TO BE RESCINDED

5101:3-3-14 **Assessment process for nonmedicaid placements in medicaid-certified nursing facilities.**

(A) The purpose of this rule is to set forth the assessment process and requirements for people seeking admission to medicaid-certified nursing facilities (NFs) who are not seeking medicaid payment for their NF stays.

(1) The purpose of the assessment process is to provide each individual (as defined in paragraph (B)(8) of this rule), and his or her representative (defined in paragraph (B)(12) of this rule), if applicable, with all of the following:

(a) An assessment of the individual's long-term care needs. The assessment may consist of a paper review (as defined in paragraph (B)(11) of this rule), or a paper review and an in-person assessment (as defined in paragraph (B)(9) of this rule). The Ohio department of human services (ODHS) or its designee decides the nature of the assessment in accordance with paragraph (D) of this rule.

(b) A determination of whether the individual needs NF services or that an alternative source of long-term care would be more appropriate. The determination criteria are set forth in paragraph (F) of this rule.

(c) The opportunity to receive:

(i) Information about alternative sources of long-term care (as defined in paragraph (B)(3) of this rule) that may be available to the individual; and

(ii) A recommendation of which source or sources of long-term care are most appropriate given the individual's physical, mental and psychosocial needs, the availability and effectiveness of informal support and care, and the availability of those alternative sources of long-term care. The criteria used to make the recommendation are set forth in paragraph (G) of this rule.

(2) A NF that has a provider agreement with ODHS may only admit an individual as a resident after it receives evidence that the individual is exempt from or has met the preadmission requirements of the assessment process (set forth in paragraphs (C) and (D) of this rule), and after the individual has met any applicable preadmission screening (PAS) requirements set forth in rule 5101:3-3-151 of the Administrative Code. The NF may receive this information from a hospital, another NF, ODHS, and/or obtain it directly

from the individual or the individual's representative.

(3) A NF that has a provider agreement with ODHS may retain certain individuals as residents only if they meet the postadmission requirements specified in paragraphs (C)(2)(a)(i), (C)(2)(a)(v), and (D)(5) of this rule, and if the individuals meet any applicable annual resident review (ARR) requirements set forth in rule 5101:3-3-152 of the Administrative Code. This provision only applies to those individuals who were admitted under time-limited conditional exemptions which expire, or under conditional exemptions that require the NF to notify ODHS or its designee within twenty-four hours of admission to the NF. The assessment process requirements for an individual who is a current NF resident are set forth in paragraph (D)(5) of this rule.

(4) The individual, the individual's representative, and the receiving NF, if known, are notified of the results of the assessment process. The notification requirements are set forth in paragraph (I) of this rule.

(5) The individual and, if applicable, the individual's representative retain the right to choose the source of long-term care he or she prefers, regardless of the outcome of the assessment process.

(6) The person who conducts the assessment process must be certified by ODHS or its designee. The certification requirements are specified in paragraph (K) of this rule.

(7) An individual or individual's representative who has a complaint regarding the assessment process may seek resolution. The complaint resolution procedures are set forth in paragraph (J) of this rule.

(8) An individual may be exempt from the assessment process set forth in this rule. The criteria that must be used to determine whether an individual is exempt are listed in paragraph (C) of this rule. An individual may be determined to be exempt from or subject to the assessment process by a hospital, a NF, or by ODHS or its designee, depending upon the following circumstances:

(a) For hospitalized individuals, the hospital is responsible for determining whether the individual is exempt, or must have an assessment, and for informing the individual and, if applicable, the individual's representative;

(b) For those individuals and/or their representatives who voluntarily seek information regarding the assessment process from ODHS or its

designee, ODHS or its designee is responsible for determining whether the individual is exempt or must have an assessment, and for informing the individual and, if applicable, the individual's representative;

(c) For all other individuals, the receiving NF or NF in which the individual already resides is responsible for determining whether the individual is exempt, or must have an assessment, and for informing the individual and, if applicable, the individual's representative.

(9) An individual who is seeking admission to, or retention as a resident in, a NF and does not meet the exemption criteria set forth in paragraph (C) of this rule must have an assessment. This includes, but is not limited to any individual seeking admission to a NF from a setting other than a hospital or a NF, any hospitalized individual who is not known to meet the medicaid level of care criteria for at least an intermediate level of care, or any individual residing in a NF who was admitted under a conditional exemption on or after the effective date of this rule whose exemption has expired and wishes to remain in the NF. The assessment process is initiated by a request for an assessment which must occur prior to admission to a NF. The process by which the request is made is set forth in paragraph (D) of this rule. Hospitalized individuals or individuals with an emergency need for NF placement shall not have their NF admissions delayed by the assessment process if the assessment is requested prior to the time of admission to the NF.

