



Health Resources  
Development Service

Oklahoma State  
Department of Health

Health Facility Systems  
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## ALZHEIMER'S DISEASE OR RELATED DISORDERS SPECIAL CARE DISCLOSURE FORM

All questions relate to the specialized Alzheimer's disease or related disorders care the individual facility provides. The use of the word "resident" refers to residents with Alzheimer's disease or related disorders.

### Facility Instructions

1. Complete this Disclosure Form according to the care and services your facility provides. You may **not** amend the form, but you may attach an addendum to expand on your answers.
2. Provide copies of the Disclosure Form to anyone who requests information on the care for Alzheimer's or related disorders in your facility.
3. If the facility is a Continuum of Care Center (CCRC), indicate the service at Facility type. For instance, if the Alzheimer's beds are in the Assisted Living Center (ALC) portion/service of a CCRC, list as ALC, not CCRC, so that service can be identified with the bed type. If a CCRC has Alzheimer beds, in the ALC, and the nursing facility (NF), a disclosure form is to be submitted for each facility type.
4. The form is to be submitted with the application, for renewal, change of ownership, and bed additions that affect the total number of licensed beds in the facility. For these submittals the form is to be mailed with the application to PO Box 268823, Oklahoma City, OK 73126-8823.

### Facility Information

Facility Name: Cedarcrest Care Center  
 License Number: 3700473045 Telephone Number: 918-251-3200  
 Address: 1306 E. College St. Broken Arrow, OK 74012  
 Administrator: Tracy Owen Date Disclosure Form Completed: 5/15/17  
 Completed By: Tracy Owen Title: Administrator  
 Number of Alzheimer Related Beds: 30  
 Maximum Number of participants for Alzheimer Adult Day Care: -0-

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### What types of providers must furnish a Disclosure Form?

State rules require the Disclosure Form be provided by any nursing or specialized nursing facility, residential care home, assisted living center, continuum of care facility, or adult day care center that advertises, markets or otherwise promotes they provide care or treatment to residents with Alzheimer's disease or related disorders in a special unit or under a special program.

### What is the purpose of the Disclosure Form?

This Disclosure Form gives families and other interested persons the facility description of the services it provides and how these services target the special needs of residents with Alzheimer's disease or related disorders. Although the information categories are standardized, the information reported is facility-specific. This format gives families and other interested persons consistent categories of information, so they can compare facilities and services. The

Disclosure Form is *not* intended to take the place of visiting the facility, talking with other residents' family members, or meeting one-on-one with facility staff. This form contains additional information, which families can use to make more informed decisions about care.

**Check the appropriate box below.**

- New application. Complete this form in its entirety and submit with your application before entering into an agreement to provide care or treatment as a Specialized Alzheimer Care provider.
- No change, since previous application submittal. Submit this form with your renewal application.
- Limited change, since previous application submittal. Only respond to the form items changed, and submit this form with your renewal application.
- Substantial change, in the information previously submitted. This box is applicable to bed changes, changes of ownership, or other changes that would not occur with a renewal application submittal.

**PRE-ADMISSION PROCESS**

A. What is involved in the pre-admission process?

- Visit to facility       Home assessment       Medical records assessment
- Written Application       Family interview       Other: \_\_\_\_\_

B. Services (see following chart)

Service	Is it offered? Yes/No	If yes, is it included in the base rate or purchased for an additional cost?
Assistance in transferring to and from a wheelchair	Yes	Base
Intravenous (IV) therapy	No	
Bladder incontinence care	Yes	Base
Bowel incontinence care	Yes	Base
Medication injections	Yes	Base
Feeding residents	Yes	Base
Oxygen administration	Yes	Base
Behavior management for verbal aggression	Yes	Base
Behavior management for physical aggression	Yes	Base
Meals ( <u>2</u> per day)	Yes	Base
Special diet	Yes	Base
Housekeeping ( <u>1</u> days per week)	Yes	Base
Activities program	Yes	Base
Select menus	Yes	Base
Incontinence products	Yes	Base
Incontinence care	Yes	Base
Home Health Services	No	

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Temporary use of wheelchair/walker	Yes	Base
Injections	Yes	Base
Minor nursing services provided by facility staff	Yes	Base
Transportation (specify)	No	
Barber/beauty shop	Yes	Add'l cost

C. Do you charge more for different levels of care? .....  Yes  No  
 If yes, describe the different levels of care. \_\_\_\_\_

**I. ADMISSION PROCESS**

A. Is there a deposit in addition to rent? .....  Yes  No  
 If yes, is it refundable? .....  Yes  No  
 If yes, when? \_\_\_\_\_

B. Do you have a refund policy if the resident does not remain for the entire prepaid period?  Yes  No  
 If yes, explain days are prorated

C. What is the admission process for new residents?

- Doctors' orders     Residency agreement     History and physical     Deposit/payment  
 Other: \_\_\_\_\_

Is there a trial period for new residents? ..... Yes  No  
 If yes, how long? \_\_\_\_\_

D. Do you have an orientation program for families? .....  Yes  No

If yes, describe the family support programs and state how each is offered.

