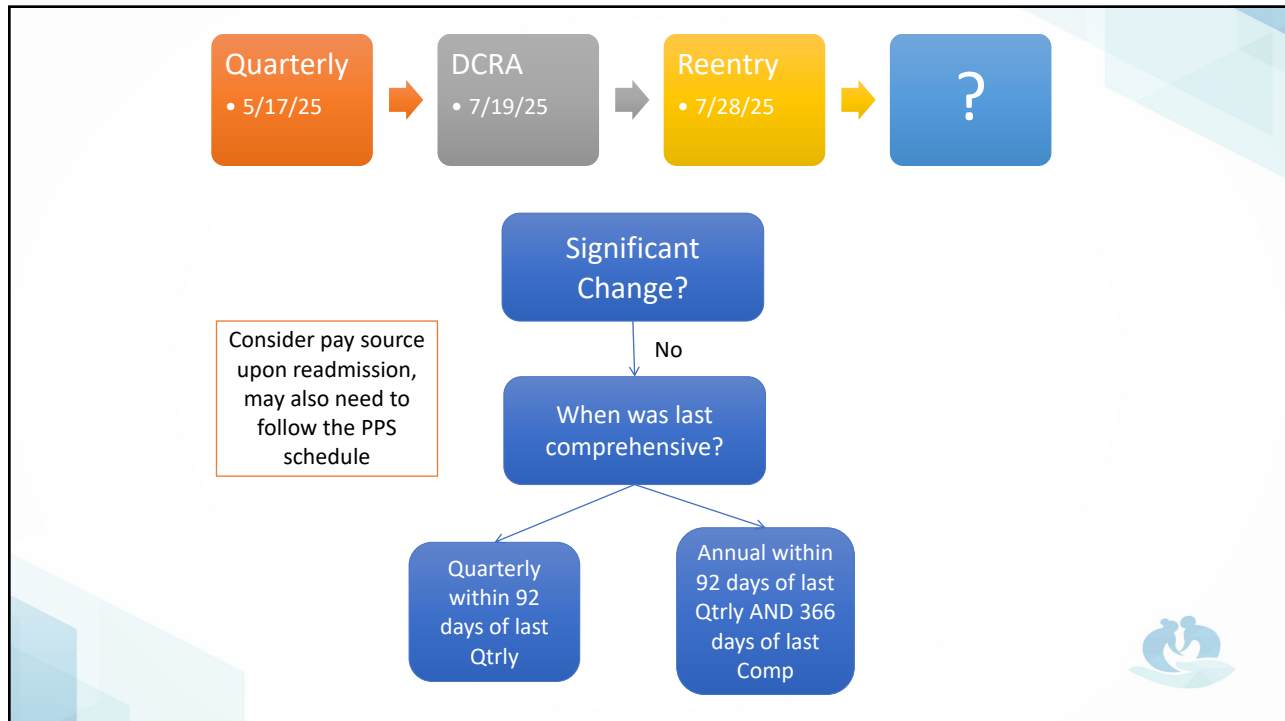
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12



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Admission Assessment

- ARD must be NLT Day 14
 • ***Not really practical to set ARD ON day 14!***
- Completion (Z0500b) NLT Day 14
- CAA Completion (V0200B2) NLT Day 14
- Care Plan Completion (V0200C2) NLT CAA Completion + 7 Days.
- Transmission NLT 14 days from Care Plan Completion.
- If also following the PPS schedule, very common to combine Admission with PPS 5 day on day 8.
 - Day 8 is last possible day for PPS 5 day.

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If resident discharged prior to completion of Section V, a comprehensive assessment may be in progress. Although the resident has been discharged, the facility may complete and submit the assessment. **The following guidelines apply to completing a comprehensive assessment when the resident has been discharged:**

- Complete MDS and indicate date in Z0500B.
- Complete the care area triggering process by checking all triggered care areas in V0200A, Column A.
- Sign and enter the date the CAAs were completed in V0200B
- Dash fill all of the “Care Planning Decision” items in V0200A, Column B, which indicates that the decisions are unknown.
- Sign and enter date that care planning decisions were completed at V0200C. Use the same date used in V0200B.



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Quarterly

- Used to track status between comprehensive assessments to ensure critical indicators of gradual change in a resident’s status are monitored.
 - CAAs not required but we are still required to review information from Qtrly & determine if a revision(s) to the care plan is necessary.
 - No specific timeframe for care plan review after Qtrly
- ARD must be NLT 92 days from ARD of last OBRA assessment.
- Completion (Z0500B) must be no later than ARD + 14 days.
- Transmission NLT 14 days from Completion.



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Annual

- Comprehensive
 - CAAs & Care Planning
- ARD must be:
 - NLT 92 days from ARD of previous Quarterly assmt
 - NLT 366 days from ARD of previous Comprehensive.
- Completion (Z0500B) NLT ARD +14 days.
- CAA Completion (V0200B2) NLT ARD + 14 days.
- Transmission NLT 14 days from Care Plan Completion.



