5101:3-3-40

Numeric Identifier

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. 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.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. 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			
2. COGNITIVE LOSS			
3. VISUAL FUNCTION			
4. COMMUNICATION			
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL			
6. URINARY INCONTINENCE AND INDWELLING CATHETER			
7. PSYCHOSOCIAL WELL-BEING			
8. MOOD STATE			
9. BEHAVIORAL SYMPTOMS			
10. ACTIVITIES			
11. FALLS			
12. NUTRITIONAL STATUS			
13. FEEDING TUBES			
14. DEHYDRATION/FLUID MAINTENANCE			
15. DENTAL CARE			
16. PRESSURE ULCERS			
17. PSYCHOTROPIC DRUG USE			
18. PHYSICAL RESTRAINTS			

B.

1. Signature of RN Coordinator for RAP Assessment Process

2. Month — Day — Year

3. Signature of Person Completing Care Planning Decision

4. Month — Day — Year

TN #00-014 APPROVAL DATE DEC 06 2001
SUPERSEDES
TN #95-10 EFFECTIVE DATE 10/1/00

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

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 Indwelling Catheter	Psychosocial Well-Being	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	2																				B2b
B4	Decision making	1,2,3																				B4
B5	Decision making	3																				B5
B5a to B5f	Indicators of delirium	2																				B5a to B5f
B6	Change in cognitive status	2																				B6
C1	Hearing	1,2,3																				C1
C4	Understood by others	1,2,3																				C4
C6	Understand others	1,2,3																				C6
C7	Change in communication	2																				C7
D1	Vision	1,2,3																				D1
D2a	Side vision problem	2																				D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2																				E1a to E1p
E1n	Negative expression	1,2																				E1n
E1o	Withdrawal from activities	1,2																				E1o
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
E6	Change in behavioral symptoms	2																				E6
E5	Change in behavioral symptoms	2																				E5
F1a	Expressed sad feelings	2																				F1a
F2a to F2d	Unsettled relationships																					F2a to F2d
F2e	Caring for pet/plants	2																				F2e
F3b	Lost roles																					F3b
F3c	Gain roles/activities	2																				F3c
G1aA - G1jA	ADL self-performance	1,2,3,4																				G1aA - G1jA
G1aA	Eat/feeding	1,2,3,4																				G1aA
G2A	Bathing	1,2,3,4																				G2A
G3a	Dressing upper/lower	1,2,3																				G3a
G6a	Bedfast	2																				G6a
G9a-d	Bedfast, half-bedfast, capable	2																				G9a-d
H1a	Bowel incontinence	1,2,3,4																				H1a
H1b	Bladder incontinence	1,2,3,4																				H1b
H2b	Constipation																					H2b
H2d	Oral problem																					H2d
H3c,d,e	Catheter use																					H3c,d,e
H3g	Use of diapers																					H3g
I1i	Hypotension																					I1i
I1j	Peripheral vascular disease																					I1j
I1ee	Depression																					I1ee
I1ff	Cataracts																					I1ff
I1ll	Glaucoma																					I1ll
I2	HIV																					I2
I3	Dehydration diagnosis	276.5																				I3
J1a	Weight loss/gain																					J1a
J1c	Dehydrated																					J1c
J1d ✱	Insufficient fluid																					J1d
J1f	Dizziness																					J1f
J1g	Fever																					J1g
J1i	Hallucinations																					J1i
J1j	Impaired judgment																					J1j
J1k	Lung aspirations																					J1k
J1m	Seizure																					J1m

TN #00-014 APPROVAL DATE
SUPERSEDES
TN #98-10 EFFECTIVE DATE 10/1/00

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

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 Indwelling Catheter	Psychosocial Well-Being	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
~~J3a~~	~~Hasteady gait~~																					J3a
J4a,b	Fell																					J4a,b
~~J4c~~	~~Hip fracture~~																					J4c
K1b	Swallowing problem																					K1b
~~K1c~~	~~Mouth pain~~																					K1c
K3a	Weight loss	1																				K3a
~~K3a~~	~~Taste alteration~~																					K3a
K4c	Leave 25% food																					K4c
~~K5a~~	~~Parenteral/IV feeding~~																					K5a
K5b	Feeding tube																					K5b
~~K5c~~	~~Mechanically altered~~																					K5c
K5d	Syringe feeding																					K5d
~~K5e~~	~~Therapeutic diet~~																					K5e
L1a,c,d,e	Dental																					L1a,c,d,e
~~L1f~~	~~Daily cleaning teeth~~	~~No~~																				L1f
M2a	Pressure ulcer	2,3,4																				M2a
~~M2a~~	~~Pressure ulcer~~	~~1,2,3,4~~																				M2a
M3	Previous pressure ulcer	1																				M3
~~M4e~~	~~Impaired tactile sense~~																					M4e
N1a	Awake morning																					N1a
~~N2~~	~~Involved in activities~~	0																				N2
N2	Involved in activities	2,3																				N2
~~N5a,b~~	~~Prefers change in daily routine~~	~~1,2~~																				N5a,b
O4a	Antipsychotics	1,7																		*		O4a
~~O4b~~	~~Antiseptics~~	~~1,7~~																		*		O4b
O4c	Antidepressants	1,7																		*		O4c
~~O4e~~	~~Diuretic~~	~~1,7~~																				O4e
P4c	Trunk restraint	1,2																				P4c
~~P4c~~	~~Trunk restraint~~	~~2~~																				P4c
P4d	Limb restraint	1,2																				P4d
~~P4e~~	~~Chair prevents rising~~	~~1,2~~																				P4e

