WAC 388-107-0120 Initial comprehensive person-centered service plan. (1) The enhanced services facility must ensure that when the person-centered service planning team develops the initial comprehensive person-centered service plan, the team integrates the information contained in the following documents:

(a) The resident's preadmission assessment;

(b) Initial comprehensive assessment;

(c) Initial person-centered service plan; and

(d) The medicaid client's comprehensive assessment reporting evaluation (CARE) assessment.

(2) The enhanced services facility must ensure strategies for solving conflict or disagreement within the process of the development of the initial comprehensive individual treatment plan, including clear conflict-of-interest guidelines for all planning participants.

(3) The enhanced service facility must ensure the person-centered service planning team:

(a) Completes the initial comprehensive person-centered service plan within fourteen days of the resident's move-in date;

(b) Provide the initial comprehensive person-centered service plan to the resident in a clear and understandable format that is accessible to the resident, including those with disabilities and persons with limited English proficiency;

(c) Ensures the resident, or the resident's representative, when applicable, consents to the initial person-centered service plan in writing and that the plan is signed by all individuals on the person-centered service planning team; and

(d) Distributes a copy of the initial comprehensive person-centered service plan to the resident and all others responsible for the implementation of the plan.

(4) The enhanced services facility must ensure the person-centered service planning team includes the following in each resident's initial comprehensive person-centered service plan:

(a) A list of the care and services to be provided;

(b) Identification of who will provide the care and services;

(c) When and how the care and services will be provided;

(d) A method for the resident to request updates to the plan as needed;

(e) A list of services the resident may self-direct;

(f) How medications will be managed, including how the resident will receive medications when the resident is not in the facility;

(g) The resident's daily activities preferences, spiritual or cultural preferences, or both, interests, strengths and needs and how the facility will meet those within the behavioral challenges of the resident;

(h) Other preferences and choices about issues important to the resident, including, but not limited to the setting in which the resident resides, food, daily routine, grooming, and how the enhanced services facility will accommodate these preferences and choices;

(i) Communication barriers the resident may have and how the enhanced services facility will use communication techniques and nonverbal gestures to communicate with the resident;

(j) A hospice care plan if the resident is receiving hospice care services from a licensed hospice agency;

(k) Advance directives, if the resident chooses, that are validly executed pursuant to chapters 70.122 and 71.32 RCW, as applicable;

(l) A plan for working with the department of corrections (DOC) if the resident is under the supervision of DOC, collaborating to maximize treatment outcomes and reduce the likelihood of reoffense;

(m) A plan that maximizes the opportunities for independence, maintaining health and safety, recovery, employment, the resident's participation in treatment decisions, collaboration with peer-supported services, and care and treatment provided in the least restrictive manner appropriate for the resident and consistent with any relevant court orders with which the resident must comply;

(n) A plan that addresses factors and barriers that prevent the resident from being placed in a less restrictive community placement upon discharge from the ESF;

(o) A plan that identifies factors that support the resident during the resident's transition to the ESF and a future transition to a less restrictive community placement;

(p) A plan that identifies all current medications, including the resident's ability to self-medicate in a more independent living situation; and

(q) A behavioral support plan to prevent crisis and maintain placement in the facility that includes the following:

(i) A crisis prevention and response protocol that outlines specific indicators which may signal a potential crisis for the resident;

(ii) Specific interventions and pre-crisis prevention strategies for each of the resident's indicators of a potential crisis;

(iii) A crisis prevention and response protocol that outlines steps to be taken if the prevention or intervention strategies are unsuccessful in diverting the crisis including the community crisis responder's coordination plan; and

(iv) A description of how to respond to a resident's refusal of care of treatment, including when the resident's physician or practitioner should be notified of the refusal.

[Statutory Authority: RCW 70.97.230 and HCBS Final Rule 42 C.F.R. WSR 16-14-078, § 388-107-0120, filed 7/1/16, effective 8/1/16. Statutory Authority: Chapter 70.97 RCW. WSR 14-19-071, § 388-107-0120, filed 9/12/14, effective 10/13/14.]