# Annual Review of Secured Unit Assessment
## Assisted Living

Resident Name: _____ Room Number: _____

**Facility Review:** The current resident assessment for placement on a secured unit continues to be accurate.

**Date:**_____

**Signature of Staff Person Completing Review:** _____

**Facility Review:** The current resident assessment for placement on a secured unit continues to be accurate.

**Date:**_____

**Signature of Staff Person Completing Review:** _____

**Facility Review:** The current resident assessment for placement on a secured unit continues to be accurate.

**Date:**_____

**Signature of Staff Person Completing Review:** _____

**Facility Review:** The current resident assessment for placement on a secured unit continues to be accurate.

**Date:**_____

**Signature of Staff Person Completing Review:** _____

# GUIDELINE

## Self Administration of Medication Assessment
*Assisted Living*

**PURPOSE** To evaluate the resident's ability to safely self medicate.

**INSTRUCTIONS**

1. Enter the resident's name and room number at the top of the assessment form.
2. Complete the assessment section by entering a checkmark (✓) in the appropriate column when answering each question.
3. Document any comments in the "Comments" section.
4. Determine the resident's ability to safely self administer medications.
    - If the resident is only able to self administer specific types of medications, specify which medications the resident is able to safely self administer.
5. If the resident is unable to safely self administer medications, document the reasons why the resident is unsafe.
6. The licensed nurse shall sign the completed assessment. Physician signature will be obtained by signing the physician order.
7. File the *Self Administration of Medication Assessment* form in the assessment section of the medical record.
8. Review and update assessment at least annually and with a significant change in resident condition.

# Self Administration of Medication Assessment

Resident Name: _____ Room Number: _____

| ASSESSMENT CRITERIA | ABLE | UNABLE | N/A | COMMENTS |
|---|---|---|---|---|
| 1. The resident can demonstrate correct technique for all medications administered. (I take this by mouth, I put one drop in each eye, I place this pill under my tongue, I take one puff on inhaler) | | | | |
| 2. The resident can demonstrate knowledge of the name, dose, and time of all medications. (This is my heart pill, this is my water pill, this is my blood pressure pill. I take one of these in the morning, I take this pill with food, I take 2 of these pills twice a day) | | | | |
| 3. The resident can demonstrate recognition of the colors and shapes of all medications. (I take three pills in the morning- one is this blue, one is this orange capsule, and the third is this white one) | | | | |
| 4. The resident can state the purpose of all medications. (The white pill is my water pill, this white pill is my blood thinner, this pill is for my heart) | | | | |
| 5. The resident can state common side effects of all medications. (I have to watch for dizziness with my water pill, my blood pressure may go too high if I forget to take my BP medication, I watch for bruising with my blood thinner) | | | | |
| 6. Resident can correctly document self administration of medications. (marks an X on MAR or calendar for each medication taken) | | | | |
| 7. Resident correctly states situations warranting use of PRN medications. (I take this pill for pain, I take this pill for shortness of breath) | | | | |

## ASSESSMENT RESULTS

❑ Resident is able to self administer the following medications: _____

❑ Resident is unable to self administer medications at this time for the following reasons: _____

_____ _____

*Licensed Nurse Signature* *Date*

## REVIEWS

| Date | Reason for Review | Able to Self Administer Meds | Signature |
|---|---|---|---|
| | | ❑ Yes ❑ No | |
| | | ❑ Yes ❑ No | |
| | | ❑ Yes ❑ No | |
| | | ❑ Yes ❑ No | |

# MEDICATION SELF-ADMINISTRATION VIA MED MINDER ASSISTED LIVING

During his/her initial assessment _____, and/or his/her responsible party, has elected to self-administer medications using a med minder.
It is acknowledged that a positive decision to self-administer via med minder is subject to assessment by the resident's physician as to the resident's cognitive, and visual ability to carry out this responsibility. Should it be determined that the resident is able to self-administer medications, it is understood that the medications will be set up on a _____ basis by _____. As needed, the staff of Traditions will assist with reminding the resident to take the medications. Annually it will be determined if the resident wishes to continue with the self-administration of medications via the med minder. If the resident and/or responsible party wishes the staff to begin administration of medications at any time throughout the year, the Resident Care Coordinator or on-duty LPN is to be contacted.

| | |
|---|---|
| Facility Representative | Resident/Responsible Party |
| Date | Date |

## ANNUAL REASSESSMENT

I wish to continue doing self-medication via the med minder.

| Resident/Responsible Party Signature | Staff Signature | Date |
|---|---|---|

I wish to continue doing self-medication via the med minder.

| Resident/Responsible Party Signature | Staff Signature | Date |
|---|---|---|

I wish to continue doing self-medication via the med minder.

| Resident/Responsible Party Signature | Staff Signature | Date |
|---|---|---|

I wish to continue doing self-medication via the med minder.

| Resident/Responsible Party Signature | Staff Signature | Date |
|---|---|---|

I wish to continue doing self-medication via the med minder.

| Resident/Responsible Party Signature | Staff Signature | Date |
|---|---|---|

I wish to continue doing self-medication via the med minder.

| Resident/Responsible Party Signature | Staff Signature | Date |
|---|---|---|

# ANNUAL MEDICATION SELF-ADMINISTRATION REVIEW ASSISTED LIVING

I understand that as a resident at _____, I have the right to self-administer medications prescribed for me by my physician. However, at this time, I wish to defer the responsibility of drug administration to the licensed staff of this facility. If I change my mind during the course of the year and wish to administer my own medicine, I will inform the LPN Supervisor or Director of Nursing.

Resident Signature _____ Staff Signature _____ Date _____

Annual review ~ I wish to defer the responsibility of my drug administration to the licensed staff of this facility.

Resident Signature _____ Staff Signature _____ Date _____

Annual review ~ I wish to defer the responsibility of my drug administration to the licensed staff of this facility.

Resident Signature _____ Staff Signature _____ Date _____

Annual review ~ I wish to defer the responsibility of my drug administration to the licensed staff of this facility.

Resident Signature _____ Staff Signature _____ Date _____

Annual review ~ I wish to defer the responsibility of my drug administration to the licensed staff of this facility.

Resident Signature _____ Staff Signature _____ Date _____

Annual review ~ I wish to defer the responsibility of my drug administration to the licensed staff of this facility.

Resident Signature _____ Staff Signature _____ Date _____

# Shift Report

POLICY

Traditions requires a status report of each resident to be completed in a clinician-to-clinician report at each change of shift, to ensure effective communication of clinical information.

PROCEDURE

1. The nurse going off duty will obtain the completed *24 Hour Report* during the shift.
2. The nurse coming on duty will identify the nurse currently assigned to the residents they will be assigned on the coming shift.
3. The clinician-to-clinician report will be conducted in an area that ensures resident confidentiality.
4. The nurse going off duty will report the resident's:
    a. Name, age, attending physician
    b. Diagnosis, pertinent comorbidities
    c. Goals and progress
    d. Changes in condition, treatment plan, and goals
5. The nurse going off duty will update the *24 Hour Report*, as needed.
6. The oncoming nurse will provide a verbal report to the appropriate State Tested Nursing Assistance (STNAs).

# Signing Residents Out

## POLICY

Traditions encourages outside socialization for the residents when appropriate. A cognitively intact resident may leave the facility independently or families and/or friends may take the cognitively impaired resident from the facility. Traditions will track the departure and return on a sign out sheet.

## PROCEDURE

1. Ensure the resident and/or responsible party agrees to the outing.
2. Provide scheduled medications with written instructions to the resident and/or responsible party, as applicable.
    - Document that medications were given with written instructions in the Nursing Notes.
3. Obtain signature of the resident or the responsible party taking the resident from the facility on the *Agreement to Accept Responsibility for Resident* form (Skilled Nursing Facilities) or Facility Log (Assisted Living Facilities).
4. Provide the resident or responsible party with the facility's telephone number.
5. Instruct the resident or responsible party to contact the supervisor if a delay of more than one hour is anticipated.
6. Instruct the resident or responsible party to notify the nurse when they return from the outing.
7. Record the date and time on the *Agreement to Accept Responsibility for Resident* form when the resident returns and staff signature. (Skilled Nursing Facilities)
8. See the *Missing Resident Policy and Procedure* if the resident has not returned within acceptable time frame.

# GUIDELINE

## Skilled Nursing Charting

**POLICY**

Traditions will provide clinical documentation to support the resident's need for skilled care.

**PROCEDURE**

### MEDICARE PART A (Skilled Nursing Facility Only)

1. On a daily basis, the licensed nurse will complete the *Medicare Skilled Nursing Observation Charting* form.
   - Assessment of all body systems identified on the form
2. Additional documentation to be completed each shift will include the following:
   - Narrative notes describing any abnormal findings and other additional clinical information as applicable
   - Primary reason that the resident is receiving skilled services

### MEDICARE PART B (Skilled Nursing and Assisted Living Facilities)

1. If a resident experiences a change in previous level of functioning, nursing staff will refer the resident to therapy for screening/evaluation and document the resident's previous level of functioning, the current decline identified, and the reason for referral in the nursing notes.
2. If the resident is picked up under Medicare Part B Services, the licensed therapist will obtain a physician order for treatment.

# Skilled Nursing Observation Charting

Resident Name: _____ Room Number: _____ Shift: _____
Nurse Signature: _____ Date: _____ Skilled for: _____

**DECISION MAKING**
- ❒ Independent – can choose daily tasks on own
- ❒ Requires assist with new situations only
- ❒ Requires supervision and cues
- ❒ Rarely/never makes decisions
- ❒ Able to make self understood
- ❒ Difficulty finding words or completing thoughts
- ❒ Can make simple concrete requests only
- ❒ Not Applicable

**GASTROINTESTINAL**
- ❒ Bowel sounds (+) x 4 quadrants
- ❒ Abnormal bowel sounds _____
- ❒ GT ❒ JT ❒ NG tube present
- ❒ Tube feeding tolerated well (no N/V/D aspiration)
- ❒ C/o nausea ❒ antiemetic offered (if ordered)
- ❒ Vomited approx. amt _____ cc
- ❒ Emesis appearance _____
- ❒ Abdomen distended
- ❒ C/o GI pain
- ❒ Not Applicable

**SKIN CONDITION**
- ❒ Skin intact
- ❒ Wound present. Stage ❒ I ❒ II ❒ III ❒ IV

**OR**
- ❒ Multiple stage: ❒ I ❒ II ❒ III ❒ IV *(If new wound, please add to narrative)*

Above wound(s) is/are: ❒ Pressure ❒ Stasis
- ❒ Burn present. Degree: ❒ I ❒ II ❒ III
- ❒ Open lesion present (not on foot)
- ❒ Pressure relieving device for bed present
- ❒ Turning/repositioning program is in place
- ❒ Nutrition/hydration program in place to manage skin condition
- ❒ Ulcer care given per order/protocols
- ❒ Surgical wound care rendered per orders
- ❒ Application of dressings (not to feet)
- ❒ Application of dressings to feet
- ❒ Application of ointments/meds to feet
- ❒ Infection of foot present
- ❒ Open lesion on foot present
- ❒ Not Applicable

**MOOD STATE**
- ❒ Pleasant mood – no s/s of depression/anger
- ❒ Negative statements made
- ❒ Repetitive questions
- ❒ Calling out: ❒ Continuous ❒ Occasional
- ❒ Persistent anger displayed (self/others)
- ❒ Self deprecation present
- ❒ Unrealistic fears expressed
- ❒ Believes something terrible will happen to self
- ❒ Repetitive health complaints
- ❒ Repetitive non-health related complaints
- ❒ Unpleasant mood in morning
- ❒ Insomnia/change in sleep pattern
- ❒ Sad/anxious appearance
- ❒ Crying, tearfulness present
- ❒ Repetitive physical movements (restlessness)
- ❒ Withdrawn from activities of interest
- ❒ Decreased social interaction

Mood easily altered? ❒ yes ❒ no
Intervention: _____
- ❒ Not Applicable

**NEUROLOGICAL**
- ❒ LOC A X O X 3
- ❒ Confused to place
- ❒ Confused to place and time
- ❒ Confused to person/place/time
- ❒ PERRLA ❒ Unequal pupils
- ❒ Seizure activity noted (see narrative)
- ❒ Weakness in extremity: _____
- ❒ Speech problem: _____
- ❒ Comatose
- ❒ Not Applicable

**SURGICAL SITE(S)**
- ❒ Incision site: _____
- ❒ Appears free of infection or new trauma
- ❒ Appears in need of new/revised Tx (see narrative note)
- ❒ Pain: _____ (pain rating 1 – 5)
- ❒ Intervention: _____
- ❒ Not Applicable

**BEHAVOIRS**
- ❒ No behaviors observed
- ❒ Wanders halls oblivious to safety
- ❒ Verbally abusive towards others
- ❒ Physically abusive to others
- ❒ Socially inappropriate behavior observed
- ❒ Resistant to care (refused meds, TX, assist)

Behaviors easily altered? ❒ yes ❒ no
- ❒ Not Applicable

**RESPIRATORY**
- ❒ Normal breathing pattern noted
- ❒ Dyspnea present ❒ c/o S.O.B.
- ❒ Rales _____
- ❒ Rhonchi _____
- ❒ Wheezing _____
- ❒ Suctioned ❒ q ___ hours ❒ PRN at ___
- ❒ O2 at ____ liters ❒ N.C. ❒ Concentrator
- ❒ CAP in place and operational
- ❒ Trach care rendered at: _____ AM/PM
- ❒ Resp. treatment given at: _____
- ❒ Not Applicable

**MEDICATION ADMINISTRATION**
- ❒ No adverse reactions/side effects observed per facility guidelines
- ❒ Side effect observed (see narrative)
- ❒ Current medication regimen appears effective
- ❒ Resident teaching offered r/t administration
- ❒ Injections given at _____ (time)
- ❒ No adverse conditions r/t injections present
- ❒ IV present. Site: _____
- ❒ IV site appearance: _____
- ❒ IV dressing. Changed per order/protocol
- ❒ IV tubing changed per order/protocol
- ❒ No complications r/t IV therapy
- ❒ Problem observed r/t IV's (see narrative)
- ❒ TPN in use
- ❒ Not Applicable

**ADL's**
- ❒ Bed mobility ❒ Independent ❒ Req. assist
- ❒ Transfers ❒ Independent ❒ Req. assist
- ❒ Ambulation ❒ Independent ❒ Req. assist
- ❒ Dressing ❒ Independent ❒ Req. assist
- ❒ Eating ❒ Independent ❒ Req. assist
- ❒ Toilet use ❒ Independent ❒ Req. assist
- ❒ Pers. Hygiene ❒ Independent ❒ Req. assist
- ❒ Not Applicable

**CARDIAC**
- ❒ No evidence of cardiac compromise
- ❒ Peripheral edema present: L/R/B
- ❒ HR: _____ Rhythm: _____
- ❒ C/o chest pain ❒ Pain rating _____ (1 – 5)
- ❒ Duration of chest pain: _____ minutes
- ❒ PRN meds administered r/t chest pain
- ❒ Cyanosis present _____
- ❒ Not Applicable

**VITAL SIGNS**
- ❒ BP _____ / _____
- ❒ HR _____
- ❒ RR _____
- ❒ Temp _____ F ❒ Oral ❒ Rectal ❒ Axillary
- ❒ Time: _____

**CIRCULATORY**
- ❒ No circulatory compromise
- ❒ (+) pedal pulses ❒ (-) pedal pulses R/L
- ❒ Extremity color: _____
- ❒ Extremity warmth: _____
- ❒ Capillary refill is < _____ seconds
- ❒ Numbness: _____
- ❒ Tingling: _____
- ❒ Edema: _____
- ❒ Not Applicable

**HYDRATION**
- ❒ Skin turgor: ❒ Adequate ❒ Poor
- ❒ Input: _____ cc ❒ Output: _____ cc
- ❒ Increased confusion observed
- ❒ Abnormal vital signs
- ❒ Not Applicable

**TEACHING**
- ❒ Offered – see Teaching Sheet
- ❒ Refused – see Teaching Sheet
- ❒ Unable to teach – see Teaching Sheet
- ❒ Not applicable

**ISOLATION**
- ❒ Positive culture for: _____
- ❒ Reverse isolation indicated
- ❒ Universal precautions only
- ❒ Not Applicable

**PAIN**
- ❒ Pain free
- ❒ Experiencing pain ❒ Pain controlled
- ❒ Pain site: _____
- ❒ Pain medication used (see MAR)

# NARRATIVE NOTE

| DATE | TIME | DISC | INTERDISCIPLINARY NARRATIVE NOTE (All notes MUST be signed) |
|---|---|---|---|

# Skills Performance Checklist – NURSE

Employee Name: _____ Hire Date: _____

**DIRECTIONS:** Enter the date and reviewer's initials on the appropriate line once the skill is tested and complete. The first set of skills is required for all new hire employees and as needed. The second set of skills will be used as needed. Procedures for Skills Performance can be found in the Nursing Practice Manual.

| ON HIRE RESPONSIBILITIIES & SKILLS | On Hire<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials |
|---|---|---|---|
| 1. Vitals Signs including Pulse Ox | | | |
| 2. Hand washing | | | |
| 3. Med Pass (oral, nasal, ophthalmic, rectal, inhalers, injection) | | | |
| 4. Suctioning | | | |
| 5. Oxygen | | | |
| 6. G Tube | | | |
| 7. Bladder Scan | | | |
| 8. Pressure Ulcer Development | | | |
| 9. Glucose Chemstrip | | | |
| 10. Hemoccults | | | |

