

COMMUNITY CARE LICENSING DIVISION

*"Promoting Healthy, Safe and
Supportive Community Care"*

TECHNICAL SUPPORT PROGRAM

Self-Assessment Guide

RESIDENTIAL CARE FACILITY FOR THE ELDERLY PREADMISSION QUESTIONNAIRE



CDSS
CALIFORNIA
DEPARTMENT OF
SOCIAL SERVICES

Please fax this form when complete to
760-743-8847 or E-mail to:
JOHNEGAMBLE@AOL.COM
For questions call 760-743-8843 anytime.
www.oakhillresidential.org

**TECHNICAL SUPPORT PROGRAM
RESIDENTIAL CARE FACILITY FOR THE ELDERLY
PREADMISSION QUESTIONNAIRE**

The following questionnaire is designed to assist licensees in identifying specific medical and behavioral issues that may affect the placement of and/or services to be provided to prospective residents of Residential Care Facilities for the Elderly (RCFE). The questions on this form should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes; the licensee should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs.

The information on this form supplements the Preplacement Appraisal Information form (LIC 603), but does not replace it. While the information gathered from this form should assist licensees in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: _____

Applicant's Name: _____ DOB: _____

Current Residence:
Own home _____ With family _____ Board & Care _____ SNF _____ Hospital _____

Reason for Placement in RCFE: _____

Applicant's Physician: _____

A. INCIDENTAL MEDICAL SERVICES ASSESSMENT

YES **NO**

1. Oxygen Administration

 Does the applicant use oxygen? If yes, explain. _____

_____ (See 87703)

 Does the applicant need assistance? If yes, explain. _____

_____ (Exception required. See 87703)

 Does the applicant use liquid oxygen? If yes, explain. _____

_____ (Exception required. See 87701(a)(12) policy)

INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

YES

NO

2. Intermittent Positive Pressure Breathing (IPPB) Machine

Does the applicant use an IPPB? If yes, explain.

_____ (See 87704)

Does the applicant need assistance? If yes, explain. _____

_____ (Exception required. See 87704)

3. Colostomy/Ileostomy

Does the applicant have a colostomy or ileostomy? If yes, explain.

_____ (See 87705)

Does the applicant need assistance? If yes, explain. _____

_____ (Exception required. See 87705)

4. Enema/Suppository/Fecal Impaction Removal

Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain. _____

_____ (See 87706)

Does the applicant need assistance? If yes, explain. _____

_____ (See 87706)
(Procedures must be performed by an Appropriately Skilled Professional [ASP])

5. Catheter Care

Does the applicant have a catheter? If yes, explain. _____

_____ (See 87707)

Does the applicant need assistance? If yes, explain. _____

_____ (Exception may be required. See 87707)

INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

YES **NO**

 6. Bowel and Bladder Incontinence
Is the applicant incontinent of bowel or bladder? If yes, explain. _____

_____ (See 87708)

 7. Contractures
Does the applicant have contractures? If yes, explain. _____

_____ (See 87709)

 Does the applicant need assistance? If yes, explain. _____

_____ (Exception required. See 87709)

 Do the contractures severely affect the applicant's ability to function?
(If yes, not allowed in an RCFE. See 87709)

 8. Diabetes
Does the applicant have diabetes? If yes, explain. _____

_____ (See 87710)

 Does the applicant require assistance with performing or reading
glucose tests, drawing up injectable medications or administering
injections? If yes, explain. _____

_____ (Procedures must be performed by an ASP. See 87710)

INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

YES

NO

9. Injections

Does the applicant need any injections? If yes, explain. _____

_____ (See 87711)

Does the applicant need assistance with drawing up and administering the injections? If yes, explain. _____

_____ (Procedures must be performed by an ASP. See 87711)

10. Healing Wounds

Does the applicant have any healing wounds? If yes, explain. _____

_____ (Exception required. See 87713)

Does the applicant have stage 1 or 2 dermal ulcers (bedsores)? If yes, explain. _____

