#10 Admitting, Monitoring, and Discharging Residents

ADULT FAMILY HOME
ADMINISTRATOR STUDENT MANUAL | *VERSION 5.2*

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Module 10 – Admitting, Monitoring, and Discharging Residents
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Admitting, Monitoring, and Discharging Residents

Introduction

This module discusses admitting, monitoring, and how to discharge a resident. To admit someone to your home, you must be able to determine if you and your staff can meet their needs.
A current assessment and preliminary care plan/interim service summary can help you make this determination. The assessment and preliminary care plan will give you a good idea of the resident's needs; physically, mentally, and socially.

When considering admitting a resident, think about you and your staff, then ask yourself:

- Do they require a one or two person assist?
- Are they ambulatory?
- Will they impact your ability to evacuate everyone in 5 minutes?
- Can I meet their medication regime?
- Will nurse delegation be required?

This is an exciting time – but **take the time** you need to make these decisions. Schedule time to meet them! Does the potential resident you see match the one described in the assessment? Ask them to visit your home, so you can share your house rules and expectations.

There are a lot of things to consider. Make sure you can meet all the expectations and requirements, there isn't a "try out" period. Be sure you understand the rules about discharging a resident. Being clear on expectations from both you and the resident will help contribute to and make for a smooth transition.

Once you have decided to admit the resident, you will need to determine their baseline and set up a schedule for ongoing monitoring. A change in a resident's condition may mean that they are at risk. Action can be taken only if you notice any changes in a resident's condition and address them, the sooner the better. Changes that are not recognized and addressed can lead to serious outcomes such as medical complications, a trip to the hospital, or even death. Using the Stop and Watch tool can help structure your observations and determine if there has been a change in your resident's condition.

Discharging a resident can be difficult. In this module we will cover when a resident can be discharged from your home and when discharge is not an option.

NOTE: Be sure when you accept an assessment from your private assessor it includes the preliminary service plan **WAC 388-76-10340**. The assessor completes this document along with the assessment and gives both to you when complete. Your Medicaid assessment includes a Service Summary/Service Plan rather than a preliminary service plan.

Learning Objectives

At the end of this module, you will be able to …

- Explain how to successfully support a resident moving into your home
- List the resident documents needed prior to admission
- Explain the process of setting up Nurse Delegation
- Develop a negotiated care plan and know when it needs to be updated
- Share the expectations of working with your resident's health care provider to address their changing medical needs
- Explain when you can discharge a resident and who you will need to coordinate with during the discharge process

What Do You Know?

True or False

1. A completed signed care plan from the assessor replaces the need for a Negotiated Care Plan
2. New residents may experience placement trauma and need time to adjust to their new normal
3. You must ensure the individual has a safe place to go before they are discharged

Before You Admit a Resident

There are several things to consider before you admit a resident.

First – Can You Admit the Resident? Is the Person a good fit for Your Home?

Is this a resident that you can even consider for your home? Are you qualified to care for this resident, is your license in good standing, how will your current residents be impacted? If any of those situations apply, you may need to act first.

Conditions on Your License

WAC 388-76-10970

When you apply for your initial license (WAC includes current license), the licensor may impose conditions or limits on your license. Some of these conditions may include**:**

- Correction of deficiencies within a specified time
- Training related to the deficiencies
- Limits on the type of residents the adult family home may admit or serve
- Discharge of any resident when the department finds discharge is needed to meet that resident's needs or for the protection of other residents (current license)
- Change in license capacity (current license)
- Removal of the adult family home's designation as a specialized home (current license)
- Prohibition of access to residents by a specified person
- Demonstration of ability to meet financial obligations necessary to continue operation

Stop Placement

The department may order a stop placement and prohibit the admission of residents if your AFH does not meet the AFH rules and requirements. Once a stop placement is in place, you cannot admit any new residents until the stop placement has been removed. If requested, RCS may allow you to accept a resident that wishes to return home during a stop placement from the hospital or nursing home. WAC 388-76-10980

Specialty Training

To admit a person with dementia, an intellectual disability, or mental health diagnosis, you must have completed the specialty training related to that condition and have it noted on your license. WAC 388-76-10505

> NOTE: If a resident develops dementia or a mental health condition while living in a facility without that specialty designation, the provider, entity representative, resident manager and facility administrator (or designee) have 120 days to complete the specialty training, and demonstrate competency per WAC 388-112A-0490.

Current Residents

To successfully support a new resident, it is important that you not only consider them, but also their impact on the other residents and caregivers involved. This can include, but is not limited to, their formal and informal supports, your current residents, and staff. Identify any required adjustments that will be needed to your home's routine. Any change in your home's routines can be difficult for some people, so considering all these components first can help in alleviating stress during this transitional time. WAC 388-76-10545 (3)

Sex Offender Notification for Medicaid Applicants

You may learn from a Case Manager (CM) or through the CARE assessment and transition process that a potential Medicaid resident is a registered sex offender.

Ask yourself:

- Can you safely and appropriately meet the resident's needs?
- Do you have adequate safeguards in place to protect residents?
- Do you need additional information from the resident or from law enforcement? Washington Association of Sheriffs and Police Chiefs.

Remember, as outlined in the November 17, 2021 Dear Provider Letter #2021-063 *New Notification Policy Regarding People Registered as Sex Offenders Living in Long-Term Care Settings or Receiving Long-Term Care Services and Supports*; "You **have the duty** to protect residents from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion". WAC 388-76-10670

We will talk more about these issues when we get to the Resident Safety section of the module.
If you determine it is safe to transition the individual into your home, you should notify all current residents and their representatives that a person registered as a sex offender will be living with them. Later we will discuss the process for how you are notified if you have a current resident that is a sex offender and actions you can take.

Second - Can You Meet their Needs?

Review their assessment and preliminary care plan thoroughly **PRIOR** to admission. Do not hesitate to contact your assessor with any questions you may have.

To determine if you can safely meet their needs, consider these key points:

- Do you have enough qualified staff? **WAC 388-76-10545 (1)(a)**
- Does this person have any durable medical equipment that requires training?
- Is there a need for a bed rail evaluation? If yes, are the documents signed and in order?
- Will this resident impact your ability to evacuate all your residents in 5 minutes?
- Do you have the skills for a complicated medication regime?
- Will nurse delegation be required?
- Does this person exhibit challenging behaviors? If so:
    - Is there a crisis plan in the assessment/care plan?
    - Were you provided with an **ALTSA Individual with Complex Behaviors** DSHS 10-234a form?
    - Do you have the training and support to cope with complex behaviors?
- Do you and your staff have the required specialty training to provide care for residents with dementia, mental health needs, and/or intellectual disabilities? WAC 388-76-10505
- Do any of your residents have care needs that require a Medical Test Site Waiver license?

After you have made the determinations above, **the next step is to meet them!** Best practice is to meet the person where they currently reside. Many providers have traveled to other towns, hospitals, and other facilities to visit people interested in living in their AFH.

Third – What Changes Will Need to Be Made?

- Do safety protocols and supplies need to be updated?
- Is there enough seating for everyone?
- Are any changes needed to their bedroom?
- Do you have a state Medical Test Site Waiver (MTSW) license if needed?

Medical Test Site Waiver License Requirements

Certain types of medical testing require a state Medical Test Site Waiver (MTSW) license. MTSW Licensure is required if your AFH administers a medical test (such as a COVID-19 test or a blood glucose test), or interprets the test result, or acts upon the test results. Examples of activities performed by you or your staff that require a MTSW license include:

- Using a rapid COVID-19 test for residents.
- Testing blood glucose for a resident.
- Dipping test sticks in urine to test for ketones or other analytes.
- Reporting a test result to a medical provider who may adjust a resident's diet or medication in response to a test result.

A MTSW is not required if you or your staff perform and interprets your/their own medical test and/or shows the results to someone else. For example, one of your staff takes a rapid COVID-19 test and then calls you to let you know if they will or will not be coming to work.

If a MTSW is required, then you **must** apply for a MTSW license through the Department of Health (DOH). Review and follow the instructions in the Certificate of Waiver Test Site (MTS) Application Packet.

For addition information review Provider Letter #2024-047 for reporting requirements or if you have questions about your MTSW application status, missing license, replacement copies of your license, or completing the application.

.Schedule a Visit to Your Home

When you have determined that you are able to admit and meet the needs of the potential resident, invite them and/or the family to visit your home. Give them a tour of your home and the opportunity to meet the other residents. This is a good time to share a written copy of your **Resident's Rights and Services,** fees, facility policies and services available which is required **before** they move in. WAC 388-76-10530

Working with an Alternate Decision Maker

An alternate decision maker is a legal advocate for an incapacitated person. They make decisions for your resident, within their scope of authority, when the resident is unable to do so.
Residents have rights even when they have an alternative decision maker. The intent of resident rights laws is to:

- Ensure residents can exercise reasonable control over their life decisions.
- Ensure a resident's right to a dignified existence and self-determination.
- Ensure that a resident's quality of life includes a safe, clean, comfortable, and homelike environment.

By RCW 11.88.010 (1)(e), a person is considered "incompetent" by reason of mental illness, developmental disability, senility, habitual drunkenness, excessive use of drugs, or other mental incapacity, of either managing his or her property or caring for himself or herself, or both. The terms "incompetent," "disabled," or "not legally competent," in this guardian section mean a person who is "incapacitated" 11.88.010(1)(f)

Guardians

Guardianships are established by the courts. There are several types of guardians with different levels of authority (RCW 11.88, 11.92). Be sure you understand which type of guardian you are working with and their level of authority by reviewing their Letters of Guardianship. Check the date to ensure the document is current. Since 2011, guardianship letters are only valid for a maximum of 5 years. Without a valid letter, the guardian does not have legal authority to act.

Some counties may go for long periods before they require a guardian to report. Until the case is reviewed by the court, the older letters of guardianship continue to be valid. If you have any questions, check with your case manager or an attorney.

If a guardianship was established by a tribal court, only that court has the authority to modify it. Each individual tribe has its own rules and regulations which it applies to guardianship issues. If you are working with a tribal resident and have any concerns about their guardianship, check with their DDA or HCS case manager. If there is not a CM, contact the tribe's social services for assistance.

Guardians have the legal authority, and corresponding duty, to care for the personal and property interests of an incapacitated person.

Guardianship Authority can be confusing. Guardians **do not** have the authority to make these types of choices or decisions:

- Freedom of expression – Lifestyle choices, recreation, leisure, religious activities
- Freedom of movement – Community access, mobility, community involvement
- Individual preferences – clothes, food, drink, use of possessions, friends
- Cannot keep an individual in the AFH against their will

It is important to note that the AFH provider, entity representative, resident manager, or staff cannot become a resident's guardian per WAC 388-76-10235.

Alternatives to Guardianship

Not every person with an intellectual disability or dementia needs a guardianship. Medical decision making can often be addressed by closely related family members, assuming they are available for medical emergencies. Other supports can be met by good case management and other available programs.

The order of Medical Decision-Making Authority is as follows:

#1 – The resident

#2 – Alternate legal decision makers by order of Priority:

1. Guardian
2. Durable Power of Attorney (DPOA) for Health Care
3. Spouse or Registered Domestic Partner
4. Adult child (all)
5. Parents
6. Adult brothers and sisters

Power of Attorney vs. Durable Power of Attorney

Power of Attorney (POA)

A legal document giving one person the power to act for another person. The person may have broad or limited authority to make legal decisions regarding the person's property and/or finances. Authority is limited to the express terms of the document and capacity of the individual.

Durable Power of Attorney (DPOA)

A DPOA does not have the same authority as a guardian. While a guardianship may be "full" or have limits, a DPOA only has authority in a specified area. A DPOA is an agreement between a "competent person" and another person. The competent person has given specific decision-making authority to the DPOA if the person becomes incapacitated.

A DPOA typically does not expire. Review this document thoroughly and ensure you understand its authority. To make decisions about a resident's care, the DPOA must be for medical/health care. Obtain a copy for your resident's record.

The AFH provider, entity representative, administrator, or employees of the home cannot act as a resident's DPOA unless they are the resident's spouse, adult child, or brother or sister. WAC 388-76-10240

Advanced Directive/POLST Form

An advanced directive is a legal document (as a living will) signed by a capacitated person to provide guidance for medical and health-care decisions (such as termination of life support or organ donation) in the event the person become incapacitated and unable to make such decisions.

