Service Plans That Live in Practice

Compliance and resident-centered care across Washington assisted living, memory care, and nursing homes

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WHCA | 60-minute session to grow for long term success

Three settings, one leadership obligation

The terminology and timing differ. The expectation for individualized, implemented care remains consistent.

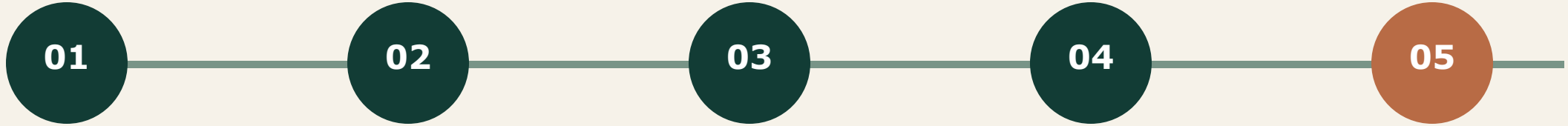
SETTING	CORE PLAN	TIMING / REVIEW	RESIDENT-CENTERED REQUIREMENT
Assisted living	Initial resident service plan, then negotiated service agreement	Initial plan at admission. NSA within 30 days. Update after change and at annual review.	Resident participation, assessed preferences, clear roles, service timing, and agreed interventions.
Certified memory care	Individualized NSA plus dementia-specific information	Full assessment at least every 6 months. Update when condition or needs change.	Life history, behavior meaning, activity preferences, communication, movement, and staffing response.
Nursing homes	Comprehensive person-centered plan of care	Baseline plan within 48 hours under federal rule. Comprehensive plan within 7 days after assessment. Review after significant change and through quarterly assessment.	Measurable objectives, resident goals and choices, interdisciplinary input, and implementation by qualified staff.

Leadership implication **Standardize the management system while preserving the correct legal pathway for each setting.**

Washington requirements verified September 2026

The service-plan control cycle

Compliance becomes reliable when every change moves through the same closed-loop process.



01 Assess

Capabilities, needs, risks, preferences, decision-making authority

02 Agree

Resident goals, service choices, roles, frequency, and acceptable alternatives

03 Translate

Clear direction that staff can follow on every shift

04 Deliver

Right service, right time, documented response, respectful approach

05 Verify and revise

Observe outcomes, detect change, reassess, update, communicate

Change triggers

Fall or injury, hospital return, medication effect
Behavior pattern, weight or intake change, new resident preference

Recommended workflow shown. Required update triggers and timelines vary by setting.

Resident-centered plans connect choice to observable action

RESIDENT VOICE

“I want to walk to breakfast. Please cue me before offering hands-on help.”

Assessment finding

New orthostatic dizziness and two nighttime falls. Resident uses a walker and values independence.

Service direction

Offer “Bob” standby assistance for the first morning transfer and after nighttime toileting. Cue before touch. Bob uses a walker and has a transfer pole for transfers at bedside. Encourage hydration. He prefers cold water and iced tea with lemon. Stop and notify the nurse the same shift for dizziness, near-fall, or refusal with increased weakness.

Washington memory care in 2026

Certified settings must connect the new regulatory structure to each resident's daily experience.

2026

Memory Care
and
Cognitive deficit support

ASSESSMENT	**Full assessment at least every 6 months for residents with dementia in certified memory care.**
INDIVIDUALIZATION	**Life history, communication, ability to initiate activity, and behavior patterns inform the negotiated service agreement.**
DAILY DELIVERY	**Activities reflect function, interests, habits, and preferences. Staffing plans support assessed waking, sleeping, and eating needs.**
TRANSPARENCY	**Required disclosure includes staffing information. Significant staffing reductions require notice within 30 days.**
CLINICAL LEADERSHIP TEST	**Can staff explain what a behavior may communicate and the individualized response the resident prefers?**

Washington rules verified September 2026

Paper compliance and practice compliance

A complete record matters. Leaders also verify whether the plan is current, understood, and delivered.

COMMON FAILURE	LEADERSHIP CONTROL
Assessment finding never reaches the plan	Trace high-risk findings to a named intervention and owner
“Assist as needed” creates shift-to-shift variation	Use observable actions, timing, resident preference, and escalation thresholds
Update waits for the annual review	Build event-based triggers with due dates and escalation
The record differs from what staff know or do	Interview staff and observe care during leadership rounds
Plan requirements exceed available staffing	Reconcile assessed needs, assignments, competencies, and staffing plans

Recommended leading indicators Timely change-trigger closure, current signatures, actionable interventions, staff-to-plan match, resident confirmation

Leading indicators shown are recommended management measures, not regulatory thresholds.

A 30-day clinical leadership commitment

Start with a small trace audit, repair the system, and verify the resident experience.

DAYS 1–7

Trace

Sample 10 residents across settings. Follow assessment findings through the plan, assignment, staff knowledge, and resident experience.

DAYS 8–14

Standardize

Define change triggers, accountable roles, due dates, escalation, and the handoff method for every shift.

DAYS 15–21

Validate

Review revised plans with residents or representatives. Confirm direct care staff can describe and deliver the current approach.

DAYS 22–30

Sustain

Bring trends to quality review. Assign corrective actions, track leading indicators, and repeat focused audits monthly.

A service plan earns its value when the resident recognizes themselves in it and staff can carry it out on the next shift.

OPEN DISCUSSION

Questions & answers

Thank you for joining—and for putting your communities and residents first.