

Move ins and Move outs in an Assisted Living Community

- The client move in should always provide a complete explanation of what constitutes a social model. This is the time to educate regarding the breadth *and* limits of an Assisted Living.
- Clarify and explain that the AL in Kentucky is not a medical model & your community is neither a nursing home nor a hospital (community emergency buttons should be used for emergencies... not simple every day tasks).

Why concern ourselves with semantics?

Why not simply use the words “admission and discharge?”

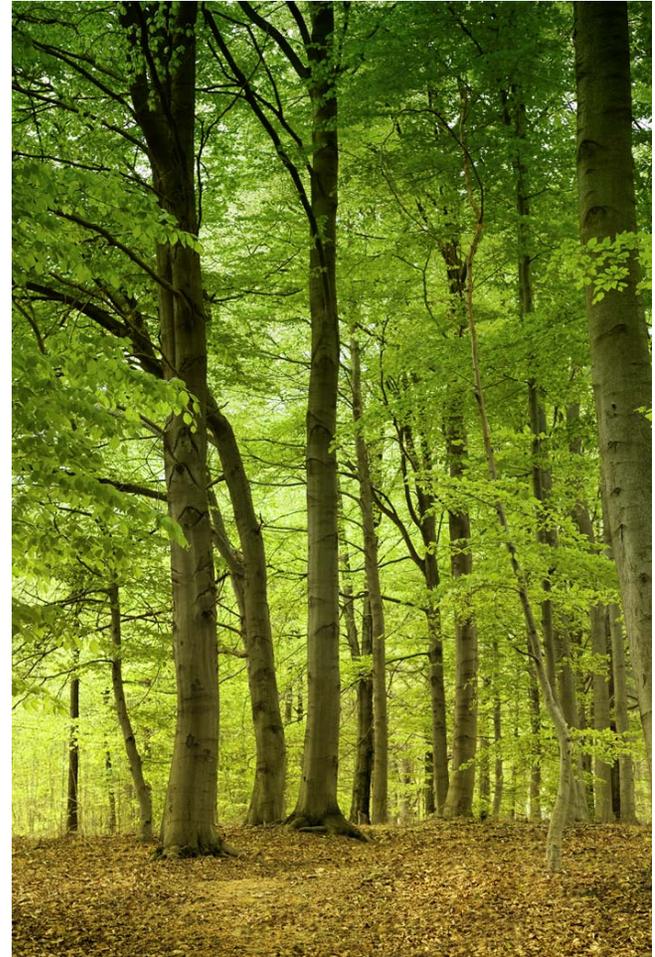


The public is largely uninformed regarding Assisted Living regulations

- The use of terms “Admission and discharge” strongly imply medical intervention and many *current* clients/families of AL do not know the parameters of the social model. They know only of the medical model.
- It is all of our jobs to enlighten and clarify and educate. The term “over the level of care” should be understood and recognized by, not just clients and families, but by staff of the Assisted Living communities.
- This is accomplished by being up front and honest with all clients about the eventuality of physical decline and the parameters to which the Assisted Living cannot go.

From where do Clients come?

- Many Assisted Living communities actively market to hospitals
- Advantages?
- Disadvantages?



Medicare benefits for eligible Americans

If a Medicare eligible client has been in the hospital for 3 days and is discharged from the hospital with orders for PT or OT or Speech Therapy and/or skilled nursing intervention (such as injections, wound treatment etc) then this client qualifies for Medicare paid residency in a nursing home with 24 hour nursing *and* CNA coverage for up to 3 months.

Moving a Medicare eligible client from hospital to an Assisted Living

- A Sentinel event has occurred
- Client is weak
- Physician has ordered skilled services
- Client's judgment/mental acuity is likely compromised because;
- It takes up to 6 weeks for a geriatric to fully metabolize & evacuate anesthesia-narcotics.
- Fall risk during this period doubles.

The Functional Needs Assessment

- The FNA is proof of a client's function during a specific segment of time
- It is a record that you have assessed and verified that this client is appropriate for move in, as well as continued residency.
- Be up front and honest with all clients with regard to their FNAs.
- Elicit their attention to the process so they may self motivate in order to remain in the AL.
- Facilitating dependency, (“spoiling”) a client by doing things for them only hastens decline and ultimate need for move out.

Documentation

- Are your functional needs Assessments accurate? Are all listed questions answered? With explanation?
i.e.: “Does Mrs. Smith understand simple concepts?”
Answer- “no” ??
- If a client has a temporary health condition is it documented?
- Is the anticipated length of the temporary condition documented?
- Are frequent FNAs being done to accordingly reflect impairment or decline...or improvement?
- Is there a written plan to ensure that the client is not a danger during the temporary health condition phase?
- Is there a written evacuation plan for this client?

HOSPICE

- A client MAY have Hospice upon move in if they meet all AL eligibility criteria.
- A hospice client must continue to meet all AL criteria during residency OR must have documentation of a temporary condition for which safety measures are detailed, and evacuation is assured via externally contracted or family presence.

Move outs

We receive objections-complaints when families-clients consider themselves out of the communication loop

