Complaint/Suggestion Notification

DATE	TIME	PERSON COMPLETING FORM

PERSON MAKING COMPLAINT/SUGGESTION	
	☐ RESIDENT ☐ FAMILY MEMBER ☐ OTHER ________________

COMMENT/SUGGESTION

EMPLOYEE'S RESPONSE/FOLLOW-UP

ADMINISTRATOR'S RESPONSE/FOLLOW-UP

RESOLVED?
☐ YES ☐ NO

Facility Audit

HR / BUSINESS OFFICE	Regulation	Compliant	Noncompliant	Notes
1. Administrator Certificate	87564			
2. Administrator education/experience	87564			
3. Activity Person/Director education/experience	87578			
4. Criminal clearance for non-licensed staff.	87219			
5. All staff have Criminal Record Statement (LIC 508).	87219			
6. Appropriate staff have exemptions.	87219			
7. Appropriate staff have first aid card.	87575			
8. All staff have an LIC503.	87565			
9. All staff have proof of age & photo ID.	87565			
10. All staff have signed Abuse Reporting form SOC341A.	W&I Code			
11. All staff have Personnel Record LIC501.	87565			
12. Appropriate staff have copy of driver's license or DMV printout.	87565			
13. Nurses name and title tags worn in at least 18-point type while working in the facility.	B&P Code 680			
14. Facility license posted	87115			
15. All licensing reports, except those for unfounded complaints, which have been received within the past twelve months and all licensing reports from the last annual or comprehensive visit are placed conspicuously for public review.	H&S Code 1569			
16. Facility fire clearance	87220			
17. Current plan of operation:	87222			
a. Statement of purposes and program goals				
b. Admission Agreement				
c. Admission policies				
d. Staffing plan, qualifications and duties				
e. Plan for training staff				
f. Facility and grounds sketches, showing dimensions				
g. Transportation arrangements for residents				

h. Statement regarding handling and safeguarding residents' money and/or valuables and surety bond if appropriate				
i. Visitation and communication with residents policy				
j. Dementia plan of operation				
k. Hospice waiver when appropriate	87716.1			
l. Bedridden policies and procedures				
18. Disaster & Mass Casualty Plan including posting exiting plans and telephone numbers	87223			
19. Current and complete Emergency Plan LIC610E	TSP			
20. Theft and loss policies and procedures	87227.1			
21. Posting of the facility's policy regarding theft and investigative procedures	H&S 1569			
22. Current register of all residents in the facility	87571			
23. Procedures for filing confidential complaints posted	87572			
24. Copy of resident rights or, in lieu of a posted copy, instructions on how to obtain additional copies of these rights	87572			
25. Current Employee Rights Poster and Wage Order posted.	Labor Code			
26. Copies of activity schedules for previous at least six months	87578			
27. Dated weekly employee time schedule displayed conveniently for employee reference	87580			
28. Written licensed home health agency/facility agreements	87702			
29. Admission Agreement (signed and dated original)	87568			
30. Telecommunication Device Notification Form	87568			
STAFF TRAINING				
31. All Staff:				
a. Theft and loss policy review twice annually	H&S 1569			
b. Abuse reporting policy review annually	W&I 15655			
c. On the job training or documentation of related experience in the job assigned to them	87565			
d. Documentation of fire and earthquake drills (dementia - at least once every three months on each shift 87224)	TSP			
32. Direct Care Staff:				
a. Ten hours initial training	87565			
b. Eight hours medication training	H&S 1569.69			
c. Four hours annual general training	87565			
d. Four hours annual medication training	H&S 1569.69			
33. Direct Care Staff Caring for Residents with Dementia:	87225.1			
a. Six hours dementia orientation				

b. Eight hours annual training				
FOOD SERVICE				
34. Copies of menus as served for the last 30 days.	87576			
35. Menus written at least one week in advance.	87576			
36. Documentation designating a fulltime staff member who has primary responsibility for food planning, preparation and service.	87576			
37. Written record of a food service consultant's visits unless the fulltime staff member who has primary responsibility for food service is a nutritionist, dietitian, or home economist.	87576			
38. Ventilating systems in food preparation areas are in working order.	87576			
39. Aisles in the food service area are of sufficient width to permit easy movement of personnel, mobile equipment and supplies.	87576			
40. Freezers of adequate size shall be maintained at a temperature of 0 degrees F (-17.7 degrees C).	87576			
41. Refrigerators of adequate size shall maintain a maximum temperature of 40 degrees F (4 degrees C).	87576			
42. Soaps, detergents, cleaning compounds, pesticides and other toxic substances are not be stored in food storerooms, kitchen areas, or where kitchen equipment or utensils are stored.	87576			
43. Supplies of nonperishable foods for a minimum of one week are on hand.	87576			
44. Supplies of perishable foods for a minimum of two days are on hand.	87576			
45. All kitchen areas shall be kept clean and free of litter, rodents, vermin and insects.	87576			
46. Food storage and food preparation areas are clean.	87576			
47. Trash cans have tight fitting covers.	87576			
48. All equipment, fixed or mobile, and dishes, shall be kept clean and maintained in good repair and free of breaks, open seams, cracks or chips.	87576			
49. Disinfection system for dishes and utensils use hot water at a minimum temperature of 170 degrees F (77 degrees C) at the final rinse cycle of dishwashing machines, or;	87576			
50. Disinfection system for dishes and utensils is completed by a method approved by the licensing agency or by the local health department.	87576			
51. Adaptive devices are available for self-help in eating as needed by residents.	87576			
PHYSICAL PLANT SAFETY				
52. Walls, ceilings, windows, floors, carpet, window screens, etc. are clean and in good repair.	87691			
53. No foul odors present.	87691			
54. Hallways, stairwells, etc. are unobstructed.	87691			
55. Smoke detectors operate properly.	87691			
56. Fire extinguishers are present and are not expired per the attached charge tag.	87691			
57. Room temperature is between 68 degrees F and 85 degrees F.	87691			
58. Resident call/signal/pager systems operate properly.	87691			
59. Exit alarms, if exiting presents a hazard, operate properly.	87691			

