



Health Resources  
Development Service  
Oklahoma State  
Department of Health

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HRDS

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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: Green Tree at Sand Springs

License Number: AL7228 Telephone Number: 918-246-8733

Address: 4402 South 129th West Avenue, Sand Springs, OK 74063

Administrator: Julie Dyson Date Disclosure Form Completed: 01 / 29 / 2019

Completed By: Traci Girrens Title: Operation Support Assistant

Number of Alzheimer Related Beds: 16

Maximum Number of participants for Alzheimer Adult Day Care: 0

### 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	Additional Cost
Intravenous (IV) therapy	No	
Bladder incontinence care	Yes	Additional Cost
Bowel incontinence care	Yes	Additional Cost
Medication injections	Yes	Additional Cost
Feeding residents	No	
Oxygen administration	Yes	Additional Cost
Behavior management for verbal aggression	Yes	Additional Cost
Behavior management for physical aggression	Yes	Additional Cost
Meals ( <u>  3  </u> per day)	Yes	Included
Special diet	Yes	Additional Cost
Housekeeping ( <u>  1  </u> days per week)	Yes	Additional Cost if more frequently.
Activities program	Yes	Included
Select menus	Yes	Included
Incontinence products	No	
Incontinence care	Yes	Additional Cost
Home Health Services	Yes	Via third-party contract with resident

Temporary use of wheelchair/walker	Yes	Included
Injections	Yes	Additional Cost
Minor nursing services provided by facility staff	Yes	Additional Cost
Transportation (specify)	Yes	Scheduled
Barber/beauty shop	Yes	Contracted Vendor

C. Do you charge more for different levels of care? .....  Yes  No  
 If yes, describe the different levels of care. Based on assessment

**I. ADMISSION PROCESS**

A. Is there a deposit in addition to rent? .....  Yes  No  
 If yes, is it refundable? .....  Yes  No  
 If yes, when? Prorated if move out is within thirty (30) days.

B. Do you have a refund policy if the resident does not remain for the entire prepaid period?  Yes  No  
 If yes, explain Prorated for the prepaid period only if resident needs exceed or safety concern.

C. What is the admission process for new residents?

Doctors' orders     Residency agreement     History and physical     Deposit/payment  
 Other: Assessment

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.  
Caregivers support group and Welcome time with the Director

**II. DISCHARGE/TRANSFER**

A. How much notice is given? Thirty (30) days written notice unless resident is a danger to self or others.

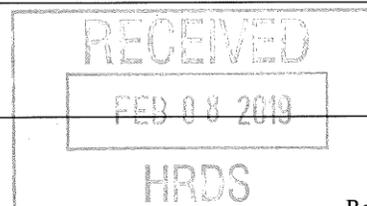
B. What would cause temporary transfer from specialized care?

Medical condition requiring 24 hours nursing care     Unacceptable physical or verbal behavior  
 Drug stabilization     Other: Danger to self or others.

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: \_\_\_\_\_

D. Who would make this discharge decision?  
 Facility manager     Other: Family Physician



- 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: 120 days or change of condition.

C. What types of programs are scheduled?

- Music program  Arts program  Crafts  Exercise  Cooking  
 Other: Pet therapy, entertainment and outings.

How often is each program held, and where does it take place? In the building and surrounding city 3-4 times a week, 2-3 times a week, exercise daily and programs in the common area.

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?

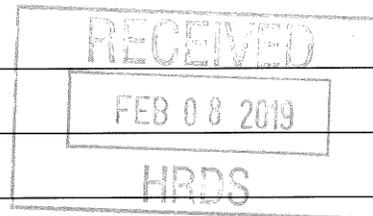
- Redirection  Isolation  
 Other: Community designed specialized activities.

G. What techniques do you use to address wandering?

- Outdoor access  Electro-magnetic locking system  Wander Guard (or similar system)  
 Other: Activities, redirection, and secure gates.

H. What restraint alternatives do you use?

None.



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



Wandering paths       Rummaging areas       Others: Secured unit enclosed

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 Administrator

B. What is the daytime staffing ratio of direct care staff 3:16

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

C. What is the daytime staffing ratio of licensed staff? 2:16

D. What is the nighttime staffing ratio of direct care staff? 2.5:16

What is the nighttime Ratio of Direct Staffing to Residents in the Special Care Unit? 1:16

E. What is the nighttime staffing ratio of licensed staff? LPN until 10:00 p.m.

**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.**

See attached.

