

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name: _____ Medical Record No.: **Attachment 4.19D**

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- Check if RAP is triggered.
For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
 - Describe:
 - Nature of the condition (may include presence or lack of objective data and subjective complaints).
 - Complications and risk factors that affect your decision to proceed to care planning.
 - Factors that must be considered in developing individualized care plan interventions.
 - Need for referrals/further evaluation by appropriate health professionals.
 - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
 - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
- Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
- For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	<input type="checkbox"/>		<input type="checkbox"/>
2. COGNITIVE LOSS	<input type="checkbox"/>		<input type="checkbox"/>
3. VISUAL FUNCTION	<input type="checkbox"/>		<input type="checkbox"/>
4. COMMUNICATION	<input type="checkbox"/>		<input type="checkbox"/>
ADL FUNCTIONAL/ REHABILITATION POTENTIAL	<input type="checkbox"/>		<input type="checkbox"/>
6. URINARY INCONTINENCE AND INDWELLING CATHETER	<input type="checkbox"/>		<input type="checkbox"/>
7. PSYCHOSOCIAL WELL-BEING	<input type="checkbox"/>		<input type="checkbox"/>
8. MOOD STATE	<input type="checkbox"/>		<input type="checkbox"/>
9. BEHAVIORAL SYMPTOMS	<input type="checkbox"/>		<input type="checkbox"/>
10. ACTIVITIES	<input type="checkbox"/>		<input type="checkbox"/>
11. FALLS	<input type="checkbox"/>		<input type="checkbox"/>
12. NUTRITIONAL STATUS	<input type="checkbox"/>		<input type="checkbox"/>
13. FEEDING TUBES	<input type="checkbox"/>		<input type="checkbox"/>
14. DEHYDRATION/FLUID MAINTENANCE	<input type="checkbox"/>		<input type="checkbox"/>
15. DENTAL CARE	<input type="checkbox"/>		<input type="checkbox"/>
16. PRESSURE ULCERS	<input type="checkbox"/>		<input type="checkbox"/>
17. PSYCHOTROPIC DRUG USE	<input type="checkbox"/>		<input type="checkbox"/>
18. PHYSICAL RESTRAINTS	<input type="checkbox"/>		<input type="checkbox"/>