The Physician Orders for Life Sustaining Treatment (POLST) form is a written medical order from a medical practitioner. The POLST form is for people who have chronic health conditions and/or those who are seriously ill or medically frail. It is most useful for people who want less than fully aggressive medical treatment in their current health state.

Representative Payee – Financial

If the only issue a person needs assistance with is financial, they may not need a guardianship. A representative payee can be established for disability or Social Security benefits.

Emergency Admissions

You **must** have a complete and current assessment and preliminary service plan for each resident that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home WAC 388-76-10330.

Exception: You can admit a resident without an assessment or preliminary care plan **if a true emergency exists**. A true emergency exists if the individual's life, health, or safety is at serious risk because of where they are currently residing or if harm has already occurred. If a true emergency does exist, you must ensure:

- **For Private Residents** – the assessment and preliminary service plan are completed within 5 working days after admission.
- **For Medicaid Residents** – you must obtain approval from a CM before admission. If you get verbal approval, document the date, time, and name of the CM who gave approval in the resident's record. WAC388-76-10395

Admitting a Resident

Coordinating the Move for Medicaid Residents

For Home and Community Services (HCS) residents:

- If they are moving from a facility, a HCS CM will coordinate the move into your home with your assigned CM (if applicable).
- If your resident is moving from their own home, an Area Agency on Aging (AAA) CM will coordinate the move in coordination with HCS.

  The AAA CM will work with you for the first 30 days of admission and then transfer CM responsibility to HCS.
- Once client responsibility and room and board are determined, the resident's CM will use CARE to authorize AFH Services effective the day your resident moves in.
- Their ongoing CM will schedule a 30-day follow-up visit with you either in person or by phone.

For Developmental Disabilities Administration (DDA) residents:

- The DDA CM will provide you with your regional ***Performance and Quality Improvement Specialist (PQIS)*** contact information. The PQIS will meet with you and answer any questions you have about DDA services.
- Once your DDA resident has settled in, the PQIS will arrange a visit (in about 30-90 days) to see how it is going and make sure you have everything you need. They will discuss any concerns with your resident's CM so they can act if needed.

Get Ready for Your New Resident – Setting Up Supports

- ☐ **Medications** - Arrange with the pharmacy to have medications delivered on move in day with their Medication Administration Record (MAR). Ask resident/family to switch to your LTC pharmacy if possible.
- ☐ **Nurse Delegation** – If required, arrange for your Nurse Delegator to be available on the day of arrival. If your resident is receiving Medicaid, this can be arranged through the resident's CM. Have staff available for training if they will be assisting with the medication regime.
- ☐ **Meal Planning** - Dietary restrictions will be in the assessment/preliminary care plan. Ensure initial needs are addressed in meal planning. See Module 6, Nutrition and Activities.
- ☐ **Create the Resident Record –** See Module 6, Setting Up Your Home.

Set Up Supports

Long-Term Care Pharmacy

We learned about long-term care (LTC) pharmacies in module 6. LTC pharmacies are specifically designed to provide services to individuals and seniors living in a LTC setting. Ask your resident if they are willing to have their prescriptions moved to your pharmacy. If so, contact the pharmacy so they can have any needed prescriptions delivered by the day of admission. If the resident is unsure, discuss the pros and cons of using the long-term care pharmacy compared to a regular pharmacy.

Nurse Delegation

The Nurse Delegation (ND) Program, under Washington State law, allows long-term care workers (LTCW) working in certain settings to perform certain nursing tasks – such as administration of prescription medications or blood glucose testing and insulin injections – normally performed only by licensed nurses. A registered nurse must teach and supervise the LTCW, as well as provide nursing assessments of the patient's condition. WACs 246-840-910 to 970

Before residents can receive ND, the Registered Nurse Delegator (RND) must determine that:

- The resident is in a stable and predictable condition. This means the RN determines the resident's clinical and behavioral status does not fluctuate and is consistent, and the resident does not require a frequent nursing presence or evaluation. Residents with terminal conditions and those who are on sliding scale insulin can be or may be stable and predictable.
- The delegated task is not prohibited.
- If there is a legal representative, they have given consent for delegation to occur. Consent is only needed for the initial delegation; new consent is not needed when nursing tasks change. However, the RND must get new consent if the authorized representative changes.
- The RND:
    - Teaches and supervises LTCWs who are qualified (Nursing Assistant-Registered, Nursing Assistant – Certified, Home Care Aide – Certified) to perform selected nursing tasks on a

regular basis and identifies any additional training the LTCW may need to perform the nursing task properly and safely.
    - Verifies the LTCW has met all training and registration requirements: 9-hour Nurse Delegation Core Training and the 3-hour Special Focus on Diabetes Training (optional but necessary for Insulin administration).
    - Assesses the competency of the LTCW performing the nursing task.
    - Considers language and cultural diversity that may impact delegation.
    - Verifies that the LTCW is **willing and able** to perform the nursing task.
    - Verifies other specific criteria described in the Nurse Delegation protocol are met.
- You can find DSHS approved ND Community Instructors: Find a Training Class

Prohibited Tasks

RNDs **cannot** delegate the following care tasks under any circumstances:

- Administration of medications by injection (intramuscular, intradermal, subcutaneous, intraosseous, and intravenous) except for insulin and non-insulin diabetic medication.
- Sterile procedures
- Central line maintenance
- Acts that require nursing judgment

Nurse Delegation Forms	Delegation of Nursing CARE Tasks WACs	
• Nursing Assistant credentials and Training DSHS 10-217 • Consent for Delegation Process, Page 1 DSHS 13-678 • Instructions for Nursing Task, Page 2 DSHS 13-678 • Nursing Visit DSHS 14-484 • Change in Medical Orders DSHS 13-681 • PRN Medication DSHS 13-678A • Nurse Delegation: Assumption of Delegation DSHS 13-378B • Nurse Delegation: Rescinding Delegation DSHS 13-680	246-840-910	Purpose.
	246-840-920	Definitions.
	246-840-930	Criteria for delegation.
	246-840-940	Washington state nursing care quality assurance commission community-based and in-home care setting delegation decision tree.
	246-840-950	How to make changes to the delegated tasks.
	246-840-960	Rescinding delegation.
	246-840-970	Accountability, liability, and coercion.
	246-840-990	Fees and renewal cycle.

NOTE:

- Delegating nurses contracted with DSHS have set rates for reimbursement. If a registered nurse is delegating for a private pay resident, rates may be different. Ensure your private pay residents understand that different delegating nurses charge different fees.
- The delegating nurse does not do assessments for equipment or teaching for lifts etc. They may check with the provider if they know how to use the equipment during an assessment but are not the authorized entity for this type of assessment or training.

Behavioral Health Support for Providers

- When a person is in pain, they may act out – check out DDA's Caregiver Alert #25 – When a person engages in challenging behaviors, check for pain or illness.
- The Individual with Complex Behaviors (10-234a) form MUST be part of the referral you receive from your case manager for a Medicaid resident that has complex behaviors. You MUST keep a copy in the resident's record.
- When admitting this individual, you are ensuring the safety of all your residents.
- You MUST inform your case manager of any change to the resident's complex behaviors.

A quick reminder about the BHST and resources:
"Residential Care Services (RCS) has developed the Behavioral Health Support Team (BHST), offering resident specific consultation and group trainings for staff in every part of the state. Whether a provider is rural or urban, nursing home or assisted living facility, adult family or supported living home, our team is available to support providers who are serving individuals with behavioral health challenges. The goal of the RCS Behavioral Health Support Team is long-term success for individuals with behavioral challenges living in long-term and community-based settings. Sometimes it is helpful to contact us before a crisis, as we can help navigate issues before they get to that point." RCSBHST@dshs.wa.gov)

NOTE: Page 1 and 2 screen shots of the Individual with Complex Behaviors Form (10-234a) are included below. Only the instructions pages (3 and4) are not included.

Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION

Individual with Complex Behaviors

CLIENT'S NAME

CLIENT ACES ID NUMBER | REGION

MENTAL HEALTH DIAGNOSIS
☐ Yes ☐ No
Principle diagnosis:

Current presentation in Section 1.

Information can be obtained from, conversation with Psychiatrist, Nurse, Medical Physician, Social Worker, Mental Health Professional, Counselor, or Certified Peer Specialist.

CLINICAL IMPRESSIONS

RISK ASSESSMENT Completed by Hospital or Behavioral Health Provider
☐ Yes ☐ No ☐ NA
Date:

INDIVIDUAL CRISIS PLAN
Document within CARE the expected date Crisis Plan is to be received by provider.
☐ Yes ☐ No ☐ NA

MEDICATION AND MEDICAL CONDITIONS MONITORING
Is the individual taking medication as directed and agreeable to medical treatment(s):
☐ Yes ☐ No ☐ NA
Last medication review:

COORDINATED BEHAVIOR SUPPORT AND TEAM MEETINGS ESTABLISHED
Complete a comment within CARE in Treatment List: Type Programs: Behavior Management Plan detailing the plan. Refer to WAC: 388-107: 388-106-0336 ☐ Yes ☐ No ☐ NA

Section 1. Check one or all that apply (documentation must be present in file)

Current presentation and behaviors that increase risk of behavioral crisis.

Check all relevant boxes below.

	HISTORY OF OCCURRENCE INDICATE FREQUENCY AS DAILY, WEEKLY, OR MONTHLY		
	30/60/90 DAYS	1–2 YEARS	3-5+ YEARS
☐ **Assaultive** (significant aggression or physical abuse toward others) Violent Mood Swings, Unpredictable / Impulsive Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **Destructive** (significant property destruction which puts self or others at risk) Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **Self-Injurious** (suicidal behavior; significant self-injury, danger to self). Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **History of felony and/or misdemeanor type behavior. May or may not have been charged** (shoplifting, theft, trespassing, buying liquor for minors, forgery, malicious mischief, motor vehicle citations, disturbing the peace, harm to animals, stalking, etc.). Citations or related accusations against any population. Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **Challenging Sexualized Behavior** Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐
☐ **History of arson.** Describe / clarify (please list any charges related to this behavior): Frequency:	☐	☐	☐

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LEGAL STATUS

- ☐ Current charge pending; if checked, specify: _____
- ☐ Not Guilty by Reason of Insanity (NGRI)
- ☐ Current Less Restrictive Alternative (LRA) (attach copy of court order)
- ☐ Conditional release (attach conditions of release)
- ☐ Current incarceration status; projected release date: _____
- ☐ Early release
- ☐ Convictions
- ☐ DOC supervision
- ☐ Registered Offender Notifications (specify): _____ ☐ NA

CASE MIX COMPLETED

Document findings within CARE under Relationships / Interests within comments in Electronic Case Record (ECR).

☐ Yes ☐ No ☐ NA

STAFFING PLAN COMPLETED

Plan must be provided and kept in the provider file and Electronic Case Records (ECR) and documented with the CARE assessment.

☐ Yes ☐ No ☐ NA

Emergency situations of Individual – see definition section: ☐ Yes ☐ No ☐ NA

Section 2. (Only complete if agency requires) Addendum

INFORMATION VERIFICATION BY:

- ☐ Police report ☐ Court records ☐ Psychiatrist, Nurse
- ☐ Medical Physician
- ☐ Social Worker
- ☐ Mental Health Professional
- ☐ Counselor
- ☐ Certified Peer Specialist.
- ☐ Self-report ☐ Parent / guardian
- ☐ Psycho-sexual assessment
- ☐ Other (specify):

CURRENT DAY PROGRAM

- ☐ Employment ☐ School
- ☐ Community access ☐ None
- ☐ Other

CURRENT RESIDENCE (SEE STAFF INSTRUCTIONS)

☐ AFH ☐ AL ☐ ARC ☐ CFH ☐ CH ☐ CPRS ☐ DOC ☐ EARC ☐ ESF ☐ ESH ☐ GH/GTH ☐ ICF/ID
☐ JR ☐ SL ☐ WSH ☐ Own home ☐ Parent / relative home
☐ Other (specify):

SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, CFC, CFC+COPES, RSW, ETC.)

This form was completed based on available information.