(10) The assessment process may be conducted before or after admission to a NF, depending on the circumstances outlined in paragraph (D) of this rule. The timeframes within which assessments must be conducted are also specified in paragraph (D) of this rule.

(11) An individual who is subject to the preadmission screening and annual resident review (PASARR) requirements set forth in either rule 5101:3-3-151 or 5101:3-3-152 of the Administrative Code must meet those requirements even if that individual is exempt from the assessment requirements set forth in this rule.

(12) An individual who is exempt from the assessment process may choose to request an assessment. If so, ODHS or its designee shall conduct the assessment process for the individual in accordance with paragraphs (D)(1) to (D)(1)(b) of this rule.

(B) Definitions. Unless otherwise specified in paragraphs (B)(1) to (B)(14) of this rule, all terms used in this rule have the same meanings as in rules 5101:3-3-05, 5101:3-3-06, 5101:3-3-07, 5101:3-3-08, and 5101:3-3-15 of the Administrative

Code.

(1) "Admission for a convalescent stay." A NF admission is considered to be an admission for a convalescent stay if it meets all of the following criteria:

(a) The individual is admitted directly from a hospital after receiving inpatient care at that hospital; and

(b) The individual requires the level of services provided by a NF for the condition which was treated in the hospital; and

(c) The individual's attending physician has provided written certification, signed and dated no later than the date of discharge from the hospital, that the individual is likely to require the level of services provided by a NF for less than thirty days.

(2) "Agency" may mean ODHS or its designee. If ODHS delegates the various functions related to the assessment process to more than one entity, "agency" means the designee which performs the assessments.

(3) "Alternative source of long-term care" means any source of long-term care other than a NF and includes a rest home licensed under Chapter 3721. of the Revised Code, an adult care facility licensed under Chapter 3722. of the Revised Code, an assisted living facility licensed under Chapter 3726. of the Revised Code, home and community-based services (as defined in paragraph (B)(7) of this rule), and a nursing home licensed under Chapter 3721. of the Revised Code that is not a nursing facility as defined in section 5111.20 of the Revised Code.

(4) "Delayed in-person assessment" means an in-person assessment (as defined in paragraph (B)(9) of this rule) which may be conducted at any specified time within a maximum of one hundred eighty calendar days after the individual has been admitted to a NF.

(5) "An individual with emergency need." Whether or not a person is "an individual with emergency need" is determined by ODHS or its designee and includes, but is not limited to, any individual identified by a county department of human services (CDHS) adult protective services worker as having an emergency need for long-term care, and any individual in a hospital emergency room who is likely to require NF admission.

(6) "Geriatric long-term care" means a set of health, personal, and social services

delivered over a sustained period to individuals aged sixty years and over.

(7) "Home and community-based services" means health and social services provided to individuals in their own homes or in community care settings, regardless of funding or payment source, and may include any one or more of the following:

(a) Case management;

(b) Home health services, including intermittent skilled nursing services, private duty nursing, and/or home health aide services;

(c) Homemaker services;

(d) Chore services;

(e) Respite care;

(f) Adult day care;

(g) Home-delivered meals;

(h) Personal care;

(i) Physical, occupational, and speech therapy; and

(j) Any other health and social services provided to individuals that allow them to retain their independence in their own homes or in community care settings.

(8) "Individual." For purposes of this rule, "individual" means any person who is seeking admission to a medicaid-certified nursing facility who is not seeking medicaid vendor payment for that NF stay at the time of admission.

(9) "In-person assessment" means that part of an assessment in which assessors certified by ODHS, in accordance with the provisions of paragraph (K) of this rule, conduct a face-to-face visit with the individual and, to the extent possible, with the individual's formal and informal care givers and/or representative, to review and discuss the individual's care needs and preferences, and to access information necessary to make a recommendation regarding the most appropriate source of long-term care for that individual.

(10) "Informal support" means family members, friends, or others who provide care or services to an individual instead of or in addition to a formal arrangement with an outside provider of home and community-based services (as defined in paragraph (B)(7) of this rule).

