CA

82068.2 Needs and Services Plan

(a)

Prior to admission, the licensee shall determine whether the day program can meet the prospective client's service needs.

(b)

If the client is to be admitted and has no restricted health condition(s) as specified in Section 82092, then, no later than 30 days after admission, the licensee shall complete a written Needs and Services Plan.

(c)

If the client is to be admitted, and has a restricted health condition as specified in Section 82092, then the licensee shall develop the Needs and Services Plan prior to admission and must include a Restricted Health Condition Care Plan, as specified in Section 82092.2 in addition to the requirements in Section 82068.2(f).

(d)

If the client has an existing needs appraisal or individual program plan (IPP) completed by a placement agency, or a consultant for the placement agency, the Department may consider the plan to meet the requirements of this section provided that: (1) The needs appraisal or IPP is not more than one year old. (2) The licensee and the placement agency agree that the client's physical, mental and emotional status has not significantly changed since the assessment.

(1)

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(2)

The licensee and the placement agency agree that the client's physical, mental and emotional status has not significantly changed since the assessment.

(e)

The written Needs and Services Plan specified in Section 82068.2(f), shall be maintained in the client's file.

(f)

The completed Needs and Services Plan shall include: (1) The client's desires and background and formal supports, obtained from the client, the client's family or their authorized representative, if any, regarding the following: (A) Admission to the facility. (B) A written medical assessment including primary physician, health problems and medical history, prescribed medications and their strength, quantity, frequency required and purpose as specified in Section 82069(b)(3). (C) Mental and emotional functioning. (D) Functional limitations including physical impairments or concerns as follows: 1. Bathing. a. Does not bathe or shower self. b. Performs some bathing or showering tasks. c. Bathes or showers self independently. 2. Dressing: a. Does not dress self. b. Puts on some clothing by self. c. Dresses self completely. 3. Grooming: a. Does not tend to own personal hygiene. b. Tends to some personal hygiene tasks. c. Tends to own personal hygiene. 4. Toileting: a. Not toilet trained. b. Does not toilet by self. c. Goes to toilet by self. 5. Transferring: a. Unable to move in and out of a bed or chair. b. Needs assistance to transfer. c. Is able to move in and out of a bed or chair. 6. Repositioning: a. Unable to reposition. b. Repositions from side to side. c. Repositions from front to back and back to front. 7. Wheelchair: a. Unable to sit

without support. b. Sits without support. c. Needs assistance moving wheelchair. d. Moves wheelchair independently. e. Does not use wheelchair. 8. Continence:a. No bowel and/or bladder control. b. Some bowel and/or bladder control. c. Use of assistive devises, such as a catheter. d. Complete bowel and/or bladder control. 9. Eating: a. Does not feed self. b. Feeds self with assistance from another person. c. Feeds self completely. 10. Vision: a. Severe/profound impairment. b. Mild/moderate impairment. c. No vision impairment. 11. Hearing: a. Severe/profound loss. b. Mild/moderate loss. c. No hearing loss. 12. Communication: a. Does not express nonverbally. b. Does not express verbally. c. Expresses by sounds or movements. d. Expresses self well, both verbally and nonverbally. 13. Walking: a. Does not walk. b. Walks with support. c. Walks well alone. 14. Medical history and conditions. 15. Need for prescribed and non-prescribed medications. 16. Mental and emotional conditions. 17. Socialization and cognitive status. 18. Propensity for behaviors that result in harm to self or others and that require supervision. 19. Ability to manage his/her own finances and cash resources. (E) A social history. (F) Identification of formal support systems. (2) A description of limitation of activities of daily living skills. (3) Scheduled days of attendance. (4) A summary of the assessment findings in Sections 82069(b)(1) through (5) and plans for providing services to meet the identified needs, including: (A) A plan to provide, arrange, or assist in transportation of the client to and from the day program. (B) Time-limited goals and objectives of the care and services to be provided, with provisions for review and modifications as needed. (C) An individual activity plan designed to meet the needs of the client for psychosocial and recreational activities. (D) Recommendations for referrals to other service providers and therapy which the adult day program will coordinate. (5) Specific service needs, if any.

(1)

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Does not walk. b. Walks with support. c. Walks well alone. 14. Medical history and conditions. 15. Need for prescribed and non-prescribed medications. 16. Mental and emotional conditions. 17. Socialization and cognitive status. 18. Propensity for behaviors that result in harm to self or others and that require supervision. 19. Ability to manage his/her own finances and cash resources. (E) A social history. (F) Identification of formal support systems.

(A)

Admission to the facility.

(B)

A written medical assessment including primary physician, health problems and medical history, prescribed medications and their strength, quantity, frequency required and purpose as specified in Section 82069(b)(3).

(C)

Mental and emotional functioning.