At time of admission, policies and general information about facility is discussed

**II. DISCHARGE/TRANSFER**

A. How much notice is given? 30 days if non-emergency, sooner depending on type of emergency

B. What would cause temporary transfer from specialized care?

- Medical condition requiring 24 hours nursing care     Unacceptable physical or verbal behavior  
 Drug stabilization     Other: hospice care

C. The need for the following services could cause permanent discharge from specialized care:

- Medical care requiring 24-hour nursing care     Sitters     Medication injections  
 Assistance in transferring to and from wheelchair     Bowel incontinence care     Feeding by staff  
 Behavior management for verbal aggression     Bladder incontinence care     Oxygen administration  
 Behavior management for physical aggression     Intravenous (IV) therapy     Special diets

Other: only behaviors that could not be redirected or treated, or caused harm to staff, other residents or self

D. Who would make this discharge decision? \_\_\_\_\_

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- E. Do families have input into these discharge decisions?.....  Yes  No
- F. Do you assist families in making discharge plans? .....  Yes  No

**III. PLANNING AND IMPLEMENTATION OF CARE (check all that apply)**

A. Who is involved in the service plan process?

- Administrator  Nursing Assistants  Activity director  Family members  
 Licensed nurses  Social worker  Dietary  Physician  Resident

B. How often is the resident service plan assessed?

- Monthly  Quarterly  Annually  As needed  
 Other: \_\_\_\_\_

C. What types of programs are scheduled?

- Music program  Arts program  Crafts  Exercise  Cooking  
 Other: \_\_\_\_\_

How often is each program held, and where does it take place? Programs are listed on monthly calendar for daily events. 2 activity directors daily who organize events/activities

D. How many hours of structured activities are scheduled per day?

- 1-2 hours  2-4 hours  4-6 hours  6-8 hours  8+ hours

E. Are residents taken off the premises for activities?.....  Yes  No

F. What specific techniques do you use to address physical and verbal aggressiveness?

- Redirection  Isolation  
 Other: Separation if incident is between 2 residents

G. What techniques do you use to address wandering?

- Outdoor access  Electro-magnetic locking system  Wander Guard (or similar system)  
 Other: \_\_\_\_\_

H. What restraint alternatives do you use?

We do not use restraints unless medically warranted

I. Who assists/administers medications?

- RN  LPN  Medication aide  Attendant  
 Other: \_\_\_\_\_

**IV. CHANGE IN CONDITION ISSUES**

What special provisions do you allow for aging in place?

- Sitters  Additional services agreements  Hospice  Home health

If so, is it affiliated with your facility?.....  Yes  No

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Other: \_\_\_\_\_

**V. STAFF TRAINING ON ALZHEIMER'S DISEASE OR RELATED DISORDERS CARE**

A. What training do new employees get before working in Alzheimer's disease or related disorders care?

Orientation: 8 hours       Review of resident service plan: 1 hours  
 On the job training with another employee: 40 hours  
 Other: 16 hrs classroom trng. & orientation for new hires

Who gives the training and what are their qualifications?  
Wings - Certified State Nurse Aide Training Program  
Nurse - RN - meets qualifications as established by Health Dept.

B. How much on-going training is provided and how often?  
(Example: 30 minutes monthly): 2 hrs of inservice trng monthly

Who gives the training and what are their qualifications?  
DDN - RN      Restorative - CNA      Consultants  
Genesis - Therapist      Administrator      Oxygen Provider

**VI. VOLUNTEERS**

Do you use volunteers in your facility?.....  Yes     No

If yes, please complete A, B, and C below.

A. What type of training do volunteers receive?

Orientation: \_\_\_\_\_ hours       On-the-job training: \_\_\_\_\_ hours  
 Other: \_\_\_\_\_

B. In what type of activities are volunteers engaged?

Activities       Meals       Religious services     Entertainment       Visitation  
 Other: \_\_\_\_\_

C. List volunteer groups involved with the family:

\_\_\_\_\_; \_\_\_\_\_;  
\_\_\_\_\_; \_\_\_\_\_;  
\_\_\_\_\_; \_\_\_\_\_;

**VII. PHYSICAL ENVIRONMENT**

A. What safety features are provided in your building?

Emergency pull cords       Opening windows restricted       Wander Guard or similar system  
 Magnetic locks       Sprinkler system       Fire alarm system  
 Locked doors on emergency exits  
 Built according to NFPA Life Safety Code, Chapter 12 Health Care  
 Built according to NFPA Life Safety Code, Chapter 21, Board and Care  
 Other: \_\_\_\_\_

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B. What special features are provided in your building?

Wandering paths       Rummaging areas       Others: Fenced courtyard

C. What is your policy on the use of outdoor space?

Supervised access       Free daytime access (weather permitting)

**VIII. STAFFING**

A. What are the qualifications in terms of education and experience of the person in charge of Alzheimer's disease or related disorders care?

8 hr. job orientation, 40 hrs on the job trng, 16 hrs nurse aide training in classroom

B. What is the daytime staffing ratio of direct care staff? See attachment

What is the daytime staffing ratio of Direct Staffing to Residents in Special Care Unit? 1 to 6

C. What is the daytime staffing ratio of licensed staff? See attachment

D. What is the nighttime staffing ratio of direct care staff? "

What is the nighttime Ratio of Direct Staffing to Residents in the Special Care Unit? " "

E. What is the nighttime staffing ratio of licensed staff? " "

**NOTE: Please attach additional comments on staffing policy, if desired.**

**IX. Describe the Alzheimer's disease special care unit's overall philosophy and mission as it relates to the needs of the residents with Alzheimer's disease or related disorders.**

The goal of the specialized care unit is to ensure all needs are met (social, physical, mental), ensure dignity in all stages of Alzheimer's, and provide environmental that creates security and comfort.

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