

CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING



This chapter provides information about the CAAs, Care Area Triggers (CATs; the Minimum Data Set [MDS] triggering mechanism), and the process for care plan development for nursing home residents.

4.1 Overview of the Resident Assessment Instrument (RAI) and CAAs

The care delivery system in a nursing home is complex yet critical to successful resident care outcomes and is guided by both professional standards of practice and regulatory requirements. The delivery of care to meet the needs of a resident is based upon the completion of a comprehensive assessment and the development of a care plan based upon the assessment. Documentation of this assessment process is necessary to assure continuity of care and to identify declines, improvements, or maintenance of a resident's condition.

The assessment process known as the RAI involves the completion of the MDS, the CAAs, and the development of a comprehensive care plan. The RAI process requires the facility staff to, at a minimum, complete standardized assessment data for each resident at regular intervals. The intent is to develop an individualized plan of care based on the identified needs, strengths, and preferences of the resident. As discussed in Chapter 1, the RAI consists of three basic components: MDS Version 3.0, the CAA process, and the RAI utilization guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once care area issues/conditions have been identified. Each component flows naturally into the next: the MDS identifies actual or potential areas of concern, and nursing home staff conduct an assessment of these triggered areas of concern in order to identify, to the extent possible, the causes and risk factors related to the problem for the triggered area under assessment. This review assists the facility's efforts, where possible, to remove, modify, or stabilize actual or potential risks and/or underlying causal factors based upon the condition of the resident.

The CAA process functions as a decision facilitator, which means it should lead to a more thorough understanding of the areas of concern that have been triggered for further review. The assessment of the causes and contributing factors will provide the interdisciplinary team (IDT) with a baseline of clinical information that is necessary for the development of a comprehensive plan of care. Using the results of the assessment, the IDT and the resident and/or resident's representative, will be able to identify areas of concern:

- That warrant intervention,

- That impact on the resident's functioning to assist with development of interventions for improvement, to the extent possible, or to maintain the present level of functioning and to prevent decline, to the extent possible, based upon the resident's condition and choices and preferences for interventions;
- If the resident is at risk of decline, that minimize decline in order to avoid functional complications, to the extent possible, including pain or the development of contractures; or
- That may address palliative care, including symptom relief or pain management.

4.2 What Are the CAAs?

The MDS alone is not a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident issues/conditions, strengths, and preferences. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated that facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable. Therefore, the goal of the CAA process is to guide the IDT through a comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental, and psychosocial needs of residents.

The CATs are specific response options from the MDS that are indicators of 20 particular care areas that affect nursing home residents. When a trigger is entered as the response on a resident's MDS, additional assessment and review of the care area are required to determine the status of the issue. Thus, the CATs and CAAs form a critical link between the MDS and care planning.

Each care area comprises: (1) an introduction that provides general information about the issue or condition and (2) a list of items and responses from the MDS that are considered CATs for the issue or condition.

Each triggered CAA **must** be assessed further to facilitate care plan decision making, but it **may or may not** represent a condition that should be addressed in the care plan.

There are 20 CAAs in Version 3.0 of the RAI. The CAAs in the RAI cover a number of areas that are addressed in a typical nursing home resident's care plan. In previous versions of the RAI, Resident Assessment Protocols (RAPs) were mandated as the tools for completing the assessments of the triggered care areas. For MDS 3.0, no specific tool is mandated as long as the tools are current and founded on evidence-based or expert-endorsed research, clinical practice guidelines, and resources.

Care Area Assessments in the Resident Assessment Instrument, Version 3.0

Delirium	Cognitive Loss/Dementia
Visual Function	Communication
Activity of Daily Living (ADL) Functional/Rehabilitation Potential	Pain
Urinary Incontinence and Indwelling Catheter	Return to Community Referral
Psychosocial Well-Being	Mood State
Behavioral Symptoms	Activities
Falls	Nutritional Status
Feeding Tubes	Dehydration/Fluid Maintenance
Dental Care	Pressure Ulcer
Psychotropic Medication Use	Physical Restraints

4.3 How Are the CAAs Used?

CAAs are not required for Medicare assessments. CAAs are required **only** for comprehensive clinical assessments (Admission assessments, Annual assessments, Significant Change in Status Assessments [SCSAs], or Significant Correction of a Prior Full Assessments [SCPAs]). However, when a Medicare assessment is combined with a comprehensive clinical assessment, the CAAs must be completed in order to meet the requirements of the comprehensive clinical assessment. CAAs may also be used any time the nursing home wishes to provide in-depth focused reviews of any issue/condition for which a CAA has been developed regardless of whether an MDS assessment is due.

Use the CAA process as a guide to expand your assessment findings from the MDS, and then “chart your thinking.” CAA documentation should include the underlying causes, contributing factors, and unique risk factors related to the care area condition for the specific resident. A risk factor increases the chance of having a negative outcome or complication. For example, compromised bed mobility increases the risk of a pressure ulcer. In this example, compromised bed mobility is the specific risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the pressure ulcer is the complication. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident’s highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines.

A CAA should provide nursing home staff with comprehensive information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition. This information assists nursing home staff in deciding whether a triggered condition actually does limit the

resident's functional status or whether the resident is at particular risk of developing the condition.

If the condition is found to be a problem for the resident, the CAA information should assist the IDT in determining whether the care area issue/condition can be eliminated or reversed or, if not, whether special care must be taken to maintain a resident's current level of functioning.

In addition to identifying causes and risk factors that contribute to the resident's care area issue/condition, the CAA information may assist the IDT to:

- Find associated causes and effects. Sometimes an identified concern, such as a fall, for example, may be associated with the administration of a new medication that causes dizziness. More often, a care area issue/condition (e.g., falls) stems from a combination of multiple factors (e.g., new medication, resident forgot walker, bed too high, etc.).
- Determine whether multiple triggered conditions are related.
- Suggest a need to get more information about a resident's condition from the resident, resident's family, responsible party, attending physician, direct care staff, rehabilitative staff, laboratory and diagnostic tests, consulting psychiatrist, etc.
- Determine whether a resident is a good candidate for rehabilitative interventions.
- Identify the need for a referral to an expert in an area of resident concern.
- Begin to formulate care plan goals and approaches.

4.4 What Does the CAA Process Involve?

There are various models for completing the in-depth CAA process for a resident with a triggered care area. Per the OBRA statute, assessment of the resident's triggered care areas must be completed or coordinated by a registered nurse (RN). However, it is generally accepted that the CAAs will be completed by various members of clinical disciplines as appropriate to the needs of individual residents. Facilities may also establish procedures in which certain CAAs are always reviewed by a particular discipline (e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs, if triggered). The IDT may also review CAAs in a joint manner and have the assessment process flow seamlessly into care planning.

There are no mandates regarding the specific process for how nursing home staff uses the CAAs. Rather, nursing home staff should be creative and experiment until they find what works most efficiently and effectively for them to achieve the desired outcome: a sound and comprehensive assessment that is used to develop an individualized plan of care for each resident. The general process is as follows:

First, a CAA may have several MDS items or sets of items that are defined as triggers. Only one of the trigger definitions must be present for a CAA to be triggered. Most nursing homes use automated systems to identify triggered care areas, but for nursing homes that do not use an automated system, the CAT legend will provide the information necessary to manually identify triggered CAAs.

Second, nursing home staff should assess the resident in the areas that have been triggered using current, evidence-based or expert-endorsed research and clinical practice guidelines/resources. The assessment information gathered during this step should be adequate to guide the assessor(s) in determining the nature of the issue or condition and understanding the causes specific to the resident. While there is not a prescribed Centers for Medicare & Medicaid Services (CMS) protocol for performing a CAA, the IDT members should determine which current clinical protocols, tools, resources, research, and standards of practice they will use for assessment and care planning approaches. The facility should be able to identify these resources upon request.¹

Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention and develop, revise, or continue the care plan.

