

**(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.**

**Interpretive Guidelines §483.20(i):**

Whether the MDS *assessments* are manually completed, or computer generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the MDS record. When MDS forms are completed directly on the facility's computer (e.g., no paper form has been manually completed), then each individual assessor signs and dates a computer generated hard copy, *or provides an electronic signature*, after they review it for accuracy of the portion(s) they completed. Backdating completion dates is not acceptable – *note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.*

**§483.20(j) Penalty for Falsification**

**(1) Under Medicare and Medicaid, an individual who willfully and knowingly--**

**(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or**

**(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.**

**(2) Clinical disagreement does not constitute a material and false statement.**

**Interpretive Guidelines §483.20(j):**

MDS information serves as the clinical basis for care planning and delivery. With the introduction of additional uses of MDS information such as for payment rate setting and quality monitoring, MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher RUG scores, untriggering *CAA(s)*, *or unflagging QI(s)*, where the information does not accurately reflect the resident's status, may be indicative of payment fraud or avoidance of the quality monitoring process. Such practices may include but are not limited to a pattern or high prevalence of the following:

- Submitting MDS Assessments (including any reason(s) for assessment, routine or non-routine) or tracking *records*, where the information does not

accurately reflect the resident's status as of the ARD, or the Discharge or *Entry* date, as applicable;

- Submitting correction(s) to information in the *QIES ASAP system* where the corrected information does not accurately reflect the resident's status as of the original ARD, or the original Discharge or Entry date, as applicable, or where the record it claims to correct does not appear to have been in error;
- Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error;
- Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met;
- Delaying or withholding MDS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Entry Tracking information, or correction(s) to information in the *QIES ASAP system*.

When such patterns or practices are noticed, they should be reported by the State Agency to the proper authority.

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**§483.20(d) (A facility must..) use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.**

### **§483.20(k) Comprehensive Care Plans**

**(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:**

**(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and**

**(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).**

#### **Interpretive Guidelines §483.20(k):**

An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest