

2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in items A0310A and A0310F (Entry/discharge reporting). PPS reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

The table provides a summary of the assessment types and requirements for the OBRA-required assessments, the details of which will be discussed throughout the remainder of this chapter.

RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14 th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days AND ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14 th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

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RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14 th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

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RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day <i>and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)</i>
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day <i>and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)</i>

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RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Entry tracking record	A0310F = 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F = 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment

Comprehensive Assessments

OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of:

- Admission Assessment
- Annual Assessment
- Significant Change in Status Assessment
- Significant Correction to Prior Comprehensive Assessment

Each of these assessment types will be discussed in detail in this section. They are **not** required for residents in swing bed facilities.

Assessment Management Requirements and Tips for Comprehensive Assessments:

- The ARD (item A2300) is the last day of the observation/look-back period, and day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
- If a resident had an OBRA Admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the time frame in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.³ In closing the record, the nursing home should note why the RAI was not completed.

³ The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- If a resident dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.⁴ In closing the record, the nursing home should note why the RAI was not completed.
- If a significant change in status is identified in the process of completing any OBRA assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- The nursing home may combine a comprehensive assessment with a Discharge assessment.
- In the process of completing any OBRA comprehensive assessment except an Admission and an SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into iQIES, and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days).
- The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment.
- May be combined with a 5-Day assessment or SNF Part A PPS Discharge assessment (see Sections 2.10 and 2.11 for details) or any Discharge assessment type.

OBRA-required comprehensive assessments include the following types, which are numbered according to their MDS 3.0 assessment code (item A0310A).

01. Admission Assessment (A0310A = 01)

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:

⁴ The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

Assessment Management Requirements and Tips for Admission Assessments:

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., is considered day "1" of admission.
- The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.
- The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than day 14.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
- For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status **requires** an Entry tracking record **each time** the resident returns to the facility and an OBRA Discharge assessment **each time** the resident is discharged.
- The nursing home may combine the Admission assessment with a Discharge assessment when applicable.

02. Annual Assessment (A0310A = 03)

The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.

Assessment Management Requirements and Tips for Annual Assessments:

- The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

03. Significant Change in Status Assessment (SCSA) (A0310A = 04)

The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.

A “**significant change**” is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered “self-limiting”;
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

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

A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.

Assessment Management Requirements and Tips for Significant Change in Status Assessments:

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.
- An SCSA is appropriate when:
 - There is a determination that a significant change (either improvement or decline) in a resident's condition from *their* baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
 - The resident's condition is not expected to return to baseline within two weeks.
 - For a resident who goes in and out of the facility on a relatively frequent basis and reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from an SCSA during the intervening period, the staff must complete an SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
- An SCSA may **not** be completed prior to an OBRA Admission assessment.
- An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving *their* highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O01 *10K1*. Completing an Admission assessment followed by an SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required.
- An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice

election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

- If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O01 *10K1*. Completing an Admission assessment followed by an SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required.
- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When an SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

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

Note: this is not an exhaustive list

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

Some Guidelines to Assist in Deciding If a Change Is Significant or Not:

- A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin an SCSA. This time frame may vary depending on clinical judgment and resident needs. For

example, a 5% weight loss for a resident with the flu would not normally meet the requirements for an SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

- An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, “potential for weight loss.” This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted.
- **If there is only one change**, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique, and the IDT must make the decision as to whether or not the resident will benefit from an SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing an SCSA that does not meet the criteria for completion.
- An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- An SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.
- **Decline in two or more of the following:**
 - Resident's decision-making ability has changed;
 - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9[©]), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
 - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;
 - Any decline in an ADL physical functioning area (*e.g., self-care or mobility*) (at least 1) where a resident is newly coded as *partial/moderate* assistance, *substantial/maximal assistance*, *dependent*, *resident refused*, or *the activity was not attempted* since last assessment and does not reflect normal fluctuations in that individual's functioning;
 - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
 - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type when it was not used before; and/or
- Emergence of a condition/disease in which a resident is judged to be unstable.
- **Improvement in two or more of the following:**
 - Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, *setup or clean-up assistance, or supervision or touching* assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
 - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
 - Resident's decision making improves;
 - Resident's incontinence pattern improves.