CASE MANAGER'S SIGNATURE DATE

I have reviewed all information for **Name**, and upon acceptance of said individual will incorporate the information received to develop **Name**'s negotiated care plan or person-centered service plan pursuant to WAC: For detailed information regarding Adult Family Home Negotiated Care Plan refer to (WAC 388-76-10355 through 388-76-10385; Assisted Living Negotiated Service Agreement (WAC 388-78A-2130 through 388-78A-2160); and Person-centered service plan for Enhanced Service Facility (WAC 388-107-0110 through 388-107-0130)

PROVIDER'S SIGNATURE DATE

DISTRIBUTION: Client Electronic Case Record Provider

INDIVIDUAL WITH COMPLEX BEHAVIORS
DSHS 10-234A (REV. 05/2019)

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Move in Day – The First Few Hours

When a new resident moves into your AFH, it is important to make sure they feel at home from day one. Complete all the necessary health and safety procedures to ensure a successful transition. Think about how you would feel moving into a new home with people you did not know – what would make you feel more comfortable? What would make you feel more at home?

- Greet and welcome your new resident to their home.
- Introduce them to their fellow residents and staff.
- Give a tour of the home if needed – Show them where their bedroom is.
- Review and organize their meds – ensure you have the current MAR, review contents of the pharmacy packaged medications, such as a bubble pack, bingo card, blister packaging, etc.
- Review preliminary care plan with resident/decision maker as you will be developing their Negotiated Care Plan within the next 30 days.
- Complete a full head to toe review and vitals. Document a baseline and ensure all records from their Primary Care Physician (PCP) are up to date.
    - If you use a Home-Based Primary Care Services, such as a visiting doctor, discuss this option with your resident.
- Have a home admissions packet prepared
    - House rules
    - Admission documents
    - Sit with them if needed to inventory their possessions and label clothing
- Work with them to develop a schedule as close to possible as the one they had prior to moving into your home and that will meet any obligations they have, for example: being to work on time.
- Have staff available to assist with other residents during admission.
- Review Preliminary Care Plan with POA/guardian/resident - document preferences for bedtime, mealtime, foods, personal care support. These will be added to your Negotiated Care Plan (NCP).

Medical Devices

A "medical device" is any piece of medical equipment used by the resident to treat an assessed need. The device cannot be used as a restraint or for staff convenience. Some devices such as transfer poles, posey or lap belts, side rails, Hoyer lifts, and sit-to stand lifts have known safety risks. Before a medical device with a known safety risk is used by a resident, you must provide the resident and their family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device.

An assessment must be completed to identify the resident's need and ability to use the medical device safely. The medical device assessment can be documented in the resident's assessment or as a stand-alone assessment in the resident's record. You must show that the device was properly installed. Indicate how the resident will use the device in their NCP. WAC 388-76-10650, WAC 388-76-10000, AFH Provider Letter #2016-021

Transportation

Your resident may need help updating their transportation information to go to a job or participate in community activities. If they use Dial a Ride, they will need to update the pick-up and drop-off address. If they have access to regular transit, do they know how to use it? Contact the local transit and request transit training if needed.

GROUP ACTIVITY – Moving Day

Situation: A new resident is moving in.

- What would the first day in your home look like? What would you make you more comfortable if you were moving into a new home?
- Come up with a list of ways you can make your resident more comfortable when they arrive.

Negotiated Care Plan (NCP)

The NCP must include a list of the care and services to be provided, with details on the resident's preferences and choices, and how services will be delivered to accommodate these preferences and choices. WAC 388-76-10355

Negotiated Care Plan WACs	
388-76-10355	Negotiate Care Plan
388-76-10360	NCP – Timing of Development – Required
388-76-10365	NCP – Implementation - Required
388-76-10370	NCP – Persons Involved in the Development
388-76-10375	NCP – Signatures – Required
388-76-10380	NCP – Timing of reviews and revisions
388-76-10385	NCP – Copy to CM - Required

You must ensure the initial NCP is developed and completed within 30 days of your resident's admission. You must involve the individuals listed below when developing the NCP. The negotiated care plan is reviewed and agreed to, signed, and dated by the resident and AFH provider. WAC 388-76-10360, WAC 388-76-10370, WAC 388-76-10375

People Involved in the Development of the NCP

You must include the following people in the development of your resident's NCP:

- The resident – to the degree they are able
- The resident's family if the resident agrees
- The resident's representative if there is one
- Any professionals involved in the resident's care
- Any person the resident has asked to be included
- The CM if your resident is receiving Medicaid

NCP Contents

You must use the resident assessment and preliminary care plan/service summary to develop a written negotiated care plan. You must ensure each NCP includes the information in WAC 388-76-10355:

- A list of the care and services to be provided
- Who will provide the care and services
- When and how the care and services will be provided
- How medications will be managed, including how the resident will get their medications when they are not in the home
- The resident's activity preferences and how their preferences will be met
- Other preferences and choices that are important to the resident and how you will accommodate their preferences and choices. Choices can include:
    - Food
    - Their daily routine
    - Grooming
- If needed, include a plan to:
    - Follow in case of a foreseeable crisis due to a resident's assessed needs
    - Reduce tension, agitation, and problem behaviors
    - Respond to resident's special needs, including, but not limited to medical devices and related safety plans
    - Respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal
- Identification of any communication barriers the resident may have and how you will use behaviors and nonverbal gestures to communicate with the resident.
- A statement of the ability for the resident to be left unattended for a specific length of time; and
- A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.

For Medicaid residents, you must give the CM a signed and dated copy of the NCP when the plan is initially completed and each time it is updated. You have 30 days from the time you receive the assessment from the CM to return the NCP, regardless of the reason for the update. You can send a copy of their negotiated care plan through a secure email or fax to the CM. WAC 388-76-10385

Tips for Writing Care Plans

- Think logically and follow a process
    - What is the problem?
    - What is the goal for this problem? What can the resident do, what are their preferences?
    - What will you do to meet this goal?
- Be detailed with **who** will do **what**, **when**, **where**, and **how often**.

For Example:

Assessment	Detail – Resident Abilities/Preferences	Goal	Care Plan
Impaired mobility	Can ambulate; uses walls and furniture as props. Resident prefers to use wheeled walker to ambulate. Gets up unassisted with history of 3 falls in the last 3 months (no injuries)	Prevent resident falls Minimize potential injuries from falls	Remind resident to: • Use walker • Call for help when needed Caregiver will: • Ensure walker is always within reach • Monitor resident frequently • Ensure bed/chair alarms are functioning prior to resident use • Inform provider immediately when safety equipment does not function properly • Lower bed to lowest position • Place fall matt next to bed when resident sleeps Anticipate Needs • Offer toileting every 2 hours • Offer water and snacks

Reviews and Revisions

You are required to review and update each resident's NCP:

- When there is a significant change in the resident's physical, mental, or emotional functioning
  or
- When the negotiated care plan no longer adequately addresses the resident's current care needs and preferences
  or
- A least every twelve months WAC 388-76-10380

Negotiated Care Plan (NCP) Template

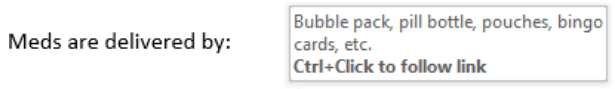
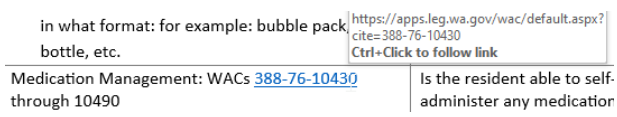
You can find the Adult Family Home Resident Negotiated Care Plan (NCP) template and instruction sheet on-line on the DSHS Long-Term Care Professionals & Providers/Residential Care Services/Information for Adult Family Home Providers (located under "Forms" section).

The NCP template follows the structure of a Medicaid CARE assessment. Many private assessment follow this same format. This structure makes it easier to follow the flow of the assessment, and along with the preliminary care plan/service summary, start your NCP. You are not required to use this template. you can use any template/format can be used if all the elements in WAC 388-76-10355, outlined above, are covered.

The NCP template is designed to be completed on your computer and then printed for your resident's file. The file is a Word Document – **be sure to save the file with your resident's name and date**.

How to Use the Template

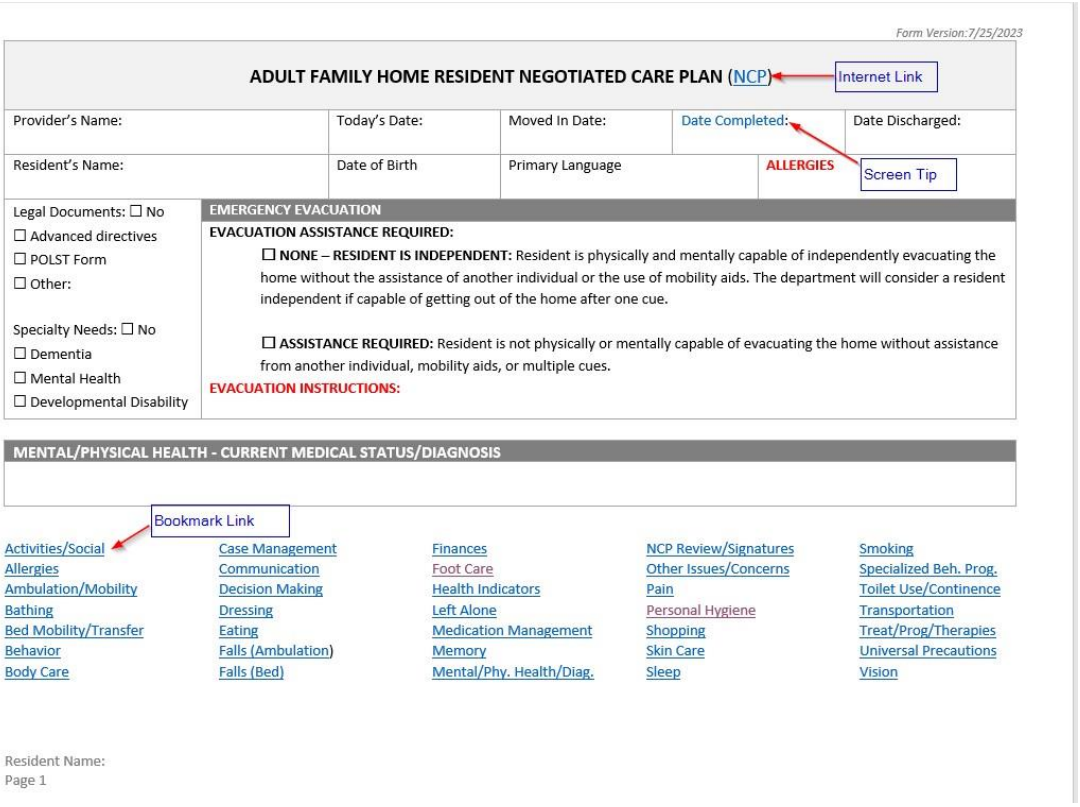
The template has many built in tools to help you build your NCP. For example, when you place your cursor over any blue text in the template or instructions, you will be able to perform one of the following actions:

a. Display a **screen tip** that provides you with instructions or helpful hints.	
b. Move to a "**Bookmarked**" location. A word or phrase that has a bookmark, like in the example, will act as a "link". When clicked, will move you to that section in the document.	
c. Access an **internet site** Clicking on the blue text, you will open the WAC internet page.	

NOTE: I*gnore the "Ctrl+Click to follow link" in* ***screen tips*** *or* ***document bookmarks.*** ***I****t is disabled and will not work. You will need to use the Ctrl+Click to access links to WACs and other webpages.*

The open table format allows you to copy and paste information directly into the NCP template.

Sample Screens – Template



Form Version:7/25/2023

ADULT FAMILY HOME RESIDENT NEGOTIATED CARE PLAN (NCP) ← Internet Link

Provider's Name:	Today's Date:	Moved In Date:	Date Completed:	Date Discharged:
Resident's Name:	Date of Birth	Primary Language	ALLERGIES ← Screen Tip	

Legal Documents: ☐ No
☐ Advanced directives
☐ POLST Form
☐ Other:

Specialty Needs: ☐ No
☐ Dementia
☐ Mental Health
☐ Developmental Disability

EMERGENCY EVACUATION

EVACUATION ASSISTANCE REQUIRED:

☐ **NONE – RESIDENT IS INDEPENDENT:** Resident is physically and mentally capable of independently evacuating the home without the assistance of another individual or the use of mobility aids. The department will consider a resident independent if capable of getting out of the home after one cue.

☐ **ASSISTANCE REQUIRED:** Resident is not physically or mentally capable of evacuating the home without assistance from another individual, mobility aids, or multiple cues.

