



ALZHEIMER'S DISEASE OR RELATED DISORDERS SPECIAL CARE DISCLOSURE FORM

Authority: Alzheimer's Disease Special Care Disclosure Act (63 O.S. Section 1-879.2a) and Alzheimer's Disease Special Care Disclosure Rules (OAC 310:673). 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 if you make any changes from prior disclosures in services, at license renewal, and with bed additions that affect the total number of licensed beds in the facility. The form is to be mailed to PO Box 268823, Oklahoma City, OK 73126-8823.

Facility Information

Facility Name: Grandwood Assisted Living

License Number: AL2103 Telephone Number: 918-787-2011

Address: 2001 Sunrise Blvd, Grove, OK 74344

Administrator: Roxanne Fanning Date Disclosure Form Completed: 03 / 16 / 2020

Completed By: Reggie Herring Title: Member

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 form. First time submission.
- No change since previous submission. Check this box and submit this form and your prior form. If a change in form versions, it may require a new form submission.
- Limited change since previous submission. Submit a new form.
- Substantial change, submit a new form.

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 <input checked="" type="checkbox"/>	included in base rate
Intravenous (IV) therapy	No <input checked="" type="checkbox"/>	
Bladder incontinence care	Yes <input checked="" type="checkbox"/>	included in base rate
Bowel incontinence care	Yes <input checked="" type="checkbox"/>	included in base rate
Medication injections	Yes <input checked="" type="checkbox"/>	included in base rate
Feeding residents	Yes <input checked="" type="checkbox"/>	included in base rate
Oxygen administration	Yes <input checked="" type="checkbox"/>	included in base rate
Behavior management for verbal aggression	Yes <input checked="" type="checkbox"/>	included in base rate
Behavior management for physical aggression	Yes <input checked="" type="checkbox"/>	included in base rate
Meals (3 _____ per day)	Yes <input checked="" type="checkbox"/>	included in base rate
Special diet	Yes <input checked="" type="checkbox"/>	included in base rate
Housekeeping (1 _____ days per week)	Yes <input checked="" type="checkbox"/>	included in base rate
Activities program	Yes <input checked="" type="checkbox"/>	included in base rate
Select menus	Yes <input checked="" type="checkbox"/>	included in base rate
Incontinence products	No <input checked="" type="checkbox"/>	
Incontinence care	Yes <input checked="" type="checkbox"/>	included in base rate
Home Health Services	No <input checked="" type="checkbox"/>	

Temporary use of wheelchair/walker	Yes	<input checked="" type="checkbox"/>	included in base rate
Injections	Yes	<input checked="" type="checkbox"/>	included in base rate
Minor nursing services provided by facility staff	Yes	<input checked="" type="checkbox"/>	included in base rate
Transportation (specify)	Yes	<input checked="" type="checkbox"/>	scheduled days included; extra on unscheduled days
Barber/beauty shop	Yes	<input checked="" type="checkbox"/>	beauty shop at facility but resident pays beautician

C. Do you charge more for different levels of care? Yes No
 If yes, describe the different levels of care. see level of care assessment and market rate sheet

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 if 30 day written notice is given, 50% of the pro-rated rent is refunded

C. What is the admission process for new residents?

- Doctors' orders Residency agreement History and physical Deposit/payment
 Other assessment by facility nurse

Is there a trial period for new residents? Yes No
 If yes, how long? 30 day evaluation

D. Do you have an orientation program for families? Yes No
 If yes, describe the family support programs and state how each is offered.
family is oriented at admit and we have open door policy

II. DISCHARGE/TRANSFER

A. How much notice is given? 30 days; if resident poses threat to self, other residents or staff then immediate or if required care is beyond out scope

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: _____

D. Who would make this discharge decision?

- Facility manager Other: Family, POA, Case Manager, 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 Resident
- Licensed nurses Social worker Dietary Physician

B. How often is the resident service plan assessed?

- Monthly Quarterly Annually As needed
- Other: upon admission and upon significant change

C. What types of programs are scheduled?

- Music program Arts program Crafts Exercise Cooking
- Other: shopping, movies, gardening, games

How often is each program held, and where does it take place? _____
daily in facility, varies away from 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: staff education, medication adjustments by physician, geripsych services

G. What techniques do you use to address wandering?

- Outdoor access Electro-magnetic locking system Wander Guard (or similar system)
- Other: keypad security exits

H. What restraint alternatives do you use?

n/a

I. Who assists/administers medications?

- RN LPN Medication aide Attendant
- Other: third party healthcare provider

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: 4 hours
- Review of resident service plan: 4 hours
- On the job training with another employee: 3 shifts hours
- Other: continual dementia and alzheimer inservice

Who gives the training and what are their qualifications?

Facility administrator, facility rn and lpn, alz assoc personnel, homehealth/hospice providers

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

(Example: 30 minutes monthly): one hour semi-monthly

Who gives the training and what are their qualifications?

Facility Administrator, Facility RN, Homehealth/Hospice providers, Alzheimer organizations, parkinsons support groups

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: 8 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: keypad exits

B. What special features are provided in your building?

Wandering paths

Rummaging areas

Others: secured 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?

certified positive approach to care (PAC), continued education in related matter annually, 20 yr experience in Alzheimer and Dementia care

B. What is the daytime staffing ratio of direct care staff? minimum 1:12

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

C. What is the daytime staffing ratio of licensed staff? minimum 1:12

D. What is the nighttime staffing ratio of direct care staff? minimum 1:20

What is the nighttime Ratio of Direct Staffing to Residents in the Special Care Unit? 1:6

E. What is the nighttime staffing ratio of licensed staff? 1:20

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.

Philosophy Statement attached

Philosophy Statement

We recognize the variety of interests, abilities, and needs of the residents with Alzheimer's disease and related disorders. WE also believe in the social models for services and programming which emphasizes involvement in activities of life at whatever level is possible or desired.

All services will focus on assistance. Our role is not to "do for" but to "assist with" each resident's identified needs. By emphasizing assistance, we will support independence and promote dignity for the residents in our memory care unit.

Activity and service intensity will be determined by the interest, abilities, and functional limitations of the identified resident's needs. An individualized assistance/service plan will be developed for each resident, using a team approach with resident, family and staff participation.

Grandwood Assisted Living & Memory Care

The following per month price structure for Grandwood Assisted Living is based on the level of care needed and type of apartment rented. Care levels are determined by the personal care needs of the resident based on an assessment done at the time of admission.

	Square Footage	Level I 0-8 pts	Level II 9-20 pts	Level III 21-32 pts	Level IV 33-45 pts	Level V 46-57 pts
Studio	291	\$3,392.00	\$3,792.00	\$4,192.00	\$4,592.00	\$4,992.00
Efficiency	365	\$3,459.00	\$3,859.00	\$4,259.00	\$4,659.00	\$5,059.00
Studio Deluxe	377	\$3,532.00	\$3,932.00	\$4,332.00	\$4,732.00	\$5,132.00
One Bedroom	365	\$3,672.00	\$4,072.00	\$4,472.00	\$4,872.00	\$5,272.00
Two Bedroom	657	\$5,495.00	\$5,895.00	\$6,295.00	\$6,695.00	\$7,095.00
2 nd Person Fee	Each person will have \$300 deducted from rental price for double occupancy					

Basic Assisted Living Services Include:

- * Medication Administration
- * Medication Ordering (*Medication Cost not Included*)
- * Consultant Registered Nurse
- * Emergency Nurse Call System (*Additional \$150 refundable deposit for personal pendants*)
- * Fire Sprinkler and Alarm System
- * Scheduled Activities and Special Events
- * Contract Dietician
- * Three Home Style Meals Served Daily
- * Private Dining Room Available for Residents and Family Use (*With Reservation*)
- * Weekly Housekeeping and Linen Service
- * Apartment Maintenance
- * Weekly Transportation (*On designated days*)
- * Library
- * Individual Apartment Mailboxes
- * Whirlpool Available Anytime (*for those needing no assistance*)
- * Laundry Room for Resident Use
- * Full Service Beauty Salon Located Within
- * Refrigerator/Freezer/Microwave Units in each apartment (*Excluding Efficiency Suites*)
- * Basic Cable TV Provided
- * Paid Utilities (*excludes telephone*)

Many additional services available dependent upon required care level

Grandwood Assisted Living & Memory Care

Assisted Living Focus Care

The Focus Care at Grandwood is specially designed and staffed for the higher acuity level of care.