Documentation for each triggered CAA should describe:

- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what is the problem for this resident?
- Causes and contributing factors.
- Complications affecting or caused by the care area for this resident.
- Risk factors that arise because of the presence of the condition that affect the staff's decision to proceed to care planning.
- Factors that must be considered in developing individualized care plan interventions, including appropriate documentation to justify the decision to plan care or not to plan care for the individual resident.
- Need for referrals or further evaluation by appropriate health professionals.
- What research, resource(s), or assessment tool(s) were used in performing the CAA. A source(s) need only be cited if it is not already cited as the standard source(s) used for this CAA by facility policy.
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

Identifying Need for Further Resident Assessment by Triggering CAA Conditions (CAA Process, Step 1)

Triggers identify residents who have or are at risk for developing specific functional issues/conditions and require further evaluation. A CAT provides a starting point for care planning and should be used in combination with other assessment and care planning information. A CAA may define several MDS items or sets of items as triggers (CATs). Only one of the trigger definitions must be present for a CAA to be triggered, although for many CAAs, each of the specific trigger items that are present must be investigated (e.g., each of the potential side effects for the Psychotropic Medication Use CAA must be addressed). The specific MDS response indicates that clinical factors are present that **may or may not** represent a condition that

¹ In Appendix C, CMS has provided CAA resources that facilities may choose to use but that are neither mandatory nor endorsed by the government; please note that Appendix C does not present an all-inclusive list.

should be addressed in the care plan. CATs merely provide a “flag” for the IDT members, indicating that the care area must be assessed completely prior to making care planning decisions.

When the resident’s status on a particular MDS item(s) matches one of the CATs, the CAA is triggered, requiring an in-depth assessment.

The trigger definitions can be found in the CAT Legend at the end of this chapter. The CAT Legend is a table that summarizes all of the MDS items that trigger the 20 CAAs. Facilities are not required to maintain this table in the resident’s clinical record. Rather, the table is a worksheet that may be used by the IDT members to determine which CAAs are triggered from a completed MDS assessment.

Most facilities use automated systems instead of the trigger legend form to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified.² CMS has also developed test files for facility validation of a software program’s triggering logic. Generally, software vendors use these test files to test their systems, but the nursing home is responsible for ensuring that the software is triggering correctly. At a minimum, ask whether or not the triggered CAAs are what you would have expected. Did the software miss some CAAs you thought should have been triggered? Do some of the CAAs seem to be missing and are there other CAAs triggered that you did not expect?

To identify the triggered CAAs manually using the CAT Legend:

1. Compare the completed MDS with the CAT Legend to determine which CAAs have been triggered for review. Begin by looking at the KEY in the upper left corner of the trigger legend form. Note that there are three possible ways for a CAA to trigger:

The **first**, indicated by a **solid black circle**, is the predominant method and requires only one MDS item to trigger a CAA.

The **second**, indicated by a **“2” within a solid circle**, requires two MDS items to trigger a CAA.

The **third**, indicated by an **asterisk (*)**, requires three or more MDS items to trigger a CAA.

2. Look at the two left columns of the CAT Legend. These columns list the letter and number codes as well as the name of the MDS items to be considered. The third column lists the specific resident codes that will trigger a CAA. The remaining columns list the individual CAA titles. To identify a triggered CAA, match the resident’s MDS item responses with the “Code” column. If there is a match, follow horizontally to the right until a trigger is indicated by one of the key symbols. If, for example, there is a solid circle in the column, the CAA titled at the top of that column is triggered. This means that further assessment using the CAA process is required for that particular condition.

² This process should be performed on a sample of assessment records any time changes have been made in the MDS software.

3. Note which CAAs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.
4. Continue down the left column of the CAT Legend matching recorded MDS item responses with trigger definitions until all triggered CAAs have been identified.
5. When the CAT Legend review is completed, document on the CAA Summary which CAAs were triggered by checking the boxes in the column titled "Care Area Triggered."

Different types of triggers can change the focus of the CAA review. There are **four** types of triggers:

1. **Potential Problems:** These factors suggest the presence of a problem that warrants additional assessment and consideration of a care plan intervention. These are usually narrowly defined as factors that warrant additional assessment. They include clinical factors commonly seen as indicative of possible underlying problems and consequently have generally been well understood by nursing home staff members. Examples include the presence of a pressure ulcer or use of a trunk restraint, both of which indicate the need for further review to determine what type of intervention is appropriate or whether underlying behavioral symptoms can be minimized or eliminated by treatment of the underlying cause (e.g., agitated depression).
2. **Broad Screening Triggers:** These factors assist staff in identifying hard-to-diagnose problems. Because some problems are often difficult to assess in the elderly nursing home population, certain triggers have been broadly defined and consequently may have a fair number of false positives (i.e., the resident may trigger a CAA that is not automatically representative of a problem for the resident). Examples include factors related to delirium or dehydration. At the same time, experience has shown that many residents who have these problems were not identified prior to having been triggered for review. Thus these triggered conditions should be considered carefully.
3. **Prevention of Problems:** These factors assist staff in identifying residents at risk of developing particular problems. Examples include risk factors for falling or developing a pressure ulcer.
4. **Rehabilitation Potential:** These factors are aimed at identifying candidates with rehabilitation potential. Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths. In general, these factors suggest consideration of programs to improve a resident's functioning or minimize decline. For example, MDS item responses indicating that "resident believes he or she is capable of increased independence in at least some ADLs" (Section G) may focus the assessment and care plan on functional areas most important to the resident or on the area with the highest potential for improvement.

Nursing home staff assessing a resident must ensure they know what item responses on the MDS triggered a CAA. This information can be found by using the CATs legend and is often missed when someone other than the person(s) who completed the MDS reviews the trigger legend or the triggering is automated. Referring to the triggers section of the CAA to identify relevant triggers can help to steer the assessment to factors particular to the individual resident. For example, if a staff member assigned to assess a resident who has fallen or is at risk for falls knows that the Falls CAA was triggered because the resident had a fall in the last month during

the MDS admission assessment period (MDS Item J1700A = 1), the CAA review would include a focus on causal factors and interventions. In reviewing the CAA, other factors may come to light regarding the resident's risk for falls, but knowing the trigger condition clarifies or possibly rules out certain avenues of approach to the resident's problem.

At the same time, there can also be a tendency to believe that the CAA review is limited to only those MDS items that triggered the CAA. Such a view is false and can lead to key causes and contributing factors being unnoticed and ineffective plans of care being initiated. All of the trigger conditions serve to initiate a more comprehensive review process that includes considering specific causal factors relative to the resident's status.

Assessment of the Resident Whose Condition Triggered CAAs (CAA Process, Step 2)

Reviewing a triggered CAA means doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. The CAA process is used to glean information needed to fully understand a resident's condition.

While reviewing the CAA, nursing home staff consider what MDS items caused the CAA to be triggered and what type of trigger it is (i.e., potential problem, broad screen, prevention of problem, or rehabilitation potential). This focuses the review on information that will be helpful in deciding if a care plan intervention is necessary, and what type of intervention is appropriate.

The information obtained from the assessment of a triggered care area helps to identify the possible causes, contributing factors, and risk factors related to the care area. After completing the assessment, analyzing the information collected, and drawing conclusions about the causes and factors contributing to the care area as well as risk factors for this resident, the next step is to develop a resident-specific care plan based directly on these conclusions. The information obtained during the CAA process is used to supplement clinical judgment and stimulate creative thinking when attempting to understand or resolve difficult or confusing symptoms and their causes. It is the understanding and insight of members of the IDT that will help integrate these factors into a meaningful resident assessment and care plan.