(D)

Functional limitations including physical impairments or concerns as follows: 1. Bathing. a. Does not bathe or shower self. b. Performs some bathing or showering tasks. c. Bathes or showers self independently. 2. Dressing: a. Does not dress self. b. Puts on some clothing by self. c. Dresses self completely. 3. Grooming: a. Does not tend to own personal hygiene. b. Tends to some personal hygiene tasks. c. Tends to own personal hygiene. 4. Toileting: a. Not toilet trained. b. Does not toilet by self. c. Goes to toilet by self. 5. Transferring: a. Unable to move in and out of a bed or chair. b. Needs assistance to transfer. c. Is able to move in and out of a bed or chair. 6. Repositioning: a. Unable to reposition. b. Repositions from side to side. c. Repositions from front to back and back to front. 7. Wheelchair: a. Unable to sit without support. b. Sits without support. c. Needs assistance moving wheelchair. d. Moves wheelchair independently. e. Does not use wheelchair. 8. Continence:a. No bowel

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1.

Bathing. a. Does not bathe or shower self. b. Performs some bathing or showering tasks. c. Bathes or showers self independently.

a.

Does not bathe or shower self.

b.

Performs some bathing or showering tasks.

c.

Bathes or showers self independently.

2.

Dressing: a. Does not dress self. b. Puts on some clothing by self. c. Dresses self completely.

a.

Does not dress self.

b.

Puts on some clothing by self.

c.

Dresses self completely.

3.

Grooming: a. Does not tend to own personal hygiene. b. Tends to some personal hygiene tasks. c. Tends to own personal hygiene.

a.

Does not tend to own personal hygiene.

b.

Tends to some personal hygiene tasks.

c.

Tends to own personal hygiene.

4.

Toileting: a. Not toilet trained. b. Does not toilet by self. c. Goes to toilet by self.

a.

Not toilet trained.

b.

Does not toilet by self.

c.

Goes to toilet by self.

5.

Transferring: a. Unable to move in and out of a bed or chair. b. Needs assistance to transfer. c. Is able to move in and out of a bed or chair.

a.

Unable to move in and out of a bed or chair.

b.

Needs assistance to transfer.

c.

Is able to move in and out of a bed or chair.

6.

Repositioning: a. Unable to reposition. b. Repositions from side to side. c. Repositions from front to back and back to front.

a.

Unable to reposition.

b.

Repositions from side to side.

c.

Repositions from front to back and back to front.

7.

Wheelchair: a. Unable to sit without support. b. Sits without support. c. Needs assistance moving wheelchair. d. Moves wheelchair independently. e. Does not use wheelchair.

a.

Unable to sit without support.

b.

Sits without support.

c.

Needs assistance moving wheelchair.

d.

Moves wheelchair independently.

e.

Does not use wheelchair.

8.

Continence:a. No bowel and/or bladder control. b. Some bowel and/or bladder control. c. Use of assistive devises, such as a catheter. d. Complete bowel and/or bladder control.

a.

No bowel and/or bladder control.

b.

Some bowel and/or bladder control.

c.

Use of assistive devises, such as a catheter.

d.

Complete bowel and/or bladder control.

9.

Eating: a. Does not feed self. b. Feeds self with assistance from another person. c. Feeds self completely.

a.

Does not feed self.

b.

Feeds self with assistance from another person.

c.

Feeds self completely.

10.

Vision: a. Severe/profound impairment. b. Mild/moderate impairment. c. No vision impairment.

a.

Severe/profound impairment.

b.

Mild/moderate impairment.

c.

No vision impairment.

11.

Hearing: a. Severe/profound loss. b. Mild/moderate loss. c. No hearing loss.

a.

Severe/profound loss.

b.

Mild/moderate loss.

c.

No hearing loss.

12.

Communication: a. Does not express nonverbally. b. Does not express verbally. c. Expresses by sounds or movements. d. Expresses self well, both verbally and nonverbally.

a.

Does not express nonverbally.

b.

Does not express verbally.

c.

Expresses by sounds or movements.

d.

Expresses self well, both verbally and nonverbally.

13.

Walking: a. Does not walk. b. Walks with support. c. Walks well alone.

a.

Does not walk.

b.

Walks with support.

c.

Walks well alone.

14.

Medical history and conditions.

15.

Need for prescribed and non-prescribed medications.

16.

Mental and emotional conditions.

17.

Socialization and cognitive status.

18.

Propensity for behaviors that result in harm to self or others and that require supervision.

19.

Ability to manage his/her own finances and cash resources.

(E)

A social history.

(F)

Identification of formal support systems.

(2)

A description of limitation of activities of daily living skills.

(3)

Scheduled days of attendance.

