V0200: CAAs and Care Planning

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

V0200: CAAs and Care Planning (cont.)

Item Rationale

Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. The CAA Summary documents the interdisciplinary team's and the resident, resident's family or representative's final decision(s) on which triggered care areas will be addressed in the care plan.

Coding Instructions for V0200A, CAAs

Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.

For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. For each triggered care area, indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.

Coding Instructions for V0200B, Signature of RN Coordinator for CAA Process and Date Signed

V0200B1, Signature

Signature of the RN coordinating the CAA process.

V0200B2, Date

Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment. This date is considered the date of completion for the RAI.

Coding Instructions for V0200C, Signature of Person Completing Care Plan Decision and Date Signed

V0200C1, Signature

Signature of the staff person facilitating the care planning decision-making. Person signing does not have to be an RN.

V0200C2, Date

The date on which a staff member completes the Care Planning Decision column (V0200A, Column B), which is done after the care plan is completed. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and CAAs), as indicated by the date in V0200B2.

Following completion of the MDS, CAAs (V0200A, Columns A and B) and the care plan, the MDS 3.0 comprehensive assessment record must be transmitted to *i*QIES within 14 days of the V0200C2 date.

Clarifications:

The signatures at V0200B1 and V0200C1 can be provided by the same person, if the person actually completed both functions. However, it is not a requirement that the same person complete both functions.

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

Complete all required MDS items from Section A through Section Z and indicate the date of completion in Z0500B. Encode and verify these items.

Complete the care area triggering process by checking all triggered care areas in V0200A, Column A.

Sign and enter the date the CAAs were completed at V0200B1 and V0200B2.

Dash fill all of the "Care Planning Decision" items in V0200A, Column B, which indicates that the decisions are unknown.

Sign and enter the date that care planning decisions were completed at V0200C1 and V0200C2. Use the same date used in V0200B2.

Submit the record.

*Please see Chapter 2 for additional detailed instructions regarding options for when residents are discharged prior to completion of the RAI.

SECTION X: CORRECTION REQUEST

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the *Internet* Quality Improvement and Evaluation System (*i*QIES).

A modification request is used to correct a*n i*QIES record containing incorrect MDS item values due to:

transcription errors,
data entry errors,
software product errors,
item coding errors, and/or
other error requiring modification

The modification request record contains correct values for all MDS items (not just the values previously in error), including the Section X items. The corrected record will replace the prior erroneous record in *i*QIES.

In some cases, an incorrect MDS record requires a completely new assessment of the resident in addition to a modification request for that incorrect record. Please refer to Chapter 5 of this manual, Submission and Correction of the MDS Assessments, to determine if a new assessment is required in addition to a modification request.

An inactivation request is used to move an existing record in *i*QIES from the active file to an archive (history file) so that it will not be used for reporting purposes. Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes Item A0050 and the Section X items. All other MDS sections are skipped.

The modification and inactivation processes are automated and neither completely removes the prior erroneous record from *i*QIES. The erroneous record is archived in a history file. In certain cases, it is necessary to delete a record and not retain any information about the record in *i*QIES. This requires a request from the facility to the facility's state agency to manually delete all traces of a record from *i*QIES. The policy and procedures for a Manual Correction/Deletion Request are provided in Chapter 5 of this Manual.

A Manual Deletion Request is required **only** in the following three cases:

Item A0410 Submission Requirement is incorrect. Submission of MDS assessment records to *i*QIES constitutes a release of private information and must conform to privacy laws. Only records required by the State and/or the Federal governments may be stored in the *i*QIES. If a record has been submitted with the incorrect Submission Requirement value in Item A0410, then that record must be manually deleted and, in some cases, a new record with a corrected A0410 value submitted. Item A0410 cannot be corrected by modification or inactivation. See Chapter 5 of this Manual for details.

Inappropriate submission of a test record as a production record. Removal of a test record from *i*QIES requires manual deletion. Otherwise information for a "bogus" resident will be retained in the database and this resident will appear on some reports to the facility.

Record was submitted for the wrong facility. If a record was submitted to *i*QIES for an incorrect facility, the record must be removed manually and then a new record for the correct facility must be submitted to ***i*QIES. Manual deletion of the record for the wrong facility** is necessary to ensure that the resident is not associated with that facility and does not appear on reports to that facility.