	Level IV 33-45 pts	Level V 46-57 pts
Studio	\$5,012.00	\$5,517.00
Studio Suite	\$5,128.00	\$5,593.00
2 nd Person Fee	Each person will have \$300 deducted from rental price for double occupancy	
Points above 57 will be charged an additional \$25 per point each month		

Basic Assisted Living Services Include:

- * Medication Administration
- * Medication Ordering (*Medication Cost not Included*)
- * Consultant Registered Nurse
- * Emergency Nurse Call System (*Additional \$150 refundable deposit for personal pendants*)
- * Fire Sprinkler and Alarm System
- * Scheduled Activities and Special Events
- * Contract Dietician
- * Three Home Style Meals Served Daily
- * Private Dining Room Available for Residents and Family Use (*With Reservation*)
- * Weekly Housekeeping and Linen Service
- * Apartment Maintenance
- * Weekly Transportation (*On designated days*)
- * Library
- * Individual Apartment Mailboxes
- * Whirlpool Available Anytime (*for those needing no assistance*)
- * Laundry Room for Resident Use
- * Full Service Beauty Salon Located Within
- * Refrigerator/Freezer/Microwave Units in each apartment (*Excluding Efficiency Suites*)
- * Basic Cable TV Provided
- * Paid Utilities (*excludes telephone*)

Many additional services available dependent upon required care level

Grandwood Assisted Living & Memory Care

Memory Care at Grandwood Assisted Living

The Memory Care at Grandwood is specially designed and staffed for Senior's with memory related issues.

	Square Footage	MC-Level I 33-45 pts	MC-Level II 46-57 pts
Private Studio	291	\$5,786.00	\$6,160.00
Semi-Private Studio (shared)	365	\$5,371.00	\$5,746.00
Studio Deluxe	377	\$6,073.00	\$6,448.00
2 nd Person Fee	Each person will have \$300 deducted from rental price for double occupancy		
Points above 57 will be charged an additional \$25 per point each month			

Personal Support Memory Care Services Include:

- * Increased 24 Hour Staffing By Specially Trained Personnel
- * Specialized Security and Monitoring System
- * Medication Administration
- * Medication Ordering (*Medication Cost Not Included*)
- * Consultant Registered Nurse
- * Emergency Nurse Call System (*Bathroom Pull Cords*)
- * Increased Staff Attention
- * Fire Sprinkler and Alarm System
- * Specialized Activities Program and Special Events
- * Contract Dietician
- * Dietician Approved Menu Systems
- * Three Home Style Meals Served Daily
- * Private Dining Room Available for Residents and Family Use
- * Nutritional Support and Guidance during Dining
- * Assistance to Meals, Activities, Etc.
- * Coordination of Special Diet Program (*if required*)
- * Aid with Bathing Needs
- * Assistance with Transferring
- * Support with Toileting (*escorting resident to restroom, restroom reminders*)
- * Assistance with Incontinence Management
- * Housekeeping and Linen Service Three Times Weekly
- * Apartment Maintenance
- * Daily Mail Service
- * Whirlpool Available (*assisted by staff*)
- * Full Service Beauty Salon Located Within
- * Basic Cable TV Provided
- * Paid Utilities (*excludes telephone*)

Grandwood Assisted Living & Memory Care

Admission Fee Policy:

An Admission Fee of \$1500.00 shall be submitted for the admission process and to reserve a unit for the Resident. Should the Resident be delayed from moving into the facility due to circumstances beyond their control, i.e. skilled facility stay, hospital or death, the full amount of the admission fee will be refunded to the appropriate party. Once occupancy is established the admission fee is non-refundable.

If no occupancy is available the admission fee will serve as a room retainer to place Resident on a waiting list. The Resident must move-in within 30 days of vacancy notice or this fee is forfeited.