*Employee's Signature On Hire* _____ *Date* _____ *Reviewer's Signature On Hire* _____

*Employee's Signature* _____ *Date* _____ *Reviewer's Signature* _____

*Employee's Signature* _____ *Date* _____ *Reviewer's Signature* _____

# Skills Performance Checklist – NURSE (continued)

Employee Name: _____

| GENERAL RESPONSIBILITIES & SKILLS | General date/reviewer & employee initials | General date/reviewer & employee initials | General date/reviewer & employee initials |
|---|---|---|---|
| 1. IV *(Refer to Pharmacy Manual)* | | | |
| 2. Restraints | | | |
| 3. Seizure Precautions | | | |
| 4. Chest Tubes | | | |
| 5. NG Tube | | | |
| 6. Urine/Stool Specimen | | | |
| 7. Enema | | | |
| 8. Ostomy Care | | | |
| 9. JP Drain | | | |
| 10. Pinrose Drain | | | |
| 11. Peritoneal Dialysis | | | |
| 12. Pin Care | | | |
| 13. Wound Vac | | | |
| 14. Binders | | | |
| 15. Suprapubic | | | |
| 16. CPM | | | |

# Skills Performance Checklist – NURSE (continued)

Employee Name: _____

| GENERAL RESPONSIBILITIIES & SKILLS | General<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials |
|---|---|---|---|
| **17.** Isolation | | | |
| **18.** Ace Bandages | | | |
| **19.** Suture Staple Removal | | | |
| **20.** TED Hose | | | |
| **21.** Shunts | | | |
| **22.** Cast Care | | | |
| **23.** Irrigating Colostomy | | | |
| **24.** Ear Irrigation | | | |
| **25.** Wound Culture | | | |
| **26.** Other: | | | |
| **27.** Other: | | | |

# Skills Performance Checklist – NURSE AIDE

Employee Name: _____ Hire Date: _____

**DIRECTIONS:** Enter the date and reviewer's initials on the appropriate line once the skill is tested and complete. The first set of skills is required for all new hire employees and as needed. The second set of skills will be used as needed. Procedures for Skills Performance can be found in the Nursing Practice Manual.

| ON HIRE RESPONSIBILITIES & SKILLS | On Hire<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials |
|---|---|---|---|
| 1. Vitals including Pulse Ox (5) | | | |
| 2. Hand washing | | | |
| 3. Gait Belt (ambulation and transfers included) | | | |
| 4. Oxygen (optional) | | | |
| 5. Personal Care (shaving, bathing, shower, oral, nail, shampooing) | | | |
| 6. Height and Weight | | | |
| 7. Feeding and Meal % Documentation | | | |
| 8. Peri Care/Catheter Care | | | |
| 9. Urine/Stool Collection | | | |
| 10. Hoyer Lift/Sit to Stand | | | |
| 11. Restorative Nursing | | | |

_____ _____ _____
*Employee's Signature On Hire* *Date* *Reviewer's Signature On Hire*

_____ _____ _____
*Employee's Signature* *Date* *Reviewer's Signature*

_____ _____ _____
*Employee's Signature* *Date* *Reviewer's Signature*

# Skills Performance Checklist – NURSE AIDE (continued)

Employee Name: _____

| GENERAL RESPONSIBILITIES & SKILLS | General<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials | General<br>date/reviewer & employee initials |
|---|---|---|---|
| 1. TED Hose | | | |
| 2. Applying Restraints | | | |
| 3. Seizure Precautions | | | |
| 4. Ostomy Care | | | |
| 5. Making Occupied Bed | | | |
| 6. Isolation | | | |
| 7. Bladder Scan | | | |
| 8. CPM Application | | | |
| 9. Abdominal and Breast Binder | | | |
| 10. Bedpan/Urinal | | | |
| 11. Urinary Output | | | |
| 12. Other: | | | |
| 13. Other: | | | |

# Smoking Safety

(Assisted Living Facilities)

POLICY

Traditions facilities are smoke free but smoking is permitted at designated locations outside of the facility. Each facility will identify specific outdoor areas and designate them as approved smoking areas. Smoking will not be permitted in any other area(s). The objective of this policy and procedure is not to discourage or restrict one's smoking privileges, but to promote safety for all persons within the facility.

It is the responsibility of the Administrator/designee, to ensure that all staff are informed of the facility's policy on smoking.

Appropriate orientation shall be provided to residents, family members, visitors and other as deemed appropriate. The "Smoking Safety" policy will be given to each resident/responsible party to read and sign when smoking privileges are requested for a resident assessed as requiring supervision during smoking.

Residents are not to share cigarettes or lighters with one another in the smoking area or at any time unless staff supervision is present to assure the safety of those involved. Violation may result in the restriction of independent smoking privileges.

If the facility has reasonable suspicion that residents (who require supervision during smoking) may be keeping smoking materials or visitors may be providing the resident with smoking materials, then facility staff may conduct a physical inspection of the resident's storage areas for such articles.

Residents who do not comply with the smoking safety policy and procedure may be given a "Notice of Discharge" in accordance with the Resident's Rights, if the noncompliance is deemed to endanger the other residents.

The Licensed Nurse will collect smoking safety data through observation and interview and determine if the resident is considered an independent or supervised smoker.

PROCEDURE

*Assessment*

1. Initiate and complete the Smoking Safety Assessment form if the resident requests smoking privileges as follows:

    a. On admission
    b. With significant change in condition
    c. Annually

2. Review the data and determine which of the following categories best describes the resident:

   *Independent:* (Considered a "Safe Smoker")
   - Must keep smoking materials and associated articles (i.e., cigarettes, tobacco, lighters, matches) on person or in apartment. Resident may smoke as desired at designated outside smoking area and staff does not need to stay with the resident while smoking.

   *Note: If the assisted living facility is attached to a skilled nursing facility, in the same area, and skilled nursing resident have access to the assisted living resident rooms, smoking materials will be kept at the nurses' station.*

   *Supervision:* (Considered and "Unsafe Smoker")
   - Will have smoking materials and associated articles stored at the nurses' station. Staff to monitor distribution of smoking materials during smoking sessions and stay with residents while smoking at designated outside smoking area.

3. Inform the resident/responsible party of the assessment findings, the location of the outside smoking areas, and the times for supervised smoking.

4. Complete the *Resident/Responsible Party Education* form for all supervised smokers.

### *Smoking Safety – Supervised Smokers*

1. Obtain the resident's smoking material from the nurses' station and accompany the resident to the designated outside smoking area.

2. Assist the resident in lighting their cigarette, etc. as applicable.

3. Remain with the "unsafe smoker" until the end of the smoking session or the cigarette has been successfully extinguished.

4. Return the smoking supplies to the respective nurses' station.

*Residents Using Oxygen*

5. Turn the oxygen supply off, and remove the nasal cannula from the resident's face, as applicable, if they wish to smoke. Store cannula, oxygen supply, etc. away from the resident during the smoking session.

   - *Smoking is prohibited within 10 feet of an oxygen container or supply*

6. Follow all steps above (1 through 5) for Smoking Safety – Supervised Smokers.

7. Return the nasal cannula and oxygen supply to the resident and place the cannula appropriately once the smoking session is complete.

# GUIDELINE

## Smoking Assessment

(Assisted Living Facilities)

**PURPOSE** To collect data and assess resident's ability to safely smoke.

**POPULATION** Residents requesting to smoke cigarettes, cigars, and pipes

**RESPONSIBLE PERSON(S)** Licensed nurse

**INSTRUCTIONS**

1. Enter the following in the area provided:
   - Resident name
   - Date
   - Physician
   - Room number
2. Observe and interview resident while smoking (use and unlit "test" cigarette if the resident initially appears to be an unsafe smoker).
3. Answer each question by entering a checkmark (✓) in the "Yes" or "No" column as applicable.
4. Record applicable comments related to the question in the "Comments."
5. Select the statement that best describes the resident and place a checkmark (✓) next to that statement.
6. Place a checkmark (✓) in the appropriate box to reflect if goals and interventions are addressed in the Plan of Care.
7. Enter any further comments as indicated.
8. Sign and date to indicate completion of the assessment form.
9. File completed form in the assessment section of the resident's medical record.

# Smoking Assessment

(Assisted Living Facilities)

Resident Name: _____ Date: _____

Physician: _____ Room #: _____

| DATA COLLECTION (Observation & Interview) | YES | NO | COMMENTS |
|---|---|---|---|
| 1. Ability to verbalize understanding of smoking policy & procedure? | ❑ | ❑ | |
| 2. Demonstrates ability to make his/her own decisions in relation to daily activities? | ❑ | ❑ | |
| 3. Demonstrate ability to hold cigarette safely? | ❑ | ❑ | |
| 4. Demonstrate ability to light his/her cigarette safely? | ❑ | ❑ | |
| 5. Demonstrate ability to maintain control of cigarette if physically distracted (e.g., bumped)? | ❑ | ❑ | |
| 6. Demonstrates appropriate use of ashtray (i.e. does not drop ashes on self, floor, furniture, etc.) | ❑ | ❑ | |
| 7. Demonstrates ability to let go of cigarette and then retrieve it appropriately? | ❑ | ❑ | |
| 8. Demonstrates ability to independently extinguish cigarette? | ❑ | ❑ | |
| TOTALS | | | Any "NO" answers = <u>not independent</u> |

## ASSESSMENT

1. Check the one that best describes the resident:

   ❑ ***Independent:*** Does not need assistance or staff in attendance while smoking. May retain cigarettes and smoking equipment on person or in resident apartment. (Please refer to the "Smoking Safety" procedure). Considered a ***"Safe Smoker"***.

   ❑ ***Supervision:*** Requires a staff person or family member to light the cigarette and/or remain in attendance while the cigarette is burning. Cigarettes and smoking equipment will be kept at the Nurse's station. Considered an ***"Unsafe Smoker"***. Will comply with those portions of the "Smoking Safety" procedure that address Unsafe Smokers.

2. Comments: _____

_____

_____

_____ _____

*Signature/Title* *Date*

| Date | Reason for Review | New Smoking Assessment Needed | Signature |
|---|---|---|---|
| | | ❑ No - Assessment Remains Current<br>❑ Yes – New Assessment Completed | |
| | | ❑ No - Assessment Remains Current<br>❑ Yes - New Assessment Completed | |

# Resident/Responsible Party Education
## "Smoking Safety"
(Assisted Living Facilities)

In accordance with the guidelines established in the facility's Smoking Safety Policy and Procedure, family members and/or visitors may assist their loved ones to a designated smoking area in the facility. The following guidelines will be followed when monitoring and assisting your family member/loved one to smoke safely in our facility.

Our facility recommends that a smoking apron be used during smoking for residents assessed as needing "Supervision" with smoking and smoking materials. The resident's risks of smoking without an apron include, but are not limited to:

- Ruined clothing with burn holes or blackened marks from dropped ashes or cigarettes
- Fire, burns, and death to self/others

1. Resident smoking materials are stored in the resident's apartment unless the resident is assessed as requiring supervision. Cigarettes and smoking materials will be kept at the nurses' station for all supervised smokers. Please ask for assistance in obtaining smoking materials from staff. At that time, additional information will be given to you as it pertains to particular resident's smoking habits.

2. If the resident is on oxygen/nasal cannula, staff will assist with the removal of oxygen prior to leaving for the designated smoking area.

3. Family members/visitors may assist the resident to designated smoking area as outlined in the attached designated smoking areas provided during this education.

4. Family/visitors are not to give smoking materials or assistance to other residents during smoking sessions.

5. Once the cigarette is lit, family members/visitors will regularly monitor or assist the resident. Family members/visitors will monitor for dropped ashes, the length of the cigarette, and once finished, that the cigarette is extinguished and placed into an appropriate receptacle.

6. Once the resident has completed the smoking session, all smoking materials will be returned to the nurses' station. If oxygen was in place prior, the staff can assist in reapplying the oxygen at this time.

7. Family members/visitors will report any observations or concerns to staff immediately.

**I have read the above and have had the opportunity to ask questions. I will abide by the facility's "Smoking Safety" Policy and understand and agree that the resident's storage areas may be inspected by facility staff if there is reason to believe that the resident has obtained and/or is keeping smoking materials in his/her room contrary to the facility's smoking safety policies.**

Resident Signature _____ Date _____

Responsible Party/Visitor Signature _____ Date _____

Facility Witness Signature _____ Date _____

*This form will be filed in the assessment section of the resident's medical record.*

# STNA Charting
## (Electronic Medical Record)

**POLICY** The goal of the electronic medical record STNA charting system is to accurately reflect the direct care rendered to the resident within the clinical record.

**PROCEDURE** The STNA at the start of the shift picks up the personal computer device established check out procedures. The STNA uses the device to read the used to identify his/her status as a caregiver. After reading the iButton and verifying the password, the PDA confirms the status of the electronic signature of the staff member for the health record. After scanning the residents' iButton the STNA is ready to record clinical information. It is required to confirm the identity of the scanned resident. The following categories of information are available to the STNA for charting purpose and are assigned based off of the Facility's STNA assigned responsibilities within the facility and the shift for which they are working: Observation which contains: ADLs, Communications, Complaints/Pain & Skin Condition, Continence, General Assistance, Meals, Restraints/Devices, and Skin Appearance. Mood/Behavior Problems and Vital Signs are separate categories. These categories are as represented on the PDA "Application List" Screen.

**Information Gathering Process:**

The optimal method of gathering resident information is documentation on the PDA at the time the care is rendered. This usually results in increased amounts of data per resident and superior accuracy due to the point of care documentation.

STNAs will document on the PDA at the time the care is rendered or observations are made, unless resident care needs take precedence.

**STNA Main Menu**

The facility directs the STNAs to document in the following areas per shift: Any area on the STNA Main Menu to reflect the care given or resident observations.

The facility elects to utilize the following areas on the STNA Main Menu for charting

- ❒ ADLs
- ❒ Communications
- ❒ Complaints/Pain & Skin Conditions
- ❒ Continence
- ❒ General Assistance
- ❒ Meals
- ❒ Restraints/Devices
- ❒ Skin Appearance
- ❒ Mood/Behavior Problems

- ❒ Vital Signs
  - o Height
  - o Weight
  - o Temperature
  - o Pulse
  - o Respiratory Rate
  - o Blood Pressure
  - o Pulse Oximeter
  - o Blood Sugar
- ❒ Restorative Practice

**Tabs:**

ADLs: This tab utilizes the MDS methodology of measuring the resident self performance abilities and the amount of support required. Drop down boxes assist with this selection. Further explanation of this process may be found in the "Resident Assessment Instrument Use Guide". Remember if "Activity did not occur" or "Resident refused" are recorded in self performance the same answer is to be recorded in support required.

COMMUNICATIONS: Includes check off boxes under heading "responsiveness" and "communications".

COMPLAINTS/PAIN & SKIN: Complaints of pain are made in this tab including location and severity. Also contains a screen of generalized complaints including nausea, vomiting, and visual problems, among others. If any areas are identified and charted within this tab the STNA will then verbally notify the nurse.

CONTINENCE: Includes area to chart either incontinence or no incontinence of bowel or bladder. Second screen has area to describe a bowel movement. May also chart constipation, diarrhea, and whether a bedpan or briefs are used. If resident is on a scheduled toileting program it should be indicated using the continence tab.

GENERAL ASSISTANCE: This tab will be used to records common tasks performed by an STNA, data to be recorded with a check. Tasks include: General help, Assisted w/Hearing Aid, Assisted w/Visual Aid, Assisted with Transport, Assisted w/Room Care, Repositioned resident, Released Restraints, Changed Bed, Answered Call Light, Resident at Activities. If you observe the resident moving upper or lower extremities, observing a full range of motion, record your observations in "Observed Range of Motion".

MEALS: This area is used to record percentage of meal and snack intake. Follow facility policy and procedure for recording meal and snack percentage. If substitutions are offered due to refusal or poor intake, record on this screen. Intakes are recorded under this tab [press next], make sure and include all intake sources including the fluids at meals. Record catheter output only under output.

SKIN APPEARANCE: Skin appearance includes drop down boxes to record observations of skin color, touch and temperature.

VITAL SIGNS: This tab may be used to record resident Height and Weight under Appearance. Also included, are tabs for all vital signs and an area to record reporting of Abnormal Vital Signs to nurse. If any abnormal vital signs are recorded staff then needs to verbally report this information to the nurse.

MOOD AND BEHAVIOR PROBLEMS: Must indicate if was easily or not easily changed to reach the detail screen. This section includes physical aggression, verbal aggression, self injurious behavior, social inappropriate behavior, wandering, resisting care and other behaviors.

RESPONSIVENESS: This tab includes more moods and response to nursing personnel.

OTHER OBSERVATION: Includes areas to chart on bruising, lacerations, rashes, hematoma, skin tears, pressure ulcer and restraints. The charting allows for the STNA to give location in the skin categories. The restraint/positioning aide category allows for identification of device used.

The STNA will:

- Perform and document vital signs. (Height and weight are found within the Vital Signs program)
- Record pain using the PDA pain scale
- Record pain if experienced when rendering care
- Report observation of pain to nurse

If recording the pain scale, use the number to most closely reflect the resident's level of pain. The number 1 representing the least amount of pain, and 10 reflecting the most amount of pain. A "no pain" check off box resides above the number pad. Identify Chronic or Acute pain on the screen.

