**Physical Assessment & Evaluation**

**Competency**

General Information

**Physical Assessment and Evaluation General Information**

**General Information**

In health care, the only constant is change. Staying on top of the most recent material is a never-ending job. Facilities will need to ensure that they have a robust Physical Assessment Program and Physical Assessment and Evaluation policies and procedures program in place, along with employee education and a system to verify competence for quality care.

**F636 Resident Assessment**

“The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity.

 §483.20(b) Comprehensive Assessments

§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.

The assessment must include at least the following:

(i) Identification and demographic information

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychological well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnosis and health conditions.

(xi) Dental and nutritional status.

(xii) Skin Conditions.

(xiii) Activity pursuit.

 (xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge planning.

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

(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 direct care staff members on all shifts. ”1

**INTENT §483.20(b)(1)-(2)(i) & (iii)**

“To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident’s preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.1

**GUIDANCE §483.20(b)(1)-(2(i) & (iii)**

“Each facility must use the RAI specified by CMS (which includes the MDS, utilization guidelines and the CAAs) to assess each resident. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility’s responsibility to assess and address all care needed by the resident.”1

**F641 Accuracy of Assessments.**

“The assessment must accurately reflect the resident’s status.

 **INTENT §483.20(g**)

To assure that each resident receives an accurate assessment, reflective of the resident’s status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident’s status, needs, strengths, and areas of decline.

**GUIDANCE §483.20(g)**

“Accuracy of Assessment” means that the appropriate, qualified health professionals correctly document the resident’s medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e., comprehensive, quarterly, significant change in status).

 Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.”1

**F658 Comprehensive Care Plan**

“The services provided or arranged by the facility, as outlined by the comprehensive care plan, must –

1. Meet professional standards of quality.”1

**“NOTE:** Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the clinical assessment process is more fluid and should be ongoing. The lack of ongoing clinical assessment and identification of changes in condition, to meet the resident’s needs between required RAI assessments should be addressed at §483.35 Nursing Services, F726 (competency and skills to identify and address a change in condition), and the relevant outcome tag, such as §483.12 Abuse, §483.24 Quality of Life, §483.25 Quality of Care, and/or §483.40 Behavioral Health.”1

**Suggestions for Resources Related to Physical Assessment and Evaluation**

Two key resources for expectations for providers about Assessment and Evaluation include the CMS State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities and the MDS 3.0 RAI User’s Manual.

Suggested competencies for staff will include:

* Licensed Nurse(s):
	+ Assessment Process (including a functional assessment)
	+ Information gathering about resident medical history
	+ Documentation
* CNA’s:
	+ Training on the techniques that identify resident physical and functional baseline
	+ Documentation of ADL Self-Performance and Support
	+ Identification and Reporting of Change of Condition
* Interdepartmental Employees Performing Restorative Programs
	+ Identification and Reporting of Change of Condition

**F-Tag Reference General Information**

Examples of (Federal) F tags that could be cited during a survey inspection that are related to Assessment and Evaluation include:

* F600 Free from Abuse and Neglect
* F636 Resident Assessment
* F637 Significant Change in Status
* F638 Quarterly review Assessment
* F641 Accuracy of Assessments
* F642 Coordination of Assessment
* F644 Coordination of PASARR and Assessments
* F645 PASARR Screening for MH & ID
* F656 Comprehensive Care Plan-Develop and Implement
* F658 Services Provided Meet Professional Standards
* F675 Quality of Life
* F676 Activities of Daily Living –Maintain Abilities
* F677 ADL Care Provided for Dependent Residents
* F684 Quality of Care
* F686 Pressure Sores
* F688 Increase/Prevent Decrease in Range of Motion/Mobility
* F689 Free of Accident Hazards/Supervision/Devices
* F690 Incontinence
* F697 Pain Management
* F699 Trauma-informed Care
* F726 Staffing and Competency
* F740 Behavioral Health

**Link to Critical Element Pathway**

CMS Resident Assessment Critical Element Pathway includes a guide that surveyors will utilize to review and guide observations and interviews. Areas for review include:

* Review of the MDS assessments
	+ Accuracy
	+ Appropriate health professionals
		- Skills and qualifications
* Potential falsification
* Quarterly review
* Adherence to RAI guidelines
* Diagnoses
* Care Plan

Observations include identification of care and services provided to meet the resident’s needs, precautions, interactions, and skill competency.

**References**

* 1Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17) Advance Copy 6/29/22: <https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>
* Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
* LTC Survey Pathways (Download) CMS 20131 Resident Assessment Critical Element Pathway: <https://www.cms.gov/files/zip/ce-pathways.zip>