I/DD, APD & MH - RESIDENT RE-SCREENING SHEET

MCAR: 023-080-208: Operators must also re-screen a current resident who has been admitted to a hospital and/or other care facility prior to allowing the resident to return to the adult care home. **If it is determined that the resident's care needs exceed the classification of the home, the Operator may submit an out-of-class exception to the ACHP prior to readmitting the resident if the Operator determines that the home can continue to meet the resident's care needs**. **Prior to admitting the resident, the Operator shall obtain written approval from the ACHP**. If the Operator determines that the home can no longer meet the resident's care needs, this determination shall be documented on the screening sheet and shall clearly demonstrate the basis for refusing the resident's readmission to the home. A copy of the screening shall be given to the resident or the resident's representative, the resident's case manager/services coordinator, and the ACHP within 24 hours of making the determination.

Resident's legal name:_____DOB:_____

Resident's preferred name: _____

Date of Face to Face re-screening with resident:_____

Hospital/Facility name: _____

Date Admission to Hospital/Facility:_____

Use this area to identify any changes in the residents Medical or Behavioral needs.

1. Are there any new diagnoses for the resident? ☐Yes ☐No

   If so, what are they:_____

2. Will the resident require new equipment? ☐Yes ☐No, If so what type: _____

   Who is ordering the equipment?_____Delivery Date_____

   Will the new equipment fit in the room? ☐Yes ☐No

3. Is the resident room and home accessible to the resident? ☐Yes ☐No (like: ramp, grab bars).

4. Are skilled nursing tasks required? ☐Yes ☐No (like: wound care, bowel program, insulin injection).

   If a delegation or teaching is needed, who will be the RN:_____When? _____

5. Does the resident need follow up care such as Home Health, Physical Therapy? ☐Yes ☐No

   If so, who is responsible for setting up appointments?_____

6. Has there been a significant change in Support Needs:_____

_____

New Medications:_____

New Night Needs:_____

New Protocols or Treatments Identified: ☐Aspiration ☐Dehydration ☐Seizure ☐ Constipation ☐Diabetes ☐Other

_____

New Staffing Needs: have supports to behavioral/ADL needs changed? ☐ Yes ☐No
If so, please indicate: ☐ Exclusive focus ☐1:1 or ☐ 2:1, ☐ Two Person Transfer
Please note: Ensure you staff available to meet the residents needs, before reamiting.

Have Evacuation Needs Changed? ☐ Yes ☐No If so, how? (like 2 person transfer, wheel chair, walker, cueing): _____
(Keep in mind providers must be able to evacuate all occupants in 3 minutes or less)

Summary of Discharge Plan:_____
_____
_____
_____
_____

Classification Determination: Read each one of these and check the appropriate box. If you need additional information please reference the Classification Worksheet.

☐ **Resident's needs have been determined to be APD/MH/DD Level 1**
APD/MH/DD homes serve residents with 4 or fewer ADLs and has no complex medical and may not have a delegated task or a need for complex behavioral supports.

☐ **Resident's needs have been determined to be APD/MH Level 2 or DD Level 2M**
APD/MH homes serve residents with 3 or less **full** assist in ADLs, and complex medical conditions.

☐ **Resident's needs have been determined to be DD Level 2B**
2B homes serve residents who are or have a history or are searching for opportunities to injure self or others or have a history of or acts of damage to property by fire or other means. These homes do not serve residents with complex unstable medical conditions.
Oregon Intervention System (OIS) required

☐ **Resident's needs have been determined to be APD Level 3 or DD Level 2**
APD/MH/DD homes serve residents who need assistance with 4 or more ADLs and/or complex medical (skilled, unstable or life threatening). Residents may also have informal or formal behavior supports related to medical diagnosis like Dementia or Alzheimer's.

☐ I have determined that the resident's service needs are within the classification of my care home.

☐ I have determined that the resident's service needs are outside of my classification, and resident may not re-admit. Due process rights for residents? Resident was provided copy of re-screening?

☐ **Exception Request:** I have submitted an exception request to ACHP with evidence that such an exception does not jeopardize the care, health, welfare or safety of any resident. This evidence indicates that all residents' needs can be met and that all occupants can be evacuated within three minutes. Upon approval from ACHP of my exception request, I will re-admit the resident.

Operator signature:_____Date: _____