

Kansas Administrative Regulations

Department of Health and Environment

Article 39.—Licensure of Adult Care Homes

28-39-234. Quality of care.

(a) Each facility shall develop and provide a system of mental health treatment and medical care for all residents including all aspects of care from admission through discharge. The system shall include the following provisions.

(1) Each facility shall conduct for each resident an admission assessment based upon information from available sources and document the findings in the resident's record.

(2) Each facility shall write an initial treatment plan for each resident based on the admission assessments which will be used to guide the treatment provided for the resident with necessary documented revisions until the implementation of the mental health plan of care.

(3) Each facility shall conduct and document in each resident's record comprehensive assessments that will be used to formulate the mental health plan of care.

(4) Each facility shall write and implement the mental health plan of care with necessary revisions through the course of each resident's stay.

(5) Each facility shall identify and document in each resident's record a discharge plan that integrates the wishes of the resident or legal representative.

(b) A mental health plan of care for each resident shall be developed by an interdisciplinary team including the resident or the resident's legal representative, or both, within 21 days after admission. The resident, or the resident's legal representative has the ultimate authority to accept or reject the plan. The mental health plan of care shall be approved and have its progress monitored by a mental health professional.

(1) The mental health plan of care shall be based on the comprehensive assessments and directed toward objective resident outcome.

(2) Each facility shall assist each resident in obtaining access to academic services, community living skills training, legal services, self-care training, support services, transportation, treatment and vocational education as needed. These services may be provided by the facility or obtained from other providers.

(3) Services to each resident shall be provided in the least restrictive environment and shall incorporate the use of community experiences when relevant.

(4) If needed services are not available and accessible, the facility shall document the actions taken to locate and obtain those services. The documentation shall identify needs which will not be met because of the lack of available services and why they cannot be met.

(5) The mental health plan of care shall be written, dated, signed by the interdisciplinary team members, including the resident, and maintained in the resident's record.

(6) The mental health plan of care shall include:

- (A) Medical directives;
- (B) behaviorial directives;
- (C) specific services to be provided;
- (D) persons or agency responsible for providing services;
- (E) beginning dates for services;
- (F) anticipated duration of services; and
- (G) a discharge plan.

(7) The mental health plan of care shall identify the procedure to be used to determine whether the objectives were achieved. This procedure shall incorporate a process for ongoing review and revision.

(8) The interdisciplinary team shall review the mental health plan of care for each resident at least quarterly and at the time a resident's condition changes. The interdisciplinary team review shall include a written report in the resident's record which addresses:

- (A) The resident's progress toward objectives;
- (B) the need for continued services;
- (C) recommendations concerning alternative services or living arrangements; and

(D) those persons involved in the review and the date of the review.

(9) Each facility shall develop procedures for recording implementation and progress of the activities of the mental health plan of care and the resident's response. These procedures shall include the following provisions.

(A) A written progress note shall be placed in the resident's record following the delivery of each single service required by the mental health plan of care.

(B) A weekly summary shall be written by the staff and placed in the resident's record for services provided more than once a week.

(C) All progress and summary notes shall be signed and dated by the person who provides the service.

(D) Additional entries shall be provided in the resident's record when significant incidents occur.

(E) Notes shall be written in specific terms based on behavioral observations and activity responses of the resident. Entries that involve subjective interpretations of a resident's behavior or progress shall be clearly identified and shall be supplemented with descriptions of behavior upon which the interpretation was based.

(c) There shall be written policies and procedures concerning crisis intervention. These policies and procedures shall be:

(1) Directed to maximizing the growth and development of the resident by listing a hierarchy of available alternative methods that emphasize positive approaches;

(2) available in each program area and living unit;

(3) available to residents and their families; and

(4) developed with the participation, as appropriate, of residents served.

(Authorized by and implementing K.S.A. 39-932; effective May 16, 1994.)

***** Authenticated Kansas Administrative Regulation *****