EVACUATION INSTRUCTIONS:

MENTAL/PHYSICAL HEALTH - CURRENT MEDICAL STATUS/DIAGNOSIS

Bookmark Link

Activities/Social	Case Management	Finances	NCP Review/Signatures	Smoking
Allergies	Communication	Foot Care	Other Issues/Concerns	Specialized Beh. Prog.
Ambulation/Mobility	Decision Making	Health Indicators	Pain	Toilet Use/Continence
Bathing	Dressing	Left Alone	Personal Hygiene	Transportation
Bed Mobility/Transfer	Eating	Medication Management	Shopping	Treat/Prog/Therapies
Behavior	Falls (Ambulation)	Memory	Skin Care	Universal Precautions
Body Care	Falls (Bed)	Mental/Phy. Health/Diag.	Sleep	Vision

Resident Name:
Page 1

Form Version:7/25/2023

RESPONSIBLE PARTIES – CONTACTS

Those involved in care planning and Medical Contacts: Case Manager, DPOA, Guardian, Family, Doctor, Dentist, Pharmacy, etc.
Indicate which contact method is preferred.

Name	Relationship	Phone	Cell Phone	Address/Email
1.				
2.				
3.				
4.				
5.				
6.				

COMMUNICATION

SPEECH/HEARING/VISION	Resident Strengths And Abilities Prefers To Do Independently Preferences	Assistance Required Caregiver Instructions Who, How, When/How Often
Modes of Expression, for example: Speech Describe: Equipment:	**How resident makes self-understood:** **How resident understands others:** **Strength and Abilities**	**Assistance Required**
Problems with Hearing? Describe: Equipment:		
Problems with Vision? Describe: Equipment:		
Ability to Use the Phone ☐ Independent ☐ Assistance Needed ☐ Dependent ☐ Resident has own phone, number:		
Preferred Language:		

Resident Name:
Page 2

ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences	Assistance Required Who Will Provide, When, And How
Resident functional limitations that impact ADL functioning:		
AMBULATION/MOBILITY **In room and immediate living environment:** ☐ Independent ☐ Supervision/Cueing ☐ Assistance Needed ☐ Totally Dependent **Outside of immediate living environment (including outdoors):** ☐ Independent ☐ Supervision/Cueing ☐ Assistance Needed ☐ Totally Dependent ☐ **Risks for falls** ☐ **Fall prevention plan:** ☐ Resident chooses bedroom door lock **Equipment/Supplies:** Vendor: **Limitations:**	**Strengths and Abilities** **Evacuation addressed under Evacuation Plan**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required**
BED MOBILITY/TRANSFER *Transfer includes moving between bed, chair, wheelchair, standing position – excludes to/from bath/toilet*	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to

Negotiated Care Plan Review and Approval

DATE OF ORIGINAL PLAN:

Date of Review/Revision:

INVOLVED IN NCP DEVELOPMENT	PERSON SIGNING/APPROVING PLAN	SIGNATURE	DATE*
☐ Resident ☐ Resident Representative ☐ Parent ☐ Health Professional ☐ Other: ☐ Other: ☐ Other:	**PROVIDER**		
	RESIDENT		
	RESIDENT REPRESENTATIVE		
☐ Resident verbally agreed to NCP – Date: Resident Recommendations: ☐ **NCP sent to DSHS CM on:** WAC 388-76-10385			

*Enter the date you **actually read** and agreed to the plan.

Sample Screens – Instructions

INSTRUCTION SHEET FOR HCS NCP TEMPLATE

Key Points for Negotiated Care Plan development - Follow these brief instructions based on WAC 388-76-10355 through 388-76-10385 when developing your NCP:

- Must be developed within 30 days of admission based on the Assessment and the Preliminary Service Plan.
- Describes/identifies: (a) The services to be provided; (b) Who will provide the services; and (c) When and How the services will be provided.
- Is designed to meet the Resident's Needs, Preferences, and Choices.
- Is developed with input from the Resident and/or the Resident's Representative / Surrogate Decision Maker, appropriate professionals, and the case manager, if applicable (indicate on the signature page all parties that participated in the NCP development)
- Is Agreed to, Signed and Dated by the Resident and/or the Resident's Representative / Surrogate Decision Maker, and the provider.
- **Must be reviewed and Revised: (a) at least every 12 months; (b) upon any significant change in Resident's physical or mental condition; and (c) upon resident request.**
- The signed copy of the NCP must be given to the Case Manager if the Resident is receiving services (Medicaid) paid for fully or partially by the department.

INDEX ***(Click on the topic below to quickly go to that place in the instructions):***

INSTRUCTION SHEET FOR NCP HCS TEMPLATE

Hover the mouse over the blue text throughout the document for WAC references and tips

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
Overview (Return to Index)	The Negotiated Care Plan is required by WAC 388-76-10355 and other applicable regulations. You are required to be familiar with and to follow all applicable laws and rules. The screen tips provided are given to you to assist your compliance with the laws and All underlined text will either provide you with a "screen tip" which will give you additional information or take to that location in the template (like a Table of Contents located on the first page)	This section of the NCP is to document your resident's preferences/choices, strengths/abilities, and if they prefer to do it independently. Many of the tasks have unique strength & Abilities instruction/information specific to the task/issue – Check out the care tip	This section of the NCP is to document who will provide the assistance, when and how often the assistance will be provided, and how the assistance will be provided. Many of the tasks have unique strength & Abilities instruction/information specific to the task/issue – Check out the care tip
Provider's Name (Return to Index)	Enter your name and the name of your AFH		
Today's Date (Return to Index)	Enter the date you start to develop the NCP. The NCP **must** be completed within 30 days of admit WAC 388-76-10360.		
Moved In Date (Return to Index)	Enter the date your resident moved into your home. This date does not change.		
Date Completed (Return to Index)	Enter the date you complete and implement the NCP. After the plan is dated and has the required signatures, send a copy to the CM if your resident is a Medicaid recipient.		
Date Discharged (Return to Index)	Enter the date the resident has left your home.		
Resident's Name (Return to Index)	Enter the resident's name. Include other names (nicknames) they would prefer and pronouns.		
Date of Birth (Return to Index)	Enter the Resident's date of birth		
Primary Language (Return to Index)	Enter the Resident's primary language. Indicate if an interpreter is needed.		

INSTRUCTION SHEET FOR NCP HCS TEMPLATE

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
	this is documented according to WAC 388-76-10401 - 388-76-10401 (1)(a): The home must ensure that the following conditions are present for each resident (a) Privacy in each resident's bedroom, including lockable doors when chosen, with only the resident or residents who live in the room and appropriate staff having the key.		
Bed Mobility/Transfer (Return to Index)	Transfer includes moving between bed, chair, wheelchair, standing position – excludes to/from bath/toilet Indicate care level for bed mobility/transfer – independent, supervision/cueing, assistance needed, or totally dependent. Also indicate if skin care is required due to inability to position self – include any equipment or supplies used. Does the resident need a safety assessment? If so, document how you are going to keep the resident safe.	How does the resident reposition themselves in bed? Do they require assistance or turning on a schedule? Do they have special equipment or procedures such as bridging to prevent bed sores? If the resident uses a bedrail, trapeze, or transfer pole, has there been an assessment completed to explain the dangers to the resident and or their family? This assessment must be in the resident's file. See WAC 388-76-10650	Specifically, what will the caregiver need to do to help this resident while they are in bed? If any specialized equipment is used to help the resident transfer, how is it used? Is the resident a fall risk and if so, what is being done to prevent falls?
Eating (Return to Index)	How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	What kind of food does the resident like to eat? Do they have a special diet prescribed by their doctor? Do they need assistance eating or monitoring for	What does the caregiver do to help the resident eat? Do they prepare meals or ask the resident what his/her preferences are? Do they provide assistance and if so, how?

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
			If the facility doesn't manage the resident funds, how will the facility make sure resident can access funds in a timely fashion if they were to go on an outing or purchase items? How will the facility assist the resident in keeping the funds/checkbook/bank statements/etc. safe?
Shopping (Return to Index)	Indicate care level for Shopping – independent, assistance, or dependent. Does the resident have any special transportation needs? How often would the resident like to go shopping and what are their preferences.	How does the resident do their personal shopping? They may like to go with a family member or purchase special items.	The AFH will provide most of the shopping for food, toiletries, etc. but some residents or their families may do some shopping. Explain how this happens for the resident.
Transportation (Return to Index)	Special transportation needs may include using a lift van, assistive devices to help get in or out of the car, seatbelt extension, etc. Indicate care level for Transportation – independent, assistance, or dependent. Does the resident need an escort? If so, how will it be provided?	What are the resident's transportation needs? Do they have a standing appointment or require special transportation?	The AFH is not required to provide transportation for residents. You do, however, need to coordinate transportation for the resident. Explain how transportation happens for the resident. For example, their family member may transport to medical appointments, or they may use medical transportation services.
Activities/Social (Return to Index)	Social/Cultural considerations, traditions, or preferences Indicate care level for Activities/Social – independent, assistance Needed, or dependent.	What activities does the resident like? Do they go to church on Sunday or meet with family at a particular time? Do they enjoy sitting outside or playing cards?	What do caregivers do to assist the resident in their activities? Do they set up transportation or facilitate an activity? The directions may read something like 'Make sure Mrs. Johnson is up, showered and

Reviewing the Assessment and Service Summary/Service Plan for NCP Development

You assessor will provide you with the resident's assessment and service summary prior/Person Centered Service Plan/Preliminary Service Plan to the resident moving into your home. These two documents are tools you will use to develop your NCP. The following screen shots of Developmental Disabilities Administration (DDA) and Home and Community Services (HCS) assessments and corresponding NCP sections will introduce you to this process.

The following screen shots are intended to provide you with a brief example of DDA/HCS assessment screens and corresponding NCP sections.

NOTE: You will notice as you develop NCPs from the HCS or DDA CARE assessment , that even though most of the two Medicaid assessments are similar in content, they may have a different look.

CARE Assessment: Toilet Use – Continence Issues

Toilet Use

How individual uses the toilet room (or commode, bed pan, urinal); transfers on/off toilet, cleanses, changes incontinence pads, manages ostomy or catheter, adjusts clothes

Self Performance and Support Provided in the last 7 days:
Extensive assistance, One person physical assist

Status and Assistance Available:
Unmet

Client Strengths:
Client is cooperative with caregiver, Can assist caregiver with transfer, Has prescription for pads/briefs

Client Limitations:
Ability fluctuates, Needs clothing adjustment

Client Preferences:
Would prefer a female caregiver

Caregiver Instructions:
Assist with clothing adjustment, Transfer client on/off toilet

Provider:
Angel Care Adult Family Home Services - 01

Continence Issues

Bladder control (last 14 days): Occasionally incontinent

Change in bladder continence (last 90 days): No Change

Bowel control (last 14 days): Continent

Change in bowel continence (last 90 days): No Change

Bowel Pattern (last 14 days):

None of these

Appliances & Programs (last 14 days):

Pads/briefs

Individual management (last 14 days): Uses independently

Toileting/Continence Section from Instructions

INSTRUCTION SHEET FOR NCP HCS TEMPLATE

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
Toileting/continence issues (Return to Index)	How individual uses the toilet room (or commode, bed pan, urinal); transfers on/off toilet, cleanses, changes incontinence pads, manages ostomy or catheter, adjusts clothes. Indicate care level for toileting/continence issues – independent, supervision/cueing, assistance needed, or totally dependent. Indicate frequency/how often toileting occurs. Are there continence issues? Indicate what they are and if there are any equipment/supplies/procedures used. Are there any limitations?	Explain what needs to be done to toilet the resident. Can they assist in the process? How does the resident prefer to toilet (bedside commode, bathroom)? Does the resident require special equipment such as a Hoyer? If incontinent, how often? Does the resident wear incontinence care products, or do they prefer to wear clothes and change if wet? Does the resident have a potential for skin breakdown due to incontinence? Can the resident complete their own incontinent care? If resident can assist with peri care, what can they do?	What does the caregiver need to do to help? How many caregivers should assist? Does the caregiver need to remain with the resident in the bathroom for safety? If required, how should the caregiver use special equipment such as a Hoyer? How often should the resident be toileted? For incontinent residents, how should caregivers protect the resident's skin? Is there a barrier cream? A particular way to cleanse the area? How often should the client be cleaned and changed? If a resident has a special request such as – do not disturb during the night – make a note here for caregiving staff.