Move Out Policy:

If at any time the resident decides to move out a written 30 day notice must be given to Grandwood Assisted Living and the resident/responsible party will be charged for the next 30 days from the date the written 30 day notice was received. When the move out date has been established a written request must also be given to Grandwood Assisted Living in order to process any refund that may be due. ****Refunds will not be sent out unless the written request for a refund has been submitted to Grandwood Assisted Living and the refund process can take up to a minimum of 10 weeks.****

Pro-Rate:

Grandwood Assisted Living and Memory Care will pro-rate if the resident moves in during the middle of the month.

Pet Policy:

Grandwood Assisted Living will allow pets providing they are less than 20 pounds. Pets are not allowed in Memory Care Units. The Resident or Responsible Party will be required to sign a pet agreement and an additional non-refundable pet deposit of \$1000.00 will be charged at the time the agreement is signed. The Resident or Responsible party will be responsible for the care of the pet. The Resident or Responsible Party will give a copy of all health and vaccination records of the pet to the Manager's office.

Level of Care Assessment

Residence: Grandwood Assisted Living Residents Name: _____

Completed By: _____ Original Admit Date: _____ Assessment Date: _____

Reason for Assessment (check one): Admission 12 month Significant Change

Circle the appropriate corresponding number for each of the listed items. Total accumulation of points will reflect appropriate level of service.

1. Health/Wellness

A. Medications

- 0 Takes no medications or takes independently
- 4 Staff administers and records medications 2 times per day or less
- 5 Staff monitors self-medication program
- 6 Staff administers and records medications 3 times per day
- 7 Staff administers and records medication 4-6 times per day
- 8 Staff administers and records medication more than 6 times per day

Additional Service Points

- +2 Monitoring is required due to use of bedside medication
- +1 Difficulty swallowing medications, includes crushing
- +2 Resists medications
- +2 Requires IM injections
- +2 Requires staff to monitor oxygen use
- +1 Staff administers inhalers/nebulizers
- +1 Resident chooses to use non-bubble/non-strip packaged medication
- +2 Staff coordinates and orders medications from mail order pharmacy

B. Diabetic Management

- 0 Resident is independent in management
 - 1 Staff assisted through observation only (1-2 times daily)
 - 3 Staff drawn/Staff administered
 - 4 Sliding scale Diabetic Management (including finger sticks)
 - + ____ Requires additional assistance not mentioned above. Please provide a detailed explanation
-
-
-

Additional Service Points

- +1 Finger Sticks required weekly (unless #4 circled above)
- +3 Finger Sticks required daily (unless #4 circled above)

C. Wellness Monitor/Treatments

- 0 Able to identify health problems, no treatment necessary
- 1 Monthly scheduled treatments i.e.... pacemaker checks
- 2 Weekly scheduled treatments (BP, Weight, Pulse, etc....)
- 3 Daily scheduled treatments (BP, weight, etc....)
- 4 Scheduled treatments required more than once per day (BP, Pulse, Weight, etc...)
- + ___ Requires additional assistance not mentioned above

Please list disease, diagnosis or infections in the space provided. Please provide a detailed explanation for additional services required, if applicable.

2. Cognitive Status

History of Dementia/Alzheimer's Disease Yes No

A. Orientation

- 0 Resident Orientated
- 1 Staff required to occasionally orient resident
- 2 Needs intermittent reminders/cues for orientation
- 3 Needs daily reminders/cues for orientation
- 4 Needs **instruction**/reminders multiple times daily; requires assistance outside of residence
- 5 Needs constant reminders/supervision in and out of Residence
- + ___ Other assistance not mentioned. Please provide a detailed explanation:

B. Decision Making

- 0 Recognizes and makes own decisions
- 1 Does not always recognize when to make decisions, but follows directions
- 2 Requires intermittent assistance or reminders
- 3 Requires daily assistance or reminders
- 4 Requires staff assistance regarding care and safety issues, one step directions
- + ___ Requires more than one person assist with related care. Please provide a detailed explanation below.