Decision Making and Documentation of the CAA Findings (CAA Process, Steps 3 and 4)

Staff who have participated in the assessment and who have documented information about the resident's status for triggered CAAs should be a part of the IDT that develops the resident's care plan. The team, including the resident, family, or resident representative, makes the final decision to proceed to address the triggered condition on the care plan.

In order to provide continuity of care for the resident and good communication with all persons involved in the resident's care, information from the assessment that led the team to their care planning decision should be clearly documented.

Documentation should focus on key issues, which may include:

- Why will you address or not address specific conditions in the care plan?
- What is it about the conditions that may affect the resident's daily functioning?
- Why did you decide that the resident is at risk, that improvement is possible, or that decline can be minimized?
- How could the resident benefit from consultation with an expert in a particular area (e.g., gynecologist, psychologist, surgeon, speech pathologist)?

For triggered conditions that do not warrant care planning:

- Why did you determine that the triggered condition is not a problem for the resident?

Written documentation of the CAA findings and decision-making process may appear anywhere in a resident's record. It can be written in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM). If it is not clear that a facility's documentation provides this information, surveyors will ask facility staff to provide such evidence. As stated in 482.20(b)(1)(xviii), "Documentation of participation in assessment: The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed staff members on all shifts."

No matter where the information is recorded, use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision-making documentation can be found in the resident's record. Also indicate in the column "Care Plan Decision" whether the triggered care area is addressed in the care plan.

4.5 When Is the RAI Not Enough?

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. Compliance with these regulations requires that the nursing home monitor the resident's condition and respond with appropriate care planning interventions.

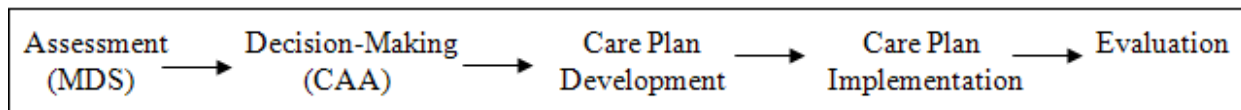
The MDS is a screening instrument and does not include detailed descriptions of all factors necessary for care planning and evaluation. When completing the MDS, the assessor simply indicates whether or not a factor is present. For certain clinical situations, if the MDS indicates the presence of a potential resident issue/condition, need, or strength, the assessor may need to

investigate and document the resident's condition in more detail. For example, if a resident is noted as having a functional limitation in range of motion on the MDS (G0400), additional documentation in the record should include the sites affected (which side of body and which extremities) and the degree of restriction in each affected site. The process of assessing a triggered care area also assists in gathering additional information for some clinical conditions.

In addition, completion of the MDS and CAAs does not necessarily fulfill a nursing home's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether the affected areas are included in the RAI. For example, the MDS includes a listing of those diagnoses that affect the resident's functioning or needs in the past 7 days. While the MDS may indicate the presence of medical issues/conditions, such as unstable diabetes or orthostatic hypotension, there should be evidence of additional assessment of these factors if they are relevant to the development of the care plan for an individual resident. The need for a physical examination detailing findings in pertinent body subsystems is another example.

Some facilities have reacted to the Federal requirements for resident assessment by creating lengthy and cumbersome assessment tools, which are completed for each resident in addition to the State RAI. This is not a Federal requirement and often not a desirable use of nursing home staff resources. **Additional assessment is necessary only for factors that are relevant for an individual resident.** For example, an extensive cognitive status assessment is not necessary if the MDS did not identify any deficits. Likewise, using multiple assessment tools that basically measure the same thing is often a poor use of clinical resources. All members of the IDT should be trained in assessment and be capable of determining what is necessary and appropriate for a particular resident. Elaborate assessment systems should not necessarily replace the judgment of team members.

4.6 The RAI and Care Planning



This manual has emphasized the concept of linkages throughout. That is, good assessment is the basis for a solid care plan, and the CAAs serve as the link between the MDS and care planning.

This section provides a discussion of how the care plan is driven not only by identified resident issues/conditions but also by a resident's unique characteristics, strengths, and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful and practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning involves looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the IDT to observe and evaluate a resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the

CAA process guides staff toward assessing triggered care areas and ultimately arriving at a more complete view of the resident's functional status.

Once the resident has been assessed using triggered CAAs, the opportunity for development or modification of the care plan exists. The triggering of a CAA indicates the need for further review, which is carried out using current, evidence-based resources specific to each CAA. Staff uses the information gathered through further review to determine whether the resident needs a new care plan or changes to an existing care plan. Even though a CAA may not have been triggered in the assessment process, the IDT must use the care plan to address a resident issue/condition in that area, if clinically warranted. Clinical judgment must be exercised in identifying problems and potential problems in developing the plan of care, including determining the role of the resident in decision making. After further CAA review of a triggered care area, staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed by the care plan. Conversely, staff may decide that items that were not triggered do affect the resident's functioning or well-being and therefore should be addressed on the care plan.

This chapter is not intended to specify a care plan structure or format. Rather the intent is to reinforce that the care plan should be based on fundamental information gathered by the MDS, further assessment triggered by the MDS, and distillation of all final assessment information into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan results from the IDT's analysis of the resident based on communication about and with the resident that is reliable, consistent, and understood by all team members. This benefits the resident by ensuring that the entire IDT and all hands-on caregivers follow the same process based upon common knowledge.

Following the decision to address a triggered condition on the care plan, key staff or the IDT should:

- Review the current care plan, if the condition is already addressed, and make changes necessary to reflect the new assessment;
- Communicate with the resident or his/her family, guardian and/or legal representative regarding the resident, care plans, and their wishes; and
- Develop new care plan problems, goals, and approaches, as needed.

Staff may choose to combine related triggered conditions into a single care plan problem that will address the initial set of causal problems and related outcomes identified in the CAA(s).

Properly executed, the assessment and care planning processes flow together into a seamless cyclical process that:

- Looks at each resident as a whole human being with unique characteristics and strengths.
- Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible issues/conditions that the resident may have (triggers).

- Provides additional assessment of potential issues/conditions by looking at possible causes and risks (CAA process).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Provides information regarding how the causes and risks associated with potential issues/conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning).
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident-centered care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the IDT finalize the care plan after completing the comprehensive assessment:

1. The RAI process (MDS and CAAs) is completed as the basis for care plan decision making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the IDT that will develop the resident's care plan.
2. The team may find during their discussions that several problematic issues/conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problematic issue/condition may overlap, and consequently the IDT may decide to address the problematic issues/conditions collectively in the care plan.
3. After assessing the resident, staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.
4. The existence of a care planning issue (i.e., a resident problematic issue/condition, need, or strength) should be documented as part of the CAA review documentation. Documentation may be done by individual staff members who have completed assessments or have participated in care planning, or as a summary note by members of the IDT.
5. The resident, family, or resident representative should be part of the team discussion or join the care planning process when desired. The individual team members may have already discussed preliminary care plan ideas with the resident, family, or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.
6. In some cases, a resident may refuse particular services or treatments that the IDT believes may assist him or her to meet the highest practicable level of well-being. The resident's wishes should be documented in the clinical record.
7. When the IDT has identified problematic issues/conditions, limitations, maintenance levels, improvement possibilities, and so forth, the IDT should state these items, to the extent possible, in functional or behavioral terms (e.g., how the condition is a problem for

the resident; how the condition limits or jeopardizes the resident's ability to complete the tasks of daily life; or how the condition affects the resident's well-being in some way).

8. The IDT agrees on intermediate goal(s) that will lead to an outcome objective.
9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.
10. The parts of the goal statement should include:

The **subject**, the **verb**, **modifiers**, and the **time frame**. See following example:

EXAMPLE			
<i>Subject</i>	<i>Verb</i>	<i>Modifiers</i>	<i>Time frame</i>
Mr. Jones	will walk	up and down five stairs with the help of one nursing assistant	daily for the next 30 days.