60. All areas appear free from insects or other vermin.	87691			
61. Bodies of water are inaccessible.	87691			
62. Emergency lighting equipment shall be maintained, at a minimum flashlights & batteries are present.	87691			
63. Disinfectants, cleaning solutions, poisons, firearms and other items which could pose a danger if readily available to clients shall be stored where inaccessible to residents.	87692			
64. Emergency and exit plans posted on all floors, wings and separate buildings.	TSP			
65. Exits signs are posted over all exit doors.	TSP			
ACCOMMODATIONS AND SERVICES				
66. Linen, mattresses, furniture clean and in good repair.	87577			
67. Mattresses and pillows are flame retardant.	87577			
68. Adequate room furniture present in resident rooms.	87577			
69. Adequate storage space in resident rooms.	87577			
70. Resident rooms are free of medications, unless authorized to be present.	87575			
71. A working telephone in a common area is present.	87573			
72. Bathroom hot water temperature is between 105 degrees F to 120 degrees F. Taps delivering water at 125 degree F (52 degree C) or above shall be prominently identified by warning signs.	87691			
73. Bathroom grab bars are present and securely fastened.	87691			
74. Non-skid mats are present in tubs and showers.	87691			
75. Night lights are present in hallways and non-private bathrooms.	87577			
76. Linen supplies and personal hygiene supplies are available in sufficient supply.	87577			
77. Stairways, inclines, ramps, etc. are equipped with sturdy hand railings and well-lit.	87577			
78. If a facility has no medical unit on the grounds, a complete first aid kit.	87575			
ACTIVITIES				
79. Notices of planned activities shall be posted in a central location.	87578			
80. Sufficient equipment and space to accommodate both indoor and outdoor activities.	87578			
RESIDENT RECORD				
81. Identification and Emergency Info	87570			
82. MD Report (annually if dementia)	87569, 87724			
83. TB test results	87569			
84. Resident Appraisal	87583			
85. Property Record (not required for private rooms)	87227			
86. Personal Rights	87572			

87. PRN Authorization	87575			
88. Current Service Plan	87583.1			
89. Narrative Notes				
MEDICATIONS				
90. Log of centrally stored medications	87575			
91. Record of destroyed medication	87575			
92. No expired medications	87575			
93. There are no permanently discontinued medications nor are there medications for any former residents in the facility.	87575			
94. Refrigerator for medication locked – only contains medication	Cal OSHA			
95. Centrally stored medications in a safe and locked place	87575			
96. All centrally stored medications shall be labeled and maintained in compliance with state and federal laws.	87575			
97. Orders present for all medication	87575			
98. Medication records maintained for 3 years	87575			
99. Adequate sharps containers in secured areas	TSP			
100. Medications stored by residents are secured and physician authorization is on file.	87575			

RCFE Training Requirements

Training Description	Hours	Required By	Topics Required	Who	When
Initial Administrator Certification	40 hours	CCL 87564.2	RCFE Core of Knowledge from a DSS/CCL approved vendor	Administrators	Prior to taking the state administrator certification exam
Administrator Recertification	40 hours	CCL 87564.3	DSS/CCL approved continuing education	Administrators	Every two years, prior to expiration
Initial Staff Training	10 hours	CCL 87565	• The aging process and physical limitations and special needs of the elderly (2 hours) • Importance and techniques of personal care services (3 hours) • Residents' rights • Policies and procedures regarding medications (2 hours) • Psychosocial needs of the elderly • Recognizing signs and symptoms of dementia in individuals.	Staff who assist residents with personal activities of daily living	Within the first four weeks of employment
Ongoing Staff Training	4 hours	CCL 87565	see above	Staff who assist residents with personal activities of daily living	Annually
Dementia Care Training	not specified	CCL 87724	• Dementia care including, but not limited to, knowledge about hydration, skin care, communication, therapeutic activities, behavioral challenges, the environment, and assisting with activities of daily living; • Recognizing symptoms that may create or aggravate dementia behaviors, including, but not limited to, dehydration, urinary tract infections, and problems with swallowing • Recognizing the effects of medications commonly used to treat the symptoms of dementia.	Staff who provide direct care to resident(s) with dementia	
Initial Dementia Training	6 hours	CCL 87725.1	see above	Staff who provide direct care to resident(s) with dementia (in facilities that advertise, promote, or otherwise hold themselves out as providing special care, programming, and/or environments for residents with dementia or related disorders)	Within the first four weeks of employment

