

**680-A RESIDENT ASSESSMENT**

EFFECTIVE DATES: 02/14/96, 11/27/18

REVISION DATES: 03/14/97, 02/01/01, 10/01/01, 03/01/06, 10/01/07, 07/01/12, 09/06/18

**I. PURPOSE**

This Policy applies to AHCCCS registered Nursing Facilities (NFs) and establishes requirements for the Resident Assessment Instrument (RAI).

**II. DEFINITIONS**

**RESIDENT ASSESSMENT INSTRUMENT (RAI)** A three part comprehensive assessment to include the Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The application of these 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 problems have been identified.

**CARE PLAN** A documented description of physical health services and behavioral health services expected to be provided to a resident, based on the resident's comprehensive assessment that includes measurable objectives and the methods for meeting the objectives.

**INTERDISCIPLINARY TEAM** A group of individuals consisting of a resident's attending physician, a registered nurse responsible for the resident, and other individuals as determined in the resident's comprehensive assessment

**III. POLICY****A. REQUIREMENTS FOR RESIDENT ASSESSMENT INSTRUMENT (RAI)**

1. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) as outlined in CFR §483.20. The RAI uses the three components listed below:
  - a. The Minimum Data Set (MDS) is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.

- b. The Care Assessment (CAA) Process is designed to assist the assessor to systematically interpret the information recorded on the MDS. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. Specific components of the CAA process as outlined in the Long-Term Care Facility Resident Assessment Instrument User’s Manual include:
        - i. Care Area Triggers (CATs)
        - ii. Care Area Assessment
        - iii. CAA Summary (Section V of the MDS 3.0)
      - c. The Utilization Guidelines provide instructions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information.
2. Assessment shall be conducted or coordinated by a registered nurse in collaboration with an interdisciplinary team. Information regarding problem areas is then used to develop the member’s individualized care plan.
  - a. A registered nurse shall sign and certify that the assessment is completed.
  - b. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.
3. A facility shall conduct a comprehensive assessment of a resident within the following timeframes as specified in CFR §413.343(b):
  - a. A facility shall complete a resident assessment for each resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this policy, “readmission” refers to a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)
  - b. A facility shall complete a resident assessment within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this policy, a “significant change” refers to a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
  - c. A resident assessment shall be completed no less than once every 12 months.
  - d. A resident's comprehensive assessment shall be reviewed by a registered nurse at least once every three months after the date of the current comprehensive assessment and if there is a significant change in the resident's condition.
4. A facility shall 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.
5. A facility shall coordinate assessments with the preadmission screening and resident



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**AHCCCS MEDICAL POLICY MANUAL**  
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review (PASARR) program to avoid duplicative testing and effort.