(4)

A summary of the assessment findings in Sections 82069(b)(1) through (5) and plans for providing services to meet the identified needs, including: (A) A plan to provide, arrange, or assist in transportation of the client to and from the day program. (B)

Time-limited goals and objectives of the care and services to be provided, with provisions for review and modifications as needed. (C) An individual activity plan designed to meet the needs of the client for psychosocial and recreational activities. (D) Recommendations for referrals to other service providers and therapy which the adult day program will coordinate.

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(B)

Time-limited goals and objectives of the care and services to be provided, with provisions for review and modifications as needed.

(C)

An individual activity plan designed to meet the needs of the client for psychosocial and recreational activities.

(D)

Recommendations for referrals to other service providers and therapy which the adult day program will coordinate.

(5)

Specific service needs, if any.

(g)

The licensee shall involve the following persons in the development of the Needs and Services Plan: (1) The client and his/her authorized representative, if any. (2) Any relative or other care provider participating in placement. (3) The placement or referral agency, if any. (4) The licensee or his/her designee. (5) A direct care staff person as defined in Section 82001(d).

(1)

The client and his/her authorized representative, if any.

(2)

Any relative or other care provider participating in placement.

(3)

The placement or referral agency, if any.

(4)

The licensee or his/her designee.

(5)

A direct care staff person as defined in Section 82001(d).

(h)

The licensee shall document the results of the initial assessment of the client, conducted pursuant to Health and Safety Code section 1180.4(a) prior to or on the day of admission. (1) The licensee shall document the initial assessment based on information available at the time of the assessment. This information shall be maintained and made current thereafter as needed. (2) This assessment shall include, but not be limited to, input from the following parties: the client, authorized representative, if any, and, if the client chooses, a person designated by the client. That designated person may be present at the time of admission in accordance with Health and Safety Code section 1180.4(a). (3) This assessment shall also include, based on the information available at the time of the initial assessment, all of the following: (A) A client's advance directive regarding de-escalation or the use of seclusion or manual restraints. This advance directive means the client's wishes regarding techniques the licensee will use related to de-escalation or the use of restraint and seclusion. 1. The licensee shall be required to honor the client's advance directive unless it violates statute, regulation, or jeopardizes the health or safety of the client or another person. 2. A

de-escalation technique is one designed to defuse a potentially dangerous interaction between two or more individuals. (B) Identification of early warning signs, triggers, or any actions or situations that cause the client to escalate, and identification of the earliest cause of aggression for the client, with a known or suspected history of aggressiveness, or who is currently aggressive. (C) Techniques, methods or tools that would help the client control their behavior. (D) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion. (E) Any trauma history, including any history of sexual or physical abuse, the client feels is relevant. (F) The client's Individual Emergency Intervention Plan, as required by Section 82168.2(a).

(1)

The licensee shall document the initial assessment based on information available at the time of the assessment. This information shall be maintained and made current thereafter as needed.

(2)

This assessment shall include, but not be limited to, input from the following parties: the client, authorized representative, if any, and, if the client chooses, a person designated by the client. That designated person may be present at the time of admission in accordance with Health and Safety Code section 1180.4(a).

(3)

This assessment shall also include, based on the information available at the time of the initial assessment, all of the following: (A) A client's advance directive regarding de-escalation or the use of seclusion or manual restraints. This advance directive means the client's wishes regarding techniques the licensee will use related to de-escalation or the use of restraint and seclusion. 1. The licensee shall be required to

honor the client's advance directive unless it violates statute, regulation, or jeopardizes the health or safety of the client or another person. 2. A de-escalation technique is one designed to defuse a potentially dangerous interaction between two or more individuals. (B) Identification of early warning signs, triggers, or any actions or situations that cause the client to escalate, and identification of the earliest cause of aggression for the client, with a known or suspected history of aggressiveness, or who is currently aggressive. (C) Techniques, methods or tools that would help the client control their behavior. (D) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion. (E) Any trauma history, including any history of sexual or physical abuse, the client feels is relevant. (F) The client's Individual Emergency Intervention Plan, as required by Section 82168.2(a).

(A)

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The licensee shall be required to honor the client's advance directive unless it violates statute, regulation, or jeopardizes the health or safety of the client or another person.

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A de-escalation technique is one designed to defuse a potentially dangerous interaction between two or more individuals.

(B)

Identification of early warning signs, triggers, or any actions or situations that cause the client to escalate, and identification of the earliest cause of aggression for the client, with a known or suspected history of aggressiveness, or who is currently aggressive.

(C)

Techniques, methods or tools that would help the client control their behavior.

(D)

Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion.

(E)

Any trauma history, including any history of sexual or physical abuse, the client feels is relevant.

(F)

The client's Individual Emergency Intervention Plan, as required by Section 82168.2(a).