Resident Assessment Critical Element Pathway

Use this pathway for the following: a) when MDS concerns are noted but you are not using a care area pathway (i.e., the care area did not require further investigation), or b) for concerns about the facility's MDS data completion or submission activities.

Record Review:

☐ MDS Accuracy Concerns:

- Does information in the MDS correspond with information obtained during observations and interviews with the resident, facility staff, and resident's family or representative;
- Have appropriate health professionals assessed the resident? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of assessing the resident;
- Based on your total review of the resident, is each portion of the assessment accurate;
- Is there any evidence that an individual willfully and knowingly coded MDS assessment information inaccurately or falsely;
- Is the quarterly review of the resident's condition consistent with information in the progress notes, plan of care, and your resident observations and interviews; and
- Based on the facility documentation, did the facility adhere to the guidelines for conducting a Resident Assessment (e.g., Significant Change in Status Assessment)?
  (Note: Facility documentation is defined as information obtained from the facility that includes resident care and issues that are tracked such as an incident/accident report, clinical record, wound log, transfer log, and ANY other type of documentation that contains evidence of resident issues.)

☐ Completion and Submission Concerns:

- Compare the alphabetical list of residents provided by the facility against the resident listing in the software. Residents on the alpha list and not in the software should be new admissions (admitted in the last 30 days). If they are not new admissions, there may be MDS submission issues (and that's why they are not in the software listing);
- Are the appropriate certifications in place, including the RN Coordinator's certification/signature of completion of an assessment or Correction Request and the certification of individual assessors of the accuracy and completion of portion(s) of the assessment or tracking record completed or corrected;
- Was the assessment completed and submitted timely? If not, why not; and
- What is the assessment type that wasn't completed or submitted timely?

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Critical Element Decisions:

1) *Does the resident assessment accurately reflect* the resident's status (e.g. comprehensive, quarterly, significant change in status)?
   If No, cite F641
   NA, assessments accurately reflected the resident's status.

2) Did the facility complete a comprehensive assessment, using the CMS-specified Resident Assessment Instrument (RAI) process, within the regulatory timeframes (i.e., within 14 days after admission and at least annually) for each resident?
   If No, cite F636
   NA, the annual assessment or admission assessment was completed timely.

3) Did the facility assess residents, using the CMS-specified quarterly review assessment, no less than once every three months, between comprehensive assessments?
   If No, cite F638
   NA, the quarterly assessment was completed timely.

4) Did the facility transmit the assessment within 14 days after completion?
   If No, cite F640
   NA, assessments were transmitted timely.

5) Did the facility ensure no one willfully and knowingly coded MDS assessment information inaccurately or falsely?
   If No, cite F64*I*

6) Did staff who completed portions of the MDS sign the assessment or tracking record certifying the accuracy and completion of the sections they completed, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request?
   If No, cite F64*I*

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