*It is recommended the STNA Send Data information at the beginning and end of the shift and every few hours throughout their shift and at least 1 hour prior to the end of the shift. This will allow the unit supervisor or other designated employee to run an audit report for completeness of STNA charting. If any new residents are admitted, messages or tasks are assigned it is important that this information is transferred to the STNA via the send data process.*

# Suicide Prevention

## POLICY

Traditions designs and implements processes that strive to provide physical and psychosocial services that adequately care for all residents admitted to the facility. In an attempt to identify and prevent psychosocial dysfunction, the staff will not only observe the physical functioning of the resident but they will also observe psychosocial functioning. This process allows the staff to detect early warning signs of major mood changes and/or possible suicidal ideation and obtain and provide appropriate interventions.

If the resident expresses suicidal ideation, the following steps will be taken to prevent a suicide attempt.

## PROCEDURE

1. Report resident statements of suicidal ideations **IMMEDIATELY** to your immediate supervisor.
2. If it is found that the resident is suicidal, assign staff to stay with the resident one-on-one.
3. Notify physician and obtain an order for an immediate psychological evaluation.
4. Notify and involve family/significant other of the situation and physician orders.
5. Transfer the resident to an appropriate facility for further evaluation and treatment.

# Licensure and Certification Survey Notification Protocol

## POLICY

Traditions will adhere to all State and Federal laws. The Vice President of Clinical Services will monitor all survey results. The following protocol is to be utilized by Traditions in all instances of licensure and/or certification surveys, follow-up surveys, and complaint investigations conducted by State and/or Federal agencies.

## PROCEDURE

1. The Administrator (or in his/her absence, the DON) shall immediately (same day) contact the Vice President of Clinical Services at the corporate office upon entry of the survey team in the building.

2. The Vice President of Clinical Services shall immediately contact the Regional Director of Operations.

3. During the course of the survey, the Administrator/designee shall immediately contact the Vice President of Clinical Services, if during the course of the survey, the team mentions any of the following: ***immediate jeopardy, extended, partial extended, or expanded survey, substandard care,*** or ***criminal abuse or neglect.***

4. After the exit conference with the survey team, notes of same shall be prepared which summarize the exit conference and shall be immediately (same day) faxed to the Vice President of Clinical Services.

5. Immediately upon receipt from the State or Federal agency, the Form 2567 Statement of Deficiencies ***along with all cover letters*** shall be faxed to the Vice President of Clinical Services.

6. The Administrator shall cause any required Plan of Correction (which are required to be filed with the state within 10 days) to be prepared in such a manner that there is sufficient time (at least 4 days) for review by the Vice President of Clinical Services. In cases involving lengthy 2567's, portions should be faxed to the above as they are completed.

7. Send the final Plan of Correction to the Vice President of Clinical Services.

# Assisted Living Survey Readiness

## Survey Entry and Management Checklist

- ❑ Census with room numbers
- ❑ Floor plan with room numbers
- ❑ Any physical changes since last survey

**Identification of Services:**

- ❑ Medication administration
- ❑ Supervision of Special Diets
- ❑ Dressings
- ❑ Tube Feedings
- ❑ Other Skilled Care
- ❑ Secured Unit
- ❑ Animals/pets
- ❑ Resident rooms lock
- ❑ Adult Day Care on site
- ❑ Med pass times: _____
- ❑ List of Residents/Diets
- ❑ List of Residents Types of Dressings
- ❑ List of Residents
- ❑ List Residents & Type of Skilled Care
- ❑ Protocol (R150)
- ❑ Protocol (R202)
- ❑ Master/Duplicate Keys (R247)
- ❑ List Residents receiving AL Services ★

**Required Information:**

- ❑ Completed Facility Information Document
- ❑ Admission Packet, including Resident Agreement (R149, R280)
- ❑ List of residents with Risk Agreements (R181, R152)
- ❑ List of residents who were given discharge notices
- ❑ Activity calendar (R280), Local Newspaper (R280), Transportation Info (R209)
- ❑ Residents funds (surety bond, written authorizations, 5 accounts since last survey)
- ❑ Meal times: _____
- ❑ Copies of current week's menus and spreadsheet of day for survey
- ❑ Incident Log since last annual inspection with documented evidence of PPA notification when applicable (R205)
- ❑ Monthly self-inspection for Fire Safety
- ❑ Fire and Disaster Drill Reports for last twelve months
- ❑ State Fire Marshal's most recent report
- ❑ Transfer Agreement (R227)
- ❑ Inspection report of the central heating system (R231)
- ❑ Staffing schedules for previous week (R123-R131)
- ❑ Employee Personnel Files (i.e. administrator, four new employees, two long term employees)
- ❑ Employee Personnel Files providing care to Assisted Living Waiver residents ★
- ❑ List of employees under age 18 ★
- ❑ Criminal background check log
- ❑ Grievance Committee information

★ to be completed only if the facility is an Assisted Living Waiver provider

## AL Survey Information Request

**Entrance Conference:** Explain purpose of visit, give tentative exit date and time, establish contact person, space to work, where to find charts and resident agreements.

**Request:**

- ❑ Floor Plan with numbers ★
- ❑ List of residents with room numbers ★
- ❑ List showing residents receiving personal care, special diets, tube feedings, residents self-administering medications; receiving home health, adult day care, residents restrained, using psychoactive drugs
- ❑ If nurses administering medications, medication times
- ❑ Meal Times
- ❑ Menus for week of survey, including spreadsheets with portion sizes
- ❑ Fire and Disaster Drills

If managing funds _____ surety bond 17-61 (C)(3) **R201**

- ❑ Written authorization witnessed by outside person 17-61 (C) **R201**
- ❑ Written protocol regarding animals and pets 17-61 (D) **R202**
- ❑ Incident log containing time, place and date of occurrence, general description of incident, care provided or action taken 17-62 (B)(2) **R205**
- ❑ Infection control policies and procedures 17-62(C) **R206**
- ❑ Universal Precautions used by staff 17-62(C) 3 through 7 **R206**
- ❑ Yearly fire inspection report 17-53(A) **R210**
- ❑ Written disaster preparedness plan including evacuation procedures, fire, missing residents, tornadoes/floods **R215**
- ❑ Monthly fire safety inspections recorded on form provided by ODH 17-63(Q) **R223**
- ❑ Any fires since last survey? Reported to fire marshal? 17-63(T) **R226**
- ❑ Transfer Agreements for adverse conditions in facility 17-63(U) **R227**
- ❑ Central heating inspection (must be checked every two years by contractor) 17-65(A) **R231**
- ❑ Written policy for temperatures outside acceptable range 17-66(D) **R253**
- ❑ Grievance committee members, 1 staff to 2 residents/sponsors 3721.12(A)(2) **R279**
- ❑ Transfer and discharge rights/policy 3721.16 **R239**
- ❑ Copy of Residents Rights 3721.12 **R333**
- ❑ Any resident grievances? 3721.17 **(no N tag for this)**
- ❑ Copy of Resident Agreement
- ❑ Annual licensure report 17-51(F) **R108**
- ❑ Schedules for last full pay period (all staff)
- ❑ Personnel Files: Administrator, each new employee since last survey, department heads, any contract staff (dietitian)

★ Include these items in packet, all others are for reference only

# Medicaid Waiver Survey Readiness

**The following *(current)* documentation *should be included with the assisted living waiver application.* (Please review your copy of the Conditions of Participation and Service Specifications for documentation requirements):**

- ❑ Statement of ownership and list of all persons with 5% or more ownership of organization
- ❑ Governing body: full name and address of each member of the governing body
- ❑ Table of organization for the Residential Care Facility
- ❑ Worker's Compensation certificate
- ❑ Insurance Declarations page/documentation of all liability and insurance coverage
- ❑ Copy of registration with Ohio Secretary of State
- ❑ Completed, signed W-9 form
- ❑ Facility floor plan/layout designating the living units that meeting the living space requirements
- ❑ Statement supporting compliance with non-discrimination laws in service delivery
- ❑ Policy/procedure/forms for documenting incidents affecting client health or well-being (i.e. incident report form)
- ❑ Description of how the service delivery documentation requirements will be met (i.e. forms, procedures)

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**The applicant must also maintain evidence of compliance with ALL program requirements, including:**

Consumer Records:

- ❑ AAOA notification of significant changes that may affect the consumer's needs
- ❑ Consumer and AAOA notification prior to termination of service

Facility Staff and Volunteers Records

- ❑ Use of volunteers only with staff supervision
- ❑ Facility staff under the age of 18 years of age may not assist with medication administration or supervision, provide transportation or deliver hands-on assistance with bathing, toileting, or transferring without on-site supervision
- ❑ Facility staff delivering waiver services described on the care plan may not be the waiver consumer's parent, stepparent, or spouse
- ❑ Annual continuing education requirements
- ❑ Facility staff orientation process and personnel records must document the following:
  - ❑ Interventions with cognitively/behaviorally impaired consumers
  - ❑ Confidentiality
  - ❑ Service plan process and risk assessment process
  - ❑ Employee code of ethics
  - ❑ Instruction in the following areas: reporting requirements of suspected abuse, neglect, exploitation, confidentiality, volunteer supervision, limitations on tasks provided by staff under 18 years of age, limitations of facility staff delivering services to a parent, stepparent or spouse
  - ❑ BCII documentation
  - ❑ Any other documentation verifying compliance with each Condition of Participation and Services Specification

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It should be understood that the review process has inherent limitations. *But the provider is still obligated to deliver service and maintain records in accordance with prescribed regulations, regardless of whether or not those particular procedures or regulations are chosen for review during a given monitoring visit. Because a record was not requested/reviewed in the past does not mean it will not be requested in the future.*

## Medicaid Waiver

# Staff Documentation Review

**(minimum review of at least 3 staff persons)**

**Facility:** _____ **Date:** _____

| **Name:** | **Name:** | **Name:** |
|---|---|---|
| Position: | Position: | Position: |
| Hire Date: | Hire Date: | Hire Date: |
| BCII Check completed? Y N | BCII Check completed? Y N | BCII Check completed? Y N |
| Sent w/in 5 days of hire? Y N | Sent w/in 5 days of hire? Y N | Sent w/in 5 days of hire? Y N |
| Rec'd w/in 60 days? Y N | Rec'd w/in 60 days? Y N | Rec'd w/in 60 days? Y N |
| License Expires: | License Expires: | License Expires: |
| Qualifications: | Qualifications: | Qualifications: |
| 1 yr experience? Y N<br>OR<br>COALA or 60 hrs training? Y N<br>OR<br>Medicare Competency? Y N<br>OR<br>Nurse Aide Registry? Y N<br><br>Written and skills testing? Y N | 1 yr experience? Y N<br>OR<br>COALA or 60 hrs training? Y N<br>OR<br>Medicare Competency? Y N<br>OR<br>Nurse Aide Registry? Y N<br><br>Written and skills testing? Y N | 1 yr experience? Y N<br>OR<br>COALA or 60 hrs training? Y N<br>OR<br>Medicare Competency? Y N<br>OR<br>Nurse Aide Registry? Y N<br><br>Written and skills testing? Y N |
| Orientation Includes: | Orientation Includes: | Orientation Includes: |
| Code of Ethics? Y N | Code of Ethics? Y N | Code of Ethics? Y N |
| Reporting abuse/neglect? Y N | Reporting abuse/neglect? Y N | Reporting abuse/neglect? Y N |
| Spouse/parent/step policy? Y N | Spouse/parent/step policy? Y N | Spouse/parent/step policy? Y N |
| Confidentiality? Y N | Confidentiality? Y N | Confidentiality? Y N |
| Job description? Y N | Job description? Y N | Job description? Y N |
| Performance Appraisal? Y N | Performance Appraisal? Y N | Performance Appraisal? Y N |
| # CEU hours completed? | # CEU hours completed? | # CEU hours completed? |
| Over age of 18? Y N | Over age of 18? Y N | Over age of 18? Y N |
| Volunteer? Y N | Volunteer? Y N | Volunteer? Y N |

Notes: _____

# GUIDELINE

## Interdisciplinary Resident Teaching Record

**PURPOSE** To document ongoing resident/caregiver education and achievement of criteria.

**RESPONSIBLE PERSON(S)** The attending clinician will initiate the form as it is needed. The attending clinician will document on the form as the teaching occurs.

**PLACEMENT** The *Interdisciplinary Resident Teaching Record* will be filed in the Nurses' Notes section of the resident's medical record by the attending clinician when teaching is completed.

**INSTRUCTIONS**

1. Enter the resident's name, room number, and physician on the appropriate lines.
2. Check who must meet the knowledge of skill criteria, resident or caregiver.
3. Document in the left column the "Teaching Discussed."
4. Enter the date and the clinician's initials in the box corresponding to the teaching discussed.
5. Document in the "Special Learning Needs" section any potential block to learning such as the following issues:
   - Visual
   - Hearing
   - Dexterity (i.e., cannot manipulate syringe)
6. "Clinician's Signatures" with initials are placed at the bottom of page two.

# Interdisciplinary Resident Teaching Record

Resident Name: _____ Room # _____

| KNOWLEDGE OR SKILL CRITERIA TO BE MET BEFORE DISCHARGE BY THE: ❒ RESIDENT ❒ CAREGIVER | TEACHING AND/OR REINFORCEMENT | | | | | |
|---|---|---|---|---|---|---|
| | DATE | INITIAL | DATE | INITIAL | DATE | INITIAL |
| **Disease Process:** | | | | | | |
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| **Medications:** | | | | | | |
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| **Activity/Rehabilitation:** | | | | | | |
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# Interdisciplinary Resident Teaching Record *(page 2)*

Resident Name: _____ Room # _____

| KNOWLEDGE OR SKILL CRITERIA TO BE MET BEFORE DISCHARGE BY THE: ❒ RESIDENT ❒ CAREGIVER | TEACHING AND/OR REINFORCEMENT | | | | | |
|---|---|---|---|---|---|---|
| | DATE | INITIAL | DATE | INITIAL | DATE | INITIAL |
| **Equipment/Supplies:** | | | | | | |
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| **Nutrition:** | | | | | | |
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| **Social Services:** | | | | | | |
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| Special Learning Needs: ❒ Visual | | | | | | |
| ❒ Hearing | | | | | | |
| ❒ Dexterity (if can't manipulate syringe) | | | | | | |
| ❒ Cognitive deficient | | | | | | |
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| SIGNATURE | INITIALS | SIGNATURE | INITIALS |
|---|---|---|---|
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# Clinical Documentation for Residents on Part B Therapy

**POLICY**

Traditions facilities will complete clinical documentation for all residents on Part B therapy services. The purpose of the clinical documentation is to support the need for therapy services and the resident's progress made during therapy. Medical Records and clinical staff will coordinate the review of clinical documentation for residents on Part B therapy service to ensure complete and timely documentation is in place.

**PROCEDURE**

1. Upon identifying residents who would possibly benefit from therapy services, referrals are made to therapy using the *IDT Form.*

2. A facility designated staff person is responsible for distribution of and tracking of *IDT Forms.*

3. Upon completion of the therapy screen/evaluation, the therapist is responsible to notify the other members of the IDT through morning/weekly meetings or other facility specific processes.

4. At the time a physician order is received for Part B therapy service, nursing staff/nurse manager will complete a nursing note identifying the reason why the resident needs therapy.

5. Nursing staff/nurse manager will complete weekly nursing progress notes for all residents on Part B therapy service until they are discharged from Part B service. The note will identify the resident's participation/progress in therapy.

6. Medical Records staff will complete regular audits of clinical documentation for residents on Part B therapy service. Any issues identified will be communicated to the Director of Nursing/Designee for correction.

7. Continued issues with clinical documentation to support Part B therapy will be addressed by the CQI Committee as needed.

# Training Attendance Record

POLICY

In-service training attendance records will be maintained for a minimum of fifteen (15) years.

PROCEDURE

1. Document the following on each in-service education program offered in the facility:
    - Date(s) and time(s) offered
    - Presenter
    - Subject
    - Length of presentation
    - Objectives
    - Location (classroom, activities, etc.)
    - Signatures and titles of those attending
    - Pre- and/or post test (if applicable)
    - Evaluations if applicable
    - Self study material if applicable
2. Place program material in an area designated by the facility.
3. Present the information as requested by State surveyors.

# Transfers – External

POLICY

Traditions has designed and implemented processes which strive to ensure the appropriate care and treatment as ordered by a physician. At times these processes require the resident be transferred outside the facility for reasons such as, but not limited to, the following:

- Consultation – Care, treatment, and/or testing to be provided by a consultant unable to provide such care, treatment, and/or testing at the facility
- Emergency Room – Change in condition requiring diagnostic testing and/or treatment the facility is not credentialed to provide
- Hospital – Change in condition which requires and admission for diagnostic testing, procedures, and treatment unable to be provided by the facility

PROCEDURE

1. Notify the family of the type of impending transfer:
   - Consultation
   - Emergency Room
   - Hospital
2. Notify the physician if a transfer to the Emergency Room is required and obtain the order.
3. Complete *Resident Transfer* form when transferring to an emergency room, hospital, and/or another facility.
4. Provide copies of appropriate medical record information when transferring for a consultation.

