Ohio Administrative Code

Rule 3701-17-10 Resident assessments; advanced care planning.

Effective: July 17, 2025

(A) Each nursing home, in accordance with this rule, will conduct awritten 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 needed and the professional's scope of practice, as defined by applicable law, and be based on personal observation and judgment. This paragraph does not forbid 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 will 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 will have been updated no more than five days prior to admission.

(C) Upon admission, the nursing home will 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;

(3) Presenting physical, psycho-social and mental status;

(4) Ability to conduct the activities of daily living;

(5) Head to toe skin status assessment;

(6) Risk for elopement; and

(7) Preferences related to discharge timeline.

The nursing home will 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 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 will obtain any special equipment, furniture or staffing that is needed to address the presenting needs of the resident. The nursing home will develop a baseline care plan to meet the specific needs of each resident identified through this admission assessment until such time as the care plan obligated by rule 3701-17-14 of the Administrative Code is developed and implemented.

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

(1) The comprehensive assessment will be performed within fourteen days after the individual begins to reside in the facility.

(2) Subsequent to the initial comprehensive assessment, a comprehensive assessment will be performed at least annually thereafter. The annual comprehensive assessment will be performed within thirty days of the anniversary date of the completion of the resident's last comprehensive assessment.

(E) The comprehensive assessment will include documentation of the following:

(1) Preferences of the resident including hobbies, usual activities, bathing, sleeping patterns, socialization and religious;

(2) Medical diagnoses;

(3) Psychological, and intellectual disabilities and developmental diagnoses and history, if applicable;

(4) Health history and physical, including cognitive functioning, sensory and physical impairments, and the risk of falls;

(5) Psycho-social history;

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

(7) Nutritional and dietary needs, food preferences, and need for any adaptive equipment, and needs for assistance and supervision of meals;

(8) Height, weight and history of weight changes;

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

(10) The resident's risk of falls;

(11) Vision, dental and hearing function, including the need for eyeglasses or other visual aids;

(12) Dental function; including the need for dentures or partial dentures;

(13) Hearing function, including the need for hearing aids or other hearing devices;

(14) Head to toe skin status assessment;

(15) Ability to conduct activities of daily living;

(16) Any other alternative remedies and treatments the resident is taking or receiving; and

(17) Risk of elopement.

The documentation needed by this paragraph will 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 will periodically reassess each resident, at minimum, every three months, unless a change in the resident's physical or mental health or cognitive abilities necessitates an assessment sooner. The nursing home will update and revise the assessment to reflect the resident's current status. This periodic assessment will include documentation of at least the following:

(1) Changes in medical diagnoses;

(2) Updated nutritional needs and needs for assistance and supervision of meals;

(3) Height, weight and history of weight changes;

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

(5) A functional assessment as described in paragraph (E)(9) 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)(5) of this rule;

(8) Any changes in cognitive, communicative or hearing abilities or mood and behavior patterns;

(9) Head to toe skin assessment;

(10) Ability to conduct activities of daily living; and

(11) Risk of elopement.

(G) Nursing homes that conduct resident assessments in accordance with 42 C.F.R. 483.20, using the resident assessment instrument specified by rule 5160-3-43.1 of the Administrative Code, will be considered in compliance with paragraphs (D), (E) and (F) of this rule.

(H) Each nursing home will participate in advance care planning with each resident or the resident's sponsor if the resident is unable to participate,on admission to the nursing home and thereafter, for each resident, on a quarterly basis 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.

(I) If the nursing home has a designated smoking area, the nursing home will include the following in the assessment conducted in accordance with paragraphs (D), (E), and (F) of this rule for each resident that smokes;

(1) An assessment of the resident's ability to smoke without supervision and without a smoking apron; and

(2) An evaluation of and changes to cognitive, communicative, mood, or behavioral patterns associated with smoking.