Examples (SCSA):

1. *Resident* T no longer responds to verbal requests to alter *their* screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. *They are* also starting to resist *their* daily care, pushing staff away from *themselves* as the *staff members* attempt to assist with *their* ADLs. This is a significant change, and an SCSA is required, since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. *Resident* T's behavioral symptoms could have many causes, and an SCSA will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of *Resident* T's disruptive behavior.
2. *Resident* T required *supervision* with ADLs. *They* fractured *their* hip and upon return to the facility require *maximal* assistance with all ADLs. Rehab has started and staff is hopeful *they* will return to *their* prior level of function in 4–6 weeks.
3. *Resident* G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission *they were* very frail, had trouble thinking, *were* confused, and had many behavioral complications. The course of treatment led to steady improvement and *they are* now stable. *They are* no longer confused or exhibiting inappropriate behaviors. The resident, *their* family, and staff agree that *they have* made remarkable progress. An SCSA is required at this time. The resident is not the person *they were* at admission - *their* initial problems have resolved and *they* will be remaining in the facility. An SCSA will permit the interdisciplinary team to review *their* needs and plan a new course of care for the future.

Guidelines for When a Change in Resident Status Is Not Significant:

Note: this is not an exhaustive list

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a

psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require an SCSA).

- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate an SCSA).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

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

Note: this is not an exhaustive list

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for an SCSA, an SCSA is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

Examples (SCSA):

1. *Resident* M has been in this nursing home for two and one-half years. *They have* been a favorite of staff and other residents, and *their child* has been an active volunteer on the unit. *Resident* M is now in the end stage of *their* course of chronic dementia, diagnosed as probable Alzheimer's. *They* experience recurrent pneumonias and swallowing difficulties, *their* prognosis is guarded, and family members are fully aware of *their* status. *They are* on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of *their child* in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, *Resident* M's care is of a high quality, and as *their* physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.

2. *Resident* K came into the nursing home with identifiable problems and has steadily responded to treatment. *Their* condition has improved over time and has recently hit a plateau. *They* will be discharged within 5 days. The initial RAI helped to set goals and start *their* care. The course of care provided to *Resident* K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if *Resident* K is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if *they are* not discharged, an SCSA is required by the end of the allotted 14-day period.
3. *Resident* P, too, has responded to care. Unlike *Resident* K, however, *they* continue to improve. *Their* discharge date has not been specified. *They are* benefiting from *their* care and full restoration of *their* functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring an SCSA at this time. However, if *their* condition *were* to stabilize and *their* discharge was not imminent, an SCSA would be in order.

Guidelines for Determining When a Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation:

- If an SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.⁵
- PASRR is not a requirement of the resident assessment process but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.
- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the SMH/ID/DDA authorities and the State Medicaid Agency is available at <http://www.cms.gov/>.
- The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

⁵ The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

Referral for Level II Resident Review Evaluations Is Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:

Note: this is not an exhaustive list

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident's plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.
- A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with an SCSA.)

Example (PASRR & SCSA):

1. *Resident* L has a diagnosis of serious mental illness, but *their* primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and *they* become ambulatory, even if other conditions exist for which *Resident* L receives medical care, *they* should be referred for a PASRR evaluation to determine whether a change in *their* placement or services is needed.

Referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:

Note: this is not an exhaustive list

- A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).
- A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.
- A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

04. Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A = 05)

The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an Admission assessment, and its ARD and completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment.

A “**significant error**” is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2. The error has not been corrected via submission of a more recent assessment.

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

Assessment Management Requirements and Tips for Significant Correction to Prior Comprehensive Assessments:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCPA is appropriate when:
 - the erroneous comprehensive assessment has been completed and transmitted/submitted into iQIES; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

Non-Comprehensive Assessments and Entry and Discharge Reporting

OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but **not** completion of the CAA process and care planning. The OBRA non-comprehensive assessments include:

- Quarterly Assessment
- Significant Correction to Prior Quarterly Assessment
- Discharge Assessment – Return not Anticipated
- Discharge Assessment – Return Anticipated

The Quarterly assessments, OBRA Discharge assessments and SCQAs are not required for Swing Bed residents. However, Swing Bed providers are required to complete the Swing Bed Discharge item set (SD).