# GUIDELINE

## Resident Transfer

**PURPOSE**

To communicate to the receiving facility the condition of the resident being transferred.

To provide documentation in the transferring facility's medical record the resident condition at the time of transfer, mode of transportation, destination, signature of nurse initiating transfer, and the date and time of the transfer.

**POPULATION**

The form will be completed on all residents transferred to another facility.

**RESPONSIBLE PERSON(S)**

The licensed nurse responsible for documenting the transfer will complete the form.

**INSTRUCTIONS**

1. Complete the resident information.
2. Enter the name and telephone number of the center as the "transferring facility."
3. Enter the name of the "receiving facility."
4. Document if the receiving facility and the physician were notified.
5. Document the following family member/legal representative's information:
    - Name
    - Address
    - Telephone number
    - If family member/legal representative contacted
6. Enter the attending physician's name,
    - The "face sheet" of the medical record may be attached to the transfer form for the receiving facility.

7. Place a checkmark (✓) in the appropriate boxes under the "Medical History" section and complete other subject areas. *Do not leave any subject areas unchecked or blank.*

8. Document the destination of the transfer and the transportation provided.

9. Enter the current resident vital signs and the time taken.

10. Document immediate medical problem/assessment is the resident is being transferred to an outpatient facility or emergency room for an evaluation.

    - Enter N/A if being transferred to another long term care facility.

11. Sign, date, and time the completion of the form.

12. Enter the name and phone number of the person the receiving facility can call if they need further information regarding the resident.

13. Enter the name and telephone number of the ambulance company the resident prefers for their return transportation back to the facility. If unknown, enter N/A.

14. Assure the original white copy is forwarded (with the resident) to the receiving facility at the time of transfer and place the yellow copy in the Nurses' Notes section of the medical record.

# Resident Transfer

| Resident Name | Date | Height | Weight | Age |
|---|---|---|---|---|
| | | | | |

| Transferring Facility | Transferring Facility Phone # |
|---|---|
| | |

| Receiving Facility | Receiving Facility Contacted? ❒ Yes ❒ No | Physician Contacted? ❒ Yes ❒ No |
|---|---|---|
| | | |

| Family Member/Legal Representative Name | Home Phone # | Work Phone # |
|---|---|---|
| | | |

| Family Member/Legal Representative Address | Family Member Contacted? ❒ Yes ❒ No |
|---|---|
| | |

**If Admission/Discharge Record (face sheet) is attached, leave this section blank**

Attending Physician

## MEDICAL HISTORY

**Disabilities**
- ❒ Amputation
- ❒ Paralysis
- ❒ Contracture
- ❒ Skin Impairment

**Incontinence**
- ❒ Bladder
- ❒ Bowel
- ❒ Colostomy
- ❒ Catheter

**Behavior**
- ❒ Cooperative
- ❒ Combative
- ❒ Disruptive

**Mental Status**
- ❒ Alert
- ❒ Unresponsive
- ❒ Confused

**Eating**
- ❒ Independent
- ❒ Assisted
- ❒ Dependent
- ❒ Tube feed

**ADLs**
- ❒ Independent
- ❒ Assisted
- ❒ Dependent

**Locomotion/Ambulation**
- ❒ Independent
- ❒ Dependent
- ❒ Assisted
- ❒ Unable

**Social Involvement**
- ❒ Encourage group
- ❒ Individual

**Communication**
- ❒ Able to make needs known
- ❒ Understands speaking
- ❒ Understands English

If no, language spoken: _____

**Equipment Used**
- ❒ Appliance
- ❒ Hearing aid
- ❒ Dentures
- ❒ Glasses
- ❒ Contact Lenses
- ❒ Cane
- ❒ Walker

Other _____

**Activities Involvement**
- ❒ Yes
- ❒ No

**Weight Bearing**
- ❒ Full
- ❒ Partial
- ❒ None

**Allergies:** _____

**Diagnosis/es:** _____

**Date of Last BM** _____

Medication Administration Record Attached ❒ Yes ❒ No

Chest X-rays Attached ❒ Yes ❒ No

Immunization Record Attached ❒ Yes ❒ No

DNR Identification Form Attached ❒ Yes ❒ No

## COMPLETE AT TIME OF TRANSFER

| Destination | Transport Via |
|---|---|
| ❒ Emergency ❒ Outpatient ❒ LTC Facility | ❒ Ambulance ❒ Bus/Van ❒ Family car |

| Current Vital Signs | Time Taken |
|---|---|
| Temp _____ Pulse _____ Resp _____ BP _____ | _____ ❒ am ❒ pm |

Medical Problem/Assessment

| Nurse Signature | Date | Time | Phone # |
|---|---|---|---|
| | | | |

| Contact for further information or to give update | Phone # | Ambulance company preference for return transfer | Phone # |
|---|---|---|---|
| | | | |

*White – Receiving Facility* *Yellow – Transferring Facility*

# GUIDELINE

## TWENTY-FOUR HOUR REPORT

**PURPOSE:** To track resident clinical changes or occurrences in a twenty-four hour period.

To track census changes in a twenty-four hour period

**RESIDENT POPULATION:** This 2 sided report is completed each shift and should include all clinical and census information pertaining to all residents on each unit.

Resident specific information is entered on the 24 Hour Report - Clinical side for reasons including, but not limited to:

- Change in condition
- Calls to physician
- Lab results
- Family/Responsible Party called
- Other significant occurrences

Resident specific census information is entered on the 24 Hour Report – Census side for reasons including, but not limited to:

- Transfer to hospital or another level of care
- Leave of absence from facility
- Death
- Discharge

**RESPONSIBLE PERSON:** Entries may be made by any interdisciplinary team member. The charge nurse is responsible to ensure accurate completion on each shift.

**INSTRUCTIONS:**

1. Enter the date. The Twenty-four hours begins at 12:00 midnight and the report ends at 11:59 pm that evening.

2. Enter the resident name and a brief description of the event that occurred related to the clinical or census change

3. Enter the time the physician/family was called, as applicable

4. Enter other pertinent information as necessary

5. The night shift charge nurse is responsible to ensure that the census information entered for the 24 hour period matches the current census on the unit at midnight on each day.

6. The charge nurse totals the census activity from the census report and sign the form, confirming that the census at midnight is accurate.

7. The charge nurse is responsible for putting the 24 Hour Report Form in the Business Office Manager mailbox at midnight on each day.

8. The Business Office Manager will transfer census information changes to the *Daily Census/Roster Sheet* and census changes will be discussed in morning meetings.

9. Review the 24 Hour Report – Clinical side in facility morning meetings.

# Twenty-Four (24) Hour Report – Assisted Living

Date: _____

Manager Signature: _____

Day Shift Nurse: _____
Evening Shift Nurse: _____
Night Shift Nurse: _____

**ENTER RESIDENT NAME IN APPLICABLE BOX AND INCLUDE A BRIEF DESCRIPTION AS NEEDED.**

| | | | |
|---|---|---|---|
| **ANTIBIOTICS** | **FALLS/INJURY** | **BEHAVIORS** | **NEW PHYSICIAN ORDERS** |
| **NEW PRESSURE ULCERS** | **TRANSFERS/DISCHARGES** | **REHAB ISSUES** | |
| **ACUTE ILLNESS/CHANGE IN CONDTION** | **LABS** | **APPOINTMENTS** | **DIET CHANGES** |
| **PRN'S GIVEN (LAXATIVES)** | **FAMILY CONCERNS** | **MAINTENANCE/HOUSEKEEPING ISSUES** | **MISC. (MEDS NOT GIVEN, IV'S, TF's. etc..)** |

# TWENTY-FOUR HOUR REPORT (PAGE 2)

Begins at 12:00 midnight and ends at 11:59 p.m. the following evening

**Date/Time Started:** _____/_____

**Date/Time Ending:** _____/_____

| Resident Name | Rm# | Time | Event | Census Activity *(see codes)* | | | | | | | Nurses Signature |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | A Admit | BH Bed Hold | D Death | D/C Discharge | ER Emergency Eval | H Hospitalization | LOA Leave of Absence | |
| | | | | | | | | | | | |
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***Census Activity**: **A** = admit; **BH** = Bed Hold; **ER** = Emergency Eval ; **D/C** = discharge; **H** = hospitalization; **LOA** = Leave of Absence; **RC** = room change; **D** = death

| Census | |
|---|---|
| Total # of residents/patients on unit at 11:59 pm | |
| # of residents/patients in hospital | |
| # of residents/patients on LOA | |

**Signature of Nurse Confirming Midnight Census for this Date:** _____

# Visitation

POLICY

Traditions designs and implements processes that strive to ensure each resident the right to free and open communication with persons of their choice. Traditions facilities and their staff will continually encourage outside contact by making known to all concerned its rules and regulations regarding daily visiting hours.

PROCEDURE

1. Post the normal suggested daily visiting hours in an area readily visible to resident and their families/visitors.

2. Explain to residents/families that visiting hours are open on a general basis.

3. Obtain a physician's order if, based on medical necessity, certain residents required limited visitation privileges in order to promote their healing.

# Visitor's Log

**POLICY**

Visitors to the Traditions facilities may be asked to sign-in in the Visitor's Log book. Upon leaving the facility, visitors may be asked to sign-out.

**PROCEDURE**

1. Greet the visitor and request them to sign the log book.

# Volunteers

## POLICY

Traditions facilities recognize the need by various members of the community to participate in volunteer type activities. For this reason, Traditions has developed criteria and procedures for which the volunteer and center must meet in order to participate in a volunteer program.

A volunteer will be permitted to perform only those duties that do not require certification and/or licensure by the state. Hands-on resident care is prohibited.

## CRITERIA

The volunteer must meet the following criteria:

1. Complete an application with references
2. Obtain a two-step Mantoux test, per state regulations
3. Complete Volunteer Orientation
4. Agree to conform to the regulations of Traditions
5. Agree to keep resident information confidential according to HIPAA and facility policy.

## PROCEDURE

1. Request the volunteer candidate complete an application with references.
2. Check the references given.
3. Perform a two-step Mantoux test.
4. Schedule the candidate for an orientation which includes, but may not be limited to, the following: (format the orientation as applicable to fit the volunteer duties to be performed)
    - Tour of facility
    - Introduction to appropriate department heads
    - Introduction to immediate supervisor
    - Abuse

- Incident/Accident procedures (resident and volunteer)
- Fire procedures
- Sign-in and out procedure
- Infection control with two-tier Transmission Based Precautions
- Handwashing
- Confidentiality – HIPAA
- Conduct
- Proper wheelchair usage
- Dress code
- Resident Bill of Rights

5. Schedule the hours the volunteer wishes to work.

6. Document components of orientation and place in volunteer's file.

National Church Residences
HEALTH CARE

Job Title: Charge Nurse
Division: NCR Health Care
Date: last revised August 2007

## PURPOSE

According to prescribed policies and procedures of the organization including all applicable state, federal and local regulations and under the general supervision of the Director of Nursing, the Charge Nurse is a Registered or Licensed Practical Nurse is responsible for providing nursing care services to residents as assigned, making observations on an advanced level, forming nursing judgments, carrying out nursing actions based upon understanding of the scientific principles involved, reporting and recording observations appropriately and supervising staff.

## TYPICAL RESPONSIBILITIES

- Responsible for following facility procedures including but not limited to related to control of equipment and supplies within the nursing unit
- Must be capable of ensuring employees follow the chain of command in a manner consistent with the personnel policies
- Receives and gives an accurate report on resident's condition to provide continuity of care
- Makes walking rounds to observe all assigned residents and note any changes of their condition, mentally or physically, and reports these changes to the attending physician, family and co-workers
- Documents changes and notification to POA and doctor
- Assigns nursing assistants and supervises the efficient completion of their assignments
- Supervises and corrects poor performance of nursing assistants. Keeps Director of Nursing informed on a timely basis of poor performance problems
- Order and credit drug as needed, keeps accurate accounting of all drugs (Stock drugs, unit dose and narcotics)
- Monitor diets and supervises meal trays and snacks served to residents and the resident's intake
- Assists in passing meal trays and assists in feeding and snacks
- Exercises keen observations of noise, odors, uncleanliness, etc. Cooperates with other staff members in all departments to ensure quality environmental conditions for the residents and staff
- Reports all defects in equipment and supplies and any malfunctioning of the equipment
- Observes that all combustible materials are eliminated from closed storage areas and all poisons are kept locked
- Instructs and monitors staff in the proper handling and storage of oxygen
- Verifies change-over MARS/TARS are correctly updated and necessary changes are made to new MAR/TAR by the 1st of each month
- Observes and maintains infection control procedures (for example: no gloves on staff in hallways, soiled disposable liners are bagged and taken to soiled utility after each resident is changed, linen cart remains covered)
- Is responsible for ensuring that residents are safe (for example: Wanderguard tab is securely attached to bed/chair as ordered, Wanderguard bracelets are working properly, side rails if ordered)
- Ensures that all corridors, exit ways, nursing stations, etc., are kept free from obstruction)
- Accompanies attending physician on their rounds if they so request and notes all orders after their visit
- Directs and supervises nursing assistants assigned to residents' A.D.L.

- Demonstrates and maintains a positive, professional manner, manages time efficiently and effectively, provides leadership as a role model to promote a team approach, and participates in appropriate problem solving methods.
- With respect to Resident Rights, ensures all care is provided with respect and dignity for residents, reports all complaints made by clients and/or families to the appropriate supervisors, reports all allegations of abuse, misappropriation of funds/client property and/or any other corporate compliance items immediately.
- Must adhere to all policies, procedures, terms and conditions set forth in the NCR Employee Information Guide (EIG) as well as any facility handbook including but not limited to corporate compliance, drug free workplace, safe work practices, all federal, state, local regulations and laws.
- Performs all other duties as deemed necessary

# JOB SPECIFICATION SHEET – Charge Nurse

**Education:** Must have the ability to perform needed functions. Graduate of an accredited school of nursing or vocational school of practical nursing.

**Experience:** One to two years in healthcare preferred.

**Mental:** Must have good communication, comprehension, and interpersonal skills. Must have the ability to speak, read, write and understand English.

**Skills:** Must have working knowledge of Windows, Microsoft Office Suite, and World Wide Web.

**Licensure:** Current Ohio License in good standing.

---

**Vision:** Normal: Consistent with standard workflow.

With respect to said job description, estimate the daily time spent performing the following activities.

Rare (R) = 0-24%; Sometimes (S) = 25-49%; Frequent (F) = 50-74%; Continuous (C) = 75% plus

| | | | |
|---|---|---|---|
| R = Climbing | S = Stooping | Lifting/Carrying: | S = 10-25 lbs. |
| S = Standing | R = Pushing | | S = 26-50 lbs. |
| S = Sitting | R = Pulling | | S = 51-75 lbs. |
| S = Walking | R = Driving | | S = 76 plus lbs. |

**Consequences of Errors:** Moderate monetary responsibility.

**Supervision Received:** General supervision: Employee generally operates by himself/herself checking with supervisor when in doubt.

**Working Conditions:** Somewhat disagreeable; elements such as noise, dust, heat and oil exist but not to the extent of being continuously disagreeable.

National Church Residences
HEALTH CARE

Job Title: Nursing Assistant
Division: NCR Health Care
Date: last revised April 2007

## PURPOSE

According to prescribed policies and procedures of the organization including all applicable state, federal and local regulations and under the general supervision of the Charge Nurse and the Director of Nursing, assumes the responsibility for assisting the residents with the numerous activities of daily living while encouraging and guiding them to maintain or reach the highest level of function.

## TYPICAL RESPONSIBILITIES

- Responsible for performing and documenting all duties assigned by the Charge Nurse. Observes and records the resident's care, symptoms, emotional and physical status.
- Updates and submits all documentation in an accurate and timely manner.
- Assists resident s to reach maximum ADL potential. Assists with the resident's daily activities to include promoting the resident's mental alertness. This includes but is not limited to: Bathing, dressing, grooming; feeding residents; assisting with turning, transferring, transporting and/or ambulation; assisting with new admissions.
- Adheres to proper procedures for restraining and lifting residents.
- Provides restorative care including but not limited to range of motion, ambulation, and bowel and bladder training.
- Attends and participates in regularly scheduled interdisciplinary team meetings to coordinate care plans, follow up on changes and other communication, problem solve, receive staff support and inservice education.
- Demonstrates and maintains a positive, professional manner, manages time efficiently and effectively, promotes a team approach, participates in appropriate problem solving methods.
- With respect to Resident Rights, ensures all care is provided with respect and dignity for resident s, reports all complaints made by resident and/or families to the appropriate supervisors, reports all allegations of abuse, misappropriation of funds/client property and/or any other corporate compliance items immediately.
- Must adhere to all policies, procedures, terms and conditions set forth in the NCR Employee Information Guide (EIG) as well as any facility handbook including but not limited to corporate compliance, drug free workplace, safe work practices, all federal, state, local regulations and laws.
- Perform other duties as assigned.

# JOB SPECIFICATION SHEET – Nursing Assistant

**Education:** High School diploma /GED equivalent

**Experience:** Two to four years.

**Mental:** Must have good communication, comprehension, and interpersonal skills. Must have the ability to speak, read, write and understand English.

**Skills:** Must have working knowledge of Windows, Microsoft Office Suite, and World Wide Web.

**Licensure:** Ohio STNA or equivalent certification from another state

---

**Vision:** Normal: Consistent with standard workflow.

With respect to said job description, estimate the daily time spent performing the following activities.

