

**DANE COUNTY DEPARTMENT OF HUMAN SERVICES LONG TERM
SUPPORT
CBRF QUALITY STANDARDS**

2010 CBRF SPECIALIZED SERVICES QUESTIONNAIRE

This questionnaire should be completed by each CBRF contracting with Dane County to serve residents funded by the Community Options Program and MA Waiver. Facilities may submit policy and procedure statements to answer some or all of the questions. Additional relevant information is welcome. ***A separate questionnaire should be completed for each CBRF location within an organization.***

Please return completed forms to: South Madison Coalition of the Elderly, Attn: Sharon Larson, 128 E. Olin Avenue, Madison 53713. To receive and complete this questionnaire electronically, send an email to larson@smcelder.com. Thank you!

General Information:

Facility Name:

Facility Address:

Facility Director/Administrator:

Director/Administrator e-mail address:

Facility Phone Number:

Facility Fax Number:

Licensee Name:

Licensee Address:

Licensee Phone Number:

Target Population(s) Served:

Dementia Specific + Secured Facility: Yes No

Name/title of person completing form _____

Date completed _____

Specialized Health Services:

Are you able to work with the following issues:	Yes	No
Hoyer Lifts	<input type="checkbox"/>	<input type="checkbox"/>
Two Person Transfers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Sliding Scale Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Tube Feeding	<input type="checkbox"/>	<input type="checkbox"/>
Catheters	<input type="checkbox"/>	<input type="checkbox"/>
Bladder incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness Diagnosis/Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
End of life care with Hospice support	<input type="checkbox"/>	<input type="checkbox"/>

Specialized Staff:

Do you have the following:	Yes	No
Awake staff at night	<input type="checkbox"/>	<input type="checkbox"/>
Cook	<input type="checkbox"/>	<input type="checkbox"/>
Activity/Life Enhancement Coordinator	<input type="checkbox"/>	<input type="checkbox"/>

If "yes", indicate hours worked per week_____

Registered Nurse	<input type="checkbox"/>	<input type="checkbox"/>
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If "yes", indicate hours worked per week_____

Licensed Practical Nurse	<input type="checkbox"/>	<input type="checkbox"/>
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If you do have a Registered Nurse:	Yes	No
Do they participate in admission assessments?	<input type="checkbox"/>	<input type="checkbox"/>
Do they participate in ongoing assessments?	<input type="checkbox"/>	<input type="checkbox"/>
Are they available on call?	<input type="checkbox"/>	<input type="checkbox"/>

Miscellaneous:

	Yes	No
Do you admit residents who smoke?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is there any smoking room within the facility?	<input type="checkbox"/>	<input type="checkbox"/>
Does your facility own a bus or van that is utilized for resident outings?	<input type="checkbox"/>	<input type="checkbox"/>

If you provide outings, how often do you offer resident outings?
(ex. Once/month, twice/year, etc._

Do you allow pets?
If yes, what kind, size, etc?

Admission Policy and Procedures:

1. Please enclose a copy of any written materials about your facility which you provide to prospective residents and family members. ***Please include a copy of your Program Statement.***
2. What factors do you consider when determining whether or not a resident is appropriate for your facility upon initial assessment?
3. Do you have specific criteria by which you will know immediately that a prospective resident would not be appropriate for your facility (specific health issues, behaviors, etc)?
4. What staff members participate in the admission process?
5. How do you gather information about a potential resident's personal preferences, daily routine, likes/dislikes, interests, etc upon admission? ***Please include a copy of social history forms, personal preference forms, etc. used in the admission process.***

Health/Medical Policy and Procedures:

1. Please provide a copy of any written policies or procedures that you have related to the following:
 - Identifying and responding to health status changes/changes in condition (Please include any tracking tools utilized to monitor health issues such as blood pressures, weights, blood sugar reading, behaviors, etc)
 - Identifying and responding to health emergencies

- Process for responding when a resident falls
- Incident Reports

If there are not written policies related to each of these areas, please provide a written description below:

2. Are staff trained in medication administration on duty 24 hours per day?
 Yes No

If not, what back-up plan is in place during the hours in which no trained medication passer is available?

3. Is the pharmacy your facility utilizes available on-call to provide/deliver medications on weekends and/or evenings?
 Yes No

If not, what back up plan is in place to ensure residents receive medications on weekends and/or evenings?

4. Do you utilize a formal falls risk assessment?
 Yes No

If yes, when if the tool utilized?	Yes	No
• Upon Admission	<input type="checkbox"/>	<input type="checkbox"/>
• At the annual ISP Review	<input type="checkbox"/>	<input type="checkbox"/>
• After a fall	<input type="checkbox"/>	<input type="checkbox"/>

How is fall risk information communicated to staff?

Please include a copy of any fall risk assessment tool you are using.

Facility Staffing Patterns:

1. How many beds is your facility licensed for?
2. How many direct care staff are scheduled for each of the following shifts:
 - Days:
 - Evenings:
 - Nights:

Specialized Training:

1. Do your staff receive specialized training in providing care to persons with Alzheimer's disease and/or other related dementias?

Yes No

If yes, who provides the training and how often is the training offered?

2. Does your staff receive specialized training in providing care to persons with mental illnesses such as depression, anxiety, bi-polar disorder, etc?

Yes No

If yes, who provides the training and how often is the training provided?

3. Does your staff receive specialized training in working with persons who may exhibit challenging behaviors related to mental illness and/or dementia?

Yes No

If yes, who provides the training and how often is it provided?

4. The Assisted Living Quality Program offers free raining opportunities for assisted living staff three times per year. Are there any specific areas of training that you would like to see offered?