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals, or maintenance goals.
12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.
13. The final care plan should be discussed with the resident or the resident's legal representative.
14. The goals and their accompanying approaches should be communicated to all direct care staff who were not directly involved in developing the care plan.
15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.
16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among IDT members.

The Federal requirements for care planning in nursing homes are located at 42 CFR 483.20(k)(1) and (2) and are specified in the interpretive guidelines (F tags) in **Appendix PP** of the SOM. The SOM can be found at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

The care plan must be oriented toward:

1. Preventing avoidable declines in functioning or functional levels.
2. Managing risk factors.
3. Addressing resident strengths.
4. Using current standards of practice in the care planning process.
5. Evaluating treatment objectives and outcomes of care.
6. Respecting the resident's right to refuse treatment.
7. Offering alternative treatments.

8. Using an interdisciplinary approach to care plan development to improve the resident's functional abilities.
9. Involving family and other resident representatives.
10. Assessing and planning for care sufficient to meet the care needs of new admissions.
11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes.
12. Addressing additional care planning areas that could be considered in the long-term care setting.

The following are six general care planning areas that are useful in the long-term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

1. **Functional Status:** The conditions identified by the RAI should be clearly linked to the problematic issues/conditions addressed on the care plan.
2. **Rehabilitation/Restorative Nursing:** A resident's potential for physical, occupational, speech, psychological, respiratory, and other types of rehabilitation should be assessed and addressed by care planning.
3. **Health Maintenance:** Health maintenance includes monitoring disease processes that are currently being treated. The IDT may also decide whether or not to list on the care plan a problematic issues/conditions that no longer affect the resident, are controlled, or need no monitoring. Other areas of health maintenance may include terminal care and special treatments such as peritoneal dialysis or ventilator support.
4. **Discharge Potential:** Discharge potential for each resident needs to be assessed at admission, annually, and as needed.
5. **Medications:** The nursing home initially and periodically must conduct comprehensive assessments of a resident's needs including medications (**483.20(b)(1)(xiv)**).
6. **Daily Care Needs:** Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Nursing home staff must use their professional judgment when making these decisions.

4.7 CAA Tips and Clarifications

- It is not always necessary to review and document CAA findings on subsequent assessments as on the initial assessment. Triggers identify areas that warrant further assessment. The CAA process provides this assessment. For example, if a resident always triggers the Nutritional Status CAA, further assessment may reveal delirium or a swallowing, activity endurance, or chewing issue/condition. If the resident chooses to eat frequent snacks and still is consuming a nutritionally adequate diet, then there is no reason to complete the CAA in its entirety at each full assessment. Clearly document the initial nutritional assessment including preferences, information that confirms his or her diet is sufficient, any supporting weights, or any laboratory values that give insight into nutrition. If the resident continues to trigger this CAA for the same reasons, make a one-line entry referring to the original nutritional assessment and indicate that the resident's status has not changed. **On subsequent assessments, it is always necessary to assess**

the resident to validate that his or her status has not changed as compared with the original CAA assessment and documentation.

- Statutory requirements dictate that the RAI be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed within 14 days, which means that the initial CAA Guideline review must be conducted and documented by the end of that time. However, the CAAs may point out the need for a more extensive evaluation, which cannot be completed entirely within the time period. A good example is the Urinary Incontinence CAA. There are situations in which a complete workup completed in 14 days may be difficult. “Within 14 days of admission” is the time frame for completion of the initial CAA assessment process and documentation. Certainly nursing homes do not wait several weeks to initiate the assessment and make care planning decisions. These initial plans should be outlined in the care plan along with the plan for further assessment.
- For an Admission assessment, the resident enters the nursing home on Day 1 with a set of physician-based treatment orders. Nursing home staff typically review these orders. Questions may be raised, modifications discussed, and change orders received. Ultimately, of course, the attending physician is responsible for the orders at admission, which form the basis for care plan development. On Day 1, nursing home staff also begins to assess the resident and to identify care area issues/conditions. Both activities provide the core of the MDS and CAA process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status, and so forth. Nursing home staff determine whether or not there are issues/conditions that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident’s sense of loss at entering the nursing home). For each issue/condition, nursing home staff will focus on causal factors and will implement an initial plan of care based on their understanding of factors affecting the resident.
- Facilities have 7 days after the completion of the RAI assessment to develop or revise the resident’s care plan. The RN coordinator should sign and date the CAA Summary form after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities should use this date to determine the date by which the care plan must be completed (V0200B + 7 days).
- 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. Rather, 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 after each Quarterly review assessment and modify the care plan if necessary.
- The MDS and CAAs provide the clinician with additional information to assist in this preliminary care planning process. The MDS ensures that staff has timely access to a wide range of assessment data and the CATs provide criteria that trigger review of possible issues/conditions, via the CAAs, to ensure that staff identify issues/conditions in a consistent and systematic manner using current, evidence-based or expert-endorsed research and clinical practice guidelines/resources.
- If the admission MDS is not completed until the last date possible (the end of calendar day 14 of the stay), interventions will already have been implemented to address priority issues/conditions. Many of the appropriate care area issues/conditions will have been

identified, causes will have been considered, and a preliminary care plan initiated. The final care plan is then required no later than 7 days after the RAI assessment is completed. For triggered care areas that have already resulted in a care plan intervention, the final CAA review will ensure that all causal factors have been considered. For care area issues/conditions for which nursing home staff has not yet initiated a care program, the CAA review will focus on whether or not these conditions are, in fact, problems that require nursing home intervention. If a care area does require intervention, the information gleaned through the CAA will be used to help to identify the factors that should be considered for developing the care plan.

- For an Annual reassessment or SCSA, the process is basically the same as that described for newly admitted residents. In these cases, however, the care plan will already be in place, and staff are unlikely to actively institute a new approach to care as they simultaneously complete the MDS and CAAs. However, staff should review the approach of care to determine whether it is appropriate/relevant to the resident's current status. In addition, review of the CAAs when the MDS is complete will raise questions about the need to modify or continue services. The condition that originally triggered the CAA may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to an issue/condition did not work or was not fully implemented.
- The RAI was not designed to identify every conceivable problem that a resident might experience. An example of this is "chewing problem" in MDS Item L0200F. Although the resident might have a chewing issue/condition, checking this item does not trigger a CAA. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. In ensuring that a resident's care plan is unique and specific to the resident, it is not sufficient to rely solely on the triggered care areas.
- The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. The care plan is an interdisciplinary communication tool. Review 42 CFR 483.20(k), Comprehensive Care Plans. The comprehensive care plan 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 as required under 42 CFR 483.25. The care plan must be periodically reviewed and revised, and the services provided or arranged must accord with each resident's written plan of care. Refer to 42 CFR 483.20(d) whereby it is noted 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.
- The RN coordinator for the CAA assessment process (V0200B1) does not need to be the same RN who completes the MDS assessment (Z0500). The date entered in V0200B2 on the CAA Summary form is the date on which the RN verified completion of the CAAs, which includes assessment of each triggered care area and completion of the location and date of the CAA assessment documentation section. For Admission assessments, the CAA assessment must be completed no later than the 14th day of the stay. See Chapter 2 for detailed instructions on the MDS completion schedule.
- The Signature of Person Completing Care Planning Decision (V0200C1) can be that of any person(s) who facilitates the care planning decision making. It is an interdisciplinary

process. For Admission assessments, the care plan must be completed no later than 21 days after admission, but it cannot be more than 7 days after the date of CAA completion. The date entered in V0200C2 is the day the RN certifies that the CAAs have been completed and the day V0200C1 is signed.