Rare (R) = 0-24%; Sometimes (S) = 25-49%; Frequent (F) = 50-74%; Continuous (C) = 75% plus

| | | | |
|---|---|---|---|
| R = Climbing | S = Stooping | Lifting/Carrying: | S = 10-25 lbs. |
| F = Standing | R = Pushing | | F = 26-50 lbs. |
| S = Sitting | R = Pulling | | F = 51-75 lbs. |
| F = Walking | R = Driving | | F = 76 plus lbs. |

**Consequences of Errors:** Moderate monetary responsibility.

**Supervision Received:** General supervision: Employee generally operates by himself/herself checking with supervisor when in doubt.

**Working Conditions:** Exposure to some disagreeable conditions such as noise, odors, illness, infection and physical contact with disruptive clients.

National Church Residences
HEALTH CARE

Job Title: Universal Worker
Division: NCR Health Care
Date: last revised April 2007

## PURPOSE

According to the prescribed policies and procedures of the organization including all applicable federal, state and local regulations and under the general supervision of the Neighborhood Coordinator and the Charge Nurse, the purpose of this position is to provide direct care to the residents, and assumes the responsibility for assisting the residents with the numerous activities of daily living while encouraging and guiding them to maintain or reach the highest level of function in accordance with facility policies and procedures and report the needs and concerns to the supervisor on duty.

## TYPICAL RESPONSIBILITIES

- Performs/assists with all resident direct care needs and comforts of daily living as needed. Including but not limited to: Lifting, turning, positioning, transporting; bathing, dressing functions, oral hygiene and grooming; answering and responding to call lights in a timely and professional manner; providing restorative care including but not limited to range of motion, ambulation, and bowel and bladder training.
- Provides all additional resident care needs and comforts of daily living. Including but not limited to: Maintaining cleanliness of resident's room to include daily cleaning, deep cleaning as required, and discharge cleaning; providing for and engages in activities of interest to resident; providing restorative nursing programs necessary to maintain ADLs; Working as a team member in assigned neighborhood & cooperating with neighborhood coordinator.
- Communicates professionally and effectively, verbally and in writing.
    - Follows written and verbal directions
    - Provides exemplary customer service to residents, peers, families, managers, and visitors.
    - Reports any changes in physical or mental conditions on a timely basis
    - Follows all company, facility and state policies and procedures.
- Assists nurses with assigned tasks, including but not limited to: Measuring and recording vitals; gathering weights, measures and other documentation on the residents; making beds, cleaning closets, organizing and ensuring cleanliness of resident living areas; assisting with new admissions as assigned; assisting in the training and orientation of new staff as assigned.
- Adheres to the guidelines as outlined in the Resident Rights documentation.
    - Knows resident rights and helps the residents exercise and/or protect their rights.
    - Reports resident complaints to charge nurse or supervisory in charge, maintains confidentiality.
- Documents resident information timely, accurately and confidentially according to the procedures set forth in the electronic medical record system.
- Adheres to all policies and procedures as outlined under the Safety & Compliance policies and procedures
    - Demonstrates proper use of equipment. Reports equipment needs or repairs.
    - Uses protective equipment, follows infection control protocol standards, policies and procedures
    - Practices universal precautions

- Performs food service functions to include: Preparing residents for meals, serving food, assisting with eating, after meal care, passing snacks and fresh water/ice; recording food/fluid intake, noting changes of eating habits and appropriately reporting.
- Perform other duties as assigned

# JOB SPECIFICATION SHEET – Universal Worker

**Education:** High School diploma/GED

**Experience:** Two to four years.

**Mental:** Must have good communication, comprehension, and interpersonal skills. Must have the ability to understand read, write and understand English.

**Skills:** Must have working knowledge of Windows, Microsoft Office Suite, and World Wide Web.

**Licensure:** Ohio STNA or equivalent certification from another state

---

**Vision:** Normal: Consistent with standard workflow.

With respect to said job description, estimate the daily time spent performing the following activities.

Rare (R) = 0-24%; Sometimes (S) = 25-49%; Frequent (F) = 50-74%; Continuous (C) = 75% plus

| | | | |
|---|---|---|---|
| R = Climbing | F = Stooping | Lifting/Carrying: | S = 10-25 lbs. |
| F = Standing | F = Pushing | | F = 26-50 lbs. |
| S = Sitting | F = Pulling | | F = 51-75 lbs. |
| F = Walking | R = Driving | | F = 76 plus lbs. |

**Consequences of Errors:** Moderate monetary responsibility.

**Supervision Received:** General supervision: Employee generally operates by himself/herself checking with supervisor when in doubt.

**Working Conditions:** Exposure to some disagreeable conditions such as noise, odors, illness, infection and physical contact with disruptive residents.

National Church Residences
HEALTH CARE

Job Title: Cook
Division: Health Care Division
Date: last revised April 2008

## PURPOSE

According to the prescribed policies and procedures of the organization including all applicable federal, state and local regulations under the supervision of the Director of Dietary Services assumes the responsibility for preparing food for the residents and personnel. The Cook maintains high standards of quality food production and is in charge of the Dietary Department in the absence of the Dietary Manager.

## TYPICAL RESPONSIBILITIES

- Prepares meals according to the menus provided using standardized recipes based on standard portion control.
- Estimates food requirements and controls serving portions, eliminating waste and leftovers.
- Maintains equipment and cooking areas in a safe and sanitary manner. Cleans kitchen area and equipment. Washes pots and pans.
- Maintains daily meal census.
- Records meal serving temperatures.
- Assists in training new dietary employees.
- Oversees that all meals and snacks are prepared and sent in a timely manner so that temperature, quality and appearance of the food is maintained.
- Checks for accuracy of special diets.
- Attends inservice meetings.
- Demonstrates and maintains a positive, professional manner, manages time efficiently and effectively, promotes a team approach, participates in appropriate problem solving methods.
- With respect to Resident Rights, ensures all care is provided with respect and dignity for clients, reports all complaints made by clients and/or families to the appropriate supervisors, reports all allegations of abuse, misappropriation of funds/client property and/or any other corporate compliance items immediately.
- Must adhere to all policies, procedures, terms and conditions set forth in the NCR Employee Information Guide (EIG) as well as any facility handbook including but not limited to corporate compliance, drug free workplace, safe work practices, all federal, state, local regulations and laws.
- Performs other duties as assigned.

# JOB SPECIFICATION SHEET—Cook

**Education:** Must have the ability to perform needed functions or general/high school course work

**Experience:** One to two years.

**Mental:** Must have the ability to speak, read, write and comprehend English.

**Licensure:**

---

**Vision:** Normal: Consistent with standard workflow.

With respect to said job description, estimate the daily time spent performing the following activities.

Rare (R) = 0-24%; Sometimes (S) = 25-49%; Frequent (F) = 50-74%; Continuous (C) = 75% plus

| | | | |
|---|---|---|---|
| R = Climbing | R = Stooping | Lifting/Carrying: | S = 10-25 lbs. |
| C = Standing | S = Pushing | | S = 26-50 lbs. |
| R = Sitting | S = Pulling | | R = 51-75 lbs. |
| S = Walking | R = Driving | | R = 76 plus lbs. |

**Consequences of Errors:** Moderate monetary responsibility.

**Supervision Received:** General supervision: Employee generally operates by himself/herself checking with supervisor when in doubt.

**Working Conditions:** Good working conditions, some distractions. Due to working in facilities, exposure to some disagreeable conditions such as noise, odors, illness, infection and physical contact with disruptive residents.

EXHIBIT 9 *Supportive Services Plan (SSP)*

*(d) The monthly individual rate for board and supportive services for the ALF listing the total fee and components of the total fee for the items required by State or local licensing and list the appropriate rate for any optional service you plan to offer ALF residents. Provide an estimate of the total annual costs of the required board and supportive services you expect to provide and an estimate of the amount of optional services you expect to provide.*

Assisted living services are primarily provided through two funding sources as indicated in the Exhibit 9 (e). are Assisted Living Medicaid Waiver Program and private pay. The monthly individual rate for board and supportive services for the ALF is determined by the Ohio Department of Health. Based upon a resident's clinical assessment, a level of care will be determined on an individual basis. There are three levels with the daily rates as follows:

Level 1 $50.00/day
These residents require intermittent cuing and prompts; they are independent with medication management, they need no nursing care but require up to 2.75 hours of service per day.

Level 2 $60.00 / day
These residents require 24 hour supervision to prevent harm to self/others, medication management supervision, weekly or monthly nursing care for routine health monitoring/management, and need 2.7 – 3.35 hours of service per day.

Level 3 $70.00 / day
These residents require 24 hour supervision to prevent harm to self/others, medication administration by qualified licensed staff, and daily nursing care due to an unstable medical condition and require more than 3.35 hours of service per day.

The services that will be provided for each of these rates include: 24 hour on-site response, personal care, supportive services (housekeeping, laundry & maintenance), nursing, transportation, 3 meals per day and social/recreational programming.

## Monthly Fee Structure

**Items Included in Basic Services Rate**

- Supervision of and assistance with ADL's 7 days a week, 24 hours a day
- Supervision of and assistance with IADL's on an as needed basis
- Medication assistance, and supervision
- Emergency Response Plan as outlined
- Three meals per day
- Coordination, implementation, and updates of a service plan by the ALF Care Management staff, and licensed nursing staff
- Development of an Admission Plan as outlined
- Basic program activities (other activities may require an additional fee)
- Education, information, and programs as provided by our supportive services coordinator

## II. ALF for Private Pay

**Basic Services Rate = $1,800 per month**

Items Included in Basic Services Rate

- Supervision of and assistance with ADL's 7 days a week, 24 hours a day
- Supervision of and assistance with IADL's on an as needed basis
- Medication assistance, and supervision
- Emergency Response Plan as outlined
- Three meals per day
- Coordination, implementation, and updates of a service plan by the ALF Service Coordinator
- Development of an Admission Plan as outlined
- Basic program activities (other activities may require an additional fee)
- Education, information, and programs as provided by our supportive services coordinator

Please note that the service plan will be reviewed and updated by the assisted living interdisciplinary team as required by the state regulatory standards.

**Please see the attached letter indicating third party reimbursement sources for the ALF Program and an informational brochure from the State of Ohio on its Medicaid waiver program**

Ohio | Department of Aging

**Ted Strickland**, Governor
**Barbara E. Riley**, Director

October 1, 2009

Scott Hunley
U.S. Department of Housing & Urban Development
Federal Office Building
200 North High Street
Columbus, Ohio 43215

Dear Mr. Hunley:

The Ohio Department of Aging (ODA) enthusiastically supports the National Church Residences' (NCR) application to convert three additional floors of the *Portage Trail Village* into an assisted living facility through HUD's Assisted Living Conversion Grant program.

ODA understands that NCR will convert 48 unit of affordable housing into 39 assisted living units. This conversion supports the ODA's goal of allowing low-income elderly individuals to age in place and expands the availability of assisted living waiver services.

ODA administers Ohio's Assisted Living Medicaid Waiver Program. The waiver program is in the fourth year of operation and the demand for assisted living waiver services continues to grow. At the end of SFY 09, over 1500 consumers were enrolled in the waiver and more than 650 eligible consumers were waiting for enrollment. Approximately, 23% of eligible consumers in need of a qualified and willing provider are located in the region served by the Portage Trail Village community. In September 2009, the state submitted a request to CMS to expand the approved waiver slots from 1800 to 3009.

To quality for this program, eligible participant must meet Medicaid financial eligibility requirements and require hands-on assistance with two or more activities of daily living. The assisted living waiver service is provided within a three-tier reimbursement cost structure and includes: 24 hour on-site response, personal care, housekeeping, laundry, maintenance, nursing, transportation, 3 meals a day, and social/recreational programming. An individual service plan is developed for each consumer and determines the tier reimbursement (Tier I: $50.00/day; Tier 2: $60.00/day; Tier III: $70.00/day). If all 39 current residents are eligible for waiver enrollment and require the highest level of service (Tier III), an annual service payment to the ALCP would be $81,900 per month or $982,800 annually.

ODA is developing an additional waiver service, Enhanced Community Living, to increase enriched housing options in Ohio. The Enhanced Community Living service builds upon the benefits offered by traditional personal care/homemaker services by utilizing a flexible service delivery approach and will provide on-site access to personal care, health status monitoring and care coordination to tenants of subsidized housing communities such as Portage Trail

50 W. Broad Street / 9th Floor
Columbus, OH 43215-3363 U.S.A.
www.aging.ohio.gov
614 | 466-5500 Main
614 | 466-5741 Fax
614 | 466-6191 TTY

Village. Tenants residing in the remaining unlicensed portion of the Portage Trail Village site who are enrolled in the ODA administered Medicaid waiver would be able to access this service. The availability of the new waiver service at Portage Trail Village would result in an affordable housing community that can offer three levels of service: independent, enhanced, and assisted living.

Affordable assisted living services and enriched housing settings are very much needed in the State of Ohio. We applaud NCR for submitting this application to increase the availability of housing with services in our state. We hope the U.S. Department of Housing & Urban Development looks favorably upon their application.

Sincerely,

Barbara E. Riley, Director

CC: Michelle Norris, NCR Senior Vice President/ Chief Development Officer
Hope Roberts, ODA, Assisted Living and RSS Manager

**Program Profile**

# Assisted Living Medicaid Waiver Program

## What is the Assisted Living Medicaid Waiver Program?

- This Medicaid waiver program provides services in certified residential care facilities to delay or prevent nursing facility placement.
- Assisted living promotes aging in place by supporting consumer desire for independence, choice and privacy. The services help preserve the independence of the individual, as well as maintain ties to family and friends.

## Who is eligible for the Assisted Living Waiver Program?

Eligible participants must:

- Be current nursing facility residents or existing Medicaid waiver (PASSPORT, Ohio Home Care, Choices) participants OR current residents of residential care facilities who have paid privately for at least six months;
- Be age 21 or older;
- Need hands-on assistance with dressing, bathing, toileting, grooming, eating or mobility;
- Meet the financial criteria for Medicaid eligibility (see below); and
- Be able to pay monthly room and board.

## What are the financial eligibility criteria for the Assisted Living Waiver Program?

- County Departments of Job and Family Services determine financial eligibility of interested participants.
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- Depending on income, participants may be required to pay a *patient liability* each month toward the cost of services.

## Who Provides Assisted Living Services?

Providers must be:

- Licensed as a residential care facility by the Ohio Department of Health; and
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Ohio Department of Aging
50 W Broad St/9th Fl
Columbus, OH
43215-3363

www.GoldenBuckeye.com
1-866-243-5678

Continued...

Ohio Department of Aging is an equal opportunity employer and service provider.
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Continued...

**What services are provided by the Assisted Living Waiver Program?**

Two types of services are provided by the program:

- **Assisted Living Services** include: 24 hour on-site response, personal care, supportive services (housekeeping, laundry, and maintenance), nursing, and transportation, 3 meals per day and social/recreational programming.
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**How do I apply for the Assisted Living Waiver Program?**

- Call toll-free **1-866-243-5678** to contact the Area Agency on Aging serving your community for details on how to apply.
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- Then, your county Department of Job and Family Services will determine financial eligibility.
- After meeting all eligibility criteria, you will be enrolled (pending slot availability).

**Where can I learn more about the Assisted Living Waiver Program?**

- Visit the following Ohio Department of Aging Web page for more information about the Assisted Living Waiver.
  **www.goldenbuckeye.com/families/alwaiver.html**

Company

Inside:

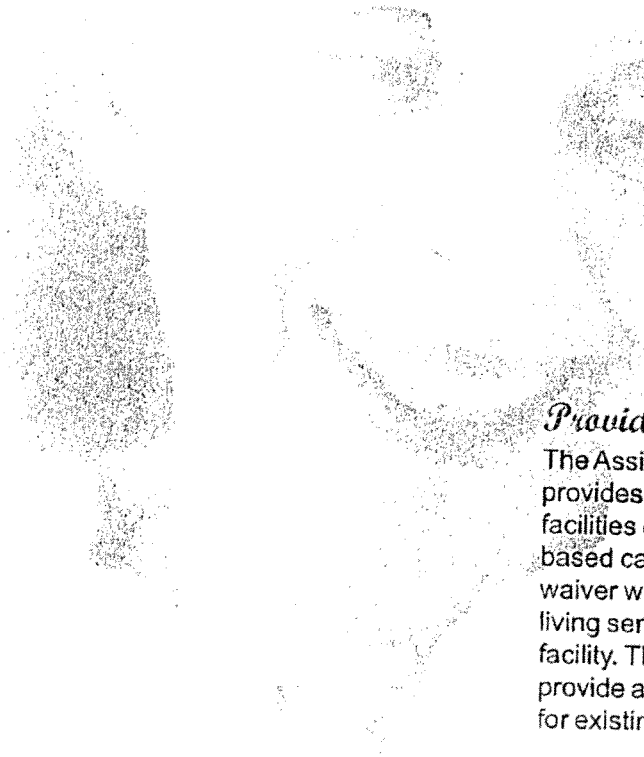
- Covered Costs in the Assisted Living Waiver Program
- Out-of-Pocket Costs for Consumers
- Provider Qualifications
- Provider Certification and Timeline
- Identifying a Potential Assisted Living Waiver Customer
- Provider Reimbursement Rate
- Three-Tier Model of Reimbursement

Assisted Living Waiver

*Community of Providers*

# Assisted Living Waiver

Grace
Northwestern Ohio
Community of
Providers



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The Assisted Living Waiver Program provides consumers who are in nursing facilities or who are receiving community-based care under another Medicaid waiver with the option to receive assisted living services in a residential care facility. The program is not designed to provide an alternative source of payment for existing assisted living residents.