Tracking records include a select number of MDS items and are required for **all** residents in the nursing home and swing bed facility. They include:

- Entry Tracking Record
- Death in Facility Tracking Record

Assessment Management Requirements and Tips for Non-Comprehensive Assessments:

- The ARD is considered the last day of the observation/look-back period, therefore it is day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for March 14, then the beginning of the observation period for MDS items requiring a 7-day observation period would be March 8 (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be March 1 (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA.

For example:

- Resident A has a Quarterly assessment with an ARD of March 20th. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23rd and returns on March 25th. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continues with the assessment that was not fully completed before discharge and may complete the assessment by April 3rd (which is day 14 after the ARD).
- Resident B also has a Quarterly assessment with an ARD of March 20th. *They* go to the hospital on March 20th and returns March 30th. While there is no significant

change the facility decides to start a new assessment and sets the ARD for April 2nd and completes the assessment.

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.⁶ In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.⁶ When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and an SCPA, if it is identified that a significant error occurred in a previous comprehensive assessment that has already been submitted and accepted into iQIES and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous comprehensive assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan.
- The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a 5-Day assessment or SNF Part A PPS Discharge Assessment (see Sections 2.10 and 2.11 for details).

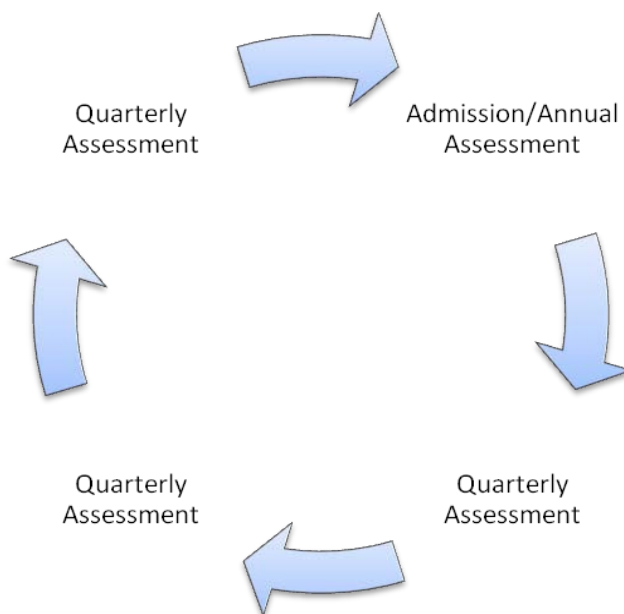
⁶ The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

05. Quarterly Assessment (A0310A = 02)

The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

Assessment Management Requirements and Tips:

- Federal requirements dictate that, at a minimum, three Quarterly assessments be completed in each 12-month period. Assuming the resident does not have an SCSPA or SCQA completed and was not discharged from the nursing home, a typical 12-month OBRA schedule would look like this:



- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, States may have more stringent restrictions.
- The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSPA, SCQA, SCQA, or Annual assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).

06. Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A = 06)

The SCQA is an OBRA non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (item A2300) and completion dates (item Z0500B) depend on the date the determination was made that there is a significant error in a previous Quarterly assessment.

A “**significant error**” is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

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

Assessment Management Requirements and Tips:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCQA is appropriate when:
 - the erroneous Quarterly assessment has been completed (MDS completion date, item Z0500B) and transmitted/submitted into iQIES; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be less than or equal to 14 days after the determination that a significant error in the prior Quarterly has occurred (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after determining that the significant error occurred.

Tracking Records and Discharge Assessments (A0310F)

OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring. Entry and discharge reporting is required for residents in Swing Beds or those in respite care.

If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit OBRA Discharge assessments and Entry tracking records every time until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

OBRA-required Tracking Records and Discharge Assessments include the following types (item A0310F):

07. Entry Tracking Record (Item A0310F = 01)

There are two types of entries – admission and reentry.

Admission (Item A1700 = 1)

- Entry tracking record is coded an Admission every time a resident:
 - is admitted for the first time to this facility; or
 - is readmitted after a discharge return not anticipated; or
 - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.