(11) "Paper review" means that part of the assessment process in which assessors certified by ODHS, in accordance with the provisions of paragraph (K) of this rule, conduct a review of all available written materials, and any recommendations received from the individual's attending physician, regarding the physical, mental, and psychosocial condition and related service needs of an individual in order to determine:

(a) Whether the individual needs nursing facility services; and

(b) Whether there is a need to conduct an in-person assessment and, if so, to determine whether:

(i) The in-person assessment must be completed prior to admission to the NF; or

(ii) That a delayed in-person assessment may be conducted.

(12) "Representative" means a person acting on behalf of an individual. A representative may be a family member, attorney, hospital social worker, or any other person chosen by the individual, or a court, or as otherwise specified in paragraphs (D)(2)(b) and (D)(5)(b) of this rule, to act on the individual's behalf.

(13) "Substantial improvement in the individual's medical condition" means that the individual's medical condition has improved to the extent that the individual no longer requires the level of services available in a NF. That is, the change is such that the individual would no longer meet at least the minimum nonfinancial criteria for an intermediate level of care set forth in rule 5101:3-3-06 of the Administrative Code.

(14) "Supporting documentation" means any written material that substantiates a written or oral statement regarding an individual's condition or circumstances. "Supporting documentation" may include, but is not limited to, copies of pertinent medical records such as a physician's history and physical examination report, physician's orders, social history, nursing assessments or progress notes, therapist evaluation reports or progress notes, psychological/psychiatric evaluation reports, or any other written statement or

professional assessment that provides information relevant to the aspect of the individual's condition that is to be documented.

(C) Exemptions. An individual may be totally exempt from the assessment process, or conditionally exempt.

(1) Total exemptions. An individual is totally exempt from the assessment process under any one or more of the following circumstances:

(a) The individual is to receive care in the NF under a contract for continuing care as defined in section 173.13 of the Revised Code;

(b) The individual has a contractual right to admission to a NF operated as part of a system of continuing care in conjunction with one or more facilities that provide a less intensive level of services, including a rest home licensed under Chapter 3721. of the Revised Code, an adult-care facility licensed under Chapter 3722. of the Revised Code, or an independent living arrangement;

(c) The individual is to receive continual care in a home for the aged that is exempt from taxation under section 5701.13 of the Revised Code;

(d) The individual is to be admitted to a nursing home that is not a medicaid-certified NF and does not have a provider agreement with ODHS for the provision of NF services.

(e) The individual is receiving hospice services in accordance with either Part 418 of the Code of Federal Regulations, or rules 5101:3-56-01 to 5101:3-56-061 of the Administrative Code;

(2) Conditional exemptions. An individual may be conditionally exempt prior to admission to a NF and later be required to have an assessment (as specified in paragraphs (C)(2)(a) to (C)(2)(a)(v)(c) of this rule), or an individual may be determined by ODHS or its designee to be exempt from all or part of the assessment process while the assessment is being conducted (as specified in paragraphs (C)(2)(b) to (C)(2)(b)(iii) of this rule).

(a) An individual is conditionally exempt prior to admission to a NF under any of the following circumstances:

(i) The individual is to receive care in the NF for not more than fourteen days in order to provide temporary relief to the individual's

primary caregiver and the NF notifies ODHS or its designee of the admission not later than twenty-four hours after the individual has been admitted;

(ii) The individual is to be transferred from another NF, unless it is determined by either the sending or receiving NF that the individual's medical condition has improved substantially (as defined in paragraph (B)(13) of this rule) since the individual was admitted to the sending NF;

(iii) The individual is to be readmitted to a NF following a period of hospitalization, unless the hospital or NF determines that the individual's medical condition has improved substantially (as defined in paragraph (B)(13) of this rule) and, since admission to the hospital, no longer requires NF services;

(iv) The individual is seeking an admission for a convalescent stay, as defined in paragraph (B)(1) of this rule, and the admitting NF obtains, and maintains in the individual's resident record at the facility, written documentation from the discharging hospital, and/or the individual's attending physician, which verifies that each of the defining criteria for an admission for a convalescent stay has been met, unless it is later determined by the NF that the individual will remain in the NF for more than twenty-nine days; or

(v) The individual is admitted to the NF directly following an inpatient hospital stay, and the NF notifies ODHS or its designee of the admission not later than twenty-four hours after the individual is admitted, and there is supporting documentation that the individual's physical or mental condition causes the individual to meet one of the following criteria:

(a) The individual requires hands-on assistance with one activity of daily living (ADL) and hands-on assistance with medication administration (as these are defined in rule 5101:3-3-06 of the Administrative Code);

(b) The individual requires hands-on assistance with two ADLs; or

(c) Due to a cognitive impairment other than MR/DD, including but not limited to dementia (as these terms are defined in

rule 5101:3-3-151 of the Administrative Code), the individual requires the presence of another person, on a twenty-four-hour-a-day basis for the purpose of supervision to prevent harm (as defined in rule 5101:3-3-06 of the Administrative Code). This does not necessarily mean there is a need for constant one-on-one supervision.