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Discharge: Used to Track Quality

Return Anticipated

- Completed when resident is discharged and expected to return in 30 days.
 - Hospital
 - Respite

Return Not Anticipated

- Completed when resident is discharged and not expected to return in 30 days.

Must be completed (Z0500b) within 14 days of discharge date.
Must be submitted within 14 days of completion.



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Significant Change in Status Assessment

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 “self-limiting”
2. Impacts more than one area of the resident’s health status; and
3. Requires interdisciplinary review and/or revision of the care plan.



2-22

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Significant Change in Status

- May be completed any time after Admission Assmt completion.
- When it is not clear whether SCSA guidelines are met, the nursing home may take up to 14 days to determine.
- After determination made, the nursing home should document the initial identification of a significant change in the resident’s status in the progress notes.
- SCSA is appropriate when significant change (either improvement or decline) in a resident’s condition from his/her baseline has occurred as indicated by comparison of the resident’s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and condition is not expected to return to baseline within two weeks.



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Significant Change in Status time lines

- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).



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Some Guidelines to Assist in Deciding if a Change is Significant or Not:

- A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement.
 - May include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- If there is only one change**, staff may still decide that the resident would benefit from a SCSA.
 - Must document rationale for completing a SCSA that does not meet criteria.



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Guidelines for Determining a Significant Change in a Resident's Status:

- The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required.



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Guidelines for Determining a Significant Change in a Resident's Status:

- A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin an SCSA.
- This time frame may vary depending on clinical judgment and resident needs. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for an SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.



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Guidelines for Determining a Significant Change in a Resident's Status: Note: this is not an exhaustive list

- An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted.



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- If there is only one change, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique, and the IDT must make the decision as to whether or not the resident will benefit from an SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing an SCSA that does not meet the criteria for completion.
- SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.



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Significant Change examples (not exhaustive list)

Decline in two or more of the following:

- Resident's decision-making ability has changed
- Presence of a new mood item not previously reported and/or an increase in the symptom frequency
- 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 (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted 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;



2-25

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Significant Change examples, continued

Decline in two or more of the following (cont)

- 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 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type when it was not used before; and/or
- Emergence of a condition/disease in which a resident is judged to be unstable.



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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, setup or clean-up assistance, or supervision or touching 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;
- Resident's incontinence pattern improves.



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Guidelines for When a Change in Resident Status is not Significant:

- Discrete, easily reversible cause(s) for which the IDT can initiate corrective action.
- Short-term acute illness, such as a mild fever secondary to a cold.
- Well-established, predictable cyclical patterns of clinical s/s associated with previously diagnosed conditions
 - (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease).
- Resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Resident has stabilized but is expected to be discharged in the immediate future.



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Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions:

- Not required when the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.
 - If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required.



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SCSA & Hospice Changes


- SCSA required when terminally ill resident
 - enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or
 - changes hospice providers and remains a resident at the nursing home or
 - Disenrolls from hospice
- The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than).
- If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, 00100K. Completing an Admission assessment followed by an SCSA is not required. The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.



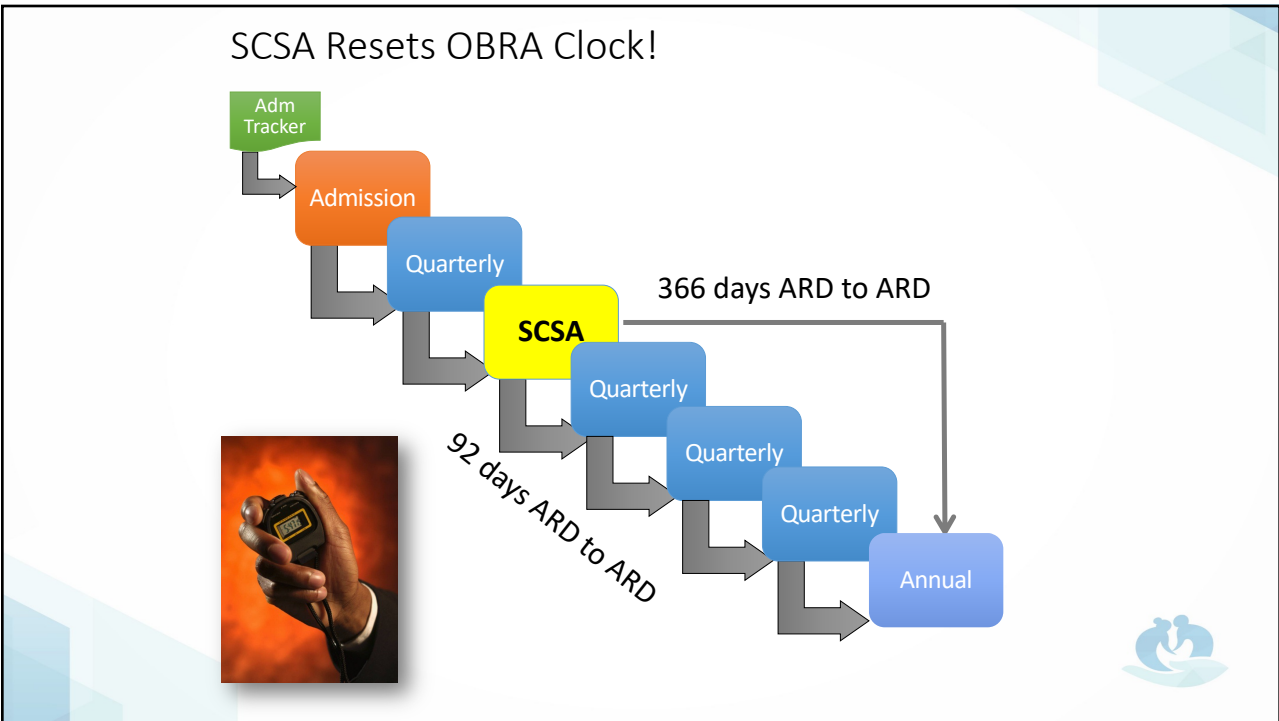
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Guidelines for Determining When A Significant Change Should Result in Referral for a PASRR Level II Evaluation:

