**Physical Assessment & Evaluation**

**Competency**

Suggested Implementation Checklist

**Suggested Implementation Checklist: Physical Assessment and Evaluation**

| **Regulation** | **Recommended Action** |
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| **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 non licensed direct care staff members on all shifts. ”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 | Review discipline-specific assessments to assure that physical assessment findings are integrated into the data collection where appropriate.  Establish the physical assessment components of focused (condition-specific) assessments and assure that assessment tools contain areas for documentation of physical assessment findings relevant to the condition being assessed.   * Provide education for all disciplines on completion of the MDS 3.0 RAI process |
| **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 | Develop and implement assessment education and competency evaluations for nurses for physical assessment,   * Develop and implement education for nursing assistants’ collection and reporting of new symptoms or changes in residents’ status or function.   Review the assessment documentation tools to assure that physical assessment findings are integrated into the tool.  Review the assessment policies and procedures to delineate which discipline will complete each assessment, section of the MDS, Care Area Assessments and corresponding care plan.  Assure that assigned staff have education and reference resources for completing the assigned documentation.  Assure that each person participating in the assessment process has verified competency. |
| **F644**  **“§483.20(e) Coordination.**  A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:    §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.    §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.”1 | Review facility policy and procedure for coordination of assessments with the pre-admission screening and resident review (PASARR) program  Review facility policy and procedure for incorporating recommendation for the PASARR level II in to the resident assessment, care planning and transitions of care  Review facility policy and procedure for referring all level II residents and all residents with newly evident or possible serious mental disorders, ID or related condition for level II resident review upon a significant change in status assessment  Educate nurses completing the assessment process on the coordination of assessment information from the PASARR into the resident assessment, care plan and transitions of care  Educate nurses completing the assessment process on referring level II residents with new or possible serious mental disorder, ID or related condition upon a significant change in status |
| **F726: 483.35: Nursing Services**  “The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).  §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.    §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident’s needs.  §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.  **INTENT §483.35(a)(3)-(4),(c)**  To assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents’ needs safely and in a manner that promotes each resident’s rights, physical, mental and psychosocial well-being.”1 | Develop and implement assessment education and competency evaluations for nurses for physical assessment,   * Develop and implement education for nursing assistants’ collection and reporting of new symptoms or changes in residents’ status or function. * Review, revise and institute a Nursing Policy and Procedure in accordance with the new RoP and the MDS 3.0 RAI Manual.   Update all definitions and new terms in policies, procedures and education.  Develop a training plan for the Interdisciplinary Team.  Provide staff training on the revised Nursing Policy and Procedure. Update training for orientation, annual, agency staff, as needed.  Conduct updated training for Management Personnel on supervising and monitoring competencies with resident assessment and evaluation. |
| **F656 Comprehensive Care Plan**  “§483.21(b)(1) The facility must develop and implement a comprehensive person centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.”1  “The services provided or arranged by the facility, as outlined by the comprehensive care plan, must –  (iii) Be culturally-competent and trauma-informed.”1 | Review facility policy and procedure on completion of the comprehensive care plan  Provide education to the interdisciplinary team on completing of the person-centered, comprehensive care plan to meet the residents needs as identified in the comprehensive assessment   * Educate nurses on including the results from the resident’s physical assessment in the resident’s care plan * Educate the interdisciplinary team in including cultural preferences and/or trauma-informed approaches, based upon the resident assessment |
| **F657 Comprehensive Care Plan**  ”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 | Assure that nursing staff, including nursing assistants, have knowledge about how to identify changes in a resident’s condition or function.  Assure that there is a formal system for nursing assistants to report observed changes in residents’ function or conditions to a nurse for assessment. |
| **F658: Services Provided Meet Professional Standards**  Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—  (i) Meet professional standards of quality.”1 | Ensure training and competency:   * Physical Assessment * Medical conditions relevant to the facility population * Care Plan Development * Care Plan Evaluation and Revisions * Documentation * Communication |
| **F684: Quality of Care**  “Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices”1 | Review of facility policies, procedures and training materials to ensure best practice approach and current standards of practice are included |
| **F697 Pain Management**  “The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.”1  “An assessment or an evaluation of pain based on professional standards of practice may necessitate gathering the following information, as applicable to the resident:  • History of pain and its treatment (including non-pharmacological and pharmacological treatment and whether or not each treatment has been effective);  • History of addiction, past and/or ongoing and related treatment for OUD;  • Characteristics of pain, such as: (intensity, pattern, location, frequency and duration)  • Impact of pain on quality of life (e.g., sleeping, functioning, appetite, and mood);  • Factors such as activities, care, or treatment that precipitate or exacerbate pain as well as those that reduce or eliminate the pain;  • Additional symptoms associated with pain (e.g., nausea, anxiety);  • Physical and psychosocial issues (physical examination of the site of the pain, movement, or activity that causes the pain, as well as any discussion with resident about any psychological or psychosocial concerns that may be causing or exacerbating the pain);  • Current medical conditions and medications including medication assisted treatment for OUD; and  • The resident’s goals for pain management and his or her satisfaction with the current level of pain control.”1 | Review and revise as necessary, the facility pain assessment process to include updates for F697:   * History of addiction, past and/or ongoing and related treatment for opioid use disorder * Current medical conditions and medications including medication assisted treatment for opioid use disorder   Provide education to nurses on the updated pain assessment process |
| **F699 Trauma-informed care**  **“**The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.”1  **Assessment**  **“**Facilities should use a multi-pronged approach to identifying a resident’s history of trauma as well as his or her cultural preferences. This would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others.”1 | * Review and revise if necessary, assessment tools to include psychosocial screening and history of trauma or traumatic event (resources available at: <https://www.thenationalcouncil.org/program/center-of-excellence/#TRAUMA> * Provide education for the interdisciplinary team on updated assessment tools |
| **F740 Behavioral Health Services**  **“**Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.”1 | * Review and revise if necessary, the assessment process for residents with behavioral health needs to include assessment and person-centered care planning * Educate the interdisciplinary team on the assessment process for behavioral health services |

**References and Resources**

* 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>