C. Wandering

- 0 No issues of wandering, or wanders within Residence safely
- 1 Wanders safely in residence, requires intermittent reminders to find areas
- 2 Wanders safely in Residence, requires daily reminders to find areas
- 3 Intermittently wanders outside and requires minimal redirection
- 4 Wanders out and requires minimal redirection (weekly)
- 5 Wanders outside daily, and/or trespasses into other residents rooms
- 6 Requires constant supervision and redirection due to wandering
- 7 Major elopement risk, attempts multiple times daily
- 8 Resists redirection, becomes agitated, and/or requires a GPS device for safety.
- ___ Other; please provide a detailed explanation below.

3. Physical Functional Status

Mobility

- 0 Independent/Independent with supportive device (cane, walker, wheelchair, etc)
 - 2 Requires intermittent verbal reminder and/or stand-by assist
 - 3 Requires verbal reminders, stand-by assist daily
 - 4 Requires intermittent assistance from one staff member
 - 5 Requires daily assistance from one staff member
 - 6 Requires intermittent assistance with wheelchair
 - 7 Requires daily assistance with wheelchair
 - + ___ Requires assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

B. Stability/Falls

- 0 Does not Fall
 - 1 Rarely Falls, 0-5 times per year
 - 2 Occasionally falls, 6-10 times per year
 - 3 Falls occur on monthly basis
 - 4 Unsteady on feet, falls weekly
 - 5 Needs daily/nightly checks due to falls
 - + ___ Requires assistance not mentioned above. Please provide a detailed explanation below:
-
-
-

D. Dressing

- 0 Independent with dressing
 - 1 Requires intermittent reminders/cues/assistance with preparation
 - 2 Requires daily reminders/cues/assistance with preparation of dressing
 - 3 Requires intermittent assistance with fastening, choosing clothes, dressing
 - 4 Requires assistance with fastening, choosing clothes, dressing (daily)
 - 5 Requires assistance with fastening, choosing clothes, dressing (several times daily)
 - 6 Requires more than one staff member to assist with related care. Please provide a detailed explanation below.
-
-
-

E. Grooming

- 0 Independent with grooming
 - 1 Requires occasional cueing or reminders with hand/face washing, combing hair, cleaning teeth/dentures, shaving, deodorant use, and nails
 - 2 Requires intermittent supervision and cueing while completing above tasks
 - 3 Requires daily supervision and cueing while completing above tasks
 - 4 Requires intermittent staff assistance to find supplies and assist with tasks
 - 5 Requires daily staff assistance to find supplies and assist with tasks
 - 7 Requires more than one person to assist with related care.
 - ___ Requires assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

F. Bathing/Showering

- 0 Independent with bathing/showering or bathing/showering provided by outside entity
 - 1 Needs reminders or help in or out of shower (2 times weekly)
 - 2 Needs reminders or help in or out of shower (4 or more times weekly)
 - 3 Needs help in/out of shower, turning water on or off, washing feet/back, stand-by assistance (3 or less times weekly); whirlpool more than once per week
 - 5 Needs help in/out of shower, turning water on or off, washing feet/back, stand-by assistance (3 or more times weekly); whirlpool more than twice per week
 - 6 Requires up to one person assist with related care
 - 7 Requires more than one person assist with related care
 - + _____ Requires assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

4. Nutrition

A. Dining Services

- 0 No special diet, no problems eating
 - 1 Needs constant encouragement to eat meals
 - 2 Special diet required (based on physician orders)
 - 3 Special diet required, may or may not need reminders from staff to adhere to diet (daily)
 - 4 Special supplements needed in between meals
 - 5 Requires feeding with one-on-one attention
- Additional Service Points*
- +1 Swallowing difficulty
 - +1 Extended mealtime required
 - +1 For each tray to room over three/month
 - +2 Special requests (substitutions based on preference)

5. Personal Hygiene/Continence

A. Bladder

- 0 Independent/no assistance needed
 - 1 Requires reminders of self-managed toilet schedule
 - 2 Supervision of toileting, assist with use of incontinence products and related hygiene needs (weekly)
 - 3 Supervision of toileting, assist with use of incontinence products and related hygiene needs (daily)
 - 4 Requires assistance with toileting, application of incontinence products and related hygiene needs (weekly)
 - 5 Requires assistance with toileting, application of incontinence products and related hygiene needs (daily)
 - 6 Requires 2 person assist with related care
 - 7 Frequently soils carpet/furniture
 - + _____ Requires up to one person assist with related care. Please provide a detailed explanation below:
-
-
-

B. Bowel

- 0 Independent/no assistance needed
 - 2 Needs program or occasional reminders regarding problems with constipation or diarrhea (weekly)
 - 4 Needs program or occasional reminders regarding problems with constipation or diarrhea (daily)
 - 6 Needs assistance with bowel program i.e. enema, diet, suppository, etc.
 - 7 Total assistance required due to incontinence.
 - + ___ Requires up to one person assist with related care. Please provide detailed explanation below.
 - + ___ Requires more than one person assist with related care. Please provide a detailed explanation below.
-
-
-

6. Mental Health History/Psychosocial Status

A. Specific Behaviors

- +3 Shows signs of verbal or physical abuse to others
- +3 Shows signs of anxiousness or agitation
- +3 Verbalizes suicidal tendencies
- +3 Shows signs of sexually inappropriate behavior
- +3 Removes or Destroys property intentionally or unintentionally
- +2 Shows signs of reversal of sleep cycle, insomnia

Please provide a detailed explanation of any above mentioned behaviors below:

7. Skin Integrity and Preservation

A. Assessments, monitoring, or treatment required in order to maintain or improve skin integrity

- 0 No alterations in skin integrity; independent in all aspects of maintaining skin integrity
- 2 Requires monthly assistance in order to maintain or improve skin integrity
- 4 Requires weekly assistance in order to maintain or improve skin integrity
- 7 Requires daily assistance in order to maintain or improve skin integrity
- + ___ Requires an additional staff member to assist with related care. Please provide a detailed explanation below.

Assistance to include but not limited to: assessments, monitoring, dressing changes, coordination with wound care specialist or other 3rd party vendors; coordination with physician; ordering of related supplies and medications; assistance with nutritional supplementation, turning, repositioning, and transfers.

8. Sensory

A. Hearing

- 0 Hears well, understands others
 - 1 Hearing impaired, needs verbal directions repeated daily
 - 2 Hearing impaired, frequently needs help to understand directions or instructions, multiple times daily
 - 3 Hearing impaired, constantly needs assistance with directions or instruction and some supervision
 - 4 Hearing severely impaired or deaf - supervision of adaptive equipment/requires written communication
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

B. Use of Hearing Aid

- 0 Able to use hearing aid without assistance; put in ear, clean, change batteries, etc.
 - 1 Needs reminders to use aid, change battery, clean, etc. (weekly)
 - 2 Needs reminders to use aid, change battery, clean, etc. (daily)
 - 3 Needs supervision due to misplacing of hearing aid and/or assistance with insertion and care (weekly)
 - 4 Needs supervision due to misplacing of hearing aid and/or assistance with insertion and care (daily)
 - 5 Needs constant monitoring due to frequent loss and/or misuse of hearing aid; is not able to clean, regulate, change batteries, etc.
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

C. Vision

- 0 Needs no vision assistance
 - 1 Needs reminders to wear glasses (weekly)
 - 2 Needs reminders to wear glasses (daily)
 - 3 Needs supervision due to poor eyesight (weekly)
 - 4 Needs supervision due to poor eyesight (daily)
 - 5 Needs assistance finding lost glasses, identifying objects (weekly)
 - 6 Needs assistance finding lost glasses, identifying objects (daily)
 - 7 Needs total assistance due to blindness or severe visual deficiency
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

9. Communication

A. Speech

- 0 Easily understood
 - 1 Difficult to understand, requires staff time to communicate
 - 2 Needs staff to interpret speech (weekly)
 - 3 Needs staff to interpret speech (daily)
 - 4 Unable to speak - requires other methods to communicate
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
-
-
-

B. Communication Tools

- 0 Independent use of telephone, letter writing, can open and read mail
 - 1 Requires assistance to manage communication tools (weekly)
 - 2 Requires assistance to manage communication tools (daily)
 - 3 Requires total staff management of mail and phone communications
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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C. Family Participation/Communication

- 0 Family/Responsible party communicates effectively with staff and other care providers (physician, therapist, pharmacy, insurance) family provides personal care supplies
 - 1 Occasionally Family/Responsible party requests staff to intercede with other care providers. Usually provides personal care supplies without reminders
 - 2 Family/Responsible party requires assistance to coordinate outside care visits/resolve concerns. Increased communication (phone, correspondence, etc.) by staff. Reminders needed regarding purchasing of personal care supplies.
 - 3 Frequent communication is required between family, outside care providers and staff. Requires frequent assistance/reminders regarding purchasing of personal care supplies.
 - 4 Family circumstances make communication/participation in Residence challenging. Staff time increased due to management of outside care providers.
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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8. Environment

A. Environmental Assistance

- 0 Independent/no assistance needed
 - 1 Needs reminders due to environmental problems; i.e. mobility clearance, heating, lighting, etc. (weekly)
 - 2 Needs reminders due to environmental problems; i.e. mobility clearance, heating, lighting, etc. (daily)
 - 3 Needs constant monitoring of environmental needs in and out of room
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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B. Housekeeping

- 0 Basic services, once per week
 - 1 Extra light-duty housekeeping bi-weekly
 - 2 Extra light-duty housekeeping weekly
 - 3 Housekeeping service 2 times per week
 - 4 Housekeeping service 3 times per week
 - 5 Needs daily housekeeping service due to behavior problems; i.e. clogged toilet, discarded incontinence products, food storage, excessive item storage, etc.
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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C. Laundry Assistance

- 0 Basic services, once per week linens/towels only
 - 1 Personal laundry service once weekly
 - 3 Personal laundry service 2-3 times weekly
 - 4 Personal laundry service 4-6 times weekly
 - 5 Daily laundry service required
 - + ___ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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10. Programs/Daily Routines

A. Activities Assistance

- 0 No assistance needed, schedules own day
 - 1 Needs encouragement to attend programs (weekly)
 - 2 Needs encouragement to attend programs (daily)
 - 3 Needs assistance with short attention span, redirection
 - 4 Needs constant redirection, cueing, etc.
 - + ____ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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B. Tobacco/Alcohol use

- 0 Needs no assistance
 - 1 Needs occasional reminders to smoke in designated areas
 - 2 Needs increased supervision with alcohol/tobacco use
 - + ____ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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12. Pet Care Services

A. Pets

- 0 No pet or Resident fully able to care for pet
 - 1 Staff assists with feeding pet (weekly)
 - 2 Staff assists with feeding pet (daily)
 - 3 Staff assists with feeding and toileting (weekly)
 - 4 Staff assists with feeding and toileting (daily)
 - 5 Staff needed to complete extra cleaning of waste and related issues
 - 6 Staff required for exercise of pet
 - + ____ Requires additional assistance not mentioned above. Please provide a detailed explanation below.
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Total Points: _____ Monthly Rate Based on Level of Care & Room Choice: _____

To determine the level of service required and/or requested by the resident, add total points from the assessment. An accumulation of points will determine the level of care rate.

Resident Assessment Levels:

- 0-8 points: *Personal Support Management I*
- 09-20 points: *Personal Support Management II*
- 21-32 points: *Personal Support Management III*
- 33-45 points: *Personal Support Management IV / Memory Care Level I*
- 46-57 points: *Personal Support Management V / Memory Care Level II*

Each point over 57 equals \$25.00/point/month

Interview

The signatures listed below attest a personal interview was completed between the Resident and Executive Director (or) Health Care Coordinator.

Resident/Responsible Party Date RN Consultant Date

Health Care Coordinator Date Executive Director/Administrator Date

If the Resident is mentally impaired and unable to complete the personal interview, the signatures listed below attest a personal interview was complete between the Resident's personal Physician (or) the Resident's representative and the Executive Director (or) Health Care Coordinator.

Resident Responsible Party (POA, etc) Date RN Consultant Date

Health Care Coordinator Date Executive Director/Administrator Date

Resident's Physician Date