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. ________________

________________________________________

(Except. required. See 87618)

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

________________________________________

(Except. 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. ________________

________________________________________

________________________________________ (Except. 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)

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

5. Catheter Care

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

..................................................................................................................

(See 87623)

(See 87622)

(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)
<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td><strong>10. Healing Wounds</strong></td>
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<td>☐ ☐ Does the applicant have any healing wounds? If yes, explain.</td>
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</tbody>
</table>

(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?

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<th>YES</th>
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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: ________________________________

______________________________________________________________________
D. MISCELLANEOUS

YES    NO

☐ ☐ 1. Does the applicant currently use any prescription or over-the-counter medications? If yes, please list.

<table>
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<th>Medication Name</th>
<th>Strength</th>
<th>Dose</th>
<th>Times</th>
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</table>

☐ ☐ 2. Does the applicant currently use any prescription or over-the-counter medications on a PRN basis? If yes, please list. ________________________________

PRN letter signed by the applicant’s physician required. See 87465(b)(c)(d)(e)

☐ ☐ 3. Does the applicant have any emergency medication that must be kept with him/her or at bedside? If yes, please list. ________________________________

☐ ☐ 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. ________________________________
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