Corresponding Template – Toileting/Continence Issues

ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
TOILETING/CONTINENCE ISSUES *How individual uses the toilet room (or commode, bed pan, urinal); transfers on/off toilet, cleanses, changes incontinence pads, manages ostomy or catheter, adjusts clothes* ☐ Independent ☐ Supervision/Cueing ☒ Assistance Needed ☐ Totally Dependent **Frequency/How Often:** Check in with Poppy every 2 hours Continence Issues: **Bladder Incontinence:** ☐ Yes ☐ No ☒ Occasional **Bowel Incontinence:** ☒ Yes ☐ No ☐ Occasional ☐ **Skin care due to bowel/bladder incontinence** **Equipment/Supplies/Procedures:** Pads/briefs **Limitations: Occasional needs assistance**	**Strengths and Abilities** **Poppy requires assistance with toileting. She is able to assist the caregiver with transferring on and off the toilet, but sometimes her ability to help fluctuates.** **She wears Depends** **Poppy would prefer a female caregiver**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to assist the resident during the toileting, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will set up supplies and respond to call button promptly when Poppy calls for help with toileting. Caregiver to assist Poppy to transfer on and off the toilet if needed and help adjust clothing. Caregiver will report any changes in bowel or bladder habits to MD. Caregiver will monitor Res. for s/sx of UTI (e.g., increased urgency/frequency of urine, dark/cloudy/ foul odor to urine, confusion, fatigue, etc.) and consult MD as needed.

CARE Assessment: Poppy McGee, Personal Hygiene Example

Personal Hygiene

How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum

Self Performance and Support Provided in the last 7 days:
Independent, One person physical assist

Status and Assistance Available:
Unmet

Client Strengths:
Able to brush/comb hair, Can brush teeth, Client is cooperative with caregiver, Able to do own peri-care

Caregiver Instructions:
Clean glasses, Trim fingernails as needed

Provider:
Angel Care Adult Family Home Services - 01

Provider trimmed client's finger nails one time in the last 7 days.

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
Personal Hygiene (Return to Index)	Indicate care level for Dressing – independent, supervision/cueing, assistance needed, or totally dependent. Does the resident have their own teeth, partials, or dentures. What kind of oral care is needed? Flossing, brushing, soaking? Does the resident need assistance with their hair? Does the resident need assistance with Menses Care? When/how often? Indicate if there are any equipment/supplies/procedures used. Are there any limitations?	What hygiene tasks, such as brushing teeth, cleaning dentures, brushing hair, washing face, grooming self, shaving can the resident do independently or need some help with? Can resident do tasks independently if needed items are set up?	What will staff need to do to assist resident with brushing hair, brushing teeth, cleaning dentures, shaving, putting on makeup? Do staff set up items and cue resident or do staff complete the task for the resident? Does the resident have a beard or moustache they want to keep? How will staff assist in grooming facial hair if resident does not want it shaved off? Does resident have any special personal care items or brand/product preferences the resident likes to use (favorite shaving cream, certain type of brush, favorite toothpaste)? Who will provide this if it is not an item normally offered by your AFH?

ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
PERSONAL HYGIENE– *How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum* ☒ Independent ☐ Supervision/Cueing ☒ Assistance Needed ☐ Totally Dependent ☒ Own teeth ☐ Partials ☐ Dentures ☒ **Oral Hygiene** (including dentures): ☒ Flossing ☒ Brushing ☐ Soaking ☐ **Hair Care:** ☐ **Menses Care:** **When/how often:** Daily **Equipment/Supplies/Procedures:** **Limitations:**	**Strengths and Abilities** Poppy requires setup to comb her hair, brush her teeth and put on her glasses. She needs help putting in her hearing aid. Poppy is able to do her own peri-care	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will set up supplies for personal hygiene needs and will assist as needed. Caregiver will help Poppy to put in her hearing aids. Caregiver will apply lotion after showers twice weekly. Caregiver will clip her nails and will arrange for a podiatrist to trim her thick toenails.

DDA CARE Assessment Exclusive

The DDA assessment includes a section on Protection and Advocacy Activities and Protective Supervision.

Protective Supervision

What level of monitoring does the client typically require during awake hours?

On site (on property): Cannot be left unattended. Requires a support person on the property at all times, at least during awake hours.

What assistance does the client need to handle unfamiliar/unexpected situations?

Needs someone physically present to assist: When unfamiliar or unexpected situations occur generally someone must be physically present or come to the client to help the client resolve the issue.

Is client able to summon help?

Can seek help inside the house: Client can discern when help is needed, and can summon a caregiver or roommate within the house to assist when necessary

Protection and Advocacy Activities

Activity	Frequency	Type Of Support
Advocating for self	At least once a week, but not once a day	Partial physical assistance
Making choices and decisions	At least once a week, but not once a day	**Partial physical assistance**
Protecting self from exploitation	At least once a day, but not once an hour	**Full physical assistance**
Exercising legal/civic responsibilities	At least once a week, but not once a day	Partial physical assistance
Belonging to and participating in self-advocacy/ support organizations	At least once a month, but not once a week	Partial physical assistance
Obtaining legal services	None or less than monthly	Full physical assistance
Managing money and personal finances	At least once a month, but not once a week	**Full physical assistance**
Advocating for others	At least once a week, but not once a day	Partial physical assistance

1) Would need support to advocate for himself for his personal needs of medical care or getting employment. If he were personally attacked, he would avoid any confrontation and stay away from the person.
2) Can make simple decisions of what to eat and what to wear. With these simple decisions he will need support because he does not make the safest or socially acceptable choices. He would need full support to make more complex decisions.

CLASS ACTIVITY: Completing the Negotiated Care Plan – Poppy McGee

What can you gather from the assessment and what do you gather over the first 30 days the resident is in your home.

1 HCS Poppy McGee – Eating

Assessment Section:

Eating

How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

Self Performance and Support Provided in the last 7 days:
Independent, Setup help only

Status and Assistance Available:
Unmet

Client Strengths:
No swallowing problems

Client Limitations:
Cannot cut food

Client Preferences:
Prefers small portions

Caregiver Instructions:
Bring food to client, Cut food into small pieces

Provider:
Angel Care Adult Family Home Services - 01

Help Screen

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
Eating (Return to Index)	How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) Indicate care level for eating – independent, supervision/cueing, assistance needed, or totally dependent. Indicate if there is a special dies/supplements, eating habits, and/or food allergies. Does the resident use any special equipment/supplies or procedures?	What kind of food does the resident like to eat? Do they have a special diet prescribed by their doctor? Do they need assistance eating or monitoring for choking? Do they require a soft diet or have any allergies?	What does the caregiver do to help the resident eat? Do they prepare meals or ask the resident what his/her preferences are? Do they provide assistance and if so, how? If a resident receives a supplement shake, make sure they have been approved by the resident's doctor first.

NCP Template

Form version:7/25/2023

ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences	Assistance Required Who Will Provide, When, And How
EATING *How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)* ☐ Independent ☐ Supervision/Cueing ☐ Assistance Needed ☐ Totally Dependent ☐ **Special Diet/Supplements:** ☐ **Eating Habits:** ☐ **Food Allergies:** ☐ **Equipment/Supplies/Procedures:** **Limitations:**	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required**

ADL – Eating

How the individual eats and drinks *(regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)*

- What is the level of need for Eating? Independent, Supervision/Cueing, Assistance Needed, or totally Dependent?
- Is there a special diet or supplements? If so, what are they?
- What is the resident's eating habits?
- Does the resident have any food allergies?
- Does the resident use any equipment/supplies/procedures? If so, what are they?
- Does the resident have any limitations?

Resident Strengths and Abilities - What are the resident's strengths and abilities? What does the resident prefer to do independently? What are the resident's preferences?

Assistance Required:

- Who will provide assistance?
- What will the assistance be?
- When will the assistance occur?
- How will assistance occur?

GROUP ACTIVITY: Completing the Negotiated Care Plan – Wild Free

2 DDA Wild Free – Behavior

Behavior

Current Behaviors (occurred in the last 7 days):

Name: Many incidences of uncontrollable crying/tearfulness

Behavior description:

When going to the Dr. he will cry. He may also cry if he has not talked or seen preferred friends for awhile.

Frequency: 1 to 3 Days **Alterability:** Not easily altered

Personalized interventions:

Talk with him, reassure and encourage him. Provide a positive activity after the appt. Help plan visits on regular basis with preferred friends and family.

Help Screen

NCP Template Field	Instruction – Sample Text	Strength & Abilities	Assistance Required
Psych/Social/Cognitive Status	Some of these will be listed in the resident's assessment, but others will develop over time. Be sure to have current information listed for behaviors. If a behavior is no longer happening, be sure to say so. See WAC 388-76-10355 (7)(a). It requires that a plan be developed and followed in the case of a foreseeable crisis due to a resident' assessed need.		What is it that a caregiver can do to address the behaviors or resident is displaying? Document any ono-medication interventions that they should attempt prior to giving a resident a medication (if prescribed "as needed or PRN") You may say something such as "Mrs. Jones is often tearful at night. Speak to her gently and reassure her she is safe. Give her time to express herself and listen to her concerns. If she continues to be tearful, she may have XYZ to help her sleep. If the behavior continues, contact her doctor and her daughter. **For Each Behavior/Symptom/Pattern:** • Describe specific non-medication (behavioral/environmental) interventions to address the symptoms: • Staff strategies/environmental modifications to address behavior: • If **Psychopharmacological Medication** is prescribed to address behavior, list

			medication and describe symptom that each medication is addressing (*for example Lorazepam – for Anxiety*) "Static Text" (in all documents – part of the template) **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)

Medications

The list of medications was obtained from medical record/client/caregiver on the date of this assessment. Do not use this list as the basis for assistance with or administration of medications.

1. Calmoseptine Ointment

Dose Qty: **Route:** Topical
Frequency: PRN (as needed) **Rx:** Yes

2. DEXMETHYLPHENIDATE HYDROCHLORIDE TABLETS

Dose Qty: 5 mg **Route:** Oral
Frequency: BID (2 x day) **Rx:** Yes

3. LISINOPRIL

Dose Qty: 12 mg **Route:** Oral
Frequency: QD (once daily) **Rx:** Yes

4. LORATADINE

Dose Qty: 10 mg **Route:** Oral
Frequency: PRN (as needed) **Rx:** Yes

5. METOPROLOL TABLETS

Dose Qty: 25 mg **Route:** Oral
Frequency: QD (once daily) **Rx:** Yes

6. RISPERDAL

Dose Qty: .05 mg **Route:** Oral
Frequency: QD (once daily) **Rx:** Yes

NCP Template

PSYCH/SOCIAL/COGNITIVE STATUS	Resident Strengths And Abilities Prefers To Do Independently Preferences	Assistance Required Who Will Provide, When, And How
☐ Sleep disturbance Memory Impairment ☐ Short-term ☐ Long-term ☐ Orientated to Person ☐ Impaired decision making ☐ Disruptive behavior ☐ Assaultive ☐ Resistive to care ☐ Depression ☐ Anxiety ☐ Irritability ☐ Disorientation ☐ wandering in home ☐ Exit seeking	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **NOTE: If resident becomes a danger to themselves or others, caregiver is to call 911 immediately.** **Assistance Required**
☐ Hallucinations - If checked, describe: ☐ Delusions - If checked, describe: ☐ Verbally agitated/aggressive ☐ Physically agitated/aggressive ☐ Inappropriate or unsafe behavior ☐ Suicidal Ideation ☐ Other:		
☐ ***Requires psychopharmacological medications.** WAC 388-76-10463 (link) ☐ Behavioral Health Support Crisis Plan (See attached crisis plan)		
DSHS Specialized Behavioral Programs: ☐ Meaningful Day ☐ Expanded Community Services ☐ Specialized Behavior Services ☐ Mental Health Provider/Program Contact info:		
Narrative (optional) – What does a typical day look like?		

ADL – Current Behavior, Last 7 Days

- What is the behavior?
- How is the behavior described?
- How often does it happen?
- Is Wild taking a psychopharmacological medication? If so, what? Are there intervention/changes to staff or the environment that can be made to address the behavior?
- Is there a crisis plan in place?
- Is the resident using any of the Specialized Behavioral Programs

Resident Strengths and Abilities –

- What are Wild's strengths and abilities?
- What does Wild prefer to do independently?
- What are Wild's preferences?
- Does Wild have any limitations?

Assistance Required –

- What are the caregiver instructions?
- Who will provide the assistance?
- What will the assistance be?
- When will the assistance occur?
- How will assistance occur?