- On the annual assessment, if a resident triggers the same CAA(s) that triggered on the last comprehensive assessment, the CAA should be reviewed again. Even if the CAA is triggered for the same reason (no difference in MDS responses), there may be a new or changed related event identified during CAA review that might call for a revision to the resident's plan of care. The IDT determines when a problem or potential problem needs to be addressed in the care plan.
- The CAA documentation requires information from the resident's assessment and staff's decision making about care. This should already be an easily accessible part of the medical record; in which case, a summary note may be redundant. Ask yourself this question: "If I were a newly hired caregiver for this resident, would I be able to find and understand the assessment and decision-making process?" If the answer is yes, then you should feel secure that your documentation is complete. If the answer is no, consider pulling together key information or filling in the gaps in a short note.
- The information gleaned from the CAA process is supposed to lend further insight into the problematic issues/conditions identified by the MDS. CAA documentation involves only what should already be taking place, such as clearly written assessments, decision making by staff knowledgeable about the resident's condition, and care plans developed based on a comprehensive assessment of a resident's needs, strengths, and preferences.
- What does clear documentation and decision making mean? Decision making is a written account of the team's clinical thought processes about the resident assessment findings. To accomplish this process, many people have searched for user friendly alternatives to CAA documentation. As a result, an industry of workbooks, flow sheets, checklists, and software has been created. In some cases, these products may help staff by providing structure that facilitates the clinical assessment and decision-making process; in other cases, such products have tended to create a larger paper trail and have made the process more complicated than necessary. Facilities should establish a documentation process that works for them and incorporates additional tools as they are deemed clearly beneficial in facilitating documentation and clinical decision making.
- MDS and CAA assessment information is being gathered from the point of admission, although the MDS itself may be completed later.
- The CAA review and assessment process provide a time for staff to think about and discuss key areas of concern related to the resident. There are many ways to structure this assessment process (e.g., by determining who leads the discussion or assessment; who participates; and how the resident, family, and physician are involved). But in each case, staff should:
- Review the MDS to determine which CAAs are triggered. Staff should
 - Discuss the triggered care area issues/conditions and any current treatment goals and related approaches to care with the IDT;
 - Identify the key causal factors (i.e., why the issue/condition is present);

- Review the associated and confounding factors referenced in the CAA information (i.e., things that contribute to the issue/condition or add to the complexity of the situation);
 - Ensure that information regarding the resident's status and clinical decision making is documented and that the CAA Summary (Section V of the MDS) identifies where this documentation can be found; and
 - Proceed to care planning.
- In some cases, it may be prudent to write a summary of the CAA information, especially if the assessment documentation in the record is incomplete, unclear, too scattered, or unfocused. It may also be useful to have the information summarized for quick reference by staff.
 - Good clinical practice dictates that any care plan is periodically evaluated and revised as necessary, including documentation of the resident's response to the program.
 - The plan of care should present a true picture of the resident's status. It should therefore be revised with any major change of condition (decline or improvement), as well as completing a SCSA. Refer to Chapter 2 for guidelines for SCSAs.

4.8 Care Areas

1. Delirium

Delirium is an acute cognitive loss often described as acute confusion. It is a serious condition usually caused by an underlying acute health issue/condition such as an infection, dehydration, or medication reaction. Some of its classic signs are often mistaken for the progression of dementia, particularly in the later stages of this condition. Unlike dementia, delirium has a rapid onset (hours to days). Typical signs include fluctuating states of consciousness; disorientation; decreased environmental awareness and behavioral changes; difficulty paying attention; fluctuating behavior or cognitive function throughout the day; restlessness; sleepiness during the day; rambling, nonsensical speech; and altered perceptions, such as misinterpretations (illusion), seeing or feeling things that are not there (hallucination), or a fixed false belief (delusion).

Delirium is never a part of normal aging, and it is associated with high mortality and morbidity unless it is recognized and treated appropriately. All staff who work closely with a resident should report any new onset or worsening of cognitive impairment in that resident to the charge nurse immediately.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. The information gleaned from the assessment should be used to identify and address the underlying clinical issue(s)/condition(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying clinical issues/conditions identified through this assessment process; this might include treating infections, addressing dehydration, relieving pain and depression, managing medications, ensuring optimal sensory input (e.g., with the use of glasses and hearing

aids), and promoting a normal social and functional status for the environment in which the resident is living.

2. Cognitive Loss/Dementia

The cognitive hallmarks of an independent life include the ability to remember recent events and the ability to make safe daily decisions, although the aging process may be associated with mild impairment. Otherwise, the decline in cognition is likely the result of other factors such as delirium, a mental health issue/condition, a mass lesion, a stroke, a metabolic condition, and/or dementia. Dementia is not a unique disease but a syndrome that may be linked to several causes. According to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue/condition **and** trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) **and** these troubles have an impact on the performance of daily life activities. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has symptoms of cognitive loss. The information gleaned from the assessment should be used to judge the situation to identify and address the underlying cause(s) of cognitive loss/dementia, as well as to identify any related possible contributing and/or risk factors; the next step is to develop a resident-specific care plan based directly on these conclusions. The first step will be to determine whether the cognitive issue/condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the indications are that the issue/condition is not related to reversible causes, assessment should focus on the characteristics of the cognitive issue/condition (i.e., forgetfulness and/or impulsivity and/or behavior issues/conditions, etc.) and risk factors for the resident presented by the cognitive loss to facilitate care planning specific to the resident's needs, issues/conditions, and strengths. The focus of the care plan should be to address the underlying clinical issues/conditions identified through this assessment process, such as relieving pain and depression, managing medications, ensuring optimal sensory input (e.g., with the use of glasses and hearing aids), and promoting as much social and functional independence as possible while maintaining health and safety.

3. Visual Function

The aging process leads to a gradual decline in visual acuity: a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark, and diminished ability to discriminate color. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self image, and participation in social, personal, self-care, and rehabilitation activities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has a vision diagnosis or impairment in ability to see close objects or to see small print. The information gleaned from the

assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying the two types of residents (those who have treatable conditions that place them at risk of permanent blindness [e.g., glaucoma, diabetes, retinal hemorrhage] and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances), as well as to determine any related possible contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to prevent decline when possible and to enhance vision when restoration of visual acuity is not possible, as well as to address any underlying clinical issues/conditions identified through the CAA process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

4. Communication

Normal communication involves two related activities: expressive communication (making oneself understood to others, usually verbally but also through non-verbal exchange) and receptive communication (comprehending or understanding the verbal or written communication of others). Typical expressive issues/conditions include disruptions in language, speech, and voice production. Typical receptive communication issues/conditions include changes or difficulties in hearing, speech discrimination, vocabulary comprehension, and reading and interpreting facial expressions. While many conditions can affect how a person expresses and comprehends information, the communication CAT focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident's ability to hear, to express ideas and wants, or to understand verbal content may be impaired. The information gleaned from the assessment should be used to assess the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions, as well as verbal and nonverbal strategies, in order to assist the resident in improving quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident must expand their nonverbal communication skills—one of the most basic and automatic of human abilities. Touch, facial expression, eye contact, hand movements, tone of voice, and posture are all powerful means of communicating. Recognizing and using all practical means are keys to effective communication.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic tasks of daily living, including dressing, personal hygiene, walking, transferring, toileting, changing position in bed, and eating. Nursing home staff should work to identify any

confounding issues/conditions that may require resolution before rehabilitation can be reasonably attempted. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident with some ADL deficits and at least some cognitive ability requires assistance to improve performance or prevent avoidable functional decline. The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, improving function (when possible), maintaining function, and preventing decline when improvement is not possible. An ongoing risk assessment is critical to identify factors that can lead to functional decline before it occurs.

6. Urinary Incontinence and Indwelling Catheter

Urinary incontinence is an involuntary loss or leakage of urine. There are several types of urinary incontinence, and the individual resident may experience more than one type at a time. Some of the more common types include functional, mixed, stress, transient, and urge.

Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence itself is not a normal part of aging. Urinary incontinence causes many issues/conditions, including skin rashes, falls, isolation, and pressure ulcers. It is curable in many elderly residents, and continence often is an important goal to many residents. Incontinence may affect a resident's psychological well-being and social interactions. Incontinence also may lead to the potentially troubling use of indwelling catheters. Catheter use increases the risk of life-threatening infections.

This CAA is triggered if the resident is incontinent of urine or uses a urinary catheter. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. Successful management will depend on accurately identifying the underlying cause(s) of the incontinence or reason for the indwelling catheter. Many of the causes can be successfully treated to reduce or eliminate incontinence episodes or the reason for catheter use. Even when incontinence cannot be reduced or resolved, effective incontinence management strategies must be developed to prevent complications related to incontinence. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be reserved primarily for short-term decompression of acute urinary retention. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter; the potential for removal of the catheter; and consideration of complications resulting from the use of an indwelling catheter, such as symptoms of blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.

7. Psychosocial Well-Being

Involvement in social relationships is a vital aspect of life, with most adults having meaningful relationships with family, friends, and neighbors. When these relationships are challenged, a sense of distress often clouds other aspects of life. Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity. Conversely, declines in physical functioning or cognition or a new onset or worsening of pain or other health or mental health issues/conditions may affect both social relationships and mood. Psychosocial well-being may also be negatively impacted when a person moves or experiences the death of a loved one. Thus, other contributing factors also must be considered as a part of this assessment.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident exhibits minimal interest in social involvement. The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's minimal social involvement and factors associated with reduced social relationships and engagement, as well as to identify any related possible contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes in order to stimulate and facilitate social engagement.

8. Mood State

Depression and other mood disorders, such as sadness and anxiety, are common in nursing home residents but are often underdiagnosed and undertreated. Mood disorders may be expressed by sad mood, feelings of emptiness, anxiety, or uneasiness. They are also manifested in a wide range of bodily complaints and dysfunctions, including weight loss, tearfulness, agitation, aches, and pains. Left untreated, mood disorders are disabling and associated with high mortality, functional decline, and unnecessary suffering by the resident, family, and others in the resident's life.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the Resident Mood Interview, Staff Assessment of Mood, or certain other specific issues indicate a mood issue/condition may be present. The information gleaned from the assessment should be used to identify depression, including pre-existing diagnoses or a depressed mood state that requires attention and possible diagnosis, and residents with symptoms of a severe mood disorder that place the resident or others at risk for harm. If so, immediate action is required to prevent harm and to ensure prompt intervention from the appropriate health professional. The focus of the care plan should be to address the underlying cause or causes of the resident's mood issue/condition.

9. Behavioral Symptoms

The behavior CAA focuses on troubling behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking,

scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms. The information gleaned from the assessment should be used to determine whether the resident's behavioral symptoms place the resident or others at risk for harm, as well as to identify any possible contributing and/or risk factors related to the behavior(s). The next step is to develop a resident-specific care plan based directly on these conclusions. If such behaviors place the resident or others at risk for harm, immediate action is required to prevent any harm. The focus of the care plan should be to address the underlying cause or causes, reversing the daily display of troubling behaviors, and preventing any harm from occurring.

10. Activities

There is variability within the resident population capabilities, which may alter as abilities and expectations change, disease intervenes, situational opportunities become less frequent, and/or extended social relationships become less common. The purpose of the activities CAA is to identify strategies to assist residents with increasing their involvement in activities that have interested and stimulated them in the past and/or to help them find satisfying activities to replace recreational activities that are no longer available to them because of functional or situational factors.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident may have indications of decreased involvement in social activities. The information gleaned from the assessment should be used to identify residents who have either withdrawn from recreational activities or who are uneasy entering into activities and social relationships, to identify the resident's interests, and to identify any related possible contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes and the development or inclusion of activity programs tailored to the resident's interests and to his or her cognitive, physical/functional, and social abilities in order to stimulate and facilitate social engagement. The activities should focus on helping the resident fulfill his or her wishes, use his or her physical and cognitive skills, provide enjoyment, and provide an avenue for interaction with others.

11. Falls

"Fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the

elderly who reside in nursing homes. Falls may indicate functional decline and the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost his/her balance and would have fallen without staff intervention.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's fall(s), or if the resident has not sustained a fall, the factors that place him or her at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging; it can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the resident's risk of sudden decline. For many who have had this CAA triggered, there will be no obvious, outward signs of undernutrition.

There are a number of adverse consequences of undernutrition, some of which could place the resident at risk of a premature death. Other consequences include continued weight loss, functional decline, heart and skin issues/conditions, and risk of infection. Prevention is the goal, and early detection is the key.

The Nutritional Status CAT summary focuses on an in-depth analysis of residents who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other persons will be at risk of undernutrition.

13. Feeding Tubes

This CAA focuses on the use of long-term (longer than 2 weeks) feeding tubes. There is no known evidence that the use of tube feedings improves survival in individuals with advanced dementia. Tube feeding will not prevent aspiration of gastric contents or oral secretions. Use of nasogastric and nasointestinal tubes can result in many complications including but not limited to agitation, self-extubation, infections, aspiration, unintended misplacement of the tube in the trachea or lungs, inadvertent dislodgment, and pain.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes that necessitated the feeding tube and to treat any reversible issues/conditions.

14. Dehydration/Fluid Maintenance

Dehydration is a condition in which water or fluid loss (output) far exceeds fluid intake. The body becomes less able to maintain adequate blood pressure, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. In older persons, diagnosing dehydration is accomplished not only by a physical examination but also by assessing the degree of tenting of the skin and dryness of mucous membranes. Laboratory studies including BUN/creatinine ratio and serum hemoglobin and sodium concentrations also provide valuable information. Vital signs, such as falling blood pressure and an increase in the pulse rate, may also be useful indicators of dehydration in the elderly.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. The information gleaned from the assessment should be used to identify whether the resident is dehydrated or at risk for dehydration, as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's dehydration.

15. Dental Care

Having teeth or dentures that function properly is an important requisite for nutritional adequacy. Having teeth or dentures that are clean and attractive can promote a resident's positive self-image and personal appearance, thereby enhancing social interactions between residents, residents and staff, and residents and visitors. Residents at greatest risk of dental issues caused by impaired abilities are those with multiple medical conditions and medications, functional limitations in self-care, and communication deficits. Also at risk are more self-sufficient residents who lack motivation or have no consistent history of performing oral health functions. Residents with a history of alcohol and/or tobacco use have a greater risk of developing chronic oral lesions. The dental care CAA addresses a resident's risk of oral discomfort and, in some instances, systemic illness from oral infections and cancer.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has indicators of an oral/dental issue/condition. The information gleaned from the assessment should be used to identify the oral/dental issues/conditions and to identify any related possible causes and contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's issues/conditions.

16. Pressure Ulcer

The definition of pressure ulcer, from the National Pressure Ulcer Advisory Panel, is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. However, they are one

of the most common, preventable, and treatable conditions among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. The information gleaned from the assessment should be used to draw conclusions about the resident's pressure ulcer status and to identify any related possible causes and contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent one from occurring by identifying the resident's risk and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it.

17. Psychotropic Medication Use

Any medication, prescription or non-prescription, can cause problems in some patients. However, psychotropic medications (medications that affect the mind, emotions, or behavior) are among the most frequently prescribed agents for elderly nursing home residents. Examples of adverse consequences of psychotropic medications that can seriously negatively impact a resident include postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's medication (in consultation with the physician and the consultant pharmacist) and to identify any adverse consequence of the psychotropic medication(s), as well as any related possible causes and contributing and/or risk factors. The next step is to develop a resident-specific care plan based directly on these conclusions.

When possible, the focus should be to eliminate the underlying cause of the behavior being treated with the psychotropic medication in order to be able to stop use of the medication. However, eliminating the use of the medication is not possible for some residents. In those cases, important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.