_____ (Exception required. See 87713)

Does the applicant have stage 3 or 4 dermal ulcers? (If yes, not allowed in an RCFE. See 87713)

11. Bedridden

Is the applicant bedridden? If yes, explain. _____

_____ (See 87582)

Is the condition temporary (less than 14 days)? If yes, explain. _____

_____ (See 87582)

Is the condition permanent or expected to last more than fourteen days? If yes, explain. _____

_____ (Exception and bedridden fire clearance required. See H&S 1569.72)

INCIDENTAL MEDICAL SERVICES ASSESSMENT (Continued)

YES **NO**

- 12. Gastrostomy**
Does the applicant have a gastrostomy? (If yes, not allowed in an RCFE. See 87701)
- 13. Naso Gastric (NG) Tubes**
Does the applicant have NG tubes? (If yes, not allowed in an RCFE. See 87701)
- 14. Staph Infection**
Does the applicant have a Staph or other serious infection? (If yes, not allowed in an RCFE. See 87701)
- 15. Total Care**
Does the applicant need total care (assistance with ALL activities of daily living - eating, bathing, dressing, grooming, toileting and transferring)?
- 16. Tracheostomies**
Does the applicant have a tracheostomy? (If yes, not allowed in an RCFE. See 87701)
- 17. Hospice**
Is the applicant currently receiving hospice care?

B. PERSONS WITH DEMENTIA

YES **NO**

- Does the applicant have Dementia?
- Is the applicant mentally able to respond to an emergency signal or instruction? If yes, explain. _____

_____ (See 87724)
- Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. _____

_____ (Exception or waiver required. See 87724)

C. BEHAVIORAL ASSESSMENT

Does the applicant have a history of any of the following behaviors?

YES **NO**

- | | | |
|--------------------------|--------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Physical assaultiveness |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Verbal assaultiveness |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Wandering |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Sexual assaultiveness, molestation or inappropriate sexual activity |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Disruptiveness (screaming, throwing things, argumentative) |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Property destruction |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Careless disposal of smoking materials |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Stealing |

If the answer to any of the above is yes, describe the behavior: _____

Frequency and duration of the behavior(s): _____

Approximate date of last occurrence: _____

What seems to trigger the behavior: _____

Strategies to deal with the behavior: _____

BEHAVIORAL ASSESSMENT (Continued)

Does the applicant have a history of any of the following behaviors?

YES **NO**

- | | | |
|--------------------------|--------------------------|--------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Refusal to take medication |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Refusal to get medical attention |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Refusal to bathe or wear clean clothing |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Non-compliance with house rules |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Self-abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Suicide attempts or suicidal thoughts |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Alcohol or drug abuse |

If the answer to any of the above is yes, describe the behavior: _____

Frequency and duration of the behavior(s): _____

Approximate date of last occurrence: _____

What seems to trigger the behavior: _____

Strategies to deal with the behavior: _____

MISCELLANEOUS (Continued)

YES **NO**

4. Will the applicant be willing to have all of his/her medications, including over-the-counter medications, centrally stored?
5. Does the applicant use any of the following devices?
- Glasses
- Dentures
- Hearing Aid
- Other _____
6. Does the applicant need assistance with any of the following?
- Eating. If yes, explain. _____

- Bathing. If yes, explain. _____

- Dressing. If yes, explain. _____

- Grooming. If yes, explain. _____

- Toileting. If yes, explain. _____

7. Does the applicant use any of the following?
- Cane. If yes, explain. _____

- Crutch. If yes, explain. _____

- Walker. If yes, explain. _____

- Wheelchair. If yes, explain. _____

MISCELLANEOUS (Continued)

YES **NO**

 8. Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed) _____

 9. Is the applicant unable to transfer? If yes, describe assistance needed.

 10. Does the applicant require a special diet? If yes, explain. _____

 11. Does the applicant have any skin condition or history of skin breakdown? If yes, explain. _____

 12. Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often? _____

Applicant/Responsible Person: _____
(Signature)

Date: _____

Facility Representative: _____
(Signature)

Date: _____