

3701-17-10

Resident assessments; advanced care planning.

- (A) Each nursing home, in accordance with this rule, shall require written initial and periodic assessments of all residents. The different components of the assessment may be performed by different licensed health care professionals, consistent with the type of information required and the professional's scope of practice, as defined by applicable law, and shall be based on personal observation and judgment. This paragraph does not prohibit the licensed health professional from including in the assessment resident information obtained by or from unlicensed staff provided the evaluation of such information is performed by that licensed health professional in accordance with the applicable scope of practice.
- (B) Prior to admission, the nursing home shall obtain from the prospective resident's physician, other appropriate licensed health professionals acting within their applicable scope of practice, or the transferring entity, the current medical history and physical of the prospective resident, including the discharge diagnosis, admission orders for immediate care, the physical and mental functional status of the prospective resident, and sufficient additional information to assure care needs of and preparation for the prospective resident can be met. This information shall have been updated no more than five days prior to admission.
- (C) Upon admission, the nursing home shall assess each resident in the following areas:
- (1) Cardiovascular, pulmonary, neurological status including auscultation of heart and lung sounds, pulses and vital signs; and
 - (2) Hydration and nutritional status, including allergies and intolerances; and
 - (3) Presenting physical, psycho-social and mental status.

The nursing home shall also review each resident's admission orders to determine if the orders are consistent with the resident's status upon admission as assessed by the nursing home and shall reconfirm, as applicable, the orders with the attending physician or other licensed health care professional acting within the applicable scope of practice. The nursing home shall obtain any special equipment, furniture or staffing that is needed to address the presenting needs of the resident. The nursing home shall provide services to meet the specific needs of each resident identified through this admission assessment until such time as the care plan required by rule 3701-17-14 of the Administrative Code is developed and implemented.

- (D) The nursing home shall perform a comprehensive assessment meeting the requirements of paragraph (E) of this rule on each resident as follows:

- (1) The comprehensive assessment shall be performed within fourteen days after the individual begins to reside in the facility.
 - (2) Subsequent to the initial comprehensive assessment, a comprehensive assessment shall be performed at least annually thereafter. The annual comprehensive assessment shall be performed within thirty days of the anniversary date of the completion of the resident's last comprehensive assessment.
- (E) The comprehensive assessment shall include documentation of the following:
- (1) ~~Medical diagnoses~~ Preferences of the resident including hobbies, usual activities, bathing, sleeping patterns, socialization and religious;
 - (2) Medical diagnoses;
 - (~~2~~)(3) Psychological, and ~~mental-retardation~~ intellectual disabilities and developmental diagnoses and history, if applicable;
 - (~~3~~)(4) Health history and physical, including cognitive functioning, sensory and physical impairments, and the risk of falls;
 - (~~4~~)(5) Psycho-social history ~~and the preferences of the resident including hobbies, usual activities, food preferences, bathing preferences, sleeping patterns, and socialization and religious preferences;~~
 - (~~5~~)(6) Prescription and over-the-counter medications;
 - (~~6~~)(7) Nutritional and dietary requirements, food preferences, and need for any adaptive equipment, and needs for assistance and supervision of meals;
 - (~~7~~)(8) Height, ~~and~~ weight and history of weight changes;
 - (~~8~~)(9) A functional assessment which evaluates the resident's ability to perform activities of daily living;
 - (~~9~~)(10) The resident's risk of falls;
 - (~~10~~)(11) Vision, dental and hearing function, including the need for eyeglasses or other visual aids; and
 - (12) Dental function; including the need for dentures or partial dentures;
 - (13) Hearing function, including the need for hearing aids or other hearing devices; and

~~(H)~~(14) Any other alternative remedies and treatments the resident is taking or receiving.

The documentation required by this paragraph shall include the name and signature of the individual performing the assessment, or component of the assessment, and the date the assessment was completed.

(F) Subsequent to the initial comprehensive assessment, the nursing home shall periodically reassess each resident, at minimum, every three months, unless a change in the resident's physical or mental health or cognitive abilities requires an assessment sooner. The nursing home shall update and revise the assessment to reflect the resident's current status. This periodic assessment shall include documentation of at least the following:

- (1) Changes in medical diagnoses;
- (2) Updated nutritional requirements and needs for assistance and supervision of meals;
- (3) Height, ~~and weight~~ and history of weight changes;
- (4) Prescription and over-the-counter medications;
- (5) A functional assessment as described in paragraph (E)(8) of this rule;
- (6) The resident's risk of falls;
- (7) Any changes in the resident's psycho-social status or preferences as described in paragraph (E)(4) of this rule; and
- (8) Any changes in cognitive, communicative or hearing abilities or mood and behavior patterns.

(G) Nursing homes that conduct resident assessments in accordance with 42 C.F.R. 483.20, using the resident assessment instrument specified by rule 5101:3-3-43.1 of the Administrative Code, shall be considered in compliance with paragraphs (D), (E) and (F) of this rule.

(H) ~~Beginning July 1, 2015, each~~ Each nursing home shall participate in advance care planning with each resident or the resident's sponsor if the resident is unable to participate. ~~For each resident, the~~ The advance care planning shall be provided on admission to the nursing home ~~or, in the case of an individual residing in a nursing home on July 1, 2015, as soon as practicable~~. Thereafter, for each resident, the advance care planning shall be provided quarterly each year. For purposes of this

paragraph, "advance care planning" means providing an opportunity to discuss the goals that may be met through the care provided by a nursing home.

Effective: 1/1/2018
Five Year Review (FYR) Dates: 8/8/2017 and 11/01/2022

CERTIFIED ELECTRONICALLY

Certification

10/19/2017

Date

Promulgated Under: 119.03
Statutory Authority: 3721.04
Rule Amplifies: 3721.01, 3721.04. 3721.041
Prior Effective Dates: 5/2/1966, 12/21/92, 11/20/09, 4/1/2012, 12/8/14