Wood County Board of Developmental Disabilities

PROCEDURE

Procedure #:	02-ALL-ALL-0610 (SS)	**Subject:**	PAS/RR
Effective Date:	03-15-01	**Last Revision:**	11-16-2017
Person Responsible:	Director of Service and Support Administration		

Approvals/Date:

Brent C Barn 11/24/17
Superintendent, WCBDD Date

Claude R. Kight
Department Director Date

1. Upon receipt of the request for a Further Review, the Director Service and Support Administration will assign Pre-Admission Screening/Resident Review-Developmental Disabilities (PAS/RR-DD) determination and other Service and Support Administration responsibilities to the Service Coordinator/Intake & Eligibility on an individual basis and shall notify the Ohio Department of Developmental Disabilities (DODD) that a request has been received.

2. The Service Coordinator/Intake & Eligibility shall ensure that the individual and/or authorized representative of the individual is involved in the determination process. If available and with the consent of the individual or their legal representative, the family of the individual shall also be involved in the determination process.

3. The Service Coordinator/Intake & Eligibility and/or the DODD shall be responsible for specifying and requesting any information necessary to make a PAS/RR-DD determination.

4. The Service Coordinator/Intake & Eligibility will ensure that any notifications of the PAS/RR-DD review and subsequent written and verbal information will be presented to the individual and/or their legal representative in a manner understood and which is adapted to their cultural background, ethnic origin, and means of communication.

5. The Service Coordinator/Intake & Eligibility will ensure that the individual has completed an eligibility determination through the OEDI/COEDI process, in accordance with OAC 5123:2-1-14. If there is no evidence of DD, the Service Coordinator/Intake & Eligibility will complete the Rule Out section of the OBRA Assessment Summary form required by the DODD.

6. The Service Coordinator/Intake & Eligibility will collect data and complete the evaluation and assessment of Nursing Facility (NF) need, Developmental Disability (DD), and Specialized Service need as required by OAC 5123:2-14-01. The Pre-Admission Screen will be completed and submitted to the DODD within five (5) working days of the receipt of the request. The Resident Review will be completed and submitted to the DODD within five (5) working days of the receipt of the request. At a minimum, the following documentation will be maintained in the Service and Support Administration record for all PAS/RR evaluations conducted:

- OBRA PAS/RR Evaluation Summary
- PAS/RR ID Screen (#3622)
- LOC (#3697) or alternative form specified by the ODJFS
- Social History and Personal Background
- Psychological Assessment
- OEDI/COEDI
- Medical (Admit History and Physical)
- Current Physician's Orders
- Nursing Care Plan
- Current Medications and Responses
- Minimum Data Set (MDS+)
- Other On-going Therapy Reports
- Letter of Determination

7. Data utilized by the Service Coordinator/Intake & Eligibility must be considered valid, accurate, and reflective of the current functional status of the individual.

8. The Service Coordinator/Intake & Eligibility will report the findings of the PAS/RR-DD in writing utilizing the OBRA Assessment Summary form required by the DODD and will identify the individual(s) making the determination and the individual(s) performing the assessment.

9. Based upon the results of a comprehensive analysis of all data and consideration of the most appropriate placement and service options, the Service Coordinator/Intake & Eligibility will recommend to the DODD whether or not the individual requires the level of services provided by a NF. If NF services are recommended, a recommendation will be made for specialized services to be provided or arranged by the Wood County Board of Developmental Disabilities (Board) and/or to the extent possible, services of lesser intensity to be provided by the NF to meet the individual's need. If NF services are not recommended, the Service Coordinator/Intake & Eligibility will provide a statement of the basis for that conclusion. Additional information will be provided upon request by the Service Coordinator/Intake & Eligibility to the DODD to make a determination.

