

Health Resources
Development Service

Oklahoma State
Department of Health



Health Facility System
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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: WELLINGTON PARKS, LLC.

License Number: 5531 Telephone Number: 405-677-2273

Address: 3107 TINKER DIAGONAL, DEL CITY, OK. 73115

Administrator: JIM V. McWHIRTER Date Disclosure Form Completed: 7 / 15 / 18

Completed By: JIM V. McWHIRTER / MARCI SIMMONS, RN Title: OWNER / ADMINISTRATOR #A0006

Number of Alzheimer Related Beds: 40

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	BASE RATE
Intravenous (IV) therapy	NO	
Bladder incontinence care	YES	BASE RATE
Bowel incontinence care	YES	ADDITIONAL COST
Medication injections	YES	BASE RATE OR OUTSIDE PROVIDER
Feeding residents	NO	
Oxygen administration	NO	
Behavior management for verbal aggression	YES	BASE RATE
Behavior management for physical aggression	NO	
Meals (<u>3</u> per day)	YES	BASE RATE
Special diet	NO	
Housekeeping (<u>1</u> days per week)	YES	BASE RATE
Activities program	YES	BASE RATE
Select menus	YES	BASE RATE
Incontinence products	NO	PROVIDED BY RESIDENT
Incontinence care	YES	ADDITIONAL COST
Home Health Services	YES	OUTSIDE PROVIDER/ADDITIONAL

Temporary use of wheelchair/walker	YES	provided by resident
Injections	YES	outside provider
Minor nursing services provided by facility staff	YES	BASE RATE
Transportation (specify)	YES	PHYSICIAN APPTS,
Barber/beauty shop	YES	ADDITIONAL COST

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

If yes, describe the different levels of care. BASED ON ASSISTANCE REQUIRED TO MEET NEEDS RE: ADL'S, INCONTINENCE AND BEHAVIORS

I. ADMISSION PROCESS

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

If yes, is it refundable? Yes No

If yes, when? INDIVIDUAL DOESN'T MEET ADMISSION CRITERIA UPON ASSESSMENT

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

If yes, explain REIMBURSED FOR PORTION OF MONTH DISCHARGED + OUT OF FACILITY

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.

II. DISCHARGE/TRANSFER

A. How much notice is given? 5 days

B. What would cause temporary transfer from specialized care?

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

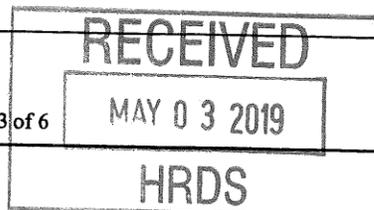
Drug stabilization Other: _____

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

Medical care requiring 24-hour nursing care Sitters Medication injections
 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: ASSISTANCE REQUIRING MORE THAN 1 STAFF PERSON

D. Who would make this discharge decision?

Facility manager Other: _____



- 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? daily/weekly in Facility

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: Distraction, Reminiscing, one on one interaction

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?

NONE

RECEIVED

MAY 03 2019

HIRDS

I. Who assists/administers medications?

- RN LPN Medication aide
 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: 2-4 hours Review of resident service plan: 1-2 hours
 On the job training with another employee: _____ hours
 Other: TRAINING EXAMS COVERING DEMENTIA + ABUSE/NEGLECT, IN SERVICES, RESIDENT CENTERED TRAINING.

Who gives the training and what are their qualifications?

NURSES, EXPERIENCED NURSE AIDES, HEALTH CARE PROFESSIONALS

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

(Example: 30 minutes monthly): 2 HOURS MONTHLY

Who gives the training and what are their qualifications?

NURSES, SUPERVISORS, HEALTH CARE PROFESSIONALS

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: 12-24 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:

HOME HEALTH / HOSPICE ; _____ ;

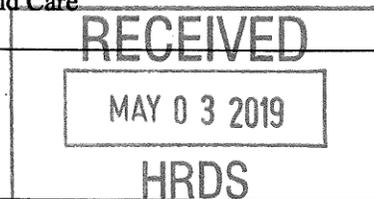
_____ ; _____ ;
_____ ; _____ ;

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: _____

B. What special features are provided in your building?



Wandering paths

Rummaging areas

Others: Outdoor courtyard enclosed, Secured, + Gated

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 Nurse, Manager Experience, Training + Experience in Dementia + ALZHEIMERS

B. What is the daytime staffing ratio of direct care staff 5:40

What is the daytime staffing ratio of Direct Staffing to Residents in Special Care Unit? 5:40

C. What is the daytime staffing ratio of licensed staff? 2:40

D. What is the nighttime staffing ratio of direct care staff? 5:40

What is the nighttime Ratio of Direct Staffing to Residents in the Special Care Unit? 5:40

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

It is our mission to provide a safe + secure Christian atmosphere to those prone to becoming confused + wandering. Our goal is to give care while maintaining a standard of excellence + respect for our residents