- If a SCSA occurs for an individual *known or suspected* to have a mental illness, mental retardation, or condition related to mental retardation, a referral to the state mental health or mental retardation/DD authority for a possible Level II PASRR evaluation must promptly occur.



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F637: Significant Change in Status Assessment: Guidelines

PROBES §483.20(b)(2)(ii)

- Did the facility identify, in a timely manner, those residents who experienced a significant change in status?
- Is there documentation in the medical record when the determination was made that the resident met the criteria for a Significant Change in Status Assessment?
- Did the facility reassess residents who had a significant change in status, using the CMS-specified RAI, within 14 days after determining the change was significant?

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Critical Element Pathway for Resident Assessment re: Sig Change

Based on facility documentation, did the facility adhere to the guidelines for conducting a Resident Assessment (e.g., Significant Change in Status Assessment)?


(Note: Facility documentation is defined as information obtained from the facility that includes resident care and issues that are tracked such as an incident/accident report, clinical record, wound log, transfer log, and ANY other type of documentation that contains evidence of resident issues.)



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Significant Correction

- Must be completed when IDT determines that a resident’s prior OBRA assessment contains a significant error.
 - Comprehensive
 - Quarterly
- It can be performed at any time after completion of an Admission assessment.



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Significant Correction Two Step Process



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Significant Correction

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. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident’s health status.



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Significant Correction

- Should document the initial identification of a significant error in an assessment in the progress notes.
- ARD must be NLT 14 days from date the facility determined a Sig. Correction occurred.
- Prior Comprehensive:
 - Completion (Z0500B) & CAA Completion (V0200b2) NLT 14 days from ARD.
 - Care Plan Completion (V0200C2) NLT 14 days from CAA Completion.
 - Transmission NLT 14 days from Care Plan Completion.
- Prior Quarterly
 - Completion (Z0500B) NLT 14 days from ARD.
 - Transmission NLT 14 days from Completion.



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Assessment Management Requirements and Tips for OBRA Assessments:

- If a resident is discharged or dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record. In closing the record, the nursing home should note why the RAI was not completed. (Page 2-21 & 2-33)
- 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. (2-34)



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Assessment Management Requirements and Tips for OBRA Assessments:

- If an SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment). (2-40)
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, States may have more stringent restrictions. (2-10)



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Combining Assessments

- Any OBRA **assessment** may be combined with the PPS 5 day **assessment** and/or the PPS Discharge as long as all requirements for both are met.
 - Tracking records may not be combined with anything else.



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Strategies

- As residents come and go, consider spacing for manageability
 - How many care plans can you do in a week?
 - What day are care plans reviewed for that neighborhood?
- Holidays/vacations: consider doing some early



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Strategies

- Review daily census for admits/discharges
- For each admission/re-entry:
 - Have they been here before?
 - Type of discharge?
 - Type of entry?
 - Start over with Admission?
 - Sig Change?
 - When is next OBRA due? Can it be combined with PPS?
- This review each day is a great time to do tracking records and update assessment schedules



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Strategies

- A word about schedules:
 - How do you communicate deadlines to IDT?
 - Make use of email/technology?
 - Paper?
 - What deadlines do you give them?
 - What happens if they don't meet deadline?
 - How are you perceived among your IDT?
 - Team player?
 - How does your software assist/detract?
 - Does your administration value and respect you as a team member?



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Questions/Discussion



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