10. The Service Coordinator/Intake & Eligibility shall make a recommendation for specialized services when the individual requires continuous supervision, treatment and training to address needs in each of the life areas in which functional limitations have been identified through evaluation and assessment of strength and needs. Specialized services will be integrated with the NF plan of care and reflected in the Individual Plan. Each service provider shall maintain a record of documented service provision.
11. The Service Coordinator will monitor the individual's progress and condition at least every 90 days and will ensure the delivery of specialized services by attendance and participation in the nursing care plan meetings and Individual Plan meetings, direct contact with the individual, and periodic record and medical chart review.
12. The Service Coordinator will address the need for other services in the Service and Support Administration Individual Service Plan.
13. The Service Coordinator/Intake & Eligibility may make a recommendation to the DODD for a Categorical Determination of a NF need when the individual is being admitted for up to 14 days for respite for the care giver and plans to return to the care giver at the end of the NF stay or the individual is being admitted pending further assessment in emergency situations requiring protective services with placement not to exceed 7 days. In the event that the individual's stay exceeds the time specified, the Service Coordinator/Intake & Eligibility will complete a Resident Review within 9 working days after the end of the specified period.
14. The Service Coordinator/Intake & Eligibility may make a recommendation to the DODD for a Categorical Determination that specialized services are not needed when the individual with DD has a diagnosis of dementia, or the individual is being admitted for up to 14 days for respite for the care giver and plans to return to the care giver at the end of the NF stay, or the individual is being admitted pending further assessment in emergency situations requiring protective services with placement in the NF not to exceed 7 days.
15. Should the individual's medical doctor issue a physician's order that the individual continues to require NF placement after the convalescent exemption expires, the Service Coordinator/Intake & Eligibility will conduct a Resident Review to determine the need for continued stay.
16. Prior to or simultaneously to an emergency stay in a NF, the Service Coordinator will participate as member of the individual's interdisciplinary team to assess the individual and to develop a plan to provide services and/or provide information regarding placement options to be implemented after the expiration of an emergency stay.
17. Prior to a respite stay in a NF, the Service Coordinator will ensure that an appropriate plan is established for the individual to return to the care give after the expiration of the respite stay.
18. When an individual who is suspected of having DD or a significant mental illness is found to be residing in a NF and who has no previous PAS/RR-DD record and upon notification of such a situation, the Director of Service and Support Administration will assign Pre-Admission Screening/Resident Review-Developmental Disabilities (PAS/RR-DD) determination and other Service and Support Administration services responsibilities to a Service Coordinator/Intake & Eligibility on an individual basis and shall notify DODD that a notification has been received. When conducting the Resident Review for such individuals, the Service Coordinator/Intake & Eligibility will determine if they are considered to be long-term residents of the NF, as defined by the 30-month rule.
19. For persons determined to be eligible for Board services, the Service Coordinator will monitor the individual's progress and condition by attendance and participation in the nursing care plan meetings, direct contact with the individual at least every 90 days, and periodic record and medical chart review.
20. In the event that a significant change in mental or physical condition occurs which would affect the individual's level of care needs, rehabilitation services, or specialized services, the Service Coordinator will initiate an immediate interdisciplinary team meeting to address the current needs assessed, and will determine the need for an updated Resident Review.
21. When conducting a PAS/RR-DD for individuals who are seeking admission into a NF, the Service Coordinator/Intake & Eligibility will adhere to the skilled level of care criteria as outlined in OAC 5101:3-3-05 for Skilled Level of Care (SLOC) and OAC 5123:2-14-01. Service Coordinators will adhere to the DD level of care criteria as outlined in OAC 5101:3-3-07 for individuals who do not meet the criteria for a skilled level of care and who are not long-term residents of the NF, as defined by the 30-month rule.
22. When it is determined that an individual is inappropriately placed because they do not have the level of care need for services provided by the NF, the Service Coordinator will provide information and advise the individual and/or their legal representative of alternative community placement options, including ICF/ID and other residential placements available, Home and Community-Based Service Waivers, and Supported Living options. The individual and/or their legal representative will sign a statement acknowledging receipt and understanding of such information regarding alternative placement options.
23. Individuals who have DD and specialized service needs *and* who are long-term residents of the NF may choose to remain in the NF even though the placement would otherwise be inappropriate. The Service Coordinator will provide information and advise the individual and/or their legal representative of alternative, appropriate community placement options, including ICF/ID and other residential placements available, Home and Community-Based Service Waivers, and Supported Living options. The individual and/or their legal representative will sign a statement acknowledging receipt and understanding of such information regarding alternative placement options.
24. In the event that it is determined that the individual must be discharged from the NF (must move) because the individual does not have a level of care need for services provided by the NF *and* the individual does not require specialized services, the Service Coordinator will simultaneously place the individual's name on a Must Move List and the Emergency Placement Waiting List maintained by the County Board (Service Coordinator/Intake & Eligibility). The Service Coordinator, in conjunction with the NF, will arrange for a safe and orderly discharge from the NF. The Service Coordinator will actively pursue all available placement options via state-wide search, contacts with surrounding county boards, and a review of vacancy listings, as consented to by the individual and/or their legal representative and in accordance with the Service and Support Administration services Placement Procedure 02-ALL-ALL-0173 (SS).

25. The County Board Service Coordinator/Intake & Eligibility will maintain a Must Move List for individuals required to be discharged from NF placements. This list shall be reviewed on a monthly basis and be maintained in the Service and Support Administration Coordinator's office. The Service Coordinator/Intake & Eligibility shall notify in writing the DODD of any individual's discharge from a NF when that individual was in a "must move" status.

References: OAC 5101:3-3-05; 5101:3-3-07; 5123:2-1-14; 5123:2-14-01
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