Signature of RN Coordinator for RAP Assessment Process

2.
Month Day Year

Signature of Person Completing Care Planning Decision

Month Day Year

TN # 98-18 APPROVAL DATE SEP 29 1998
MDS 2.0 01/30/98
SUPERSEDES
TN # 94-24 EFFECTIVE DATE 7/1/98

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Attachment 4-19D
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Key:
 ● = One item required to trigger
 ● = Two items required to trigger
 * = One of these three items, plus at least one other item required to trigger
 @ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Involving Catheter	Psychosocial and Involving Catheter	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints		
B2a	Short term memory	1	●																			B2a	
B2b	Long term memory	1	●																				B2b
B4	Decision making	1,2,3	●																				B4
B4	Decision making	1,2,3	●																				B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3		●																			C1
C2	Understood by others	1,2,3		●																			C2
C6	Understand others	1,2,3		●																			C6
C7	Change in communication	2		●																●			C7
D1	Vision	1,2,3		●																			D1
D2	Side vision problem	1,2,3		●																			D2
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2								●													E1a to E1p
E1b	Repetitive behavior	1,2																		●			E1b
E1c	Withdrawal from activities	1,2								●													E1c
E2	Mood persistence	1,2								●													E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3												●									E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3									●												E4aA - E4eA
E5	Change in behavioral symptoms	1									●												E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1a	Exaggerated responses	1									●												F1a
F2a to F2d	Unsettled relationships	1									●												F2a to F2d
F3a	Strong or weak roles	1									●												F3a
F3b	Lost roles	1									●												F3b
F3c	Overlapping interests	1									●												F3c
G1aA - G1jA	ADL self-performance	1,2,3,4				●																	G1aA - G1jA
G1eA	Bed mobility	1,2,3,4				●														●			G1eA
G2A	Bathing	1,2,3,4				●																	G2A
G3	Balance while sitting	1,2,3				●														●			G3
G6a	Bedfast	1																		●			G6a
G8aA	Resident self-behavior capable	1				●																	G8aA
H1a	Bowel incontinence	1,2,3,4																		●			H1a
H1b	Bladder incontinence	1,2,3,4																		●			H1b
H2b	Constipation	1																			●		H2b
H2b	Fecal impaction	1																			●		H2b
H3c,d,e	Catheter use	1																					H3c,d,e
H3g	Use of catheters	1																					H3g
I1i	Hypotension	1																			●		I1i
I1j	Peripheral vascular disease	1																			●		I1j
I1ee	Depression	1																			●		I1ee
I1f	Cataracts	1		●																			I1f
I1g	Glaucoma	1		●																			I1g
I2	HIV	1																					I2
I3	Dehydration diagnosis	2,7,8,5																			●		I3
J1a	Weight fluctuation	1																			●		J1a
J1c	Dehydrated	1																			●		J1c
J1d	Unsunbathed	1																			●		J1d
J1f	Dizziness	1												●									J1f
J1h	Fever	1																			●		J1h
J1i	Hallucinations	1																				●	J1i
J1j	Oral bleeding	1																				●	J1j
J1k	Lung aspirations	1																				●	J1k
J1m	Syncope	1																				●	J1m

TN # 98-10 APPROVAL DATE 01/30/98
 SUPERSEDES
 TN # 94-24 EFFECTIVE DATE 7/1/98

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Attachment 4.19D
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- Key:
 ● = One item required to trigger
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Proceed to RAP Review once triggered

MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⊕	ADL-Maintenance Trigger B ⊕	Urinary Incontinence and Inwelling Catheter	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
J1r	Unsteady gait																				
J4a	Fall												●								●
J4b	Fall												●								●
J4c	Hip fracture																				●
K1b	Swallowing problem																				●
K1c	Altered gag																				●
K3a	Weight loss													●							
K3b	Feeding problem													●							
K4a	Leave 25% food													●							
K4c	Leave 25% food													●							
K5a	Parenteral feeding													●							
K5b	Feeding tube													●							
K5c	Mechanically assisted													●							
K5d	Syringe feeding													●							
K5e	Therapeutic diet													●							
L1a,c,d,e	Dental																				
L1	Oral hygiene																				
M2a	Pressure ulcer													●							
M2b	Pressure ulcer													●							
M3	Previous pressure ulcer																				
M4a	Wound/lacer/ulcer																				
N1a	Awake morning																				
N1b	Involved in activities																				
N2	Involved in activities																				
N5a,b	Prefer change in daily routine																				
O4a	Antipsychotics																				*
O4b	Antipsychotics																				*
O4c	Antidepressants																				*
O4e	Diuretic																				
P4c	Trunk restraint																				●
P4d	Trunk restraint																				●
P4e	Limb restraint																				●
P4f	Chair restraints																				●