## Assisted Living Waiver Program

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# You're in good company

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*Consumers also receive a Medicaid card that can be used to pay for physician visits, nursing services, therapies and other services.*

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Monthly room and board costs for the consumer are based on the current SSI benefit rate, minus $50. If his or her monthly income exceeds the set rate, he or she will make a client liability payment toward the cost of services. Contact your Area Agency on Aging for the current rate.

## Provider Qualifications

To become a certified Assisted Living Waiver Program provider, the interested facility must:

1. Be licensed by the Ohio Department of Health as a residential care facility;
2. Provide single occupancy living units with a bathroom, an identifiable space for socialization and the ability to be locked; and
3. Demonstrate a capacity to provide, directly or through contract, personal care, supportive services, three meals per day, social and recreational programming and non-medical scheduled transportation and nursing services (OAC 173:39-02.16).

There is no minimum or maximum number of participants a facility can serve and the facility does not have to reserve units for waiver participants.

For a complete list of provider requirements and expectations, contact your Area Agency on Aging.

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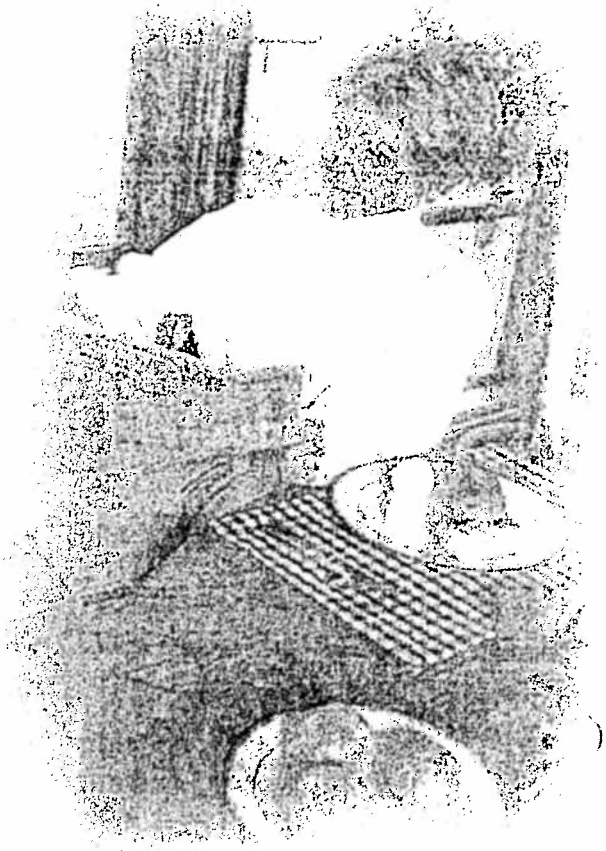

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The Ohio Department of Aging (ODA) strives to make the mandatory provider certification process as efficient as possible. The process is a cooperative effort between ODA, the Ohio Department of Health (ODH) and the Ohio Department of Job and Family Services (ODJFS), coordinated by ODA and the Area Agency on Aging (AAA). The AAA will provide technical assistance to the interested provider throughout the process.

**Overview of the certification process with maximum timelines:**

1. The interested residential care facility contacts the AAA serving the region in which the facility is located for an application packet, then returns the completed and signed application to the same AAA.

2. **Within 45 business days** of receipt of the signed application, ODH will conduct an on-site review and report its findings to the AAA.

3. **Within 30 business days** of the ODH review, the AAA will notify the applicant of any unmet requirements.

   - If the applicant meets all requirements, the AAA will recommend to ODA that the facility be Certified.
   - If the applicant does not meet all requirements, they have **20 business days** to make necessary changes.

4. **Within 45 business days** of the AAA recommendation, ODA will notify the applicant of its certification determination. ODA will coordinate with ODJFS to issue the applicant an assisted living provider agreement number and official certification.

5. **Within 10 business** days of certification determination, ODA will notify the applicant in writing of the final certification.

6. The certified assisted living provider then enters into a contract with the AAA to provide services.

*Reference:*
*OAC 173-39-03 E 1-6 (Provider Certification).*

# Identifying a Potential Assisted Living Waiver Customer

The Assisted Living Waiver Program is open to current nursing facility residents and existing Medicaid waiver (i.e., PASSPORT, Ohio Home Care or Choices) participants who would otherwise remain in or permanently enter a nursing facility. Area Agencies on Aging (AAA) assess interested consumers on several eligibility qualifications and participation requirements:

- *Age:* The consumer must be 21 years old or older at the time of enrollment.
- *Medicaid Financial Eligibility:* The consumer must be determined by his or her county Department of Job and Family Services to meet relevant Medicaid financial requirements.
- *Level of Care:* The consumer must need a nursing facility level of care, meet the requirements for a skilled or intermediate level of care and require nursing facility services if not enrolled in the waiver program.
- *Unschedulable Needs:* The consumer must have a documented need for unschedulable hands-on assistance with at least two activities of daily living.
- *Living Arrangement:* Assisted Living Waiver services are provided only in a licensed residential care facility that has been certified by ODA. The applicant may not receive assisted living services while enrolled in another Medicaid waiver or while residing in a hospital, nursing facility or RSS-funded living arrangement.
- *Hospice:* The consumer may receive hospice services while enrolled in the Assisted Living Waiver.
- *Health and Safety:* The health and safety needs of the consumer must be safely met in the residential care facility.
- *Room and Board:* The applicant must be able to pay the established room and board rate.
- *Client Agreement:* The consumer must sign a client-agency agreement to participate in the program.
- *Cost Cap:* The consumer's Assisted Living service plan costs may not exceed $27,042.70 in a twelve-month period.

2250/mo

- *Available Slot:* The consumer may be enrolled if there is an available CMS-approved, unduplicated slot for the current program year.

*Reference:*

*OAC 5101:3:33-03 (Eligibility for Assisted Living in HCBS Waivers)*
*OAC 5101:1-37 (Medicaid)*
*OAC 5101:1-39 (Medicaid)*
*OAC 5101:3-3-05 (Skilled Level of Care)*
*OAC 5105:3-3-06 (Intermediate Level of Care)*

# Provider Reimbursement Rate

The provider reimbursement rate is divided in to two parts:

- Monthly room and board costs based on the current SSI benefit rate, minus $50, paid directly to the provider by the consumer; and $573.
- A monthly reimbursement for assisted living services, paid through the Medicaid waiver.

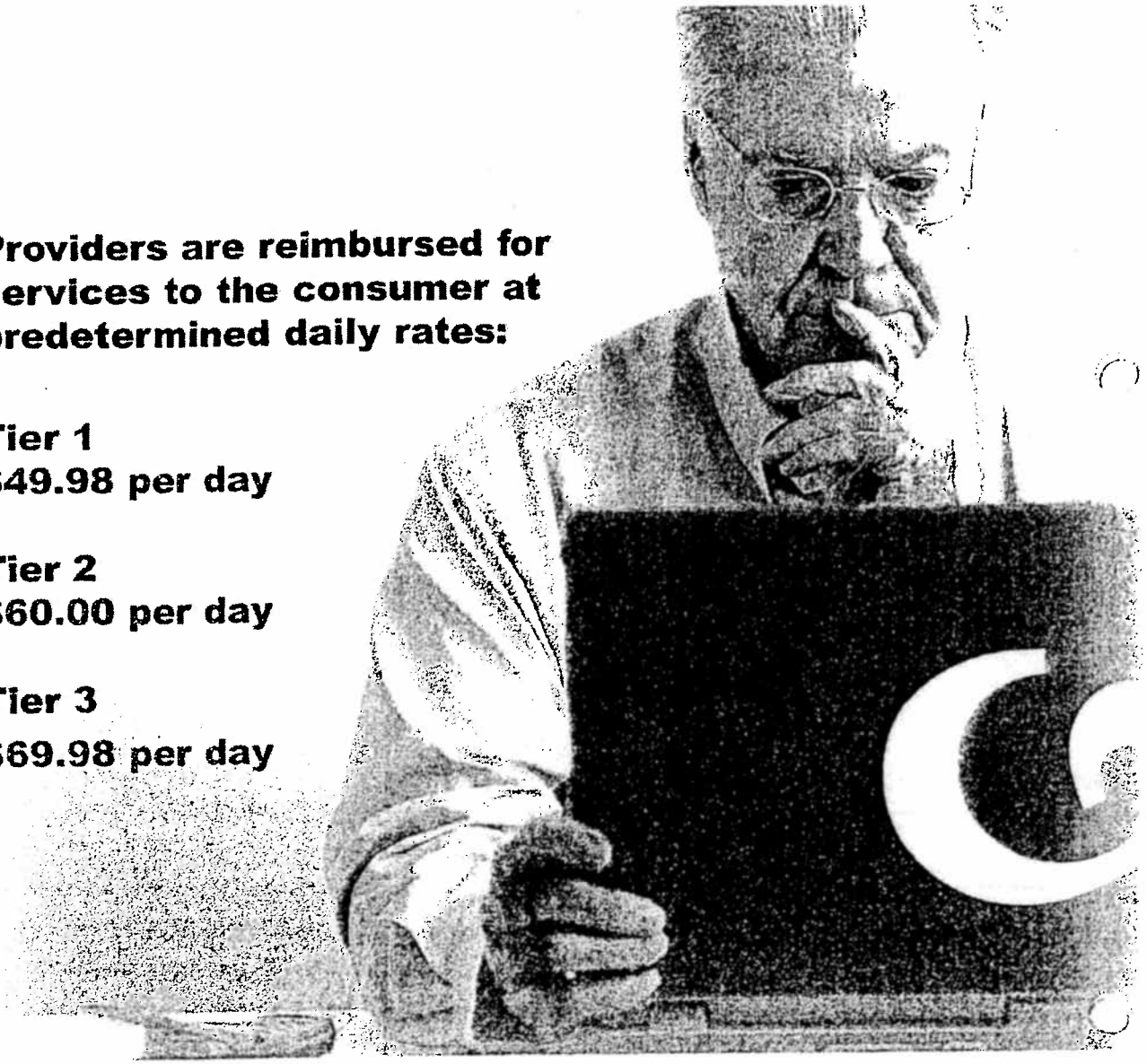
If the participant's monthly income exceeds the current SSI benefit rate, he or she will be required to make a client liability payment to the provider toward the cost of services.

**Providers are reimbursed for services to the consumer at predetermined daily rates:**

**Tier 1**
**$49.98 per day**

**Tier 2**
**$60.00 per day**

**Tier 3**
**$69.98 per day**



# Three-Tier Model of Reimbursement

Reimbursement is determined by the consumer's needs on four variables: cognitive functioning, medication administration assistance, nursing care and physical functioning. The tier level is based on an assessment conducted by the AAA.

| Category | Tier 2 | Tier 3 |
|---|---|---|
| **Cognitive Functioning** | Occasional prompts | Daily cuing and prompts | Ongoing cuing, prompts and redirection |
| **Medication Administration** | Independent with medications (requires no staff involvement) | Supervision with medication management (staff involvement with procurement, storage and reminders) | Medication administration by qualified staff |
| **Nursing** | No Individualized, scheduled, hands-on care provided by a licensed nurse | Weekly and/or monthly individualized, hands-on care provided by a licensed nurse | Daily nursing care due to an unstable medical condition, or intermittent skilled nursing care provided by the facility |
| **Physical Functioning** | Requires up to 2.75 hours of service per day | Requires more than 2.75 hours but less than 3.35 hours of servce per day | Requires more than 3.35 hours of service per day |

# *Join the Community of Providers*

Contact your Area Agency on Aging
to request an application packet:

**Area Office on Aging of Northwestern Ohio, Inc.**
2155 Arlington Avenue
Toledo, OH 43609
419-382-0624

To learn more about the Ohio Department of Aging
and the Assisted Living Waiver Program,
or locate your Area Agency on Aging:

**www.goldenbuckeye.com**
**1-866-243-5678**

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# Program Profile

## Assisted Living Medicaid Waiver Program

Ohio Department of Aging
50 W Broad St/9th Fl
Columbus, OH
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1-866-243-5678

### What is the Assisted Living Medicaid Waiver Program?

- This Medicaid waiver program provides services in certified residential care facilities to delay or prevent nursing facility placement.
- Assisted living promotes aging in place by supporting consumer desire for independence, choice and privacy. The services help preserve the independence of the individual, as well as maintain ties to family and friends.

### Who is eligible for the Assisted Living Waiver Program?

Eligible participants must:

- Be current nursing facility residents or existing Medicaid waiver (PASSPORT, Ohio Home Care, Choices) participants ;
- Be age 21 or older;
- Need hands-on assistance with dressing, bathing, toileting, grooming, eating or mobility and have unpredictable needs for assistance with activities of daily living;
- Meet the financial criteria for Medicaid eligibility (see below); and
- Be able to pay room and board.

*Individuals currently residing in an Assisted Living facility are not eligible.*

### What are the financial eligibility criteria for the Assisted Living Waiver Program?

- County Departments of Job and Family Services determine financial eligibility of interested participants.
- Individuals may not have countable assets valued at more than $1,500.
- Monthly income must not exceed 300 percent of the Social Security Insurance benefit.
- Depending on income, participants may be required to pay a *patient liability* each month toward the cost of services.

### Who Provides Assisted Living Services?

Providers must be:

- Licensed as a residential care facility by the Ohio Department of Health; and
- Certified by the Ohio Department of Aging as an Assisted Living Provider.

**Continued...**

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Merle Grace Kearns, Director • Bob Taft, Governor

Continued...

**What services are provided by the Assisted Living Waiver Program?**

Two types of services are provided by the program:

- **Assisted Living Services** include: 24 hour on-site response, personal care, supportive services (housekeeping, laundry, and maintenance), nursing, and transportation, 3 meals per day and social/recreational programming.
- **Community Transition Services** are available to individuals leaving a nursing facility to enroll in the Assisted Living waiver and helps them obtain essential household furnishings and other items.

**How do I apply for the Assisted Living Waiver Program?**

- Call toll-free **1-866-243-5678** to contact the Area Agency on Aging serving your community for details on how to apply.
- Interested individuals must complete an application, telephone screen and in-person assessment.
- Then, your county Department of Job and Family Services will determine financial eligibility.
- After meeting all eligibility criteria, you will be enrolled (pending slot availability).

**Where can I learn more about the Assisted Living Waiver Program?**

- Visit the following Ohio Department of Aging Web page for more information about the Assisted Living Waiver. **www.goldenbuckeye.com/families/alwaiver.html**

TF?

## LEVELS OF CARE

| TIER ONE | TIER TWO | TIER THREE |
|---|---|---|
| $50.00 Per Day ($1,500.) per mo. | $60.00 Per Day ($1,800.) per mo. | $70.00 Per Day ($2,100.) per mo.per person |

Add the monthly room and board rate of $573.00 per month. We bill this in advance.

| TIER ONE | TIER TWO | TIER THREE |
|---|---|---|
| $2,073 per mo. | $2,373. per mo. | $2,673.00 per mo. Per person |

TIER ONE: Requires Intermittent cuing and prompts.
Independent with medication management.
No nursing care
Individuals who require up to 2.75 hours of service per day.

TIER TWO: Requires 24 hour supervision to prevent harm to self/others
Medication management supervision
Weekly or monthly nursing care for routine health monitoring/management
Individuals who require more than 2.7 hours and less than 3.35 hours of Service per day.

TIER THREE: 24 hour supervision to prevent harm to self/others.
Medication Administration by qualified licensed staff.
Daily nursing care due to an unstable medical condition
Individuals who require more than 3.35 hours of service per day.

The liablility payment could equal as high as $700.00. This is determined by the case manager from COAAA.

## COMMUNITY TRANSITION FEE

Community transition services are designed to assist eligible consumers with the costs associated with leaving a nursing facility to establish a residence in an assisted living facility .

It includes:

1.) The purchase of essential furnishings not provided by the consumer's assisted living facility.
2.) The purchase of essential household supplies and incidentals not provided by the consumer's assisted living facility
3.) The payment of any set-up fees and/or deposits required for telephone services.

Case managers approve the items they need and the amount they have to spend.
The facility pays up front, documents all receipts and then is reimbursed by COAAA
All transactions, receipts and signatures of accepting the merchandise is placed in the patients chart.
The consumer has sixty days to purchase the items. The provider (facility) must assist in the purchase and delivery.
The maximum amount is $1,500.00.

EXHIBIT 9 *Supportive Services Plan (SSP)*

*(e) List who will pay for the board and supportive services and the amount. For example, include such items as:*

*(1) meals by sponsors - $___*
*(2) housekeeping services by the City government - $___*
*(3) personal care by State Department of Health - $___*
*(4) service paid for by state program - $___*
*(5) fees paid by tenants- $___*

The monthly individual rate for board and supportive services for the ALF is determined by the Ohio Department of Aging. Based upon a resident's clinical assessment, a level of care will be determined on an individual basis. There are three levels with the daily rates as follows:

Level 1 $50.00/day
These residents require intermittent cuing and prompts; they are independent with medication management, they need no nursing care but require up to 2.75 hours of service per day.

