Health Resources
Development Service

Oklahoma State
Department of Health

Health Facility Systems
1000 NE 10th Street
Oklahoma City, OK 73117-1207-8823
Phone 405.271.6868
Fax 405.271.7360
E-mail HealthResources@health.ok.gov

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: Oxford Glen at Owasso

License Number: AL7239 Telephone Number: _____

Address: 11113 E. 103 Street N. Owasso, OK 74055

Administrator: Lisa Truett Date Disclosure Form Completed: 5 / 11 / 17

Completed By: Heather Weaver Title: HR

Number of Alzheimer Related Beds: 42

Maximum Number of participants for Alzheimer Adult Day Care: _____

RECEIVED
MAY 15 2017
HEALTH RESOURCES
DEVELOPMENT SERVICE

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	1 person assist Included 2 person assist extra
Intravenous (IV) therapy	Available	Add'l - 3rd party
Bladder incontinence care	Yes	Add'l
Bowel incontinence care	Yes	Add'l
Medication injections	Yes	Add'l
Feeding residents	Yes	base
Oxygen administration	Available	Add'l - 3rd party
Behavior management for verbal aggression	Yes	base
Behavior management for physical aggression	Yes	base
Meals (3 per day)	Yes	base
Special diet	Yes	base - except for supplements
Housekeeping (1-2 days per week)	Yes	base
Activities program	Yes	base
Select menus	Yes	base - except for supplements
Incontinence products	Yes	Add'l
Incontinence care	Yes	Add'l
Home Health Services	Available	Add'l 3rd party

RECEIVED
MAY 15 2017
HEALTH RESOURCES

Temporary use of wheelchair/walker	Yes	base if available
Injections	Yes	Add'l
Minor nursing services provided by facility staff	Yes	base
Transportation (specify)	Yes	base - schedule add'l if companion
Barber/beauty shop	Yes	Add'l - 3rd party

C. Do you charge more for different levels of care? ..... ☒ Yes ☐ No

If yes, describe the different levels of care. more than 1 person assist w/ transfer + injectable medications or special treatments (insulin)

I. ADMISSION PROCESS

A. Is there a deposit in addition to rent? ..... ☒ Yes ☐ No

If yes, is it refundable? ..... ☐ Yes ☒ No

If yes, when? we determine resident not appropriate or dies prior to move in

B. Do you have a refund policy if the resident does not remain for the entire prepaid period? ☐ Yes ☒ No

If yes, explain No refund once admitted

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.

meetings with department heads as they explain their roles.

II. DISCHARGE/TRANSFER

A. How much notice is given? 30 days

B. What would cause temporary transfer from specialized care?

☒ Medical condition requiring 24 hours nursing care ☒ Unacceptable physical or verbal behavior

☒ Drug stabilization ☐ Other: _____

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

☒ Medical care requiring 24-hour nursing care ☐ Sitters ☒ Medication injections insulin only

☐ 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: _____

RECEIVED
MAY 15 2017
HEALTH RESOURCES DEVELOPMENT SERVICE

D. Who would make this discharge decision?

☒ Facility manager ☒ Other: Care Manager

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: change in condition and upon admission

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? 4-6 activities daily both in the facility, on the grounds, and occasional group outing

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: Simple C companion

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?

Redirection, Simple C Companion, structured activity program

RECEIVED
MAY 15 2017
HEALTH RESOURCES DEVELOPMENT SERVICE

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

☐ 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: 16 hours ☒ Review of resident service plan: 4 hours
☒ On the job training with another employee: 8 hours
☐ Other: _____

Who gives the training and what are their qualifications?
Administrator, RN, LA, various members of corporate management team w/combined experience in dementia care. Virtual dementia delivered by qualified staff

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

Who gives the training and what are their qualifications?
Typically the Care manager or Director conducts the training

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: 4 hours ☒ On-the-job training: 4 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:
Alzheimers support Group
Church on the move

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: _____

RECEIVED
MAY 15 2017
HEALTH RESOURCES
DEVELOPMENT SERVICE

B. What special features are provided in your building?

☒ Wandering paths ☒ Rummaging areas ☐ Others: _____

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?

Licensed Admistrator and licensed nurse. All employees are dementia certified

B. What is the daytime staffing ratio of direct care staff 1:6 or 7

What is the daytime staffing ratio of Direct Staffing to Residents in Special Care Unit? 1:6 or 7

C. What is the daytime staffing ratio of licensed staff? 1:42

D. What is the nighttime staffing ratio of direct care staff? 1:9

What is the nighttime Ratio of Direct Staffing to Residents in the Special Care Unit? 1:9

E. What is the nighttime staffing ratio of licensed staff? 1:42

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.

To get to know the person for who they were before they had dementia. To create an atmosphere of caring in a small environment that permits staff to care about our residents. This also allows us to support the family as they experience this devestating disease.

RECEIVED
MAY 15 2017
HEALTH RESOURCES
DEVELOPMENT SERVICE