(b) An individual shall be determined by ODHS or its designee to be exempt during the assessment process under any of the following circumstances:

(i) It is determined by ODHS or its designee that the individual has received an assessment within the past one hundred-eighty days, and there has been no substantial improvement in the individual's medical condition;

(ii) ODHS or its designee either fails to complete the assessment process within the time required by paragraph (D) of this rule, or determines while conducting the assessment process that the individual should be exempt from the assessment process; or

(iii) The individual or individual's representative signs a written statement that he or she is making an informed decision to forego participation in the in-person assessment, and that he or she has received and understood written notification that the individual may not meet medicaid level of care (LOC) criteria, and is aware of the ramifications and potential for discharge after private or third-party funds have been depleted, the average cost of a NF stay per month, and the fact that an individual must meet LOC criteria and financial criteria in order to have medicaid pay for a continuing stay in the NF.

(D) Assessment process and timeframes.

(1) An individual who is exempt from the assessment process prior to admission to a NF (as specified in paragraph (C) of this rule), may choose to request an assessment. The individual may submit an oral or written request for an assessment to ODHS or its designee, or have one requested by a representative. If an assessment is requested for an individual who is exempt from preadmission review:

(a) ODHS or its designee shall conduct the assessment at a time that is mutually agreeable to the assessor, the individual and, if applicable, the

individual's representative;

(b) ODHS or its designee shall perform both a paper review and an in-person assessment (as defined in paragraphs (B)(9) and (B)(11) of this rule), and must provide notice of the assessment results in accordance with paragraph (I) of this rule.

(2) An individual or individual's representative who is informed prior to a NF admission by ODHS or its designee, a hospital, or a NF, that the individual is subject to the assessment process, must initiate the assessment process by contacting ODHS or its designee and requesting an assessment. This includes, but is not limited to, any individual seeking admission from a setting other than a hospital who is not exempt, and any hospitalized individual who is not known to meet medicaid level of care criteria for at least an intermediate level of care. The request may be made by phone, mail or electronic facsimile (FAX) and must include certain information, depending on the individual's circumstances, as follows:

(a) Identifying information. For individuals in all settings, the request must include the individual's name, current address, date of birth, social security number, medicare/medicaid identification numbers (if applicable), race, and gender; the name, address, and phone number of the receiving NF, if known, an oral or written statement regarding the nature of the individual's present residential setting, and the name and phone number of the individual's representative, if applicable, and if known.

(b) If the individual is hospitalized and does not meet the criteria for an exemption, the hospital shall, as the individual's representative and, to the extent the information is available and/or applicable, FAX the identifying information required for individuals in all settings by paragraph (D)(2)(a) of this rule to ODHS or its designee prior to the NF admission. The hospital shall also include the following:

(i) A list of the individual's current diagnoses (as defined in rule 5101:3-3-151 of the Administrative Code); and

(ii) If applicable, the current physician's orders, or a statement regarding the individual's current need for skilled nursing or skilled rehabilitation services as defined in rule 5101:3-3-05 of the Administrative Code (for hospitalized individuals whose proposed NF admission is to be covered by a third-party payer, a statement to that effect by the hospital discharge planner is

sufficient);

(iii) If the individual's ability is impaired, written statements and supporting documentation regarding the individual's ability to perform each activity of daily living (ADL) independently, with supervision, or with assistance (as these are defined in rule 5101:3-3-06 of the Administrative Code);

(iv) If the individual has a cognitive impairment, written statements and supporting documentation regarding whether, due to a cognitive impairment other than MR/DD (as defined in rule 5101:3-3-151 of the Administrative Code), the individual requires supervision to prevent harm; and if so, whether that supervision is required on a twenty-four-hour-a-day basis or less than twenty-four hours a day;

(v) If the individual's ability to perform self-administration of medication is impaired, written statements and supporting documentation regarding the individual's ability to perform self-administration of medication independently, with supervision, or with assistance (as these are defined in rule 5101:3-3-06 of Administrative Code); and

(vi) The submitter's signature on a written statement that the submitted information is, to the best of the submitter's knowledge, an accurate reflection of the individual's condition at the time of the request.

