

COMMUNITY CARE LICENSING DIVISION

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



Keys to Success

Self-Assessment Guide for Residential Care Facilities for the Elderly (RCFE)

Pre-Admission Questionnaire



CDSS

CALIFORNIA
DEPARTMENT OF
SOCIAL SERVICES

RESIDENTIAL CARE FACILITY FOR THE ELDERLY

PRE-ADMISSION 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. It is essential for licensees to ensure, to the extent possible, that the resident's history, medical assessment, prior facility records, if applicable and existing conditions are known and care needs understood prior to admission.

This guide is not intended to be a substitute for reading and understanding the regulations. The regulation section is referenced after each question.

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: _____ Date of Birth: _____

Current Residence:

Own home _____ With family _____ Board & Care _____

Skilled nursing facility _____ Hospital _____

Reason(s) for Placement in RCFE: _____

Applicant's Physician: _____

Address: _____

Phone number: _____

Applicant's Responsible Person, (if applicable) _____

A. INCIDENTAL MEDICAL SERVICES ASSESSMENT

YES NO

1. Oxygen Administration

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

(See 87618)

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

(Exception required. See 87618)

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

(Exception required. See 87618(c)(1))

2. Intermittent Positive Pressure Breathing (IPPB) Machine

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

(See 87619)

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

_____ (Exception required. See 87619)

3. Colostomy/Ileostomy

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

_____ (See 87621)

YES **NO**

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

_____ (Exception required. See 87621)

4. Enema/Suppository/Fecal Impaction Removal

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

_____ (See 87622)

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

(See 87622)
(Procedures must be performed by an Appropriately Skilled Professional [ASP])

5. Catheter Care

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

_____ (See 87623)

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

(Some procedures must be performed by an ASP)

6. Bowel and Bladder Incontinence

 Is the applicant incontinent of bowel or bladder? If yes, explain. _____

_____ (See 87625)

7. Contractures

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

_____ (See 87626)

YES **NO**

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

(Exception required. See 87626)

 Do the contractures severely affect the applicant's ability to function?
(If yes, not allowed in an RCFE. See 87626) _____

8. Diabetes

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

(See 87628)

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

(See 87628)

(Procedures must be performed by an ASP)

9. Injections

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

(See 87629)

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

(See 87629)

(Procedures must be performed by an ASP)

YES **NO**

10. Healing Wounds

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

(Exception required. See 87631)

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

(Exception required. See 87631)

 Does the applicant have stage 3 or 4 dermal ulcers? (If yes, not allowed in an RCFE unless an exception is approved. See 87615)

11. Bedridden

 Is the applicant bedridden – unable to reposition or transfer in bed? If yes, please explain. _____

(See 87455)

 Is the applicant unable to transfer in and out of bed without assistance? If yes, explain. _____

 Is the applicant's bedridden status temporary (less than 14 days)? If yes, explain. _____

(See 87455)

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

(See H&S 1569.72)

YES NO

12. Gastrostomy

 Does the applicant have a gastrostomy? (If yes, not allowed in an RCFE unless an exception is approved. See 87615)

13. Naso Gastric (NG) Tubes

 Does the applicant have NG tubes? (If yes, not allowed in an RCFE. See 87615)

14. Staph Infection

 Does the applicant have a Staph or other serious infection? (If yes, not allowed in an RCFE unless an exception is approved. See 87615)

15. Total Care

 Does the applicant need total care (assistance with ALL activities of daily living-- eating, bathing, dressing, grooming, toileting and transferring)? (If yes, not allowed in an RCFE unless an exception or waiver is approved. See 87615)

16. Tracheostomies

 Does the applicant have a tracheostomy? (If yes, not allowed in an RCFE. See 87615)

17. Hospice

 Is the applicant currently receiving hospice care? (If yes, please see Self-Assessment Guide on 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 87705)

YES **NO**

 Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. _____

(See 87705)

C. BEHAVIORAL ASSESSMENT

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

YES **NO**

- 1. Physical assaultiveness
- 2. Verbal assaultiveness
- 3. Wandering
- 4. Sexual assaultiveness, molestation or inappropriate sexual activity
- 5. Disruptiveness (screaming, throwing things, argumentative)
- 6. Property destruction
- 7. Careless disposal of smoking materials
- 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: _____

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: _____

YES **NO**

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. _____

YES **NO**

 Walker. If yes, explain. _____

 Wheelchair. If yes, explain.

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

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

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

 11. 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: _____

Attachments:

YES **NO**