TN #00-014 APPROVAL DATE
SUPERSEDES
TN #98-10 EFFECTIVE DATE 10/1/00

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	1. Male 2. Female
3.	BIRTHDATE	Month — Day — Year
4.	RACE/ ETHNICITY	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 [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] (AA8a

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. 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

SECTION A. IDENTIFICATION AND BACKGROUND INFORMAT

6.	MEDICAL RECORD NO.	

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	a. *Code for resident disposition upon discharge* 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other b. *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* Month — Day — Year

SECTION S. STATE OF OHIO SUPPLEMENT

10.	MEDICAID MCO	Resident is enrolled in a Medicaid Managed Care Organization 0. No 1. Yes
11.	MEDICARE MCO	Resident is enrolled in a Medicare Managed Care Organization 0. No 1. Yes
12.	RESIDENT IDENTIFIER CODE	Record alternate resident identifier code if resident does not have a Social Security Number. See Instructions. *(If SSN is coded in Section AA5a, leave blank)*

Numeric Identifier

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER ⊙	1. Male 2. Female
3.	BIRTHDATE ⊙	Month — Day — Year
4.	RACE/ ETHNICITY ⊙	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 ⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊙	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 9. Reentry

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMAT

4a.	DATE OF REENTRY	Date of reentry Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. 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.	

SECTION S. STATE OF OHIO SUPPLEMENT

10.	MEDICAID MCO	Resident is enrolled in a Medicaid Managed Care Organization 0. No 1. Yes
11.	MEDICARE MCO	Resident is enrolled in a Medicare Managed Care Organization 0. No 1. Yes
12.	RESIDENT IDENTIFIER CODE	Record alternate resident identifier code if resident does not have a Social Security Number. See Instructions. *(If SSN is coded in Section AA5a, leave blank)*

5101:3-3-40 APPENDIX D - ENACTED

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:
1. Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;
2. Complete and attach this Correction Request Form to the corrected assessment or tracking form;
3. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
4. Electronically submit the new record (as in #3) to the MDS database at the State.

TO INACTIVATE A RECORD IN THE STATE DATABASE:
1. Complete this correction request form;
2. Create an electronic record of the Correction Request Form; and
3. Electronically submit this Correction Request record to the MDS database at the State.

PRIOR RECORD SECTION.
THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (*In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.*)

Prior AA1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
Prior AA2.	GENDER	1. Male 2. Female
Prior AA3.	BIRTHDATE	Month — Day — Year
Prior AA5.	SOCIAL SECURITY	a. Social Security Number
Prior AA8.	REASONS FOR ASSESSMENT	a. Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a *ONLY*) 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* DISCHARGE TRACKING (Complete Prior Date item Prior R4 *ONLY*) 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a *ONLY*) 9. Reentry b. *Codes for assessments required for Medicare PPS or the State* *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
	PRIOR DATE	(*Complete one only*) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.
Prior A3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month — Day — Year
Prior R4.	DISCHARGE DATE	*Date of discharge* Month — Day — Year
Prior A4a.	DATE OF REENTRY	*Date of reentry* Month — Day — Year

CORRECTION ATTESTATION SECTION.
COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

AT1.	ATTESTATION SEQUENCE NUMBER	(*Enter total number of attestations for this record, including the present one*)
AT2.	ACTION REQUESTED	1. MODIFY record in error (*Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below.*) 2. INACTIVE record in error. (*Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.*)
AT3.	REASONS FOR MODIFICATION	(*If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5*) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error *If "Other" checked, please specify:*
AT4.	REASONS FOR INACTIVATION	(*If AT2=2, check at least one of the following reasons; check all that apply*) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of inappropriate record d. Other reason requiring inactivation *If "Other" checked, please specify:*

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME	a. (First) b. (Last) c. (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month — Day — Year

AT7. ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payments from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Attestation Date
a.	
b.	
c.	
d.	
e.	
f.	

TN #00-014 APPROVAL DATE _____
SUPERSEDES
TN #98-10 EFFECTIVE DATE 10/1/00