



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: Legend at Mingo Road

License Number: AL7261 Telephone Number: 918-893-3500

Address: 7902 South Mingo Road, Tulsa, OK 74133

Administrator: Brandi Wyatt Date Disclosure Form Completed: 05 / 29 / 2019

Completed By: Traci Girrens Title: Operations Support Assistant

Number of Alzheimer Related Beds: 18

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: Dr. Approval

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	Included
Activities program	Yes	Included
Select menus	Yes	Included
Incontinence products	No	
Incontinence care	Yes	Additional Cost
Home Health Services	Yes	Resident 3rd Party Contract

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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	Outside Vendor

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 Prorated based on length of stay. _____

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? 30 Days _____

D. Do you have an orientation program for families? Yes No
 If yes, describe the family support programs and state how each is offered.

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 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: Non ambulatory, or assessed as a danger to self or others. _____

D. Who would make this discharge decision?

Facility manager Other: Family Physician _____

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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: 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: Therapeutic memory care devices.

G. What techniques do you use to address wandering?

- Outdoor access Electro-magnetic locking system Wander Guard (or similar system)
 Other: Activities, redirection, secure alert bracelet 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

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Other: Levels of care.

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: 4 hours Review of resident service plan: 1/2 hours
 On the job training with another employee: 16 hours
 Other: _____

Who gives the training and what are their qualifications?

The director of the building and/or the LPN.

B. How much on-going training is provided and how often?

(Example: 30 minutes monthly): 1 hour monthly

Who gives the training and what are their qualifications?

Residence Director

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: 2 hours On-the-job training: 1 hours
 Other: _____

B. In what type of activities are volunteers engaged?

- Activities Meals Religious services Entertainment Visitation
 Other: Crafts and games

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: NFPA Life Safety Code, Chapter 32, Board & Care

B. What special features are provided in your building?

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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?

Administrators License

B. What is the daytime staffing ratio of direct care staff 1:18

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

C. What is the daytime staffing ratio of licensed staff? 1:40

D. What is the nighttime staffing ratio of direct care staff? 1:22

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? RN or LPN on call

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.

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