TN # 98-10 APPROVAL DATE SEP 29 1998
 SUPERSEDES
 TN # 94-4 EFFECTIVE DATE 7/1/98

Numeric Identifier _____

MINIMUM DATA SET (MDS) — VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

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REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1. RESIDENT NAME <input type="checkbox"/>	a. (First) _____ b. (Middle Initial) _____ c. (Last) _____ d. (Jr/Sr) _____
2. GENDER <input type="checkbox"/>	1. Male _____ 2. Female _____
3. BIRTHDATE <input type="checkbox"/>	Month: <input type="text"/> <input type="text"/> Day: <input type="text"/> <input type="text"/> Year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. RACE/ETHNICITY <input type="checkbox"/>	1. American Indian/Alaskan Native _____ 2. Asian/Pacific Islander _____ 3. Black, not of Hispanic origin _____ 4. Hispanic _____ 5. White, not of Hispanic origin _____
5. SOCIAL SECURITY AND MEDICARE NUMBERS <input type="checkbox"/> [C in 1 st box if non med. no.]	a. Social Security Number: <input type="text"/> <input type="text"/> b. Medicare number (or comparable railroad insurance number): <input type="text"/>
6. FACILITY PROVIDER NO. <input type="checkbox"/>	a. State No. _____ b. Federal No. _____
7. MEDICAID NO. <input type="checkbox"/> ["+" if pending, "N" if not a Medicaid recipient]	_____
8. REASONS FOR ASSESSMENT <input type="checkbox"/>	(Note—Other codes do not apply to this form) a. Primary reason for assessment: 9. Reentry _____
9. SIGNATURES OF PERSONS COMPLETING FORM	
Signatures _____	Title _____ Sections _____ Date _____
b. _____	Date _____
c. _____	Date _____

SECTION S. STATE OF OHIO SUPPLEMENT

10. MEDICAID MCO <input type="checkbox"/>	Resident is enrolled in a Medicaid Managed Care Organization 0. No _____ 1. Yes _____
11. MEDICARE MCO <input type="checkbox"/>	Resident is enrolled in a Medicare Managed Care Organization 0. No _____ 1. Yes _____
12. RESIDENT IDENTIFIER CODE <input type="checkbox"/>	Record alternate resident identifier code if resident does not have a Social Security Number. See instructions. (If SSN is coded in Section AA.5a, skip) <input type="text"/> <input type="text"/>

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a. DATE OF REENTRY <input type="checkbox"/>	Date of reentry: _____ Month: <input type="text"/> <input type="text"/> Day: <input type="text"/> <input type="text"/> Year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4b. ADMITTED FROM (AT REENTRY) <input type="checkbox"/>	1. Private home/apl. with no home health services _____ 2. Private home/apl. with home health services _____ 3. Board and care/assisted living/group home _____ 4. Nursing home _____ 5. Acute care hospital _____ 6. Psychiatric hospital, MR/DD facility _____ 7. Rehabilitation hospital _____ 8. Other _____
6. MEDICAL RECORD NO. <input type="checkbox"/>	_____

⊙ = Key items for computerized resident tracking

= When box blank, must enter number or letter a. = When letter in box, check if condition applies

TN # 98-10 APPROVAL DATE SEP 29 1998
SUPERSEDES TN # 94-24 EFFECTIVE DATE 7/1/98

Replaces Rule 5101:3-3-40

Effective date: JUL 0 1 1998
Certification: *Carol R. Taylor*
JUN 1 9 1998
Date

Promulgated under: Revised Code Chapter 119.

Statutory Authority: Revised Code Sections 5111.02, 5111.231.

Rule Amplifies: Revised Code Sections 5111.01, 5111.02, 5111.231.

Prior Effective Dates: 10/1/92 (Emer.), 12/31/92, 4/15/93 (Emer.), 7/1/93, 12/1/93 (Emer.), 3/17/94, 7/1/94 (Emer.), 9/30/94

Review date: July 1, 2003

TN # 98-10 APPROVAL DATE SEP 29 1998
SUPERSEDES
TN # 94-24 EFFECTIVE DATE 7/1/98

5101:3-3-497
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5101:3-3-497 METHOD OF DISTRIBUTION OF FUNDS DEPOSITED IN THE HOME AND COMMUNITY BASED SERVICES FOR THE AGED FUND.