Level 2 $60.00 / day
These residents require 24 hour supervision to prevent harm to self/others, medication management supervision, weekly or monthly nursing care for routine health monitoring/management, and need 2.7 – 3.35 hours of service per day.

Level 3 $70.00 / day
These residents require 24 hour supervision to prevent harm to self/others, medication administration by qualified licensed staff, and daily nursing care due to an unstable medical condition and require more than 3.35 hours of service per day.

The services that will be provided for each of these rates include: 24 hour on-site response, personal care, supportive services (housekeeping, laundry & maintenance), nursing, transportation, 3 meals per day and social/recreational programming.

**Please see the following Supportive Services Budget.**

# Assisted Living Conversion Program
## Supportive Services Budget

**Revenue**

| | | |
|---|---|---|
| ***MEALS SERVICES REVENUE*** | | |
| Resident Contribution (Private Payments) | $ | 85,410 |
| Federal Grant | $ | |
| State Program | $ | 99,645 |
| Private Grant Donations | $ | |
| **Total Revenue - Meals** | $ | 185,055 |
| ***HOUSEKEEPING AND PERSONAL SERVICES REVENUE*** | | |
| Resident Contribution (Private Payments) | $ | |
| Federal Grant (CHSP) | $ | |
| State Program (Medicaid Programs/Enhanced Community Living) | $ | 740,220 |
| Private Grants/Donations | $ | |
| **Total Revenue - Housing and Personal Care Services** | $ | 740,220 |
| **TOTAL: ASSISTED LIVING SERVICES REVENUE** | $ | 925,275 |

**Expenses**

| | | |
|---|---|---|
| ***MEALS EXPENSES*** | | |
| Total Food Cost (raw food and labor) | $ | 177,938 |
| **Total Expenses - Meals** | $ | 177,938 |
| ***HOUSEKEEPING AND PERSONAL SERVICES EXPENSES*** | | |
| Salaries & Benefits | $ | 711,750 |
| Monitoring/Alarm Systems (Life line) | $ | |
| **Total Expenses - Housekeeping and Personal Care Services** | $ | 711,750 |
| ***MISCELLANEOUS SERVICES EXPENSES*** | | |
| Supplies | $ | 10,000 |
| Transportation | $ | 15,000 |
| Activities | $ | 10,000 |
| **Total Expenses - Miscellaneous Services** | $ | 35,000 |
| **TOTAL: ASSISTED LIVING SERVICES EXPENSES** | $ | 924,688 |

Ohio | Department of Aging

**Ted Strickland**, Governor
**Barbara E. Riley**, Director

October 1, 2009

Scott Hunley
U.S. Department of Housing & Urban Development
Federal Office Building
200 North High Street
Columbus, Ohio 43215

Dear Mr. Hunley:

The Ohio Department of Aging (ODA) enthusiastically supports the National Church Residences' (NCR) application to convert three additional floors of the *Portage Trail Village* into an assisted living facility through HUD's Assisted Living Conversion Grant program.

ODA understands that NCR will convert 48 unit of affordable housing into 39 assisted living units. This conversion supports the ODA's goal of allowing low-income elderly individuals to age in place and expands the availability of assisted living waiver services.

ODA administers Ohio's Assisted Living Medicaid Waiver Program. The waiver program is in the fourth year of operation and the demand for assisted living waiver services continues to grow. At the end of SFY 09, over 1500 consumers were enrolled in the waiver and more than 650 eligible consumers were waiting for enrollment. Approximately, 23% of eligible consumers in need of a qualified and willing provider are located in the region served by the Portage Trail Village community. In September 2009, the state submitted a request to CMS to expand the approved waiver slots from 1800 to 3009.

To quality for this program, eligible participant must meet Medicaid financial eligibility requirements and require hands-on assistance with two or more activities of daily living. The assisted living waiver service is provided within a three-tier reimbursement cost structure and includes: 24 hour on-site response, personal care, housekeeping, laundry, maintenance, nursing, transportation, 3 meals a day, and social/recreational programming. An individual service plan is developed for each consumer and determines the tier reimbursement (Tier I: $50.00/day; Tier 2: $60.00/day; Tier III: $70.00/day). If all 39 current residents are eligible for waiver enrollment and require the highest level of service (Tier III), an annual service payment to the ALCP would be $81,900 per month or $982,800 annually.

ODA is developing an additional waiver service, Enhanced Community Living, to increase enriched housing options in Ohio. The Enhanced Community Living service builds upon the benefits offered by traditional personal care/homemaker services by utilizing a flexible service delivery approach and will provide on-site access to personal care, health status monitoring and care coordination to tenants of subsidized housing communities such as Portage Trail

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Columbus, OH 43215-3363 U.S.A.
www.aging.ohio.gov

614 | 466-5500 Main
614 | 466-5741 Fax
614 | 466-6191 TTY

Village. Tenants residing in the remaining unlicensed portion of the Portage Trail Village site who are enrolled in the ODA administered Medicaid waiver would be able to access this service. The availability of the new waiver service at Portage Trail Village would result in an affordable housing community that can offer three levels of service: independent, enhanced, and assisted living.

Affordable assisted living services and enriched housing settings are very much needed in the State of Ohio. We applaud NCR for submitting this application to increase the availability of housing with services in our state. We hope the U.S. Department of Housing & Urban Development looks favorably upon their application.

Sincerely,

Barbara E. Riley, Director

CC: Michelle Norris, NCR Senior Vice President/ Chief Development Officer
Hope Roberts, ODA, Assisted Living and RSS Manager

**Program Profile**

# Assisted Living Medicaid Waiver Program

## What is the Assisted Living Medicaid Waiver Program?

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## Who is eligible for the Assisted Living Waiver Program?

Eligible participants must:

- Be current nursing facility residents or existing Medicaid waiver (PASSPORT, Ohio Home Care, Choices) participants OR current residents of residential care facilities who have paid privately for at least six months;
- Be age 21 or older;
- Need hands-on assistance with dressing, bathing, toileting, grooming, eating or mobility;
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- Be able to pay monthly room and board.

## What are the financial eligibility criteria for the Assisted Living Waiver Program?

- County Departments of Job and Family Services determine financial eligibility of interested participants.
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Company

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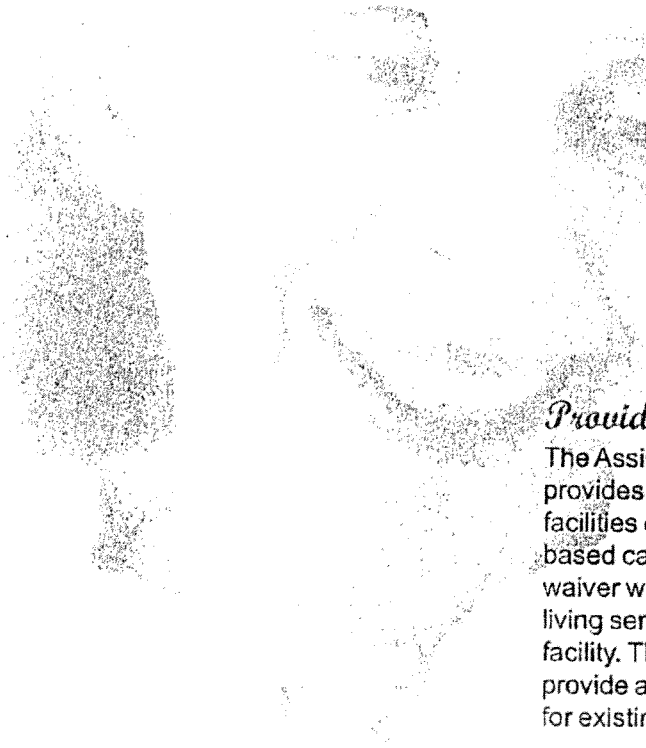
Assisted Living Waiver

*Community of Providers*

# Assisted Living Waiver

Greater Northeastern Ohio Community of Providers



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# You're in good company

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To become a certified Assisted Living Waiver Program provider, the interested facility must:

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For a complete list of provider requirements and expectations, contact your Area Agency on Aging.

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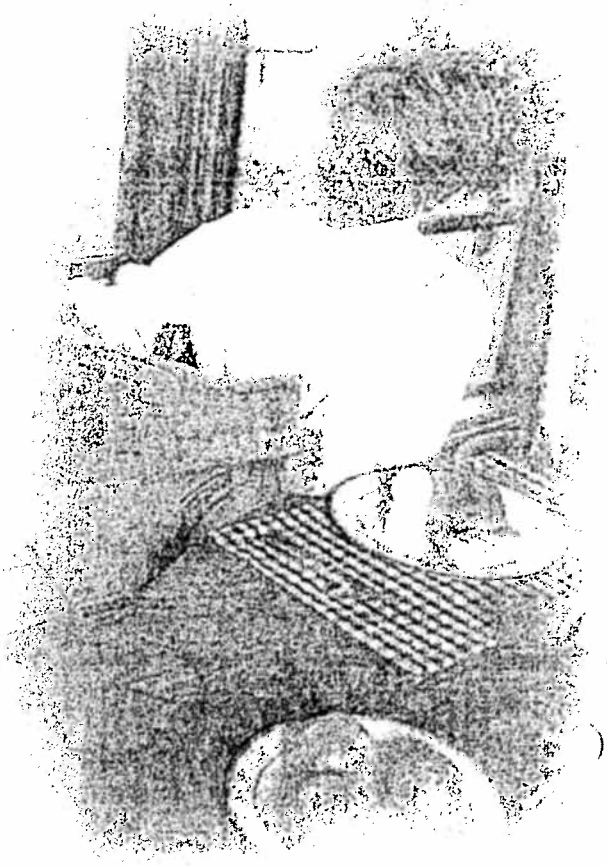

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6. The certified assisted living provider then enters into a contract with the AAA to provide services.

*Reference:*
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# Identifying a Potential Assisted Living Waiver Customer

The Assisted Living Waiver Program is open to current nursing facility residents and existing Medicaid waiver (i.e., PASSPORT, Ohio Home Care or Choices) participants who would otherwise remain in or permanently enter a nursing facility. Area Agencies on Aging (AAA) assess interested consumers on several eligibility qualifications and participation requirements:

- *Age:* The consumer must be 21 years old or older at the time of enrollment.
- *Medicaid Financial Eligibility:* The consumer must be determined by his or her county Department of Job and Family Services to meet relevant Medicaid financial requirements.
- *Level of Care:* The consumer must need a nursing facility level of care, meet the requirements for a skilled or intermediate level of care and require nursing facility services if not enrolled in the waiver program.
- *Unschedulable Needs:* The consumer must have a documented need for unschedulable hands-on assistance with at least two activities of daily living.
- *Living Arrangement:* Assisted Living Waiver services are provided only in a licensed residential care facility that has been certified by ODA. The applicant may not receive assisted living services while enrolled in another Medicaid waiver or while residing in a hospital, nursing facility or RSS-funded living arrangement.
- *Hospice:* The consumer may receive hospice services while enrolled in the Assisted Living Waiver.
- *Health and Safety:* The health and safety needs of the consumer must be safely met in the residential care facility.
- *Room and Board:* The applicant must be able to pay the established room and board rate.
- *Client Agreement:* The consumer must sign a client-agency agreement to participate in the program.
- *Cost Cap:* The consumer's Assisted Living service plan costs may not exceed $27,042.70 in a twelve-month period.

  2250/mm
- *Available Slot:* The consumer may be enrolled if there is an available CMS-approved, unduplicated slot for the current program year.

*Reference:*
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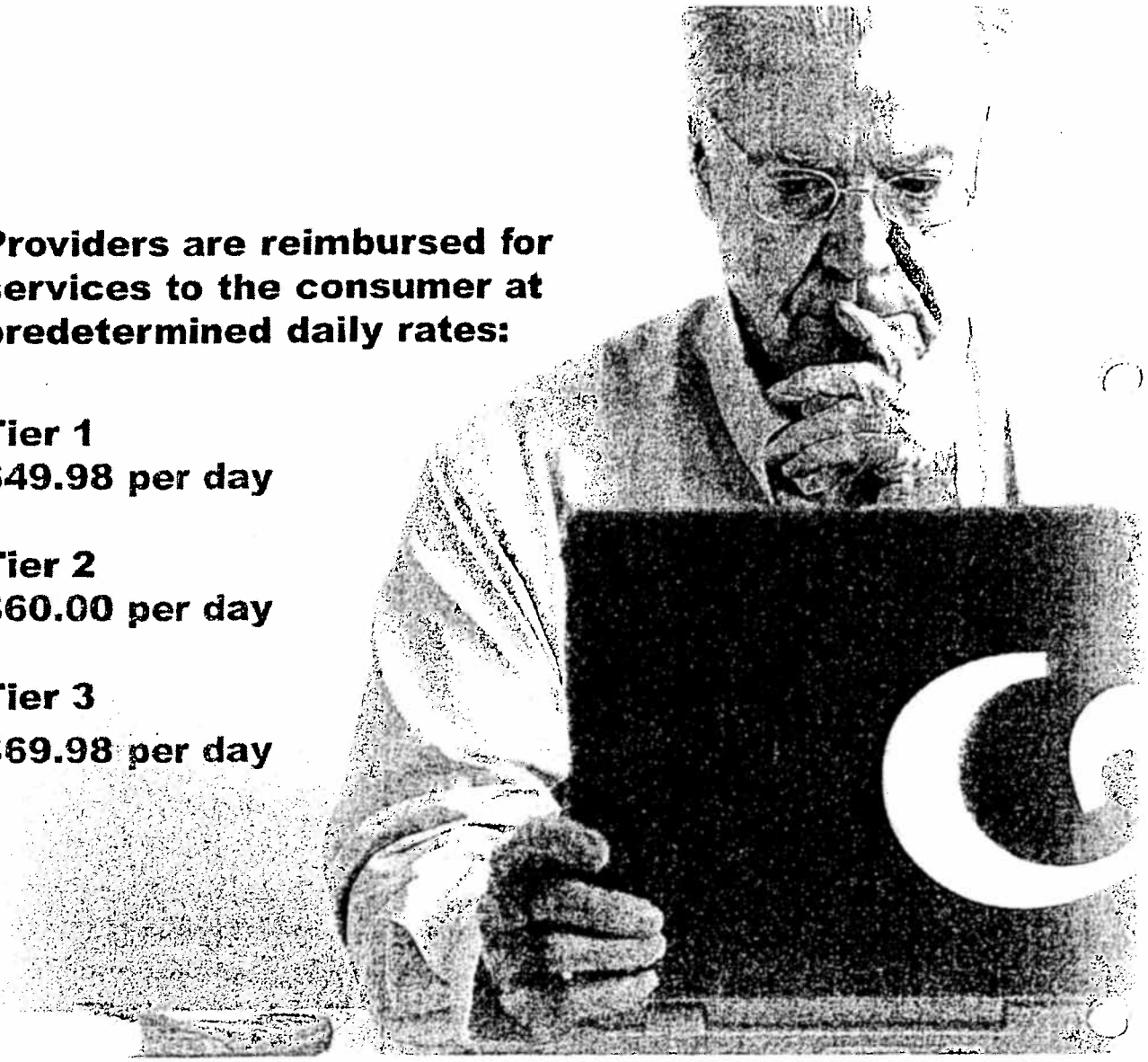
*OAC 5101:1-37 (Medicaid)*
*OAC 5101:1-39 (Medicaid)*
*OAC 5101:3-3-05 (Skilled Level of Care)*
*OAC 5105:3-3-06 (Intermediate Level of Care)*

# Provider Reimbursement Rate

The provider reimbursement rate is divided in to two parts:

- Monthly room and board costs based on the current SSI benefit rate, minus $50, paid directly to the provider by the consumer; and 573.
- A monthly reimbursement for assisted living services, paid through the Medicaid waiver.

If the participant's monthly income exceeds the current SSI benefit rate, he or she will be required to make a client liability payment to the provider toward the cost of services.



# Three-Tier Model of Reimbursement

Reimbursement is determined by the consumer's needs on four variables: cognitive functioning, medication administration assistance, nursing care and physical functioning. The tier level is based on an assessment conducted by the AAA.

| Category | Tier 2 | Tier 3 |
|---|---|---|
| **Cognitive Functioning** | Occasional prompts | Daily cuing and prompts | Ongoing cuing, prompts and redirection |
| **Medication Administration** | Independent with medications (requires no staff involvement) | Supervision with medication management (staff involvement with procurement, storage and reminders) | Medication administration by qualified staff |
| **Nursing** | No Individualized, scheduled, hands-on care provided by a licensed nurse | Weekly and/or monthly individualized, hands-on care provided by a licensed nurse | Daily nursing care due to an unstable medical condition, or intermittent skilled nursing care provided by the facility |
| **Physical Functioning** | Requires up to 2.75 hours of service per day | Requires more than 2.75 hours but less than 3.35 hours of servce per day | Requires more than 3.35 hours of service per day |

# *Join the Community of Providers*

Contact your Area Agency on Aging
to request an application packet:

**Area Office on Aging of Northwestern Ohio, Inc.**
2155 Arlington Avenue
Toledo, OH 43609
419-382-0624

To learn more about the Ohio Department of Aging
and the Assisted Living Waiver Program,
or locate your Area Agency on Aging:

**www.goldenbuckeye.com**
**1-866-243-5678**

**Changing the Face of Aging**
Ted Strickland, Governor • Barbara E. Riley, Director

Ohio Department of Aging is an equal opportunity employer and service provider.