(c) For an individual seeking an emergency admission to a NF, the individual or individual's representative must submit, by phone or FAX, the identifying information required of individuals in all settings by paragraph (D)(2)(a) of this rule and an explanation of the circumstances that are creating the emergency. If the information is readily available to the submitter and applicable to the individual, the submitter shall also include oral or written statements and supporting documentation regarding the additional information specified for hospitalized individuals as specified in paragraphs (D)(2)(b)(i) to (D)(2)(b)(v) of this rule. If the request is made by FAX, the request must also include the submitter's signature on a written statement that the submitted information is, to the best of the submitter's knowledge, an accurate reflection of the individual's condition and circumstances at the time the request is made.

(3) For those individuals who are not exempt, the assessment procedures vary depending on the individual's condition and the setting the individual is in at the time the request is made. These are as follows:

(a) Hospitalized individuals.

(i) Confirmation that the request for an assessment was submitted shall be provided by the hospital to the receiving NF as documentation that the individual has fulfilled the assessment requirements which must be met prior to the time of admission. This confirmation may be a copy of a form that was FAXed to the hospital by ODHS or its designee containing confirmation generated by a FAX machine which includes the date, time, and FAX number, printed on the FAXed pages, or a copy of a confirmation sheet which the hospital's FAX machine produced when the request was FAXed to ODHS or its designee, or a rubber stamped impression on the hospital transfer/discharge form or hospital continuity of care form, either of which must state that the request was made, and the date and time of the request and the signature of the person who made the request.

(ii) The hospitalized individual who is not exempt from the assessment process may be admitted to a NF after the NF receives the confirmation that the assessment request has been made and that the individual has met any applicable PASARR requirements set forth in rules 5101:3-3-151 or 5101:3-3-152 of the Administrative Code. That is, the individual does not have to wait until the assessment process set forth in paragraph (D)(3)(a)(iii) of this rule is completed, but the individual may have to wait until a PASARR determination has been made.

(iii) After receiving the assessment request, ODHS or its designee shall conduct a paper review. The paper review must be completed not later than two working days after the individual or the individual's representative notifies ODHS or its designee that a bed is available in a NF and/or requests an assessment. If any of the criteria set forth in paragraphs (D)(3)(a)(iii)(a) to (D)(3)(a)(iii)(c) of this rule are met, a delayed in-person assessment must also be completed as soon as is practical, but not more than one hundred eighty days following the date of admission to the NF, unless the individual is subsequently determined to be exempt in accordance with paragraphs (C)(2)(b)(i) to (C)(2)(b)(iii) of this rule.

(a) If the individual requires skilled nursing or skilled rehabilitation services (as defined in rule 5101:3-3-05 of the Administrative Code) and is expected to continue to need those services;

(b) If the assessment request contains insufficient information for making the required determinations; or

(c) If the individual does not appear to meet the non-financial medicaid level of care criteria for at least an intermediate level of care (set forth in rule 5101:3-3-06 of the Administrative Code).

(b) Individuals seeking emergency placement.

(i) ODHS or its designee shall determine whether the individual has an emergency need for NF placement as soon as possible, but not later than one working day after the request for an assessment is received; and

(a) If the individual is determined not to have an emergency need for NF services, the assessment procedures for individuals in community/other settings shall be followed (as set forth in paragraph (D)(3)(c) of this rule); or

(b) If the individual is determined to have an emergency need:

(i) ODHS or its designee shall notify the receiving NF of the date and time the assessment request was submitted, that the individual has been determined to have an emergency need, and that the individual has fulfilled the assessment requirements which must be met prior to the time of admission.

(ii) An individual with an emergency need for NF services may be admitted to a NF after the NF receives notices that the individual has fulfilled the assessment requirements which must be met prior to admission to the NF, and that the individual has met any applicable PASARR requirements set forth in rule 5101:3-3-151 of the Administrative Code. That is, the individual does not have to wait until the assessment process for

individuals with emergency needs (set forth in paragraph (D)(3)(b)(i)(b)(iii) of this rule) is completed, but may have to wait until a PASARR determination has been made.

(iii) ODHS or its designee shall conduct a paper review not later than one working day after the individual or the individual's representative notifies ODHS or its designee that a bed is available in a NF and/or requests an assessment, whichever is earlier. A delayed in-person assessment must also be completed as soon as it is practical but not later than a maximum of one hundred eighty days after the date of admission to the NF, unless the individual is subsequently determined to be exempt in accordance with paragraphs (C)(2)(b)(i) to (C)(2)(b)(iii) of this rule.

