# Health, Department of

## Wyoming Life Resource Center

### Chapter 3: Canyons Intermediate Care Facility for People with Intellectual Disabilities

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CHAPTER 3

Rules and Regulations for the Wyoming Life Resource Center

Canyons Intermediate Care Facility for People with Intellectual Disabilities

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Life Resource Center Act, W.S. § 25-5-103(i), which authorizes the Center to provide Intermediate Care Facility for People with Intellectual Disabilities services and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq*. The Department of Health licenses these services pursuant to W.S. § 35-2-901(a)(xiv), and in compliance with the Code of Federal Regulations (42 CFR 440.150-483.480(d)(5)).

Section 2. Intermediate Care Facility for People with Intellectual Disabilities Conditions of Federal Participation. To be certified to receive Federal funding as an Intermediate Care Facility for People with Intellectual Disabilities, the following standards are established in Federal regulations and adhered to by the Canyons Intermediate Care Facility for People with Intellectual Disabilities.

(a) 42 CFR 483.410(a) through (e), Condition of Participation: Governing body. Standards:

(i) Governing body

(ii) Compliance with Federal, State and local laws

(iii) Client records

(iv) Services provided under agreements with outside sources

(v) Licensure

(b) 42 CFR 483.420(a) through (d), Condition of Participation: Client protections. Standards:

(i) Protection of clients' rights

(ii) Client finances

(iii) Communication with clients, parents, and legally authorized representatives

(iv) Staff treatment of clients

(c) 42 CFR 483.430(a) through (e), Condition of Participation: Facility staffing. Standards:

(i) Qualified intellectual disability professional

(ii) Professional program services

(iii) Facility staffing

(iv) Direct care residential living unit staff

(v) Staff training program

(d) 42 CFR 483.440(a) through (f), Condition of Participation: Active treatment services. Standards:

(i) Active treatment

(ii) Admissions, transfers, and discharges

(iii) Individual program plan

(iv) Program implementation

(v) Program documentation

(vi) Program monitoring and change

(e) 42 CFR 483.450(a) through (e), Condition of Participation: Client behavior and facility practices. Standards:

(i) Facility practices-conduct toward clients

(ii) Management of inappropriate client behavior

(iii) Time-out rooms

(iv) Physical restraints

(v) Drug usage

(f) 42 CFR 483.460(a) through (n), Condition of Participation: Healthcare services. Standards:

(i) Physician service

(ii) Physician participation in the individual program plan

(iii) Nursing services

(iv) Nursing staff

(v) Dental services

(vi) Comprehensive dental diagnostic services

(vii) Comprehensive dental treatment

(viii) Documentation of dental services

(ix) Pharmacy services

(x) Drug regimen review

(xi) Drug administration

(xii) Drug storage and recordkeeping

(xiii) Drug labeling

(xiv) Laboratory services

(g) 42 CFR 483.470(a) through (l), Condition of Participation: Physical environment. Standards:

(i) Client living environment

(ii) Client bedrooms

(iii) Storage space in bedrooms

(iv) Client bathrooms

(v) Heating and ventilation

(vi) Floors

(vii) Space and equipment

(viii) Emergency plan and procedures

(ix) Evacuation drills

(x) Fire protection

(xi) Paint

(xii) Infection control

(h) 42 CFR 483.480(a) through (d), Condition of Participation: Dietetic services. Standards:

(i) Food and nutrition services

(ii) Meal services

(iii) Menus

(iv) Dining areas and service

Section 3. Purpose. This Chapter is being adopted to:

(a) Provide admission and discharge processes;

(b) Establish eligibility criteria for applicants to the Canyons program at the Center;

(c) Prescribe the Individual Program Plan process; and

(d) Define active treatment services.

Section 4. Eligibility and Application Process for Services.

(a) An applicant for residential service in the Canyons program shall first make application to the Division for services per Wyoming Medicaid Rules for the Adult Developmental Disabilities Home and Community Based Waiver or the Children's Developmental Disabilities Home and Community Based Waiver. An applicant who has already qualified for one of these two waiver services shall present documentation of qualification.

(b) The Division shall provide applicants and their families or legally authorized representatives a written resource guide regarding services for individuals with developmental disabilities in the State of Wyoming.