ALL PROCEEDS FROM COLLECTION OF THE FRANCHISE FEE ON HOSPITALS AND NURSING HOMES SHALL BE DEPOSITED IN THE "HOME AND COMMUNITY-BASED SERVICES FOR THE AGED FUND" AND SHALL BE USED TO FUND PROGRAMS AS FOLLOWS:

- (A) FIRST, TO FUND THE MEDICAL ASSISTANCE PROGRAM ESTABLISHED UNDER CHAPTER 5111. OF THE REVISED CODE; AND
- (B) SECOND, TO FUND THE PASSPORT PROGRAM ESTABLISHED UNDER SECTION 173.40 OF THE REVISED CODE; AND
- (C) THIRD, TO FUND SERVICES TO RESIDENTS OF ASSISTED LIVING FACILITIES LICENSED UNDER SECTION 3726.04 OF THE REVISED CODE WHO ARE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER CHAPTER 5111. OF THE REVISED CODE AND WHO ARE DISABLED OR SIXTY-FIVE YEARS OF AGE OR OLDER; AND
- (D) LASTLY, TO FUND THE OPTIONAL STATE SUPPLEMENT PROGRAM ESTABLISHED UNDER SECTION 173.35 OF THE REVISED CODE.

EFFECTIVE DATE: _____

CERTIFICATION: _____

DATE

PROMULGATED UNDER: RC CHAPTER 119.
STATUTORY AUTHORITY: RC SECTIONS 3721.511, 3721.58
RULE AMPLIFIES: RC SECTIONS 3721.50 TO 3721.58
PRIOR EFFECTIVE DATE: 9/30/93(EMER)

TNS # 94-07 APPROVAL DATE APR 28 1994
SUPERSEDES
TNS # 93-024 EFFECTIVE DATE 10/1/94

5101:3-3-498
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5101:3-3-498 ENFORCEMENT OF FRANCHISE PERMIT FEE PROGRAM.

- (A) ODHS MAY MAKE ANY INVESTIGATION IT CONSIDERS APPROPRIATE TO FULFILL THE RESPONSIBILITIES OF RULES 5101:3-3-492 TO 5101:3-3-499 OF THE ADMINISTRATIVE CODE.
- (B) IN ACCORDANCE WITH SECTION 3721.56, AT THE REQUEST OF ODHS, THE ATTORNEY GENERAL SHALL AID IN ANY SUCH INVESTIGATION AND SHALL INSTITUTE AND PROSECUTE ALL ACTIONS FOR ENFORCEMENT OF RULES 5101:3-3-492 TO 5101:3-3-498 OF THE ADMINISTRATIVE CODE, EXCEPT WHERE THE ATTORNEY GENERAL HAS REQUESTED THE COUNTY PROSECUTOR IN THE COUNTY IN WHICH THE HOME OR HOSPITAL IS LOCATED, TO INSTITUTE AND PROSECUTE ALL NECESSARY ACTION AGAINST A NURSING HOME OR HOSPITAL THAT HAS FAILED TO COMPLY WITH RULES 5101:3-3-492 TO 5101:3-3-498 OF THE ADMINISTRATIVE CODE.

EFFECTIVE DATE: _____

CERTIFICATION: _____

DATE

PROMULGATED UNDER: RC CHAPTER 119.
STATUTORY AUTHORITY: RC SECTIONS 3721.511, 3721.58
RULE AMPLIFIES: RC SECTIONS 3721.50 to 3721.58
PRIOR EFFECTIVE DATE: 9/30/93(EMER)

TNS # 94-07 APPROVAL DATE JUN 28 1994
SUPERSEDES
TNS # 93-024 EFFECTIVE DATE 10/1/94

5101:3-3-499
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5101:3-3-499 PROCEDURE FOR TERMINATING THE FRANCHISE PERMIT FEE PROGRAM.