18. Physical Restraints

A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. What is important is the effect the device has on the resident, not the purpose for which the device was placed on the resident. This also includes the use of passive restraints such as chairs that prevent rising. Physical restraints are associated with negative physical and psychosocial outcomes. They are almost never indicated, and at most, they should be used only as a short-term, temporary intervention. If used for any significant period of time, the physical consequences may include loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence. Further, residents who try to free themselves from restraints may fall and be injured. Also, a high risk of strangulation exists when certain types of

restraints are used. The adverse psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation.

The physical restraint CAA identifies residents who are physically restrained. Each resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident used a physical restraint during the look-back period. The information gleaned from the assessment should be used to identify the specific reasons for and the appropriateness of the use of the restraint and any adverse consequences caused by restraint use, as well as to identify any related possible risk factors related to the restraint use. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying physical or psychological condition(s) that caused the restraint(s) to be used. By addressing the underlying conditions and causes, the facility may eliminate the medical symptom that warrants the use of the restraints. In addition, a review of underlying needs, risks, or issues/conditions may help to identify other potential kinds of treatments. The goal of care is to eliminate restraint use by employing appropriate measures as necessary according to the resident's physical and/or cognitive abilities. When elimination of restraints is not possible, assessment must result in using the least restrictive device possible.

19. Pain

Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." It is a subjective experience, and "the inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment" (International Association for the Study of Pain). Pain can be affected by damage to various physiologic systems and tissues, including musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The intensity (severity) of the pain is a subjective matter and not necessarily proportional to the type or extent of tissue or system damage. The presence of pain can also increase suffering in other areas, leading to an increased sense of helplessness, anxiety, depression, decreased activity, decreased appetite, and disrupted sleep.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has active symptoms of pain. Remember that pain, including its severity, is whatever the resident says it is. The information gleaned from the assessment should be used to identify the characteristics and possible causes, contributing factors, and risk factors related to the pain. The next step is to develop a resident-specific care plan based directly on these conclusions. The focus of the care plan should be to address the underlying condition(s) that cause the pain. By addressing the underlying conditions and causes, the facility may eliminate or reduce the pain. Management of

pain extends beyond analgesia to include other interventions and treatments that focus on the person's quality of life and ability to function; therefore, a review of underlying issues may help to identify potential treatments because pain treatment plans are likely to vary depending on the cause of the pain. The goal of care is to eliminate or reduce the pain experience by employing appropriate measures as necessary according to the resident's physical and/or cognitive abilities.

Pain management should involve an interdisciplinary approach, with routine, periodic screening for pain, thorough assessment of unrelieved pain, and timely notification of the physician and intervention(s).

20. Return to Community Referral

All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the *Olmstead vs. L.C.* decision in 1999. The ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments have a responsibility to enforce and support these choices. An individual in a nursing home can choose to leave the facility at any time. An individual can request to talk to someone about returning to the community at any time. The return to community referral CAA focuses on residents who want to talk to someone about returning to the community and enables nursing home staff to directly open the discussion about the individual's preferences for service settings.

Expectations about returning to community living are unique for each individual. An individual may expect to return to his or her former home or return to a different community home, or the individual may identify a desire to stay in the nursing home. Each person's level of understanding about his or her health status and needs for physical assistance as well as the availability of family and other supports also varies. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care interventions, coordinating interdisciplinary care providers, fostering independent functioning, using rehabilitative programs, and using community referrals.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident expresses interest in returning to the community. The information gleaned from the assessment should be used to assess the resident's situation and begin appropriate care planning, discharge planning, and other follow-up measures. The next step is to develop a resident-specific care plan based directly on these findings. The goal of care planning is to initiate and maintain collaboration between the nursing facility and the local contact agency to support the individual's expressed interest in being transitioned to community living. This includes facility support for the individual in achieving his or her highest level of functioning and the involvement of the designated contact agency providing informed choices for community living. This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the

individual (and his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

4.9 Care Area Trigger (CAT) Legend

CAT LEGEND (for MDS Version 3.0)

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Proceed to RAP Review once triggered

Item	Item Description	Code	CAA 1	CAA 2	CAA 3	CAA 4	CAA 5	CAA 6	CAA 7	CAA 8	CAA 9	CAA 10	CAA 11	CAA 12	CAA 13	CAA 14	CAA 15	CAA 16	CAA 17	CAA 18	CAA 19	CAA 20	Item
A0310A	Federal OBRA reason for assessment	3,4,5	●							●			●										A0310A
B0200	Hearing	1,2,3				●																	B0200
B0700	Makes self understood	1,2,3				●																	B0700
B0800	Ability to understand others	1,2,3				●																	B0800
B1000	Vision	1,2,3,4			●																		B1000
C0500	BIMS resident interview: summary score	00-15	●	●			●																C0500
C0700	Staff assessment mental status: short-term memory OK	1		●																			C0700
C0800	Staff assessment mental status: long term memory OK	1		●																			C0800
C1000	Cognitive skills for daily decision making	1,2,3		●			●																C1000
C1300A	Signs of delirium: inattention	1,2		●																			C1300A
C1300B	Signs of delirium: disorganized thinking	1,2		●																			C1300B
C1300C	Signs of delirium: altered level of consciousness	1,2		●																			C1300C

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C1300D	Signs of delirium: psychomotor retardation	1,2		●																			C1300D
C1600	Acute mental status change	1	●																				C1600
D0200A1	PHQ resident mood interview: little interest or pleasure in doing things - presence	1							●			●											D0200A1
D0200I1	PHQ resident mood interview: thoughts better off dead - presence	1								●													D0200I1
D0300	PHQ resident mood interview: total mood severity score	00-27								●● *													D0300
D0500A1	PHQ staff assessment of resident mood: little interest or pleasure in doing things - presence	1							●			●											D0500A1
D0500I1	PHQ staff assessment: thoughts better off dead - presence	1								●													D0500I1
D0600	PHQ staff assessment: total mood score	00-30								● *													D0600
E0200A	Physical behavioral symptoms directed toward others	1,2,3		●					*														E0200A

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E0200B	Verbal behavioral symptoms directed toward others	1,2,3		●					*														E0200B
E0200C	Other behavioral symptoms not directed toward others	1,2,3		●																			E0200C
E0300	Overall presence of behavioral symptoms	1									●												E0300
E0800	Rejection of care: presence and frequency	1,2,3		●							●												E0800
E0900	Wandering: presence and frequency	1,2,3		●							●		●										E0900
E1100	Change in behavioral or other symptoms	2									●												E1100
F0500A	Resident interview: how important is it to you to have books, newspaper, magazines to read	4,5							*			*											F0500A
F0500B	Resident interview: how important is it to you to listen to music	4,5							*			*											F0500B
F0500C	Resident interview: how important is it to you to be around animals/pets	4,5							*			*											F0500C
F0500D	Resident interview: how important is it to you to keep up with news	4,5							*			*											F0500D

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F0500E	Resident interview: how important is it to you to do things with groups of people	4,5							*			*											F0500E
F0500F	Resident interview: how important is it to you to do your favorite activities	3,4,5							● *			*											F0500F
F0500G	Resident interview: how important is it to you to go outside in good weather	4,5							*			*											F0500G
F0500H	Resident interview: how important is it to you to participate in religious practices	4,5							*			*											F0500H
F0600	Primary respondent: daily/activities preferences	1							*														F0600
F0800L	Staff assessment: reading books, newspapers, magazines	Not ✓										*											F0800L
F0800M	Staff assessment: listening to music	Not ✓										*											F0800M
F0800N	Staff assessment: being around animals/pets	Not ✓										*											F0800N
F0800O	Staff assessment: keeping up with news	Not ✓										*											F0800O