(b) Eligibility under this Chapter is limited to persons who complete the application process and who meet the following requirements:

(i) A diagnosis of developmental disability, as determined by a psychologist and as defined in federal law, 42 U.S.C. 15002(8), a severe, chronic disability of an individual that:

(A) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) Is manifested before the individual attains the age of twenty-two (22) years;

(C) Is likely to continue indefinitely;

(D) Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

(I) Self-care;

(II) Receptive and expressive language;

(III) Learning;

(IV) Mobility;

(V) Self-direction;

(VI) Capacity for independent living; and

(VII) Economic self-sufficiency.

(E) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

(ii) A diagnosis of a related condition, as determined by a physician and functional limitations verified by a psychologist;

(iii) An Inventory for Client and Agency Planning services score equal to or less than seventy (70); or

(iv) When the Inventory for Client and Agency Planning score is more than seventy (70), the applicant must also have a deficit in three (3) or more of the six (6) domains noted in this section.

(c) If the applicant is eligible for Division services the applicant:

(i) Will be funded for services for a home and community based waiver;

(ii) May pursue admission to the Center;

(iii) May pursue emergency services through Medicaid Rules on home and community based waivers;

(v) Will be placed on the waiting list for services; or

(vi) May pursue temporary services at the Center.

Section 5. Admission to the Center.

(a) When an applicant notifies the Division that he chooses residential services from the Center, an admission request form may be obtained from the Center or the Division. The admission request form will be completed by the applicant or legally authorized representative and submitted to the Center.

(b) If a current waiver participant chooses to request services at the Center, an admission request form for Center services will be completed by the applicant or legally authorized representative and submitted to the Center. The Center staff will forward the request to the appropriate waiver representative.

(c) The Center staff shall receive the admission request form and coordinate with the applicant and other appropriate sources to obtain information requests, appropriate medical, demographic and programmatic information pertinent to care and services required by the applicant. The applicant or his legally authorized representative shall be responsible for submitting the admission request form and all required documentation to the Center staff.

(d) An admission request form is valid for six (6) months from the date of submission to the Center. After that time, if necessary documentation has not been received, the applicant must reapply.

(e) When all of the required documentation has been received, Center staff shall notify the applicant the formal thirty (30) day review will begin, and forward the completed application packet to the Administrator and the screening team.

(f) Membership of the screening team is determined by the Director. The preadmission screening and assessment shall be completed within thirty (30) days of receipt of completed application.

(i) The screening team shall review the applicant's information.

(ii) The screening team may assign a preliminary interdisciplinary team to include Division waiver staff for the purpose of conducting further assessments and evaluations. The preliminary interdisciplinary team may visit the applicant to complete preliminary assessments, including an assessment regarding the least restrictive, most appropriate and most integrated placement, and submit the report to the screening team.

(iii) The screening team shall conduct a final review of the applicant's information, including any report(s) submitted by a preliminary interdisciplinary team.

(vi) A recommendation shall be made to the Administrator in writing.

(g) The Administrator shall review the screening team's recommendations and make a determination regarding the request for placement. The Administrator shall notify the applicant, legally authorized representative, and referring agency representative (if applicable) in writing, regarding placement within ten (10) days after receiving the screening team's recommendation.

(h) If the applicant is denied admission, the notice of denial will be consistent with Wyoming Life Resource Center Rules, Chapter 2, Administrative Hearings.

(i) If the applicant is approved for admission, a Center interdisciplinary team will be assigned.

(j) A transition meeting will be scheduled by Center staff with the applicant, the applicant's legally authorized representative, and a representative of the Division waiver staff and current provider, if applicable, to coordinate transition to the Center.

(k) The Center Program Manager or designee will provide the client or legally authorized representative a copy of her rights after arriving at the Center.

Section 6. Initial Individual Program Plan Development.

(a) Each client admitted to the Center shall have on file at the Center an individual program plan. The individual program plan shall be prepared by an interdisciplinary team within thirty (30) days of admission for residential services under the supervision of the Program Manager. The plan shall be reviewed by the interdisciplinary team for appropriateness and feasibility of discharge or transition to another level of service thirty (30) days after implementation of the plan, at the end of each quarter for the first year, and annually thereafter.

(b) A client shall be determined no longer eligible when he:

(i) Does not meet eligibility when re-tested;

(ii) No longer meets the requirements of an Intermediate Care Facility for People with Intellectual Disabilities; or

(iii) Changes residence to another state.

Section 7. Development of the Annual Individual Program Plan by an Interdisciplinary Team.

