10A NCAC 13E .0602 PLANNING SERVICES FOR INDIVIDUAL PARTICIPANTS

(a) At enrollment of a new participant, the program shall perform an assessment and written service plan for the individual. The assessment shall address the individual's ability to perform activities of daily living and need for supervision while in the program. The mental and physical health status of the individual shall also be assessed. The service plan shall be signed and dated by the administrator or designee. The health component of the service plan shall be written and signed by a registered nurse.

(b) In developing the written service plan, the program shall include input from the participant, responsible party, other caregiver and other agency professionals with knowledge of the individual's needs. The service plan shall be based on strengths, needs, and abilities identified in the assessment. The assessment and service plan shall be reviewed to assure continued accuracy at each admission for overnight respite services. The service plan shall include:

(1) the needs and strengths of the participant;
(2) the interests of the participant;
(3) the service goals and objectives of care for the participant while in the overnight respite program;
(4) the type of interventions to be provided by the program in order to reach desired outcomes;
(5) the services to be provided by the program to achieve the goals and objectives;
(6) the roles of the participant, responsible party, other caregiver, volunteers and program staff; and
(7) the time limit for the plan, with provision for review and renewal.

(c) The participant, responsible party, other caregiver and other service providers may contribute to the development, implementation, and evaluation of the service plan.

(d) The participant's record shall include:

(1) a copy of the medical examination report;
(2) the written service plan;
(3) documentation of a tuberculosis test according to Rule .0601(f) of this Section;
(4) documentation of any contacts (office, home or telephone) with the participant's physician or other licensed health professionals from outside the facility;
(5) physician orders;
(6) medication administration records;
(7) a written description of any acute changes including any unusual behavior, change in condition, need for help or services, or any incidents or accidents resulting in injury to the participant, and any action taken by the facility in response to the changes, incidents or accidents; and
(8) how the responsible party or his or her designated representative can be contacted in case of an emergency.

(e) The program shall refer a participant to the participant's physician or other appropriate licensed health professional immediately if the participant's behavior, change in condition, any incidents or accidents resulting in injury to the participant, or need for help or services poses an immediate risk to the health and safety of the participant, other participants, or staff in the program.

(f) Any unusual behavior, change in condition, incident or accident resulting in injury to the participant, or need for help or services shall be reported by the program staff to the responsible party.

(g) Progress notes in the participant's record shall be updated every 24 hours while in the program.

(h) The participant or the responsible party may choose the days and number of days the participant will participate in the program with the administrator's approval and documented in the participant's record.

(i) The reason for any unscheduled participant absence shall be documented by the program staff on the day it occurs. Program staff shall contact or attempt to contact the absent participant or the responsible party and shall document this contact in the participant's record.

(j) The program is responsible for the participant while the participant is enrolled. A participant leaving the program for part of a day shall sign out, relieving the staff of further responsibility. If a participant has an emotional or mental impairment that requires supervision or is adjudicated incompetent, and that person needs or wants to leave the program during the day, the responsible party or individuals designated by the responsible party shall sign the participant out.

(k) The participant's responsible party or his or her designated representative shall be contacted and informed of the need to remove the participant from the program if one or more of the following conditions exists:

(1) the participant's condition is such that he or she is a danger to himself or herself, or poses a direct threat to the health of others, as documented by a physician or appropriate licensed health professional; or
(2) the safety of individuals in the facility is threatened by the behavior of the participant, as documented by the facility.

Documentation of the emergency discharge shall be retained on file in the facility.
(l) After the participant has left the program or died, the program shall maintain the participant's record in the facility for one year, and then stored for two more years.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.