- (A) IF THE UNITED STATES HEALTH CARE FINANCING ADMINISTRATION (HCFA) DETERMINES THAT THE FRANCHISE PERMIT FEE IS AN IMPERMISSIBLE HEALTH CARE RELATED TAX, THE OHIO DEPARTMENT OF HUMAN SERVICES, (ODHS) SHALL TAKE THE FOLLOWING STEPS TO CEASE IMPLEMENTATION OF RULES 5101:3-3-492 TO 5101:3-3-498 OF THE ADMINISTRATIVE CODE.
- (B) ODHS SHALL NOTIFY EACH NURSING HOME OR HOSPITAL, PREVIOUSLY ASSESSED A FRANCHISE PERMIT FEE, OF THE EFFECTIVE DATE OF THE TERMINATION OF THE FRANCHISE FEE PROGRAM, AND WHAT IMPACT THIS CHANGE WILL HAVE ON THEIR FACILITY. THE EFFECTIVE DATE OF THE TERMINATION OF THE PROGRAM WILL BE THE DATE ON WHICH HCFA DETERMINES THAT THE FEE DOES NOT QUALIFY FOR FEDERAL FINANCIAL PARTICIPATION.
- (C) ODHS SHALL CONDUCT AN ACCOUNTING OF THE FUNDS PAID TO OR COLLECTED FROM EACH NURSING HOME OR HOSPITAL ASSESSED A FRANCHISE FEE, FROM THE DATE STIPULATED IN PARAGRAPH (B) OF THIS RULE, AND DO THE FOLLOWING:
- (1) ADJUST THE RATE OF EACH NURSING HOME OR HOSPITAL ASSESSED A FRANCHISE FEE TO REMOVE ANY FUNDING ASSOCIATED WITH THE FRANCHISE FEE PROGRAM.
 - (2) FOR NURSING HOMES OR HOSPITALS WHICH PARTICIPATE IN THE MEDICAID PROGRAM, REFUND, IF NECESSARY, TO EACH NURSING HOME OR HOSPITAL ASSESSED A FRANCHISE PERMIT FEE, THE PORTION OF THE FRANCHISE PERMIT FEE, COLLECTED AFTER THE EFFECTIVE DATE STIPULATED IN PARAGRAPH (B) OF THIS RULE, THAT REPRESENTS FUNDING IN EXCESS OF THAT PROVIDED IN THE NURSING HOME OR HOSPITAL'S RATE FOR FRANCHISE PERMIT FEE PURPOSES.
 - (3) FOR NURSING HOMES OR HOSPITALS THAT DO NOT PARTICIPATE IN THE MEDICAID PROGRAM, REFUND, IF NECESSARY, TO EACH NURSING HOME OR HOSPITAL ASSESSED A FRANCHISE PERMIT FEE, ANY FEE PAID AFTER THE DATE SPECIFIED IN PARAGRAPH (B) OF THIS RULE.
 - (4) COLLECT, IF NECESSARY, AFTER THE EFFECTIVE DATE IN PARAGRAPH (B) OF THIS RULE, FROM EACH NURSING HOME OR HOSPITAL WHICH PARTICIPATES IN THE MEDICAID PROGRAM AND WHO WAS ASSESSED A FRANCHISE PERMIT FEE, ANY FUNDING PREVIOUSLY INCLUDED IN THE RATE OF A NURSING HOME OR HOSPITAL FOR FRANCHISE PERMIT FEE PURPOSES.

TNS # 94-07 APPROVAL DATE JUN 28 1994

SUPERSEDES

TNS # 93-024 EFFECTIVE DATE 10/1/94

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(5) COLLECT, IF NECESSARY, FROM NURSING HOMES OR HOSPITALS THAT DO NOT PARTICIPATE IN THE MEDICAID PROGRAM AND WHO HAVE BEEN ASSESSED A FRANCHISE PERMIT FEE, AFTER THE EFFECTIVE DATE STIPULATED IN PARAGRAPH (B) OF THIS RULE, ANY PORTION OF THE FRANCHISE PERMIT FEE DUE UP TO THE DATE SPECIFIED IN PARAGRAPH (B) OF THIS RULE.

EFFECTIVE DATE: _____

CERTIFICATION: _____

DATE

PROMULGATED UNDER: RC CHAPTER 119.
STATUTORY AUTHORITY: RC SECTIONS 3721.511, 3721.58
RULE AMPLIFIES: RC SECTIONS 3721.50 to 3721.58
PRIOR EFFECTIVE DATE: 9/30/93(EMER)

TNS # 94-07 APPROVAL DATE JUN 28 1997
SUPERSEDES
TNS # 22-024 EFFECTIVE DATE 10/1/94