Ongoing Dementia Training	8 hours	CCL 87725.1	• Effects of medications on the behavior of residents with dementia • Common problems, such as wandering, aggression, and inappropriate sexual behavior • Positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living, and social, recreational and rehabilitative activities • Communication skills (resident/staff relations) • Promoting resident dignity, independence, privacy and choice • End of life issues, including hospice	Staff who provide direct care to resident(s) with dementia (in facilities that advertise, promote, or otherwise hold themselves out as providing special care, programming, and/or environments for residents with dementia or related disorders)	Annually
Initial Medication Training (15 beds or less)	6 hours (2 of the hours are shadow)	CCL H&S Code 1569.69	• The role, responsibilities, and limitations of staff who assist residents with the self-administration of medication, including tasks limited to licensed medical professionals. • An explanation of the terminology specific to medication assistance. • An explanation of the different types of medication orders: prescription, over-the-counter, controlled, and other medications. • An explanation of the basic rules and precautions of medication assistance. • Information on medication forms and routes for medication taken by residents. • A description of procedures for providing assistance with the self-administration of medications in and out of the facility, and information on the medication documentation system used in the facility. • An explanation of guidelines for the proper storage, security, and documentation of centrally stored medications. • A description of the processes used for medication ordering, refills and the receipt of medications from the pharmacy. • An explanation of medication side effects, adverse reactions, and errors.	Staff who assist in the self administration of medications (RN, LVN, Pharmacist, and MD are exempt)	Within the first two weeks of employment. Shadowing must be completed prior to assisting with meds.
Ongoing Medication Training (15 beds or less)	4 hours	CCL H&S Code 1569.69	see above	Staff who assist in the self administration of medications (RN, LVN, Pharmacist, and MD are exempt)	Annually
Initial Medication Training (16 beds or more)	16 hours (8 of the hours are shadow)	CCL H&S Code 1569.69	see above	Staff who assist in the self administration of medications (RN, LVN, Pharmacist, and MD are exempt)	Within the first two weeks of employment. Shadowing must be completed prior to assisting with meds.
Ongoing Medication Training (16 beds or more)	4 hours	CCL H&S Code 1569.69	see above	Staff who assist in the self administration of medications (RN, LVN, Pharmacist, and MD are exempt)	Annually

Sexual Harassment Training	2 hours	AB1825	• Explain federal and California sexual harassment law • Offer practical guidance for correcting and preventing sexual harassment in the workplace	Supervisors	Within 6 months of promotion/hire date and repeated every 2 years
Bloodborne Pathogens	not specified	Cal/OSHA	• Bloodborne pathogens • Exposure control	Potentially exposed employees	Initial and annual
Emergency Action Plans	not specified	Cal/OSHA	• Emergency escape procedures and emergency escape route assignments • Procedures to be followed by employees who remain to operate critical operations before they evacuate • Procedures to account for all employees after emergency evacuation has been completed • Rescue and medical duties for those employees who are to perform them • The preferred means of reporting fires and other emergencies • Names or regular job titles of persons or departments who can be contacted for further information or explanation of duties under the plan	Impacted employees	Initial and when the plan is updated
Back Injury Prevention	not specified	Cal/OSHA	•	Impacted employees	Initial
Fire Extinguisher	not specified	Cal/OSHA	• Fire extinguisher use	Assigned employees	Initial and annual
Fire Prevention Plan	not specified	Cal/OSHA	• The employer shall apprise employees of the fire hazards of the materials and processes to which they are exposed. • The employer shall review with each employee upon initial assignment those parts of the fire prevention plan which the employee must know to protect the employee in the event of an emergency.	Exposed employees	Initial and when new hazards
First Aid	not specified	CCL and Cal/OSHA	• Basic first aid	Staff providing care (CCL) Assigned employees and supervisors (Cal/OSHA)	Initial and keep current

Employee Performance Evaluation

DATE OF REVIEW	EMPLOYEE	POSITION	DEPARTMENT

RATING SYSTEM				
1 – did not meet	2 – met some	3 – met all	4 – exceeded	5 – far exceeded

JOB DESCRIPTION (ATTACHED)
1. Strengths Identify and explain the components of the job description where they employee performed best.
2. Areas for Improvement Identify and explain those components of the job description in which the employee needs improvement.
JOB DESCRIPTION RATING (circle one): **1 2 3 4 5**

JOB PERFORMANCE		
	RATING	**COMMENTS**
Quality of work Factors to consider include accuracy, timeliness, attention to detail, flexibility, and neatness.	1 2 3 4 5	
Relationship with others Factors to consider include willingness to help coworkers and supervisors, contribution to team, rapport with clients, and responsiveness to suggestions.	1 2 3 4 5	
Work habits Factors to consider include attendance, punctuality, return from breaks, and amount of supervision required.	1 2 3 4 5	

Initiative Does the employee have positive enthusiasm, and do the initiate actions independently?	1 2 3 4 5	
Adaptability/Flexibility Factors to consider include how will the employee handles change, and ability to learn new duties.	1 2 3 4 5	
Uniform Factors to consider include adherence to uniform policies.	1 2 3 4 5	
JOB PERFORMANCE RATING (circle one):	**1 2 3 4 5**	

OVERALL PERFORMANCE					
RATE THE EMPLOYEE'S OVERALL PERFORMANCE:	**1**	**2**	**3**	**4**	**5**

ACTION PLAN

Outline goals/objectives the employee is responsible for reaching to improve their job performance during the next evaluation period.

EVALUATOR COMMENTS

SIGNATURES

EVALUATOR: ____________________ DATE: __________

EMPLOYEE: ____________________ DATE: __________

ADMINISTRATOR: ____________________ DATE: __________

SAMPLE POLICY: Change in Resident Status

The Community is a non-medical Community. It is the responsibility of the staff to provide care, yet summon medical attention when there is a change in status.

Procedure

1. Notify the Director of Assisted Living or Med Tech on duty whenever there is a change in resident status.

2. Examples of change would include, but not be limited to:

   a) Refusal of meals
   b) Decreased mobility/range of motion
   c) Change in patterns of elimination
   d) Weakness
   e) Decreased coordination
   f) Change in level of consciousness
   g) Decreased communication/response
   h) Decreased ability to communicate signs
   i) Decline in cognitive function
   j) Motor agitation or retardation
   k) Hallucinations or other unusual behavior
   l) Nausea
   m) Vomiting
   n) Elevated or subnormal temperature
   o) Wheezing
   p) Shortness of breath or exertion
   q) Complaints of pain or discomfort
   r) Edema or swelling
   s) Change in usual range of vital signs
   t) Reaction/side effect to medications
   u) Weight loss
   v) Depressive behaviors
   w) Exit seeking behaviors

3. If there is an actual change in status or ability to function the resident's physician should be notified. Always have the resident's complete chart, list of meds, current vital signs (if available), and concise list of problems.

4. If this is part of an on going problem and home health is following the resident, contact the home health nurse and explain the situation at hand.

5. Document the date and time of contacts, and with whom you spoke. Clearly document any new orders and repeat back to the physician.

6. Immediately enter the new orders on the resident's care plan and/or medication administration record if the order pertained to medications.

7. Notify the resident's family/responsible person of the change in status and Community action taken.

9. Pass on to the next shift the status change and new physician orders, utilizing the Nurse to Med Tech report.

10. If a change in status progresses to a crisis at anytime, call 911.

SAMPLE POLICY: Medication Workflow

Med Aides will follow a consistent workflow, to ensure medication orders and MARs are up to date and refills received in a timely manner.

Procedure

The following medication workflow will be followed:

A. When an order is received for a new medication

1. Place the new order on the MAR immediately
2. Fax the order to the pharmacy or request from family as appropriate
3. Place the information on the Refill/New Order Roster
4. Make a notation for report on the Nurse to Med Aide Report
5. Three hole punch and place in chart under MD orders (may flag). Use the Physician Order page when the Rx is small. Attach the Rx to the page with a stapler. Do not use tape.

B. When a medication change order is received

1. Proceed to the MAR and change as appropriate.
   Rewrite new dosage change
2. Fax new order to pharmacy if needed for any dosage changes
3. Place the information on the Refill/New Order Roster
4. Make a notation for report on the Nurse to Med Aide Report
5. Three hole punch and place in chart under MD orders

C. When a Clarification is needed from the physician

1. Write the clarification and fax to the MD
2. Place the clarification on the "pending faxes" clipboard mounted near the fax machine
3. Call the MD office to alert fax was sent
4. Make a notation on the Nurse to Med Aide Report and if necessary flag the MAR by moving the three-hole punch MAR over so it sticks out of the book as a "flag" to remind it needs attention.
5. Continue calling and faxing each shift
6. Once received, remove the clarification from the pending faxes clipboard and destroy. Follow appropriate medication change procedure with the signed order received from the MD via fax.

D. Refills

1. It is the responsibility of every staff member involved with medications to ensure the mediations are ordered appropriately.
2. Medications are ordered at least 7 days before running out. (More days when needed due to difficult or mail order pharmacies)

3. Cycle fill from the pharmacy are excluded as these meds should be coming in routinely.
4. Enter the refill on the Refill/New Medication Roster and order.
5. Notify family when necessary for pick up.
6. Each shift the med aide is to follow through with refills pending (re-fax, call pharmacy, call family etc.). Make appropriate notations on roster.
7. Should a medication run out; the nurse makes a narrative entry in the chart recapping the numerous attempts. The MD is contacted.

E. When a New or Refill Medication is delivered:

1. As soon as a medication is brought to the wellness center, it is noted as received on the Refill/New Order Roster. If it is a new med you were not expecting (e.g. family took resident to doctor and brought med with new order) it does not need to be placed on the Refill/ New Order Roster, as we are not waiting for it to arrive.
2. ALL incoming medications (from pharmacy deliveries, family etc.) are immediately placed in the incoming med box, until logged on the Centrally Stored Medication Record. The NOC shift is responsible for logging all centrally stored meds, not completed by the day or pm shift.
3. Once the meds are logged, the meds are placed in the appropriate area of the med cart or overflow meds as appropriate.
4. If a medication goes into the overflow med area, the current med in use is noted to indicate an overflow med exists by writing on the side of the bubble pack or affixing a sticker to the top of a vial. Never write on the pharmacy label.

F. Treatments

1. When a treatment order is received, after noted, it is placed on a Treatment Page which is kept with the MARs.
2. Each nurse signs off a treatment, once given.
3. The med aide flags any treatments, reminding the nurse of pending treatments
4. New treatment orders are noted on the Nurse to Med Aide Report
5. The nurse is responsible for charting to the exception and weekly in narrative charting.

G. Signing of Meds

1. All staff will pour the medication each gives, verifying the medication three times during the pour process.
2. The MARs are initialed at the time the medication is placed in the cup.
3. If for some reason a medication cannot be poured, the MAR is moved to the right, thus “flagging” the MAR, until the problem is rectified.
4. After passing medication, any required documentation is immediately made.
    a. Not in room, but expected back soon or searching: Flag MAR
    b. Medication refused but will take shortly: Flag MAR
    c. Medication refused: Circle initials, write reason for refusal on back of MAR. Notify MD as required

d. Out of building, missing pass time: Circle initials, note out of building (OOB) in back of MAR. Notify MD as required.

H. Coumadin

1. In addition to the transportation request, place all Coumadin labs on the treatment record with the MARs.
2. The nurse on duty is expected to review the Tx order pages on each shift
3. The resident is placed on alert on the Nurse to Med Aide Report until the new orders arrive following a lab.
4. Each shift is to aggressively fax and call the MD for new orders, once a lab is completed.
5. Once the order is received, the change in medication order policy is followed.

SAMPLE POLICY: Emergency/Disaster Plan

The Administrator shall develop and maintain current Emergency/Disaster policies and procedures. The Emergency/Disaster policies and procedures shall be reviewed annually by the Administrator. The Emergency/Disaster policies and procedures shall be updated as needed. Staff shall be in-serviced on appropriate Emergency/Disaster protocol and duties.

Attach your Emergency Disaster Plan here:

SAMPLE POLICY: Occurrence and Incident Reports

Injury and unusual incidents will be reported in compliance with state regulatory requirements.

Procedure

1. The Unusual Incident form (LIC 624) is used to document and report any incident which is a threat to a resident's health, safety, welfare, or rights. This is completed at the discretion of the Executive Director. This includes, but is not limited to occurrences such as:

    a) Falls.
    b) Injury.
    c) Psychiatric crisis.
    d) Unexplained absence.
    e) Any violation of resident rights.
    f) Any incident that threatens the health, welfare, or safety of the resident.

2. Any incident which is a threat to a resident's health, safety, welfare, or rights will be reported to CCL within 7 days of the incident and a report made via telephone to the Licensing Program Analyst within 24 hours of the incident.

3. The Director of Assisted Living or designated staff completes the Incident Report.

4. Incidents are reported to family/responsible party. Document the date and time the report was made to the family/responsible party in the narrative charting section.

5. All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman, state licensing agency, and in the case of assault (physical or sexual), to law enforcement.

SAMPLE POLICY: Maintenance Policy

The Licensee shall ensure that the facility is maintained in a manner that promotes staff and resident safety, cleanliness, resident satisfaction and well being. Maintenance policies shall be reviewed at a minimum annually. The policies shall be updated as necessary and maintenance changes implemented immediately when needed. The policies shall include but not be limited to housekeeping, facility and grounds maintenance, vehicle safety and upkeep, food service and laundry.

Attach your maintenance schedules here:

SAMPLE POLICY: Evictions

The Licensee may upon thirty days written notice evict the resident on the following grounds:

1. If the resident does not pay the rate for basic services within ten days of the due date.

2. If the resident does not comply with state or local law after receiving written notice of the alleged violation.

3. If the resident does not comply with general policies of the facility. These policies must be in writing, must be for the purpose of making it possible for residents to live together and must be made part of the admission agreement.

4. If, after admission, it is determined that the resident has a need not previously identified and a reappraisal has been conducted, and the licensee and the person who performs the reappraisal believe that the facility is not appropriate for the resident.

5. Change of use of the facility.

A. Three Day Eviction

The licensee of the facility may, upon obtaining prior written approval from the licensing agency, evict the resident upon three days written notice to quit upon finding of good cause. Good cause exists if the resident is engaging in behavior which is a threat to the mental and/or physical health or safety of himself/herself or to others in the facility.

B. Eviction Notification

The licensee/administrator of the facility shall, in addition to either serving thirty days notice or seeking approval from the Department and serving three days notice on the resident, notify and mail a copy of the notice to quit to the resident's responsible person, if any. Additionally, a written report of any eviction shall be sent to the licensing agency within five days. The licensee/administrator of the facility shall set forth in the notice to quit the reasons relied upon for the eviction with specific facts to permit determination of the date, place, witnesses, and circumstances.

C. Resident Right to Review of a Health Condition Relocation Order

Residents, or their responsible person, if any, shall be permitted to request a review and determination of a Department's health condition relocation order by the interdisciplinary team.

If they have no responsible person, the Long-Term Care Ombudsman and/or representative payee, if any, shall be permitted to submit a request for review and determination on behalf of the resident.

Residents, or their responsible person, if any, shall have three working days (a working day is any day except Saturday, Sunday or an official state holiday) from receipt of the relocation order, to submit to the licensee a written, signed and dated request for a review and determination by the interdisciplinary team.

The Licensee shall cooperate with the resident, or their responsible person, if any, in gathering the documentation to complete the review request. This documentation shall include, but not be limited to, the following:

1. The reason(s) for the resident disagreeing that they have the health condition identified in the relocation order and why they believe they may legally continue to reside in a residential care facility for the elderly.

2. A current medical assessment signed by the physician. "Current" shall mean a medical assessment completed on or after the date of the relocation order.

3. An appraisal or reappraisal of the resident by the licensee.

4. A written statement from a placement agency, if any, currently involved with the resident, addressing the relocation order.

The Department shall inform the resident and/or their responsible person, if any, in writing, of the interdisciplinary team's determination and the reason for that determination not more than 30 days after the resident and/or their responsible person, if any, is notified of the need to relocate.

D. Involuntary Relocation Policy

The following written relocation plan will be followed.

1. If relocation is determined to be necessary, by consultation with the physician and family or responsible party, the administrator shall determine a specific date for beginning and a specific date for completion of the process of safely relocating the resident. The time frame for relocation may provide for immediate relocation but shall not exceed 30 days.

2. The resident and their responsible person, if any, shall be notified of the need for relocation immediately.

3. The administrator will discuss with the physician the resident's health needs and the appropriate facility type for relocation. The administrator will ensure that the resident's health care needs continue to be met at all times during the relocation process by continuing to provide care and supervision for the resident until the relocation.

4. If relocation is determined to be necessary, the resident shall only be relocated to a facility that can meet the resident's needs. This may be relocation to another RCFE that provides a more appropriate level of care or even a skilled nursing facility. It is the responsibility of the administrator to ensure that the location where the resident is relocated to offers an appropriate level of care. The administrator shall visit the facility if possible and discuss the care needs of the resident with the administrator or director of the new facility.

5. Resources which may be helpful in the case of the resident being relocated. They may include the Long Term Care Ombudsman, the resident's pastor/minister/etc., Senior Citizens Programs, etc. These resources may be helpful prior to and after the relocation.

6. The administrator shall, immediately upon the determination that the move is required, shall meet with the resident and explain the need for the move which shall include the physician's determination of the need for the move. The administrator shall assure the resident that all care and supervision shall continue until the resident moves. This includes all services required to meet the resident's needs.

7. If services are required to meet the resident's needs until the resident moves, the administrator shall arrange for these services. We shall provide one on one care until the relocation. We shall request physician orders outlining appropriate care until the relocation We shall have Home Health Care provide needed care as requested by the physician. We shall document any changes in the resident and keep the physician and family informed of such changes. We shall implement any physician orders as requested by the physician due to the changes.

8. The administrator shall notify the Department immediately when the relocation has occurred, including the new address, if known.

E. Licensee-Initiated RCFE Closure

Examples of reasons for closure of the facility:

1. Change of use of the facility pursuant to department regulations.

2. Forfeiture of license resulting from sale of the property. (Applies to the sale of the property and the facility when the facility will no longer be used as an RCFE)

3. Forfeiture of license resulting from surrender of the license.

4. Forfeiture of license resulting from abandonment of the facility

If you (the resident) are evicted for one of the reasons listed above, prior to your relocation, the licensee shall:

1. Prepare a relocation evaluation of your needs. The licensee shall include in the evaluation recommendations on the best type of facility for you based on the current service plan and a list of such facilities within a 60-mile radius of the existing facility.

2. The licensee shall provide you, or your responsible person, written notice no later than 60 days before the intended eviction. The notice will include the reason for the eviction (with specific facts), a copy of your current service plan, the relocation evaluation, a list of referral agencies, and your right or your legal representatives right to contact the CDSS to investigate the reason(s) for the eviction.

3. The licensee shall discuss the relocation evaluation with you and your legal representative within 30 days of issuing the notice of eviction.

4. The licensee shall submit a written report of any eviction to the licensing agency within five days of the facility issuing the notice of eviction.

5. Upon issuing the written notice of eviction, the facility will not accept any new residents or enter into any new admission agreements.

6. The facility will refund paid preadmission fees in excess of $500, as specified in H&S Code section 1569.682(a)(6). The licensee shall pay the refund within 15 days of issuing the eviction notice, or, if you request, use the refund as a credit toward your monthly fee.

7. The facility will refund any applicable per diem amount of prepaid monthly fees. If you give a five-day notice, the refund shall be paid at the time you leave the facility and vacate the unit. Otherwise, the refund shall be paid within seven days from the date you leave the facility and vacate the unit.

8. Within 10 days of all residents having left the facility, the licensee shall send a final list of names and new locations of all residents to the CDSS and the local ombudsperson program.

SAMPLE POLICY: Allowable Health Conditions

The Community will admit and retain stable residents with health conditions that can be safely cared for by Community staff and are congruent with state licensing agency guidelines.

Procedure

1. The physician report is reviewed prior to placement to verify diagnoses and health conditions.

2. The following are examples of health conditions/needs which are managed in the community.

    a) Use of oxygen when blood gases are stable and the resident is capable of self-administration.

    b) Colostomy.

    c) Ileostomy.

    d) Tracheotomy when the resident is capable of self-care and suctioning is not required.

    e) Incontinence (both bowel and bladder).

    f) Stage I and II decubitus ulcers.

    g) Post-surgical wounds when the wound is well approximated.

    h) Diabetes including insulin dependent providing the resident has reasonable stability (e.g. no or infrequent blood glucose less than 60).

    i) Inhalation therapies.

    j) Hospice, providing a Medicare certified hospice agency, contracted by the resident/responsible party, is coordinating the care.

    k) Memory loss and dementia with manageable behaviors and no known elopement or exit-seeking patterns, unless residing in an MBK dementia care unit.

Admission Appraisal

To be completed at the time of admission.

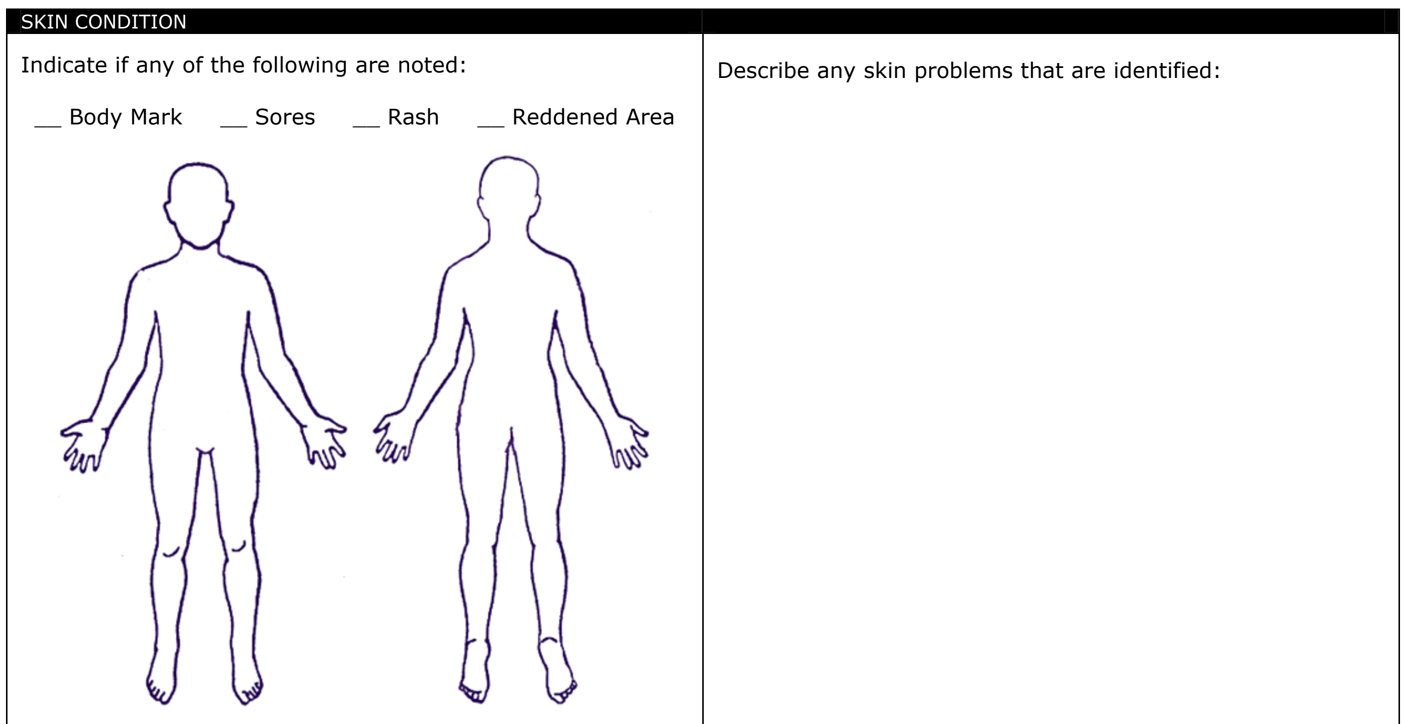
DATE	TIME	RESIDENT

HEIGHT	WEIGHT	TEMPERATURE	BLOOD PRESSURE	PULSE	RESPIRATIONS

ADMITTED FROM	TRANSPORTED BY

LAST MEAL	LAST TIME MEDICATIONS ADMINISTERED	COMPLAINTS OF PAIN OR DISCOMFORT

DESCRIBE GENERAL PHYSICAL APPEARANCE



SKIN CONDITION

Indicate if any of the following are noted:

___ Body Mark ___ Sores ___ Rash ___ Reddened Area

Describe any skin problems that are identified:

ORIENTATION - initial next to each item when completed	RESIDENT RECORD AND MEDICATIONS
___ Resident oriented to facility, including emergency exits	___ Resident chart created
___ Resident oriented to his/her bedroom	___ All medications received from pharmacy or prior residence and secured in central storage
___ Use of emergency call system explained (if applicable)	
___ Resident introduced to key staff members	

______________________________ Signature of person completing appraisal

______________ Date

SAMPLE POLICY: End of Shift Charting

All caregivers will document at the end of each shift.

Procedure

1. All caregivers sign and verify all assigned care has been completed, using the End of Shift Report. If any assigned duty was not completed, a notation will be made indicating the circumstances and action taken on behalf of the resident. The Med Tech will be verbally notified of any incompletion of assigned care.

2. Caregivers indicate action taken in response to the change in status.

3. At the beginning of each shift, on-coming staff read the end of shift reports from the last 24 hours.

4. At the end of each shift, the Med Tech reviews the end of shift charting from care staff. Report is provided to the on-coming Med Tech.

5. The Director of Assisted Living or assigned individual reviews all entries on the End of Shift Reports, initials and indicates any action taken.

6. The Director of Assisted Living or Med Tech, as assigned, documents significant information from the caregiver's charting on the End of Shift Report.

7. The Med Techs and nurses communicate at the end of shift any pertinent medication information such as reported refusals, new orders, MD communication, labs, or other concerns on the Nurse / Med Tech Report.

8. End of Shift Reports are retained for 180 days and then destroyed. The End of Shift notebook will maintain 30 days of charting at all times.

End of Shift Report

Date:	Shift:	Floor/Unit:

Staff Person	Assigned care completed?	Any service plan changes or requests?	Any change in resident status or concerns?	Any unusual occurrences?	Keys, pagers, etc. passed off
please print	if **NO** chart	if **YES** chart	if **YES** chart	if **YES** chart	-----
	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

Remember to include the action you took for any problem/occurrence noted.

Resident:		Supervisor signature: Action taken:
Staff Person:		

Resident:		Supervisor signature: Action taken:
Staff Person:		

Resident:		Supervisor signature: Action taken:
Staff Person:		

Resident:		Supervisor signature: Action taken:
Staff Person:		

Resident:		Supervisor signature: Action taken:
Staff Person:		

Grand Rounds Tool

Resident Name:	**Room:**	**Date:**

Length of placement: _________________ **Current Level of Care**: _________________

ER visits in last: 3 months: _____________________ 12 months: ___________________

Visit: _________________ **Causative factors:** __________________________________
Visit: _________________ **Causative factors:** __________________________________
Visit: _________________ **Causative factors:** __________________________________

In-patient Hospitalizations in last 12 months: __________________________________

Causative factor: ____

Home Health or Hospice Involvement: ____

Mentation

Any noted change in cognition? ___________ If yes explain: _______________________

Most recent minimental (or other assessment): ____________________________________

Any new behaviors observed? ________ If yes, explain: ____________________________

Any change in mood or affect observed? __ If yes, explain: _______________________

Any change in communication/speech? ___ If yes, explain: ________________________

Any change in usual sleep pattern? If yes, explain: ________________________________

Generally naps: _____ hours/day Usually awakens: ________ Usually retires: ________

