3701-17-10 RESIDENT ASSESSMENTS; TUBERCULOSIS TESTING.

(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; 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) For an individual beginning residence in the nursing home after the effective date of this rule, the comprehensive assessment shall be performed within fourteen days after the individual begins to reside in the facility.

(2) For a resident living in the nursing home on the effective date of this rule, a comprehensive assessment shall be performed within ninety days of the effective date of this rule. If the resident had a comprehensive assessment meeting the requirements of paragraph (E) of this rule no more than three months before the effective date of this rule, the nursing home is not required to perform another comprehensive assessment;

(3) 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;

(2) Psychological, and mental retardation and developmental diagnoses and history, if applicable;

(3) Health history and physical, including cognitive functioning, and sensory and physical impairments;

(4) 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) Prescription and over-the-counter medications;

(6) Nutritional requirements and need for assistance and supervision of meals;

(7) Height and weight;

(8) A functional assessment which evaluates the resident’s ability to perform activities of daily living;

(9) Vision, dental and hearing function; and

(10) 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;

(4) Prescription and over-the-counter medications;

(5) A functional assessment as described in paragraph (E)(8) of this rule;

(6) Any changes in the resident’s psycho-social status or preferences as described in paragraph (E)(4) of this rule; and

(7) Any changes in cognitive, communicative or hearing abilities or mood and behavior patterns.

... (I) Nursing homes that conduct resident assessments in accordance with 42 C.F.R. 483.20, using the resident assessment instrument specified by rule 5101:3-3-40 of the Administrative Code, shall be considered in compliance with paragraphs (D), (E) and (F) of this rule.

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3701-17-14 PLAN OF CARE; TREATMENT AND CARE: DISCHARGE PLANNING.

(A) The nursing home shall assure that development of a plan of care is initiated upon admission and completed and implemented for each resident within seven days of completion of the initial comprehensive assessment, required by rule 3701-17-10 of the Administrative Code. The plan shall be prepared by an interdisciplinary team that includes the attending physician or the attending advance practice nurse, or both, a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the needs of the resident and, to the extent practicable, the resident and the family or sponsor of the resident unless the resident does not wish them to be involved.

(1) The plan of care shall be consistent with the comprehensive assessment with recognition of the capabilities and preferences of the resident, and shall contain a written description of what services, supplies and equipment, are needed, when, how often, and by whom services, supplies and equipment will be provided and the measurable goals or outcomes.

(2) The plan of care shall be reviewed whenever there is a change in the resident’s condition and the needs of the resident warrants a change in the services, supplies or equipment to be provided, and at least quarterly, by the nursing home and the resident, or sponsor, or both, and shall be updated, as appropriate.

(3) Each resident shall have access to his or her assessment and plan of care at any time upon request.
(B) All skilled nursing care shall be provided by a nurse except a nurse may delegate certain tasks as authorized by Chapter 4723. of the Revised Code in accordance with the applicable rules adopted under that chapter.

(C) The nursing home shall provide all residents who cannot give themselves adequate personal care with such care as is necessary to keep them clean and comfortable.

(D) All services, supplies and equipment provided or arranged for by the nursing home shall be provided, in accordance with acceptable standards of practice and the written plans of care, by individuals who meet the applicable qualifications of this chapter.

(E) The nursing home shall assure that all residents receive adequate, kind, and considerate care and treatment at all times.

(F) The nursing home shall transfer and discharge a resident in an orderly and safe manner in accordance with Chapter 3701-61 of the Administrative Code. In anticipation of a discharge, the nursing home shall prepare the following information to be shared with appropriate persons and agencies upon consent of the resident, except the resident's right to refuse release of such information does not apply in the case of transfer to another home, hospital, or health care system, if the release is required by law or rule or by a third-party payment contract:

(1) An updated assessment that addresses the criteria outlined in paragraph (E) of rule 3701-17-10 of the Administrative Code and accurately identifies the resident's condition and continuing care need at the time of transfer and discharge;

(2) A plan that is developed with the resident and family members, with the consent of the resident, that describes what services, supplies and equipment are needed, how needed services, supplies and equipment can be accessed, and how to coordinate care if multiple care givers are involved. The plan shall also identify need for the resident and care givers' education, including resident and care giver instruction on the proper use of grab rails and other safety devices, and any accommodations to the physical environment to meet the needs of the resident; and

(3) The nursing home shall, with the consent of the resident, arrange or confirm the services, equipment and supplies in advance of discharge or transfer of the resident.

(G) If the nursing home resident is also a patient of a hospice care program, the nursing home shall communicated and work with the hospice in development and implementation of a coordinated plan of care between the nursing home and hospice. This coordinated plan of care shall:

(1) Reflect the hospice philosophy;

(2) Be based on the assessment of the resident and the unique living situation in the nursing home; and

(3) Identify the services, supplies, and equipment to be provided by the nursing home and those to be provided by the hospice care program. The nursing home shall allow the hospice care program to retain professional management of the resident's plan of care related to the
resident’s terminal illness pursuant to Chapter 3701-19 of the Administrative Code as long as the resident is receiving hospice care. The nursing home shall take directions from the hospice regarding implementation of the coordinated plan of care related to the resident’s terminal illness.

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