Assignment #9 – Completing a Negotiated Care Plan

Use either Poppy McGee or Free Will Assessment Details/Service Summary to complete the following sections of the Negotiated Care Plan Template.

- Page 1
- Communication
- 1 ADL of your choice – Not eating, or any of the examples we used
- The Medication Overview section
- 1 Medication in Medication Management
- Transportation

Monitoring a Resident

On-Going Health Care Monitoring of a Resident

On-going health care monitoring of your residents occurs daily. Once you have established your resident's baseline, you will be able to see changes in your residents over time. A change in a resident's condition may mean that they are at risk. Action can be taken only if changes are noticed and reported, the earlier the better.

As you meet the needs outlined in the NCP, you must document the actions taken and observations made. Be sure you include the date, time, and signature of person making the notation. This may be done as a daily care entry of the issue on a flow sheet or in a progress note format. Any issues that reflect a problem should contain the information about who was notified, such as provider, health care practitioner, physician, or family.

Stop and Watch Tool

The *Stop and Watch* early warning tool, designed by Florida Atlantic University, can help you identify when changes occur in your resident's condition.

Seems different than usual
Talks or communicates less than usual
Overall needs more help than usual
Participated in activities less than usual

Ate less than usual (Not because of dislike of food)
N
Drank less than usual

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

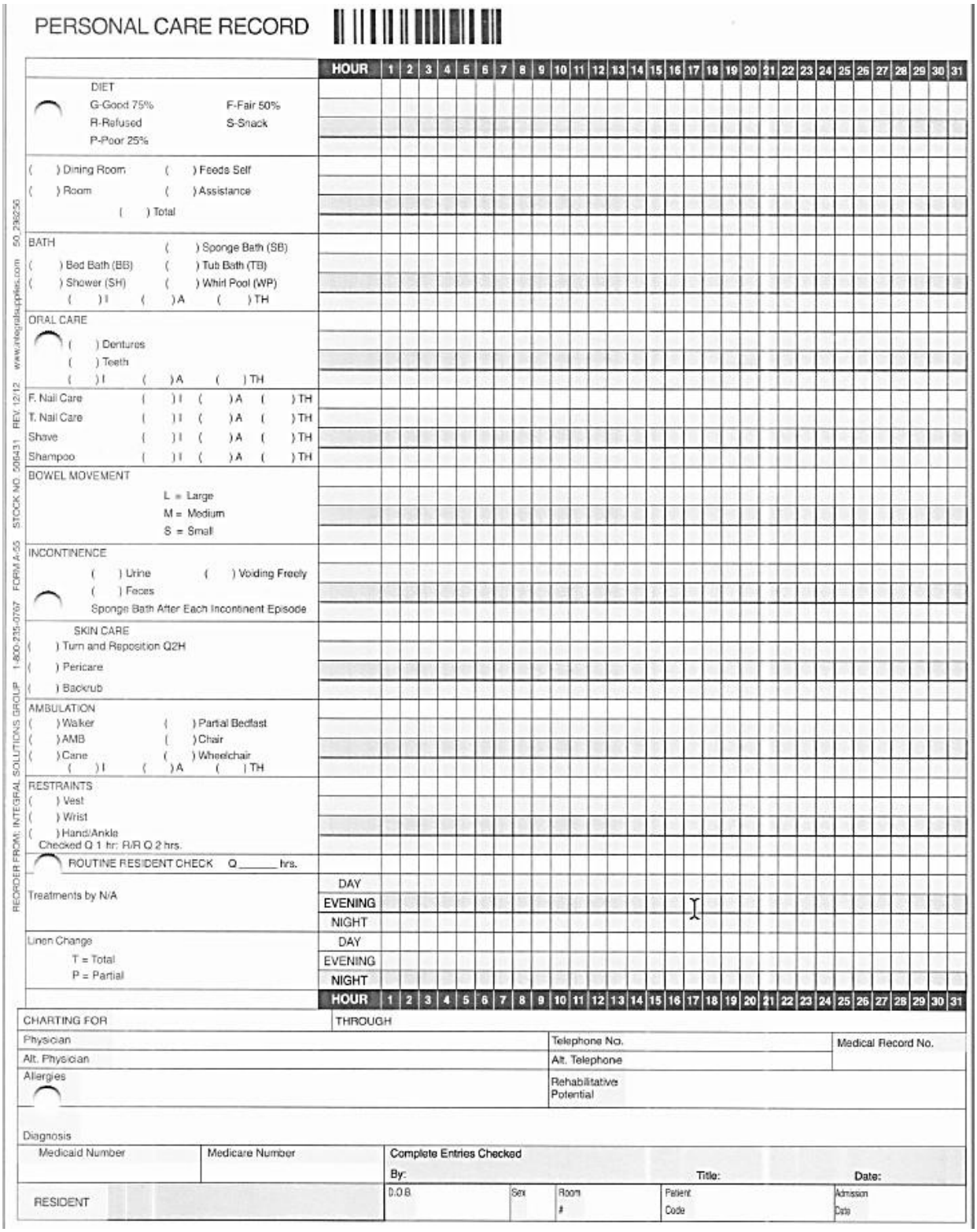
Develop a Monitoring Schedule

You may want to consider the following monitoring schedule:

- Daily
  - Look for anything unusual, positive highlights, changes in care plan
  - Complete the Daily Care Log
- Weekly
  - Head-to-toe skin integrity check
  - Vitals if appropriate (follow PCP directions)
- Monthly
  - Weight
  - Mobility status
  - Mental & behavior status
  - Safety risk

Personal Care Record

You may want to consider using a Personal Care Record form like the one below. You can find several online, or you can create your own.



PERSONAL CARE RECORD

HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

DIET
G-Good 75% F-Fair 50%
R-Refused S-Snack
P-Poor 25%

( ) Dining Room ( ) Feeds Self
( ) Room ( ) Assistance
( ) Total

BATH ( ) Sponge Bath (SB)
( ) Bed Bath (BB) ( ) Tub Bath (TB)
( ) Shower (SH) ( ) Whirl Pool (WP)
( ) I ( ) A ( ) TH

ORAL CARE
( ) Dentures
( ) Teeth
( ) I ( ) A ( ) TH

F. Nail Care ( ) I ( ) A ( ) TH
T. Nail Care ( ) I ( ) A ( ) TH
Shave ( ) I ( ) A ( ) TH
Shampoo ( ) I ( ) A ( ) TH

BOWEL MOVEMENT
L = Large
M = Medium
S = Small

INCONTINENCE
( ) Urine ( ) Voiding Freely
( ) Feces
Sponge Bath After Each Incontinent Episode

SKIN CARE
( ) Turn and Reposition Q2H
( ) Pericare
( ) Backrub

AMBULATION
( ) Walker ( ) Partial Bedfast
( ) AMB ( ) Chair
( ) Cane ( ) Wheelchair
( ) I ( ) A ( ) TH

RESTRAINTS
( ) Vest
( ) Wrist
( ) Hand/Ankle
Checked Q 1 hr; R/R Q 2 hrs.

ROUTINE RESIDENT CHECK Q_____ hrs.

Treatments by N/A — DAY / EVENING / NIGHT

Linen Change — DAY / EVENING / NIGHT
T = Total
P = Partial

HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

CHARTING FOR THROUGH

Physician | Telephone No. | Medical Record No.

Alt. Physician | Alt. Telephone

Allergies | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked By: Title: Date:

RESIDENT | D.O.B. | Sex | Room # | Patient Code | Admission Date

REORDER FROM: INTEGRAL SOLUTIONS GROUP 1-800-235-0767 FORM A-55 STOCK NO. 506431 REV. 12/12 www.integralsupplies.com 50_290256

INITIALS	SIGNATURE & TITLE	INITIALS	SIGNATURE & TITLE	INITIALS	SIGNATURE & TITLE

FORM UDA 5101-5B

MONTH	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Output ( )Foley ( )Other																																
Intake																																
Temperature ( )Other ( )Oral ( )Rectal																																
Pulse																																
Respirations																																
Blood Pressure																																
Weight																																
ROM																																
Initials (Each Shift)																																
	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

ACTIVITIES OF DAILY LIVING

I - Independent
A - Assisted
TH - Total Help
SD - Spec. Dev.
O - Other
BF - Bedfast
CH - Chair
WC - W. Chair
W - Walker
AMB - Ambul.

RESTRAINTS

R/R - Released & Repositioned
VOL - Volunteer
POD - Podiatrist

LOSS OF SENSES

( ) Speech
( ) Hearing
( ) Vision
( ) Touch
( ) Smell

COMMUNICATION

( ) No Communication
( ) Verbal
( ) Voluntary
( ) Non-Verbal
( ) Written
( ) Foreign Language

Common Health Care Monitoring Tasks


- Blood pressure
- Skin condition
- State of hydration
- Appetite/food consumption
- Weight gain or loss
- Mental/emotional status change
- Behavior change, such as wandering or exit seeking
- Ability to perform ADLs
- Mobility
- Diabetes - changes in blood sugar levels
- Safety measures for fall prevention
- Medication changes, adjustments, or additions

When to Call the Health Care Professional

Consider calling the health care provider when your resident displays these conditions:

- Abnormal fatigue
- Temperature more than 101 degrees
- Nausea, vomiting & diarrhea, or shortness of breath
- Lightheadedness
- Headache, especially residents with hypertension
- Excessive sweating
- Problems with vision beyond normal
    - Hearing and Vision.pdf (wa.gov) DDA Caregiver alert #16 (8/10/05) Common Problems of Aging: Hearing and Vision
- Increased confusion; change in mental status/behaviors
    - DDD Office of Quality Assurance—Care Giver Alert # (wa.gov) – Could it be Dementia?
    - Alert #31 The Red Flags of Change final (wa.gov)
- Strong urine odor
- Coughing
    - Aspiration.pdf (wa.gov) – Care Provider Bulletin – April 2019
- Choking, depending on seriousness, could be a 911 call
    - Choking Alert 9 2016.pdf (wa.gov) DDA Choking – Care Provider Bulletin – September 2016
    - Aspiration.pdf (wa.gov) – Care Provider Bulletin – April 2019

- High/Low blood sugars – If it is a Diabetic Emergency, it could be a 911 call. If your resident is experiencing extremely high or low blood-sugar symptoms, especially confusion, call 911.
    - DDA Diabetes (wa.gov) DDA Diabetes – Care Provider Bulletin – May 2019

High blood sugar (hyperglycemia) symptoms:	Low blood sugar (hypoglycemia) symptoms:
• High blood glucose when tested	• Low blood glucose when tested
• Increased thirst	• Shaky or nervousness
• Frequent urination	• Anxiety
• Fatigue	• Fatigue
• Nausea and vomiting	• Weakness
• Shortness of breath	• Sweating
• Stomach pain	• Hunger
• Breath smells "fruity"	• Nausea
• Very dry mouth	• Dizziness or light-headedness
• Rapid heartbeat	• Difficulty speaking
• Infections that worsen	• Confusion

- Decreased appetite/weight loss
    - UNDER WEIGHT – HEALTH RISKS (wa.gov) DDA Caregiver Alert #7 – January 2004
- Dehydration
    - Dehydration.pdf (wa.gov) DDA Care Provider Bulleting – August 2018
- Insomnia that is not normal
- Chest pain
- The beginning of a pressure ulcer
    - Photographs and Descriptions of pressure Ulcers
    - Skin Care & Pressure Sores – Part 1: Causes and Risks of Pressure Sores
    - Skin Care & Pressure Sores – Part 2: Preventing Pressure Sores
    - Skin Care & Pressure Sores – Part 3: Recognizing and treating Pressure Sores
    - DDA Care provider Bulletin – April 2017: Pressure Injuries Care Provider Bulletin.pdf
- Abnormal Edema
- A serious Fall
    - Fall Prevention December 2018.pdf (wa.gov) DDA Fall Prevention – Care Provider Bulletin – September 2018
    - Aging with a Developmental Disability: (wa.gov) – Osteoporosis – DDA Caregiver Alert #17 – August 2005
- Constipation - no bowel movement in three days
- Bowel blockage
    - Bowel Impaction.pdf (wa.gov) DDA Care Provider Bulleting – December 2016
- Gum Disease
    - GUM DISEASE (wa.gov) DDA Caregiver Alert #19

NOTE: This is not a complete list – use your best judgement when determining if you need to call the resident's health care provider.

When to Call 911

An emergency is defined as any situation that requires immediate assistance from the police/sheriff, the fire department, or an ambulance.