Demonstrates ability to use call system? _________

Interventions: ____
____

Nutrition/Hydration

Meal/fluid intake observations:____

Current weight:_______________ Weight change in last six months: _________________

Using meal supplements?________ If yes: _______________________________________

Interventions: ____
____

Mobility

Any observed changes in mobility? ______ If yes, explain: ___________________________

Any change in ability to transfer? ________ If yes, explain: ____________________________

Falls in last 90 days: ____________________ Intrinsic/Extrinsic factors:___________________

Fatigue or dyspnea on exertion noted/reported?______ If yes, explain: _________________

Current assistive devices used: ____

Interventions: ____
____

Grooming/Dressing

Any observed changes in self grooming/dressing? ________ If yes, explain: ____________

Interventions: ____
____

Continency/Skin

Any change in continency? _________ If yes, explain: _________________________________

Current Skin appraisal: ____

Skin breakdown history for past 12 months:

Problem:	Location:	Stage (if pressure sore):
_____________________	_____________________________	____________________________
_____________________	_____________________________	____________________________

Interventions: ____
____

Activities

Any observed changes in Recreational Activities? ______ If yes, explain: _______________

Out of room daily for activities? ____

Interventions: ____
____

Medication Routine

Number of psychotropics in use: ______________ Change over 6 months: _______________

High Risk Medications: ____

Pattern of Refusals: ____

Interventions: ____
____

Labs

Routine Lab concerns: ____

Labs to request? ____

Current Medical Conditions

Dx: ____

Recent presentations of additional symptoms? ________ If yes, explain: ________________

Dx: ____

Recent presentations of additional symptoms? ________ If yes, explain: ________________

Dx: ____

Recent presentations of additional symptoms? ________ If yes, explain: ________________

Notes: ____
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Appraisal of Dementia-Specific Fall Risk Factors

Resident: ____ Date _______________

Place a check by all dementia-specific conditions present. Any identified fall-risk factors must be addressed in the service plan.

GENERAL	
__ New admission or transfer to another unit	__ Bowel and/or bladder incontinence
__ Fall in 2 weeks prior to admission	__ Low body mass
__ Fall(s) within last 60 days in facility Number ____________________ Circumstances of fall(s) (Fell during): ______________________________ ______________________________ Location of fall __________________	__ Seizures __ Unstable condition __ Acute illness within last 14 days __ Mechanical restraint use at prior facility (hospital, etc)
__ No trauma	
__ Injury _________________________	
COGNITION	
__ Depression	__ Perceives abilities greater than physical capabilities
__ GDS Stage 6	__ Unable to tolerate wearing eyeglasses
__ GDS Stage 7	__ Unable to tolerate wearing hearing aid(s)
__ Change in cognitive level from GDS/FAST stage ______to ______	__ Unable to verbally communicate needs
__ Poor reasoning/judgment placing self in unsafe situations	__ Unable to comprehend bed or chair alarm
__ Unable to recognize ambulation deficits	__ Unable to gauge height accurately (steps, stairs, door thresholds)
MOBILITY	
__ Ambulatory and active	__ Nonambulatory
__ Ambulatory but weak/debilitated	__ Self-propels wheelchair
__ Ambulatory with assistance	__ Increased reliance on proprioception to maintain balance (i.e., as evidenced by removing footwear when ambulating)
__ Using assistive device: walker, cane, other ________________________________	__ Inability to transfer independently
__ Unable to use assistive devices properly	

NEUROMOTOR CHANGES	
__ Rigidity present: Arms Legs Neck Torso	__ Impaired recovery balance
__ Rigidity induced by bed/chair alarm sounds	__ Impaired arm outstretching/extension
__ Decreased grip strength	__ Slow reaction time
__ Loss of protective reflexes	
ALTERED GAIT AND BALANCE	
__ Start hesitancy and freezing	__ Unsteady standing balance
__ Shuffling (doesn't pick up feet)	__ Uses furniture to maintain standing or walking balance
__ Scissoring (one leg crosses over other in walking)	__ Sinks to feet when ambulating
__ Non-continuous walk with hesitation	__ Postural sway: Forward Left Side Right Side Backward
__ Short steps	__ Unstable rising from seated positions
__ Variation of step length	__ Unstable getting out of bed
__ Deviates from straight path	__ Unstable sitting balance
__ Difficulty making turns	__ Unable to sit up
__ One or both feet scrape ground surface	__ Unable to perform unassisted chair/bed transfers
__ Unable to step over obstacles	__ Feet slide away on ground during transfers
__ Unable to navigate around obstacles	
__ Reduced walking speed	
BEHAVIOR	
__ Self-stimulatory wandering	__ Anxiety, agitation
__ Restless pacing	__ Sleep disturbance
__ Resistive to ADL care	__ Exhibits risky behavior (attempting to stand or get out of bed unassisted
SENSORY CHANGES	
__ Vision	__ One-sided visual neglect
__ Decreased depth perception	__ Decreased peripheral vision

____ ______________________

Signature of person completing form Date

Falls Information Document

Falls are a serious problem with senior citizens that cannot be avoided in a residential community. Seniors living in an assisted living/residential care community are at risk for falls often due to underlying health concerns.

Falls can result in serious injuries, head trauma and even death. While service plan interventions may help to reduce the risk of falls, such interventions cannot be guaranteed to prevent falls.

This community does not provide one on one care and residents are not always directly monitored. This community does not make any guarantees that residents will not fall.

A service plan is developed which addresses the needs of the resident. Please review service plans and give your suggestions.

Name:________________________ Responsible Party:___________________

Signature:_____________________ Date:______________________________