1.7 Layout of the RAI Manual

The layout of the RAI manual is as follows:

- Chapter 1: Resident Assessment Instrument (RAI)
- Chapter 2: Assessments for the Resident Assessment Instrument (RAI)
- Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Assessments
- Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

Appendices

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS *Locations* RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: *Patient Health Questionnaire (*PHQ*)*-Scoring Rules and Instruction for BIMS (When Administered *i*n Writing)
- Appendix F: MDS Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 *Forms*

Section	Title	Intent
A	Identification Information	Obtain key *demographic* information to uniquely identify each resident, *administrative information,* nursing home *in which they reside*, reason for assessment*, and potential care needs, including access to transportation*.
B	Hearing, Speech, and Vision	Document *whether the resident is comatose,* the resident's ability to hear, understand, and communicate with others and *the resident's ability to see objects nearby in their environment*.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information*, and whether the resident has signs and symptoms of delirium*.
D	Mood	Identify signs and symptoms of mood distress *and social isolation*.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the *care* environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for *their* daily routine and activities.
GG	Functional Abilities and Goals	Assess the need for assistance with self-care and mobility activities*, prior function, admission performance, discharge goals, discharge performance, functional limitations in range of motion, and current and prior device use*.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a *direct* relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident. *Also includes use and indication of high-risk drug classes, antipsychotic use and drug regimen review to identify potentially significant medication issues.*
O	Special Treatments, Procedures, and Programs	Identify any special treatments, procedures, and programs that the resident received *or performed* during the specified time periods.
P	Restraints and Alarms	Record the frequency that the resident was restrained by any of the listed devices *or an alarm was used* at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation *and expectations* of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	*To identify an MDS* record already present in *i*QIES *system for modification or inactivation*.

Section	Title	Intent
Z	Assessment Administration	Provide billing information and signatures of persons completing *and attesting to the accuracy of* the assessment*, as well as the signature and date by the RN Assessment Coordinator verifying the assessment is complete*.