(c) Community/other settings.

(i) An individual who is not hospitalized, does not have an emergency need for NF services, and is not already residing in a NF is required to have both a paper review and an in-person assessment prior to admission to a NF, unless the individual is determined during the assessment to be exempt in accordance with paragraphs (C)(2)(b)(i) to (C)(2)(b)(iii) of this rule.

(ii) ODHS or its designee must complete the entire assessment process not later than five calendar days after the individual or individual's representative notifies ODHS or its designee that a bed is available in a NF and/or requests an assessment, whichever is earlier.

(4) ODHS or its designee must provide written information regarding the assessment process to an individual or representative of an individual who was admitted to a NF under the conditional exemption specified in paragraph (C)(2)(a)(v) of this rule. This information must include an overview of the potential benefits of having an assessment and provide the individual or individual's representative with the opportunity to request an assessment. The information must be mailed to the individual not later than five working days after ODHS or its designee receives notification from the NF.

(5) Current NF residents.

(a) A NF resident who was admitted after the effective date of this rule with a conditional exemption specified in paragraphs (C)(2)(a)(i) to (C)(2)(a)(iv) of this rule must undergo the assessment process if either of the following applies:

(i) An individual was admitted to a NF under a conditional exemption that presumed a time-limited stay and wants or needs to stay beyond the specified number of days; or

(ii) An individual was admitted to a NF under a conditional exemption that presumed the individual's physical or mental condition required NF services, and at the time of admission the NF discovers that the individual's medical condition has improved substantially.

(b) The NF must, as the individual's representative, notify ODHS or its designee that the individual's exemption has expired, and request an assessment as follows:

(i) The assessment must be requested not later than the date on which the exemption expires;

(ii) The assessment may be requested by phone or FAX;

(iii) The assessment request must include the identifying information required for individuals in all settings (as specified in paragraph (D)(2)(a) of this rule), an explanation of the specific type of exemption the individual had, and the reason the individual wants or needs to remain in the NF.

(c) ODHS or its designee must conduct both a paper review and an in-person assessment for the individual, unless the individual is subsequently determined to be exempt in accordance with paragraphs (C)(2)(b)(i) to (C)(2)(b)(iii) of this rule. ODHS or its designee must complete the assessment process not later than five calendar days after receiving notice from the NF that the exemption has expired.

(E) Information to be collected during the assessment process. When conducting the assessment process under this rule, ODHS or its designee shall obtain and record information necessary to make all of the determinations and recommendations that are required or requested in accordance with paragraph (B)(9) and, if applicable, paragraph (B)(11) of this rule, for each individual that is assessed. In addition to the

information which must be provided at the time the assessment is requested, ODHS or its designee may request, and the individual or individual's representative must, to the best of his or her ability, provide the following information:

(1) Information necessary for determining the need for NF services, including:

(a) Oral or written statements and supporting documentation regarding the individual's ability to perform each activity of daily living (ADL) independently, with supervision, or with assistance (as these are defined in rule 5101:3-3-06 of the Administrative Code);

(b) Oral or written statements and supporting documentation regarding whether, due to a cognitive impairment other than MR/DD (as defined in rule 5101:3-3-151 of the Administrative Code), the individual requires supervision to prevent harm; and if so, whether that supervision is required on a twenty-four-hour-a-day basis or less than twenty-four-hours-a-day;

(c) Oral or written statements and supporting documentation regarding the individual's ability to perform self-administration of medications independently, with supervision, or with assistance (as these are defined in rule 5101:3-3-06 of the Administrative Code);

(d) A list of the individual's current diagnoses (as defined in rule 5101:3-3-151 of the Administrative Code);

(e) If applicable, current physician's orders, or a statement regarding the individual's current need for skilled nursing or skilled rehabilitation services as defined in rule 5101:3-3-05 of the Administrative Code;

(f) Oral or written statements regarding the individual's ability to perform each instrumental activity of daily living (IADL) independently, with supervision, or with assistance (as these are defined in rule 5101:3-3-08 of the administrative code).