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F0800P	Staff assessment: doing things with groups	Not ✓										*											F0800P
F0800Q	Staff assessment: participating in favorite activities	Not ✓							●			*											F0800Q
F0800R	Staff assessment: spend time away from nursing home	Not ✓										*											F0800R
F0800S	Staff assessment: spend time outdoors	Not ✓										*											F0800S
F0800T	Staff assessment: participate religious activities	Not ✓										*											F0800T
G0110A1	ADL: bed mobility: self-performance	1,2,3,4,7,8					●											●					G0110A1
G0110B1	ADL: transfer: self-performance	1,2,3,4					●																G0110B1
G0110C1	ADL: walk in room: self-performance	1,2,3,4					●																G0110C1
G0110D1	ADL: walk in corridor: self-performance	1,2,3,4					●																G0110D1
G0110E1	ADL: locomotion on unit: self-performance	1,2,3,4					●																G0110E1
G0110F1	ADL: locomotion off unit: self-performance	1,2,3,4					●																G0110F1

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G0110G1	ADL: dressing: self-performance	1,2,3,4					●																G0110G1
G0110H1	ADL: eating: self-performance	1,2,3,4					●																G0110H1
G0110I1	ADL: toilet: self-performance	1,2,3,4					●	●															G0110I1
G0110J1	ADL: personal hygiene: self-performance	1,2,3,4					●																G0110J1
G0120A	ADL: bathing: self-performance	1,2,3,4					●																G0120A
G0300A	Balance: moving from seated to standing position	1,2					●						●										G0300A
G0300B	Balance: walking (with assistive device if used)	1,2					●						●										G0300B
G0300C	Balance: turning around while walking	1,2					●						●										G0300C
G0300D	Balance: moving on and off toilet	1,2					●						●										G0300D
G0300E	Balance: surface to surface transfer	1,2					●						●										G0300E
G0900A	Resident believes capable of increased independence	1					●																G0900A

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G0900B	Staff believes resident capable of increased independence	1					●●																G0900B
H0100A	Appliances: indwelling bladder catheter	1						●															H0100A
H0100B	Appliances: external (condom) catheter	1						●															H0100B
H0100D	Appliances: intermittent catheterization	1						●															H0100D
H0300	Urinary continence	1,2,3						●										●					H0300
H0400	Bowel continence	2,3																●					H0400
H0600	Constipation	1																					H0600
I1700	MRSA/VRE/clostridium diff. infection/colonization	✓																					I1700
I2000	Pneumonia	✓																					I2000
I2100	Septicemia	✓																					I2100
I2200	Tuberculosis	✓																					I2200
I2300	Urinary tract infection (UTI)	✓																					I2300
I2400	Viral hepatitis (includes type A, B, C, D, and E)	✓																					I2400
I2500	Wound infection (other than foot)	✓																					I2500

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I4200	Alzheimer's disease	✓, Not ✓							*														I4200
I4800	Dementia	✓, Not ✓							*														I4800
I6500	Cataracts, glaucoma, or macular degeneration	✓			●																		I6500
J0400	Resident pain interview: frequency	1,2																			●		J0400
J0500A	Resident pain interview: made it hard to sleep	1																			●		J0500A
J0500B	Resident pain interview: limited daily activities	1																			●		J0500B
J0600A	Resident pain interview: pain numeric intensity rating scale	4-10,7-10																			●	●	J0600A
J0600B	Resident pain interview: pain verbal descriptor scale	2,3,4																			●	●	J0600B
J0800A	Staff pain assessment: non-verbal sounds	1																			●		J0800A
J0800B	Staff pain assessment: vocal complaints of pain	1																			●		J0800B
J0800C	Staff pain assessment: facial expressions	1																			●		J0800C
J0800D	Staff pain assessment: protective movements/postures	1																			●		J0800D

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J1550A	Problem conditions: fever	✓														●							J1550A
J1550B	Problem conditions: vomiting	✓														●							J1550B
J1550C	Problem conditions: dehydrated	✓												●		●							J1550C
J1550D	Problem conditions: internal bleeding	✓														●							J1550D
J1700A	Fall history: fall during month before entry	1											●●										J1700A
J1700B	Fall history: fall 2 to 6 months before entry	1											●●										J1700B
J1800	Falls since admit/prior assessment: any falls	1											●										J1800
K0200A	Height	BMI (18.5-24.9)												●●									K0200A
K0200B	Weight	BMI (18.5-24.9)												●●									K0200B
K0300	Weight loss	1,2												●				●					K0300
K0500A	Nutritional approaches: parenteral/IV feeding	1												●		●							K0500A
K0500B	Nutritional approaches: feeding tube	1													●	●							K0500B
K0500C	Nutritional approaches: mechanically altered diet	1												●									K0500C

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K0500D	Nutritional approaches: therapeutic diet	1												●									K0500D
L0200A	Dental: broken or loosely fitting denture	✓															●						L0200A
L0200B	Dental: no natural teeth or tooth fragment(s)	✓															●						L0200B
L0200C	Dental: abnormal mouth tissue	✓															●						L0200C
L0200D	Dental: cavity or broken natural teeth	✓															●						L0200D
L0200E	Dental: inflamed/bleeding gums or loose teeth	✓															●						L0200E
L0200F	Dental: pain, discomfort, difficulty chewing	✓															●						L0200F
M0150	Is resident at risk of developing pressure ulcer	1																●					M0150
M0300A	Number of Stage 1 pressure ulcers	0-9																●					M0300A
M0300B1	Number of Stage 2 pressure ulcers	0-9												●				●					M0300B1
M0300C1	Number of Stage 3 pressure ulcers	0-9												●				●					M0300C1

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M0300D1	Number of Stage 4 pressure ulcers	0-9												●				●					M0300D1
M0300E1	Number of un-staged pressure ulcers due to dressing	0-9												●				●					M0300E1
M0300F1	Number of pressure ulcers un-staged due to slough/eschar	0-9												●				●					M0300F1
M0300G1	Number of pressure ulcers un-staged – deep tissue	0-9												●				●					M0300G1
M0800A	Worsened since prior assessment: Stage 2 pressure ulcers	0-9																●					M0800A
M0800B	Worsened since prior assessment: Stage 3 pressure ulcers	0-9																●					M0800B
M0800C	Worsened since prior assessment: Stage 4 pressure ulcers	0-9																●					M0800C
M1040A	Other skin problems: other foot/lower extremity	1														●							M1040A
N0400A	Medications: antipsychotic	1																	●				N0400A
N0400B	Medications: antianxiety	1											●						●				N0400B

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N0400C	Medications: antidepressant	1											●						●				N0400C
N0400D	Medications: hypnotic	1																	●				N0400D
P0100A	Restraints used in bed: bed rail (any type)	1,2																		●			P0100A
P0100B	Restraints used in bed: trunk restraint	1,2											●					●		●			P0100B
P0100C	Restraints used in bed: limb restraint	1,2																		●			P0100C
P0100D	Restraints used in bed: other	1,2																		●			P0100D
P0100E	Restraints in chair/out of bed: trunk restraint	1,2											●					●		●			P0100E
P0100F	Restraints in chair/out of bed: limb restraint	1,2																		●			P0100F
P0100G	Restraints in chair/out of bed: chair stops rising	1,2																		●			P0100G
P0100H	Restraints in chair/out of bed: other	1,2																		●			P0100H
Q0400A	Active discharge plan for return to community	0																				*	Q0400A
Q0400B	Determination regarding discharge to community	1																				*	Q0400B

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Q0500B	Resident response about returning to community	1																				*	Q0500B
V0100D	BIMS resident interview: summary score (prior assessment)	00-15	●																				V0100D
V0100E	PHQ resident mood interview: total mood severity score (prior assessment)	00-27								●													V0100E
V0100F	PHQ staff assessment: total mood score (prior assessment)	00-30								*													V0100F