Call 911 if:

- The resident's condition is life-threatening
- The resident's condition could worsen and become life-threatening on the way to the hospital
- Moving the resident could cause further injury
- The resident needs the skills/equipment of paramedics or emergency medical technicians
- Distance, traffic, or weather conditions could cause a delay in getting to the hospital

Providing Information to 911:

- Speak calmly and clearly
- Give name, address, phone number, exact location of the resident, and nature of problem (Print out and have by the phone)
- Do not hang up until the dispatcher indicates you can
- The 911 dispatcher can offer some basic care for you to perform while waiting for the ambulance to arrive

Waiting for First Responders

- Follow any instructions the 911 dispatcher gives you while waiting for first responders to arrive.
- If a bleeding wound is evident, apply direct pressure to the wound using cloth or bandages.
- If it is nighttime, turn on the lights to make it easier for first responders to find you.
- Have their emergency packet ready to go – the packet should include a copy of the resident's Advanced Directives, POA, or other legal documents about their wishes for care for the paramedics or hospital. If possible, include a copy of their current medications. If they have a POLST, send the original document with the resident.

When to Call 911.pdf (wa.gov)

See Provider Letter #2024-27 to learn more about What to do in a 911 outage.

Reporting Requirements for COVID-19 and Notifiable Conditions

COVID-19/FLU

Call your local health jurisdiction whenever a resident tests positive for COVID-19 or flu, or if you see a sudden increase in acute respiratory illness (two or more ill residents within 72 hours). Your local health jurisdiction can advise on testing, antiviral treatment, prophylaxis, and infection control. Visit www.doh.wa.gov/localhealth to find your local health jurisdiction.

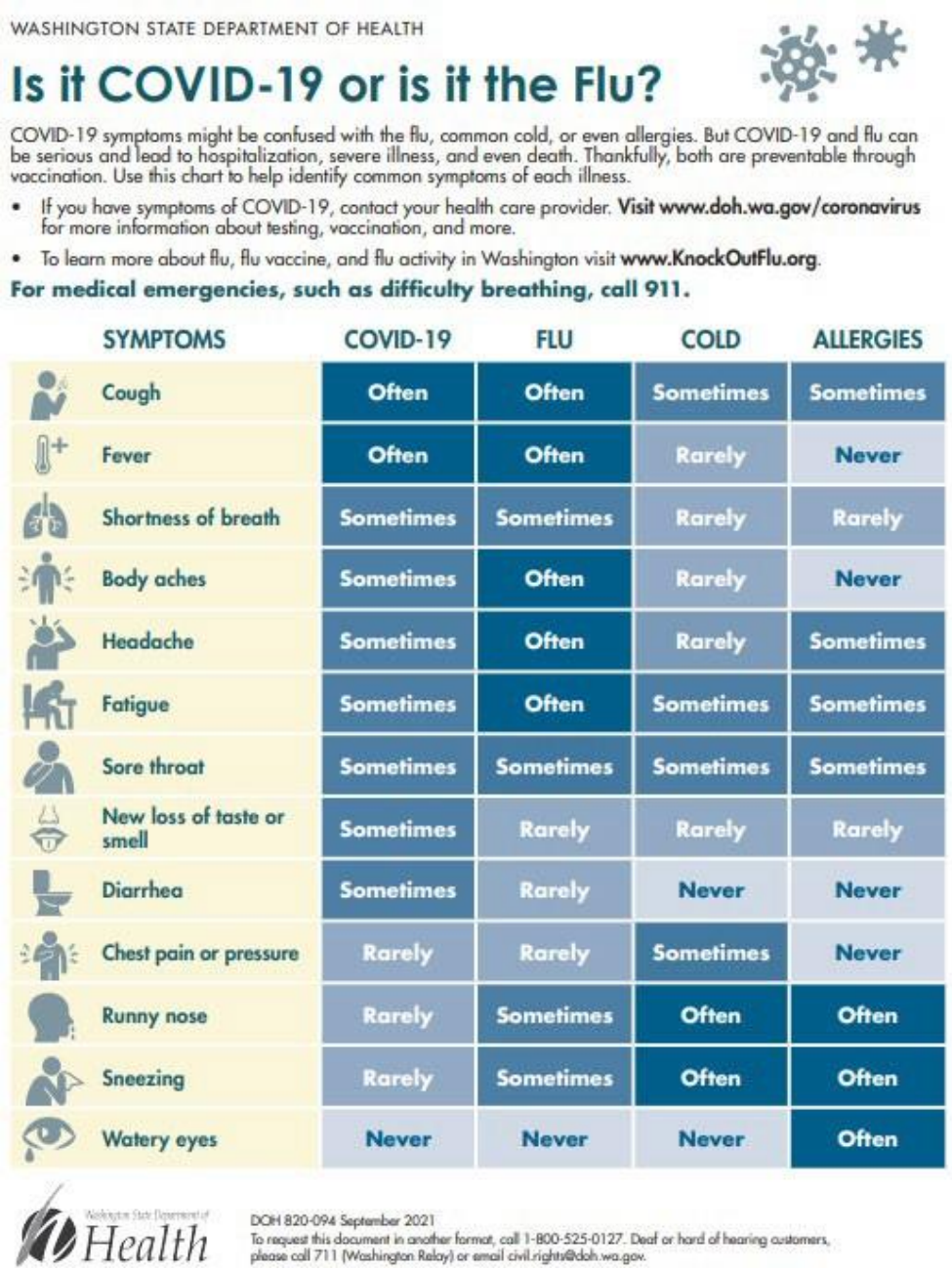
Report a suspected outbreak of COVID-19, flu, or any other communicable disease to the department online (Online Incident Report (wa.gov)) or by calling the hotline at 1-800-562-6078.

Resources: Epidemic

Provider Letter (September 20, 2022): Information for Adult Family Home Providers | DSHS (wa.gov)

Epidemic Preparedness and Response Guidelines

Information for Adult Family Home Providers | DSHS (wa.gov)



WASHINGTON STATE DEPARTMENT OF HEALTH

Is it COVID-19 or is it the Flu?

COVID-19 symptoms might be confused with the flu, common cold, or even allergies. But COVID-19 and flu can be serious and lead to hospitalization, severe illness, and even death. Thankfully, both are preventable through vaccination. Use this chart to help identify common symptoms of each illness.

- If you have symptoms of COVID-19, contact your health care provider. **Visit www.doh.wa.gov/coronavirus** for more information about testing, vaccination, and more.
- To learn more about flu, flu vaccine, and flu activity in Washington visit **www.KnockOutFlu.org**.

For medical emergencies, such as difficulty breathing, call 911.

SYMPTOMS	COVID-19	FLU	COLD	ALLERGIES
Cough	Often	Often	Sometimes	Sometimes
Fever	Often	Often	Rarely	Never
Shortness of breath	Sometimes	Sometimes	Rarely	Rarely
Body aches	Sometimes	Often	Rarely	Never
Headache	Sometimes	Often	Rarely	Sometimes
Fatigue	Sometimes	Often	Sometimes	Sometimes
Sore throat	Sometimes	Sometimes	Sometimes	Sometimes
New loss of taste or smell	Sometimes	Rarely	Rarely	Rarely
Diarrhea	Sometimes	Rarely	Never	Never
Chest pain or pressure	Rarely	Rarely	Sometimes	Never
Runny nose	Rarely	Sometimes	Often	Often
Sneezing	Rarely	Sometimes	Often	Often
Watery eyes	Never	Never	Never	Often

Washington State Department of Health

DOH 820-094 September 2021

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Notifiable Conditions

- Reporting Notifiable Conditions
  - You are legally required to notify public health authorities at their Local Health Jurisdictions of suspected or confirmed cases of selected diseases or conditions. These are referred to as notifiable conditions.
  - Refer to the Department of Health – Notifiable Conditions (PDF flyer). Depending on the condition, immediate, 24 hours, 3 business days, or monthly timeframes may apply.
  - Duties of the health care facility (WAC 246-101-305)

- List of Notifiable Conditions
  - Most of Washington State's notifiable conditions can be found on the List of Notifiable Conditions page. Access to commonly used resources such as reporting forms and investigation guidelines for public health investigators can also be found there, along with links to disease information pages for most conditions. For a complete list of notifiable conditions, see WAC 246-101.

Reporting A Significant Change, Serious Injury, Trauma, Or Death

WAC 388-76-10225 states that when there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

- The resident's family
- The resident's representative if one exists
- The resident's health care provider
- Other appropriate professionals working with the resident
- Persons identified in the negotiated care plan
- The resident's case manager if the resident is a department client
- If there is a death, you must also notify the coroner if required by RCW 68.50.010.

When to Request a Significant Change Assessment

Give the new resident time to adjust to their new home. It may seem like the person you met is not the person who moved in. Joseph Spada, Adult Family Home Administrator instructor and AFH owner, shares the following bit of wisdom:

"This isn't the resident I met last week...!"

While specific reasons vary, a main cause of early discharges is being faced with greater difficulty of care than anticipated. Dementia residents are especially prone to experiencing displacement trauma /adjustment disorder when first moving to a new setting. Failing to anticipate the displacement trauma leads to underestimating the difficulty of care including the amount of effort, manpower, caregiving time, and stress required to meet those sudden "new needs."

An Alzheimer's resident may be calm, pleasant, and functional in their familiar environment where the assessment is done but could become severely confused and disoriented upon being displaced. Although well understood, many providers are often "shocked" to discover greater needs upon moving than those noted during the assessment while the resident was in his/her familiar setting.

The assessment documents current needs, but to anticipate "probable or possible new needs" based on diagnosis or currently prescribed medication requires an astute provider.

Consequently, we see many early discharge attempts caused by "I didn't know they needed so much care." Many [new] providers do not have the experience or insight to read between the lines and anticipate realistic adjustment needs when reviewing the assessment. This causes them to underestimate the additional care and attention that cognitively impaired residents will likely need during the transition period.

For most residents, the worst of the difficulty is in the first 30 to 90 days while they adjust to a new normal. But after just a few days of chaotic evening "sundowning" behaviors, some providers are so overwhelmed that they simply cannot imagine how they'll ever be able to cope with the resident, so they want to discharge.

We talk a lot about the adjustment trauma and playing Sherlock Holmes when reviewing assessments; if you see that a resident has prescribed anti-psychotic medication, there is a reason. There must have been challenges and symptoms that required medical treatment and these will often exacerbate with the stress of moving. If a resident is diagnosed with Alzheimer's or dementia, you need to expect refusal of care & meds, confusion, disorientation, anger, repeated questions, inappropriate toileting, wandering, elopement attempts, etc.

It's much easier when a provider anticipates and plans for likely or potential future needs and what challenges could be expected in the future.

Significant Change

WAC 388-76-10000

A significant change means there is:

- A lasting change, decline, or improvement in the resident's baseline physical, mental, or psychosocial status.
- The change is significant enough so either the current assessment, or negotiated care plan, or both, do not reflect the resident's status; and
- A new assessment may be needed when the resident's condition does not return to baseline within a two-week period.

A Significant Change Assessment may be completed when:

- Requested by the resident; or
- There is a change in their cognition, ADLs, mood and behaviors, or medical condition that impacts their care plan. The change may be an improvement or a decline.

You have several ways to request a Significant Change Assessment:

- Submit a copy of your Negotiated Care Plan with changes noted.
- In writing to the CM. You can submit by fax, email (See the Appendix on how to create a secure email) or mail details outlining the change in the resident's condition that resulted in a change in care provided.
- Submit an Adult Family Home (AFH) Resident Significant Change Assessment Request (15-558) form.

When the CM receives your request, they will:

- Review the request to determine if the changes meet the criteria of a Significant Change as defined in WAC 388-76-10000.
    - **If not**, the CM will notify you that the request does not meet the WAC criteria.
    - **If yes**, the CM will complete the Significant Change Assessment within 30 working days from the date they received the written request.

Discharging a Resident

Discharging a Resident – RCS Inspection/Survey

- A resident may be moved for several reasons:
    - The result of an RCS inspection/survey. RCS may:
    - Issue a statement of deficiency
    - Put a stop placement on your AFH
    - Your license may be suspended or revoked. If this occurs, HCS and RCS work together to ensure the transfer of Medicaid residents to another residential setting
    - Close your AFH

- If your home ceases to operate due to a license suspension and/or revocation or you have voluntarily closed your home, the CM will coordinate with RCS to ensure your residents are moved in a timely manner. The CM will also help in relocating your private residents if they request it.