(2) Information necessary for determining the most appropriate source or sources of long-term care for the individual, including:

(a) A list and explanation of any sources of formal and/or informal support currently utilized and/or available to the individual outside of the NF;

(b) An oral or written statement regarding the individual's desire to remain in

the NF setting indefinitely following admission, to return home, or to go to another type of setting;

(c) An oral or written statement from the individual's attending physician regarding the likelihood that the individual's need for services at the level available in a NF will continue;

(d) A list of any other long-term care services the individual has received in the past;

(3) Any other information the assessor needs in order to make the required determinations and recommendations.

(F) Determination of need for NF services. As part of each assessment conducted under this rule, ODHS or its designee shall determine the individual's need for NF services.

(1) ODHS or its designee shall make this determination by comparing the information provided by the individual or the individual's representative regarding the individual's physical, mental, and psychosocial needs with the nonfinancial eligibility criteria set forth in rules 5101:3-3-05, 5101:3-3-06, 5101:3-3-07, and 5101:3-3-08 of the Administrative Code.

(2) Individuals shall be determined to have a need for NF services if they meet at least the minimum nonfinancial criteria for either an intermediate level of care or a skilled level of care (as set forth in rules 5101:3-3-05 and 5101:3-3-06 of the administrative code).

(3) ODHS or its designee shall explain to the individual or the individual's representative the significance of the determination that the individual either does or does not have a need for NF services, including the possible effect on the individual's future eligibility for medicaid.

(G) Recommendation of most appropriate source or sources of long-term care. As part of each in-person assessment that is completed under this rule, ODHS or its designee shall recommend the most appropriate source or sources of long-term care for the individual.

(1) To make this recommendation, ODHS or its designee shall evaluate the information obtained in accordance with paragraphs (D) and (E) of this rule and determine which of the available alternatives, or combinations of available alternatives, will meet the individual's needs in a manner which best

promotes the individual's health and safety, and is most acceptable to the individual or, where applicable, to the individual's representative.

(2) If an individual needs NF services (in accordance with paragraph (F) of this rule), ODHS or its designee may recommend that a NF is the most appropriate source of long-term care or may recommend that alternative sources of long-term care are more appropriate than admission to a NF. The recommendation shall be based on the evaluation specified in paragraph (G)(1) of this rule.

(3) If an individual does not need NF services (in accordance with paragraph (F) of this rule), ODHS or its designee must not recommend admission to a NF as an appropriate source of long-term care.

(a) If an appropriate alternative source or sources of long-term care are available to the individual, ODHS or its designee must recommend them as the most appropriate source of long-term care.

(b) If appropriate alternative sources of long-term care are not available to the individual, the notice of the recommendation (as specified in paragraph (I) of this rule) shall include a statement that there are no appropriate sources of long-term care available to the individual.

(H) Planning assistance. If ODHS or its designee determines during an assessment that an alternative source of long-term care is appropriate for the individual, it may develop a plan in consultation with the individual and/or the individual's representative for the provision of home and community-based services to the individual. If such a plan is developed, ODHS or its designee shall implement the plan agreed to by the individual or the individual's representative not later than one working day after the plan is agreed to, unless the individual or the individual's representative agrees to a later implementation date.

(I) Required notification.

(1) ODHS or its designee shall provide written notice of all required determinations and recommendations to the assessed individual and, where applicable, the individual's representative, and to the receiving NF, if known, not later than the time the determinations and/or recommendations are required to be completed (in accordance with paragraph (D) of this rule).

(2) All required notices shall explain the basis for the determination and/or recommendation, and the availability of the complaint resolution process set

forth in paragraph (J) of this rule.

(3) If ODHS or its designee determines that an alternative source of long-term care is the most appropriate source of long-term care for an individual, the notice shall include all of the following:

(a) Possible sources of financial assistance for the alternative source of long-term care;

(b) Information about providers of alternative long-term care services in the geographic area requested by the individual or representative, including but not limited to addresses, telephone numbers, types of services provided, payment sources accepted, and placement availability; and

(c) A statement to the effect that (unless the individual also received a PASARR determination that he or she does not need NF services in accordance with rules 5101:3-3-151 and/or 5101:3-3-152 of the Administrative Code) the individual is not required by this rule to seek an alternative source of long-term care and may be admitted to or continue to reside in a NF even though an alternative source of long-term care is available or the individual has been determined in accordance with this rule not to need NF services.

(4) If ODHS or its designee determines that an individual does not need NF services, the notice shall include an explanation of the significance of the determination, including the possible effect on the individual's future eligibility for medicaid.

(J) Complaint resolution.

(1) Any individual or authorized representative may file a complaint regarding the assessment process.

(a) The individual or representative shall initiate the complaint by calling or writing to the agency that performed the assessment within fifteen calendar days from the date of the assessment.

