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**	
☐	☐	1. Refusal to take medication
☐	☐	2. Refusal to get medical attention
☐	☐	3. Refusal to bathe or wear clean clothing
☐	☐	4. Non-compliance with house rules
☐	☐	5. Self-abuse
☐	☐	6. Suicide attempts or suicidal thoughts
☐	☐	7. Depression
☐	☐	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: _____

_____

_____

_____

D. MISCELLANEOUS

YES **NO**

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

Medication Name	Strength	Dose	Times

☐ ☐ 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?

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**