If there is a stop placement on your home, you will need RCS approval for any residents who are hospitalized or in a nursing facility for a short stay when they want to return home. A private pay resident converting to Medicaid is not considered a new resident.

Resident Choice **-** The resident may choose to leave. In this case, you will need to assist and coordinate the resident's transfer or discharge. Residents may move at will and are not required to give you notice. There are times when the resident's representative/guardian wants the resident to move, and they want to stay, or the resident wants to move, and the representative/guardian wants them to stay. You can also contact the CM for assistance or call the Ombudsman for help.

Reasons for Discharge - You can ask your resident to transfer or discharge from your home if:

- You can no longer meet the care needs of the resident
- The safety or health of other residents are endangered
- The resident has failed to pay
- Your AFH ceases to operate
- You are not renewing your Medicaid contract

Medicaid Discharge - If you are asking a Medicaid resident to move, you must notify their CM. The CM will review or complete an assessment and review the current Negotiated Care Plan (NCP) / Person Centered Service Plan (PCSP) to determine if there is a legitimate reason for the move that is consistent with RCW 70.129.110.

- If the CM determines that you have tried to reasonably accommodate the resident's care needs and the care needs still exceed the license or contract limit of your AFH, the CM will coordinate the relocation of the resident to a different setting.

- If the CM determines that there is no valid reason to discharge, and the resident wants to stay, they will work with you to try to resolve the issue. If the CM is unable to resolve the conflict, they may refer the issue to the Residential Care Services Complaint Resolution Unit and let the resident know they can contact the Ombudsman or file a complaint with RCS.

NOTE: Notices from RCS are confidential when related to potential or planned closures, License Revocations, and Summary Suspensions. Facility administration, residents, and families will not be advised of the pending action.

NOTE: You cannot discharge a resident simply because their status changes from private pay to Medicaid unless it is spelled out in your admission agreement and resident already signed agreeing to it.

It is very important to note that once an individual has moved into your AFH you must follow WAC 366-76-10615 and WAC 377-76-10616 before initiating a discharge. **Even if you have an acceptable reason for the resident to be discharged, you must ensure the individual has a safe place to go before they are officially discharged from your AFH.** Failure to do this can result in a deficiency or citation.

Reasonable Accommodation

"Something done to accommodate a disabled person that does not jeopardize safety or pose an undue hardship for the party (as an employer or landlord) doing it."
(Merriam-Webster)

Reasonable Accommodation - Before a home transfers or discharges a resident, the home must first:

- Attempt, through reasonable accommodations, to avoid the transfer or discharge, unless agreed to by the resident.
    - Document the current challenging needs first
    - Clearly identify needs that were NOT present prior to admission and are present now
    - Document a plan to "accommodate" those (new) needs
    - Objectively document success or failure of the plan

30 Day Notice - Notify the resident and representative, and make a reasonable effort to notify, if known, an interested family member, of the transfer or discharge and the reasons for the move in writing, 30 days prior to the discharge date, unless:

- There is an emergency per RCW 70.129.110
- The resident has been in the facility less than 30 days
- The safety and health of the individuals in the home would be endangered
- An immediate transfer or discharge is required by the resident's urgent medical needs
- The resident has been absent from the home for thirty or more days

The written notification (30 Day Notice) must be in a language and manner the resident understands and include the following:

- The reason for transfer or discharge.
- The effective date of transfer or discharge.
- The location where the resident is transferred or discharged if known at the time of the thirty-day (30) discharge notice.
- The name, address, and telephone number of the state long-term care ombuds.
- For residents with intellectual disabilities, the mailing address and telephone number of the local/regional DDA Ombuds; and
- For residents with a mental illness, the mailing address and telephone number of the local/regional Mental Health (MH) Ombuds. Local/regional Mental Health Ombuds may be replaced later in 2022 with a Statewide MH Ombuds.

Record the following in the resident's record:

- The reason for transfer or discharge.
- The effective date of transfer or discharge; and
- The location to which the resident is transferring or discharging.

If you discharge a resident in violation of WAC 388-76-10615 or WAC 388-76-10616, you must readmit the resident to your home as soon as a gender-appropriate bed becomes available.

NOTE:

- An adult family home must not refuse to admit an individual, or discharge a resident, solely because of a request to conduct authorized electronic monitoring. WAC 388-76-10725
- You must notify each resident at least ninety days before the effective date the home voluntarily decreases the scope of care, services, or activities it provides, if the change will result in the discharge of at least one resident. WAC 388-76-10535

Refunds

WAC 388-76-10540

You must refund any unspent participation within 30 days of the resident's move. You and the resident will receive correspondence from ProviderOne notifying them of the change in client responsibility. You are required to refund the difference between the amount paid and the new amount identified in correspondence to the resident.

When a resident dies, is hospitalized, or is transferred to another facility for more appropriate care and does not return to the home, the adult family home:

- Must refund any deposit or charges paid by the resident less the home's per diem rate for the days the resident actually resided, reserved, or retained a bed in the home regardless of any minimum stay policy or discharge notice requirements.
- May keep an additional amount to cover its reasonable and actual expenses incurred because of a private-pay resident's move, not to exceed five days per diem charges, unless the resident has given advance notice in compliance with the home's admission agreement; and
- Must not require the resident to obtain a refund from a placement agency or person.

The adult family home must not retain funds for reasonable wear and tear by the resident or for any basis that would violate RCW 70.129.150.

The adult family home must provide the resident with all refunds due within thirty days from the resident's date of discharge from the home.

Resident Safety

The Community Protection Act of 1990 (RCW 9A.44.130) requires a sex offender to register in the community where they live. DSHS is notified when a Level II or Level III sex offender registers a new address, and the address is a long-term care facility or AFH.

You may receive notification from the department that a person, who is required to register as a sex offender, is living in your AFH. You have the duty to protect residents. WAC 388-76-10670

You should notify all residents and their representatives of the person's sex offender status. You are required to comply with the laws that apply to your home and take the actions you decide are appropriate.

If this information is not new, is it reflected in their NCP? Do you have adequate safeguards in place to protect your residents? To make this decision, you may need more information from your resident or law enforcement. Public information is available from law enforcement at the Washington Association of Sheriffs and Police Chiefs.

Resource: Dear Provider Letter – ALTSA: AFH #2021-063 *New Notification Policy Regarding People Registered As Sex Offenders Living In Long-Term Care Settings Or Receiving Long-Term Care Services And Supports*

Notice of a Change and Transfer or Discharge Forms

- Adult Residential Care Services Notice of a Change (DSHS 05-249) – This is an optional form for notifying RCS/CM of the discharge.
- AFH Notice of Transfer or Discharge (DSHS 15-258) Optional form to notify your resident of discharge

ASSISTED LIVING FACILITY (ALF) / ADULT FAMILY HOMES (AFH)

Adult Residential Care Services Notice of a Change

To be completed by the facility. Please print.

CLIENT NAME: LAST	FIRST	MIDDLE INITIAL
SEX ☐ Male ☐ Female		DATE OF BIRTH
DSHS ACES CLIENT ID (REQUIRED FOR SUBMISSION)		PROVIDER ONE NUMBER

EFFECTIVE DATE OF ACTION

COMMENTS

Section I. Type of Action

1. ☐ Admission
2. ☐ Discharge
3. ☐ Deceased
4. ☐ Social Leave; from to
   - If exceeds 18 days in calendar year; from to
5. ☐ Change in payment status (converting to Medicaid, etc.)

Section II. Transfer / Discharge Information (Complete the following if Box 1 was checked)

1. ☐ Home
2. ☐ Hospital
3. ☐ Nursing Facility
4. ☐ Assisted Living
5. ☐ Enhanced Services Facility
6. ☐ Institution - DDA ICF-ID, DDA state facility (RHC)
7. ☐ Adult Family Home
8. ☐ Developmental Disabilities Group Home
9. ☐ Hospice / Hospice Care Center
10. ☐ Bed Hold
    a. Discharge date:
    b. Return date:
    c. Other outcome:
11. ☐ Other (specify):

REASON FOR A DISCHARGE

COMMENTS

Section III. Name of the Facility Report the Change

NAME OF THE FACILITY		PHONE NUMBER (WITH AREA CODE)
STREET ADDRESS	CITY	STATE ZIP CODE
NAME OF THE PERSON REPORTING A CHANGE	SIGNATURE	DATE

Section IV. Name of the New Facility

NAME OF THE FACILITY		PHONE NUMBER (WITH AREA CODE)
STREET ADDRESS	CITY	STATE ZIP CODE

This form is to be filled out and mailed to DMS, PO Box 45826, Olympia WA 98599-5826, or faxed to 855-635-8305.

ADULT RESIDENTIAL CARE SERVICES NOTICE OF ACTION Page 1 of 1
DSHS 05-249 (REV. 05/2015)

AGING AND LONG-TERM SUPPORT ADMINISTRATION
RESIDENTIAL CARE SERVICES

Adult Family Home Notice of Transfer or Discharge

WAC 388-76-10615

RESIDENT NAME	ADULT FAMILY HOME NAME

This notice is to inform you that the Adult Family Home intends to transfer or discharge you. If you do not understand this form, ask a relative or friend for help or read the resident resources on the following page.

This is notice that _____ intends to transfer or discharge you to
ADULT FAMILY HOME NAME

_____ on _____.
LOCATION DATE

Reason(s) for the transfer or discharge (if needed, attach a separate sheet to add more information):

☐ 1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this home. Explain:

☐ 2. The safety or health of individuals in this home are or would otherwise be endangered. Explain:

☐ 3. The resident has failed to make the required payment for their stay. Your outstanding balance is $_____. Explain:

☐ 4. The home ceases to operate. Explain:

PROVIDER SIGNATURE DATE	RESIDENT OR REPRESENTATIVE SIGNATURE DATE

Copies to: Resident and/or Representative _____
Home and Community Services Case manager (Medicaid Only)
_____

Read the information on the next page for important resources.

ADULT FAMILY HOME NOTICE OF TRANSFER OR DISCHARGE
DSHS 15-458 (REV. 06/2015)

Assignment #9: Complete Assigned Sections of a Negotiated Care Plan
Page 33

Summary Review

During this module you learned…

- How to successfully support a resident moving into your home
- The documents you need prior to admission
- How to set up Nurse Delegation
- How to develop a NCP and when it needs to be updated
- The importance of working with your resident's health care provider
- When you can discharge a resident and who you coordinate with

Test Your Knowledge

True Or False

1. You can discharge a resident after 6 months if they don't get along with your other residents.
2. You can discharge a resident because the staff does not get along with their family.
3. You have 30 days to complete your NCP.

Get Ready for Your Next Class

- Read assigned modules
- Complete Assignment #9 – Complete assigned sections of the NCP template

Acronyms Used in this Module

Acronym	Description
AAA	Area Agency on Aging
ADL	Activities of Daily Living
BHST	Behavior Health Support Team
CARE	Client Assessment and Reporting Evaluation
CM	Case Manager
CNA	Certified Nursing Assistant
CRU	Complaint Resolution Unit (RCS)
DDA	Developmental Disability Administration
DPOA	Durable Power of Attorney
HCA-C	Home Care Aide – Certified
HCS	Home and Community Services
LTC	Long-Term Care
LTCW	Long-Term Care Worker
MAR	Medication Administration Record
MH	Mental Health
NA-C	Nursing Assistant-Certified
NA-R	Nursing Assistant – Registered
NCP	Negotiated Care Plan

Acronym	Description
ND	Nurse Delegation
PCP	Primary Care Physician
PCSP	Person-Centered Service Plan
POA	Power of Attorney
PQIS	Performance and Quality Improvement Specialist
RCS	Residential Care Services
RCS BHST	Residential Care Behavior Health Support Team
RND	Registered Nurse Delegator
WAC	Washington Administrative Code

Revision Table

Date	Volume	Changes	Page(s)
1/2025	V5.2	• Minor grammar, formatting corrections • Added/removed, and repaired links throughout • Added section on Medical Test Site Waiver License Requirements (pg. 4), also under To Determine… section and What Changes need to be made • Added: **POWERPOINT** See Provider Letter #2024-27 to learn more about What to do in a 911 outage.(pg. 39) • Added Summary Review • Added: Do any of your residents have care needs that require a Medical Test Site Waiver license? To slide 6 and replaced in INST module • Added new slide (new #8) Medical Test Site Waiver License	

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