(b) The agency shall prepare a written summary documenting the nature of the complaint, the name of the complainant, and the date of the assessment for any verbal complaints that are received.

(2) Within five working days of the receipt of the complaint, the agency that

performed the assessment shall schedule an informal fact-finding conference with the individual or authorized representative at a mutually agreed upon time.

(a) The conference may be conducted in person or over the phone.

(b) The individual or representative shall be notified of the date, time, and place of the conference.

(c) The fact-finding conference shall be held no more than fifteen working days from the date on which the agency received the complaint.

(d) The agency that performed the assessment shall conduct the informal fact-finding conference.

(i) The purpose of the fact-finding conference is to determine the circumstances that gave rise to the complaint, the specific problems that the complainant wishes to have addressed, and to identify possible actions that may be initiated by the agency to resolve the complaint.

(ii) The fact-finding conference shall be conducted by the director or designee of the agency.

(iii) The agency shall issue to the individual or representative a written summary of the fact-finding conference, including any resolutions agreed upon, within five working days from the date of the conference.

(3) The individual or representative may pursue the complaint to a higher level if dissatisfied with the outcome of the fact-finding conference.

(a) The individual or representative shall notify ODHS or its designee in writing to request further review of the complaint within fifteen calendar days of the mailing date of the fact-finding conference summary.

(b) ODHS or its designee shall schedule a review conference within five working days of receiving the request for further review of the complaint.

(i) The review conference may be conducted in person or over the phone.

(ii) The individual or representative shall be notified of the date, time, and place, if applicable, of the review conference.

(iii) The review conference shall be held within fifteen working days of the date ODHS or its designee receives the request to further review the complaint.

(iv) The agency that conducted the assessment shall forward a copy of the written summary of the informal fact-finding conference to ODHS or its designee upon request.

(v) The review conference shall explore the validity of the complaint and proposed means of resolving the issues raised in the complaint, if applicable.

(vi) At the conclusion of the review conference a written summary shall be prepared. The individual or representative shall receive a copy of the written summary within thirty days of the date of the review conference.

(vii) A copy of the written summary shall be forwarded to the ODHS section responsible for oversight of the preadmission review process.

(c) If a review conference under paragraph (J)(3) of this rule is conducted by an ODHS designee, and if the individual or individual's representative is dissatisfied with the outcome of the review conference, the individual or the individual's representative may pursue the complaint with the ODHS section that is responsible for oversight of the preadmission review process. In such cases, the provisions set forth in paragraphs (J)(3)(b) to (J)(3)(b)(vii) shall apply to the review conference held with ODHS.

(K) Certification of assessors. Pursuant to section 5101.752 of the Revised Code, ODHS shall certify registered nurses (RNs) licensed under Chapter 4723. of the Revised Code and social workers (SWs) licensed under Chapter 4757. of the Revised Code to perform all assessments conducted pursuant to the requirements set forth in this rule. No assessment shall be conducted by any assessor who has not received certification prior to the performance of the assessment.

(1) If ODHS designates another agency to perform the certification process, the designee shall not subcontract those certification responsibilities to any agency authorized to perform assessments.

(2) ODHS or its designee shall issue a certificate of successful completion of the requirements for certification. The certificate shall indicate the name of the certified RN or SW assessor, the assessor's professional title, the date the requirements for certification were met, and the date the certificate was issued.

(3) In order to receive certification as an assessor, the RN or SW must have completed eighty clock hours of professional development to include geriatric long-term care training provided or arranged for by ODHS or its designee, and either:

(a) Possess a minimum of twelve total months of experience in home health care, medical social work, and/or geriatrics prior to certification; or

(b) Have been employed by ODHS, its designee, or any contracted entity, as an assessor or to conduct screening and evaluations in accordance with rules 5101:3-3-15 of the Administrative Code, prior to the effective date of this rule.

(4) To maintain certification, the assessor must complete fifteen clock hours in programs which transmit knowledge relevant to the duties of the assessor over each two year period of time, beginning with the date of certification.

(5) In the event that an assessor fails to maintain certification in accordance with paragraph (K)(4) of this rule, the assessor shall cease conducting assessments until such time as the requirement set forth in paragraph (K)(4) of this rule has been met.

Effective:

R.C. 119.032 review dates: 06/14/2007

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5101.75, 5101.752
Rule Amplifies:	5101.75, 5101.751 to 5101.753, 5101.204, 5111.231
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