Example (Admission):

1. *Resident* S. was admitted to the nursing home on February 5, 2011 following a stroke. *They* regained most of *their* function and returned to *their* home on March 29, 2011. *They were* discharged return not anticipated. Five months later, *Resident* S. underwent surgery for a total knee replacement. *They* returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the Entry tracking record for the August 27, 2011 return as follows:

A0310F = 01
A1600 = 08-27-2011
A1700 = 1

Reentry (Item A1700 = 2)

- Entry tracking record is coded Reentry every time a person:
 - is readmitted to this facility, **and** was discharged return anticipated from this facility, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

Example (Reentry):

1. *Resident* W. was admitted to the nursing home on April 11, 2011. Four weeks later *they* became very short of breath during lunch. The nurse assessed *them* and noted *their* lung sounds were not clear. *Their* breathing became very labored. *They were* discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, *Resident* W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows:

A0310F = 01
A1600 = 05-18-2011
A1700 = 2

Assessment Management Requirements and Tips for Entry Tracking Records:

- The Entry tracking record is the first item set completed for all residents.
- Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility), including upon return if a resident in a Medicare Part A stay is discharged from the facility and does not resume Part A within the same facility within the 3-day interruption window (see Interrupted Stay in Section 2.5, Assessment Types and Definitions above).
- Must be completed for a respite resident every time the resident enters the facility.
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.
- Contains administrative and demographic information.
- Is a standalone tracking record.
- May **not** be combined with an assessment.

08. Death in Facility Tracking Record (A0310F = 12)

- Must be completed when the resident dies in the facility or when on LOA.
- Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days).
- Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).
- Consists of demographic and administrative items.
- May not be combined with any type of assessment.

Example (Death in Facility):

1. *Resident* W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. *They* passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows:

A0310F = 12
A2000 = 11-13-2011
A2105 = 13

OBRA Discharge Assessments (A0310F)

OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated.

09. Discharge Assessment–Return Not Anticipated (A0310F = 10)

- Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
- Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident returns, the Entry tracking record will be coded A1700 = 1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the provider must determine whether the interrupted stay policy applies. Refer to Section 2.9 for instructions on the PPS assessments.

Examples (Discharge-return not anticipated):

1. *Resident* S. was admitted to the nursing home on February 5, 2011 following a stroke. *They* regained most of *their* function and *were* discharged return not anticipated to *their* home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows:

A0310F = 10
A2000 = 03-29-2011
A2105 = 01

2. *Resident* K. was transferred from a Medicare-certified bed to a non-certified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows:

A0310F = 10
A2000 = 12-12-2013
A2105 = 02

10. OBRA Discharge Assessment–Return Anticipated (A0310F = 11)

- Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days.
- For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that *they* will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.
- Must be completed (item Z0500B) within 14 days after the discharge date (item A2000) (i.e., discharge date (A2000) + 14 calendar days).

- Must be submitted within 14 days after the MDS completion date (item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- When the resident returns to the nursing home, the IDT must determine if criteria are met for an SCSA (only when the OBRA Admission assessment was completed prior to discharge).
 - If criteria are met, complete an SCSA.
 - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If an interrupted stay occurs, an SCSA should be completed if clinically indicated.
- If an SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
- When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

Example (Discharge-return anticipated):

1. *Resident* C. was admitted to the nursing home on May 22, 2011. *They* tripped while at a restaurant with *their child*. *They were* discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 OBRA Discharge assessment as follows:

A0310F = 11
 A2000 = 05-31-2011
 A2105 = 04

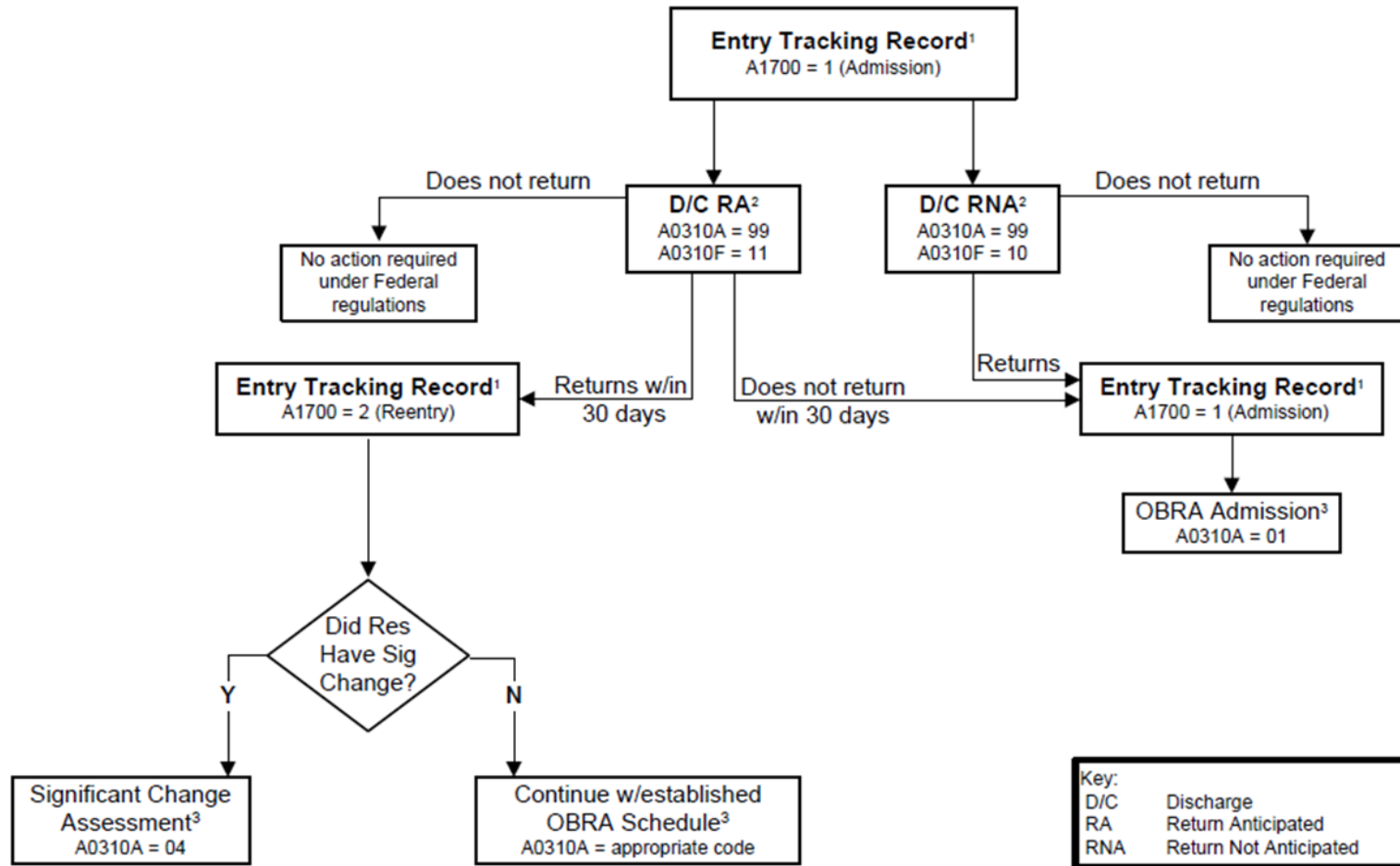
Assessment Management Requirements and Tips for OBRA Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge in Section 2.5, Assessment Types and Definitions).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed if a resident in a Medicare Part A stay is discharged from the facility regardless of whether the resident resumes Part A within the 3-day interruption window (see Interrupted Stay, Section 2.5, Assessment Types and Definitions above).
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA-required assessment when requirements for all assessments are met.

- May be combined with *any* 5-Day *and must be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000).*
- For an OBRA Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).
- The use of the dash, “-”, is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the OBRA Discharge assessment with another assessment(s) when requirements for all assessments are met.
- For **unplanned discharges**, the facility should complete the OBRA Discharge assessment to the best of its abilities.
 - An unplanned discharge includes, for example:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
 - Resident unexpectedly leaving the facility against medical advice; or
 - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

The following chart details the sequencing and coding of Tracking records and OBRA Discharge assessments.

Entry, OBRA Discharge, and Reentry Algorithms



¹A0310A = 99 A0310B = 99 A0310E = 0 A0310F = 01

²A0310B – E = appropriate code

³A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

CMS's RAI Version 3.0 Manual

CH 2: Assessments for the RAI