(a) The purpose of the interdisciplinary team process is to provide team members with the opportunity to review and discuss information and recommendations

relevant to the client's needs and to reach decisions as a team, rather than individually, on how best to address those needs, including transfer or discharge to another service.

(b) The interdisciplinary team is comprised of the client, legally authorized representative, and those individuals, professionals, and paraprofessionals who possess the knowledge, skills, and expertise necessary to accurately identify the comprehensive array of the client's needs and design a program that is responsive to those needs. The number of individuals who comprise the interdisciplinary team is based upon each client's individual needs and may vary.

(c) To ensure informed choice, placement options are reviewed annually, or anytime by request, with the client and/or legally authorized representative. The plan developed by the interdisciplinary team will include documentation of appropriateness of placement at the Center or at any other placement recommended.

(d) For a school-aged client, the home school district develops the individual education plan and the Center will coordinate the individual program plan process.

Section 8. Individualized Active Treatment Services. Each client must receive a continuous active treatment program, which includes aggressive and consistent implementation of a program of specialized and generic training, treatment, health services, and related services to acquire the behaviors necessary for the client to function with as much self-determination and independence as possible. The active treatment program is pervasive, systematic, and sufficient in scope to ensure that individuals are appropriately served by assessing each individual client's needs in the following areas:

(a) Physical Development and Health: The client's developmental history, results of the physical examination conducted by a licensed physician, physician assistant, or nurse practitioner, health assessment data (including a medication and immunization history), which may be compiled by a nurse, and skills normally associated with the monitoring and supervision of the client's own health status, and administration and/or scheduling of the client's own medical treatments.

(b) Nutritional Status: The determination of appropriateness of diet, adequacy of total food intake, and the skills associated with eating.

(c) Sensorimotor Development: The development of perceptual skills that are involved in observing the environment and making sense of it. Motor development includes those behaviors that primarily involve muscular, neuromuscular, or physical skills and varying degrees of physical dexterity. Assessment data identifies the extent to which corrective, orthotic, prosthetic, or support devices would impact the functional status of development.

(d) Affective (Emotional) Development: The development of behaviors that relate to his or her interests, attitudes, values, and emotional expressions.

(e) Speech and Language (Communication Development): The development of both verbal and nonverbal and receptive and expressive communication skills. Assessment data identifies the appropriate intervention strategy to be applied and which, if any, augmentative or assistive devices will improve communication and functional status.

(f) Auditory Functioning: The extent to which a person can hear and to the maximum use of residual hearing, if a hearing loss exists, and whether or not the client will benefit from the use of amplification, including a hearing aid or a program of amplification. Assessment may include teaching techniques for conducting the assessment or the use of electrophysiological techniques.

(g) Cognitive Development: The development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning, and problem solving.

(h) Social Development: The formation of self-help, recreation and leisure, and interpersonal skills that enable a client to establish and maintain appropriate roles and fulfilling relationships with others.

(i) Adaptive Behaviors or Independent Living Skills: The effectiveness or degree with which clients meet the standards of personal independence and social responsibility expected of their age and cultural group. Independent living skills include, but are not limited to, such things as meal preparation, doing laundry, bed making, and budgeting. Assessment may be performed by anyone trained to do so.

(j) Vocational (Prevocational) Development, as applicable: The work interests, work skills, work attitudes, work-related behaviors, and present or future employment options.

Section 9. Discharge.

(a) Transfer or discharge occurs only when:

(i) The Center cannot meet the individual's needs;

(ii) The individual no longer requires an active program in an Intermediate Care Facility for People with Intellectual Disabilities setting;

(iii) The individual or his legally authorized representative chooses for him to reside elsewhere; or

(iv) A determination is made, by testing or review, that another level of service or living situation, either internal or external, would be more beneficial.

(b) The Center will provide a reasonable time to prepare the client and her legally authorized representative for the transfer or discharge (except in emergencies).

(c) At the time of discharge, the Center shall:

(i) Develop a final summary of the client's development, behavioral, social, health, and nutritional status, and with the consent of the client or legally authorized representative, provide a copy to authorized persons and agencies.

(ii) Provide a post-discharge plan of care that will assist the client in adjusting to the new living environment.

(d) The Administrator shall formally discharge the client with written notification to the client and legally authorized representative and the court, if necessary.

(e) If a client or legally authorized representative chooses to change to another Division service provider, he shall inform Center staff of the decision. Center staff shall then contact the Division waiver staff and begin the process outlined in Wyoming Medicaid Rules for home and community based services.