# Program Profile

## Assisted Living Medicaid Waiver Program

Ohio Department of Aging
50 W Broad St/9th Fl
Columbus, OH
43215-3363

www.GoldenBuckeye.com
1-866-243-5678

**What is the Assisted Living Medicaid Waiver Program?**

- This Medicaid waiver program provides services in certified residential care facilities to delay or prevent nursing facility placement.
- Assisted living promotes aging in place by supporting consumer desire for independence, choice and privacy. The services help preserve the independence of the individual, as well as maintain ties to family and friends.

**Who is eligible for the Assisted Living Waiver Program?**

Eligible participants must:

- Be current nursing facility residents or existing Medicaid waiver (PASSPORT, Ohio Home Care, Choices) participants ;
- Be age 21 or older;
- Need hands-on assistance with dressing, bathing, toileting, grooming, eating or mobility and have unpredictable needs for assistance with activities of daily living;
- Meet the financial criteria for Medicaid eligibility (see below); and
- Be able to pay room and board.

*Individuals currently residing in an Assisted Living facility are not eligible.*

**What are the financial eligibility criteria for the Assisted Living Waiver Program?**

- County Departments of Job and Family Services determine financial eligibility of interested participants.
- Individuals may not have countable assets valued at more than $1,500.
- Monthly income must not exceed 300 percent of the Social Security Insurance benefit.
- Depending on income, participants may be required to pay a *patient liability* each month toward the cost of services.

**Who Provides Assisted Living Services?**

Providers must be:

- Licensed as a residential care facility by the Ohio Department of Health; and
- Certified by the Ohio Department of Aging as an Assisted Living Provider.

**Continued...**

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Merle Grace Kearns, Director • Bob Taft, Governor

Continued...

**What services are provided by the Assisted Living Waiver Program?**

Two types of services are provided by the program:

- **Assisted Living Services** include: 24 hour on-site response, personal care, supportive services (housekeeping, laundry, and maintenance), nursing, and transportation, 3 meals per day and social/recreational programming.
- **Community Transition Services** are available to individuals leaving a nursing facility to enroll in the Assisted Living waiver and helps them obtain essential household furnishings and other items.

**How do I apply for the Assisted Living Waiver Program?**

- Call toll-free **1-866-243-5678** to contact the Area Agency on Aging serving your community for details on how to apply.
- Interested individuals must complete an application, telephone screen and in-person assessment.
- Then, your county Department of Job and Family Services will determine financial eligibility.
- After meeting all eligibility criteria, you will be enrolled (pending slot availability).

**Where can I learn more about the Assisted Living Waiver Program?**

- Visit the following Ohio Department of Aging Web page for more information about the Assisted Living Waiver. **www.goldenbuckeye.com/families/alwaiver.html**

TF?

## LEVELS OF CARE

| TIER ONE | TIER TWO | TIER THREE |
|---|---|---|
| $50.00 Per Day ($1,500.) per mo. | $60.00 Per Day ($1,800.) per mo. | $70.00 Per Day ($2,100.) per mo.per person |

Add the monthly room and board rate of $573.00 per month. We bill this in advance.

| TIER ONE | TIER TWO | TIER THREE |
|---|---|---|
| $2,073 per mo. | $2,373. per mo. | $2,673.00 per mo. Per person |

TIER ONE: Requires Intermittent cuing and prompts.
Independent with medication management.
No nursing care
Individuals who require up to 2.75 hours of service per day.

TIER TWO: Requires 24 hour supervision to prevent harm to self/others
Medication management supervision
Weekly or monthly nursing care for routine health monitoring/management
Individuals who require more than 2.7 hours and less than 3.35 hours of Service per day.

TIER THREE: 24 hour supervision to prevent harm to self/others.
Medication Administration by qualified licensed staff.
Daily nursing care due to an unstable medical condition
Individuals who require more than 3.35 hours of service per day.

The liablility payment could equal as high as $700.00. This is determined by the case manager from COAAA.

## COMMUNITY TRANSITION FEE

Community transition services are designed to assist eligible consumers with the costs associated with leaving a nursing facility to establish a residence in an assisted living facility .

It includes:

1.) The purchase of essential furnishings not provided by the consumer's assisted living facility.
2.) The purchase of essential household supplies and incidentals not provided by the consumer's assisted living facility
3.) The payment of any set-up fees and/or deposits required for telephone services.

Case managers approve the items they need and the amount they have to spend.
The facility pays up front, documents all receipts and then is reimbursed by COAAA
All transactions, receipts and signatures of accepting the merchandise is placed in the patients chart.
The consumer has sixty days to purchase the items. The provider (facility) must assist in the purchase and delivery.
The maximum amount is $1,500.00.

**EXHIBIT 9** *Supportive Services Plan (SSP)*

*(f) A support/commitment letter from EACH listed proposed funding source per paragraph (e) above, for the planned meals and supportive services listed in the application. The letter must cover the total planned annual commitment (and multi-year amount total, if different), length of time for the commitment, and the amounts payable for each service covered by the provider/paying organization.*

The Ohio Department of Aging which administers the Medicaid Waiver program is in support of this application. As the primary funding source for the program, they have provided a "Letter of Support" which outlines the total planned annual commitment, length of time for the commitment, and the amounts payable for each service covered, which is a daily rate.

**Please see the attached letter indicating third party reimbursement sources for the ALF Program and an informational brochure from the State of Ohio on its Medicaid waiver program.**

Ohio | Department of Aging

**Ted Strickland**, Governor
**Barbara E. Riley**, Director

October 1, 2009

Scott Hunley
U.S. Department of Housing & Urban Development
Federal Office Building
200 North High Street
Columbus, Ohio 43215

Dear Mr. Hunley:

The Ohio Department of Aging (ODA) enthusiastically supports the National Church Residences' (NCR) application to convert three additional floors of the *Portage Trail Village* into an assisted living facility through HUD's Assisted Living Conversion Grant program.

ODA understands that NCR will convert 48 unit of affordable housing into 39 assisted living units. This conversion supports the ODA's goal of allowing low-income elderly individuals to age in place and expands the availability of assisted living waiver services.

ODA administers Ohio's Assisted Living Medicaid Waiver Program. The waiver program is in the fourth year of operation and the demand for assisted living waiver services continues to grow. At the end of SFY 09, over 1500 consumers were enrolled in the waiver and more than 650 eligible consumers were waiting for enrollment. Approximately, 23% of eligible consumers in need of a qualified and willing provider are located in the region served by the Portage Trail Village community. In September 2009, the state submitted a request to CMS to expand the approved waiver slots from 1800 to 3009.

To quality for this program, eligible participant must meet Medicaid financial eligibility requirements and require hands-on assistance with two or more activities of daily living. The assisted living waiver service is provided within a three-tier reimbursement cost structure and includes: 24 hour on-site response, personal care, housekeeping, laundry, maintenance, nursing, transportation, 3 meals a day, and social/recreational programming. An individual service plan is developed for each consumer and determines the tier reimbursement (Tier I: $50.00/day; Tier 2: $60.00/day; Tier III: $70.00/day). If all 39 current residents are eligible for waiver enrollment and require the highest level of service (Tier III), an annual service payment to the ALCP would be $81,900 per month or $982,800 annually.

ODA is developing an additional waiver service, Enhanced Community Living, to increase enriched housing options in Ohio. The Enhanced Community Living service builds upon the benefits offered by traditional personal care/homemaker services by utilizing a flexible service delivery approach and will provide on-site access to personal care, health status monitoring and care coordination to tenants of subsidized housing communities such as Portage Trail

Village. Tenants residing in the remaining unlicensed portion of the Portage Trail Village site who are enrolled in the ODA administered Medicaid waiver would be able to access this service. The availability of the new waiver service at Portage Trail Village would result in an affordable housing community that can offer three levels of service: independent, enhanced, and assisted living.

Affordable assisted living services and enriched housing settings are very much needed in the State of Ohio. We applaud NCR for submitting this application to increase the availability of housing with services in our state. We hope the U.S. Department of Housing & Urban Development looks favorably upon their application.

Sincerely,

Barbara E. Riley, Director

CC: Michelle Norris, NCR Senior Vice President/ Chief Development Officer
Hope Roberts, ODA, Assisted Living and RSS Manager

**Program Profile**

# Assisted Living Medicaid Waiver Program

## What is the Assisted Living Medicaid Waiver Program?

- This Medicaid waiver program provides services in certified residential care facilities to delay or prevent nursing facility placement.
- Assisted living promotes aging in place by supporting consumer desire for independence, choice and privacy. The services help preserve the independence of the individual, as well as maintain ties to family and friends.

## Who is eligible for the Assisted Living Waiver Program?

Eligible participants must:

- Be current nursing facility residents or existing Medicaid waiver (PASSPORT, Ohio Home Care, Choices) participants OR current residents of residential care facilities who have paid privately for at least six months;
- Be age 21 or older;
- Need hands-on assistance with dressing, bathing, toileting, grooming, eating or mobility;
- Meet the financial criteria for Medicaid eligibility (see below); and
- Be able to pay monthly room and board.

## What are the financial eligibility criteria for the Assisted Living Waiver Program?

- County Departments of Job and Family Services determine financial eligibility of interested participants.
- Individuals may not have countable assets valued at more than $1,500.
- Monthly income must not exceed 300 percent of the Social Security Insurance benefit. - $1,911
- Depending on income, participants may be required to pay a *patient liability* each month toward the cost of services.

## Who Provides Assisted Living Services?

Providers must be:

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Continued...

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Barbara E. Riley, Director • Ted Strickland, Governor

Continued...

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Two types of services are provided by the program:

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- **Community Transition Services** are available to individuals leaving a nursing facility to enroll in the Assisted Living waiver and helps them obtain essential household furnishings and other items.

**How do I apply for the Assisted Living Waiver Program?**

- Call toll-free **1-866-243-5678** to contact the Area Agency on Aging serving your community for details on how to apply.
- Interested individuals must complete an application, telephone screen and in-person assessment.
- Then, your county Department of Job and Family Services will determine financial eligibility.
- After meeting all eligibility criteria, you will be enrolled (pending slot availability).

**Where can I learn more about the Assisted Living Waiver Program?**

- Visit the following Ohio Department of Aging Web page for more information about the Assisted Living Waiver.
  **www.goldenbuckeye.com/families/alwaiver.html**

Company

Inside:

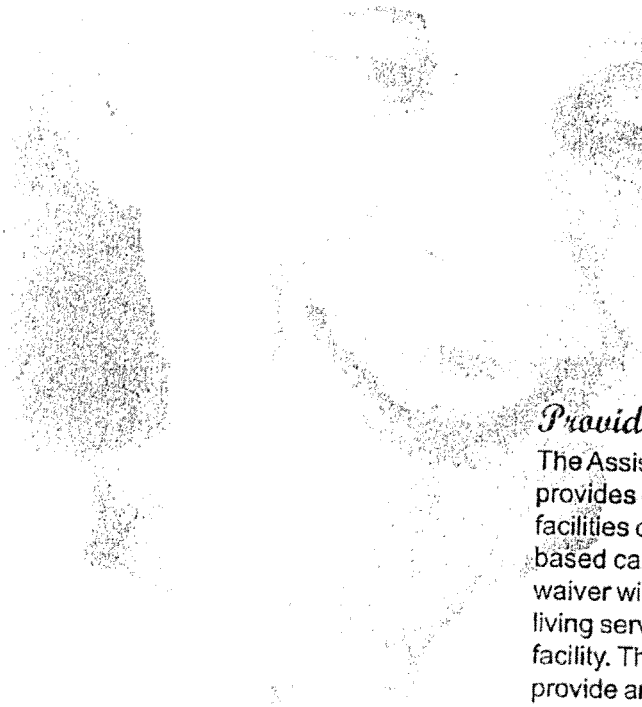
- Covered Costs in the Assisted Living Waiver Program
- Out-of-Pocket Costs for Consumers
- Provider Qualifications
- Provider Certification and Timeline
- Identifying a Potential Assisted Living Waiver Customer
- Provider Reimbursement Rate
- Three-Tier Model of Reimbursement

Assisted Living Waiver

Community of Providers

# Assisted Living Waiver

Greater Northwestern Ohio Community of Providers



## Assisted Living Waiver Program

The Assisted Living Waiver Program is a statewide, federally approved home- and community-based services waiver program that helps certain Medicaid-eligible Ohioans access services in a residential care facility. Created by the Ohio General Assembly, the program opened July 1, 2006, with the potential of serving 1,800 participants during the first year of operation (state fiscal year 2007, ending June 30, 2007).

## Providing Consumer Choices

The Assisted Living Waiver Program provides consumers who are in nursing facilities or who are receiving community-based care under another Medicaid waiver with the option to receive assisted living services in a residential care facility. The program is not designed to provide an alternative source of payment for existing assisted living residents.

## Evaluating Program Progress

Scripps Gerontology Center at Miami University, the Margaret Blenkner Research Institute at Benjamin Rose and the Jessie Richardson Foundation will conduct an independent evaluation of the program over its first year of operation. The focus of the evaluation will be consumer access, service planning and assessment, overall cost effectiveness for the state and the impact on consumers. The final evaluation report is due June 30, 2007.

# You're in good company

## Covered Costs in the Assisted Living Waiver Program

The Assisted Living Waiver Program pays for two distinct groups of services:

- *Assisted Living:* Monthly reimbursement for assisted living services.
- *Community Transition:* One-time allowance of up to $1,500, based on need, to transition from a facility to assisted living.

*Consumers also receive a Medicaid card that can be used to pay for physician visits, nursing services, therapies and other services.*

## Out-of-Pocket Costs for Consumers

Monthly room and board costs for the consumer are based on the current SSI benefit rate, minus $50. If his or her monthly income exceeds the set rate, he or she will make a client liability payment toward the cost of services. Contact your Area Agency on Aging for the current rate.

## Provider Qualifications

To become a certified Assisted Living Waiver Program provider, the interested facility must:

1. Be licensed by the Ohio Department of Health as a residential care facility;
2. Provide single occupancy living units with a bathroom, an identifiable space for socialization and the ability to be locked; and
3. Demonstrate a capacity to provide, directly or through contract, personal care, supportive services, three meals per day, social and recreational programming and non-medical scheduled transportation and nursing services (OAC 173.39-02.16).

There is no minimum or maximum number of participants a facility can serve and the facility does not have to reserve units for waiver participants.

For a complete list of provider requirements and expectations, contact your Area Agency on Aging.

## Join the Community

Certified providers are listed in a special online directory designed to guide consumers to participating facilities in their area.
**www.goldenbuckeye.com/families/alwaiver_lookup.html**

## *Provider Certification and Timeline*

The Ohio Department of Aging (ODA) strives to make the mandatory provider certification process as efficient as possible. The process is a cooperative effort between ODA, the Ohio Department of Health (ODH) and the Ohio Department of Job and Family Services (ODJFS), coordinated by ODA and the Area Agency on Aging (AAA). The AAA will provide technical assistance to the interested provider throughout the process.

**Overview of the certification process with maximum timelines:**

1. The interested residential care facility contacts the AAA serving the region in which the facility is located for an application packet, then returns the completed and signed application to the same AAA.

2. **Within 45 business days** of receipt of the signed application, ODH will conduct an on-site review and report its findings to the AAA.

3. **Within 30 business days** of the ODH review, the AAA will notify the applicant of any unmet requirements.

   - If the applicant meets all requirements, the AAA will recommend to ODA that the facility be Certified.
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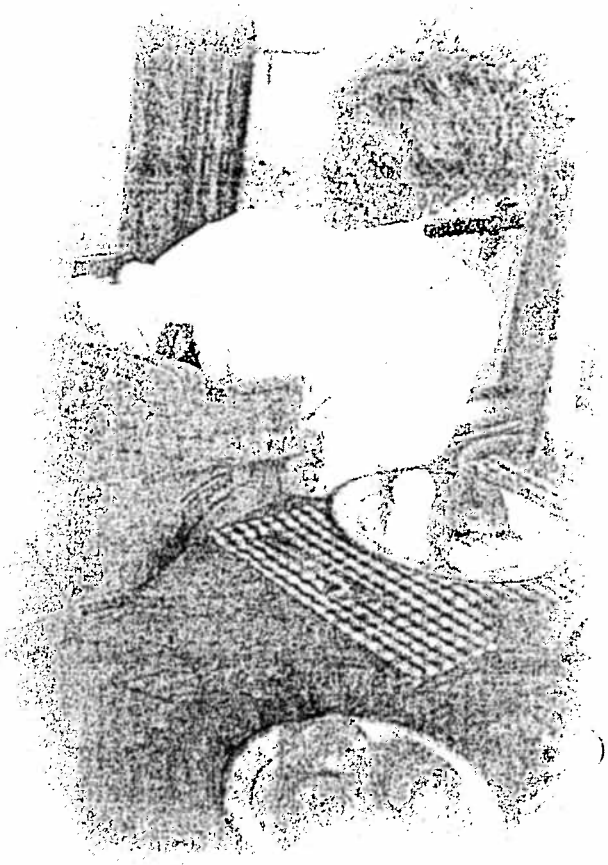

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  2250/mn
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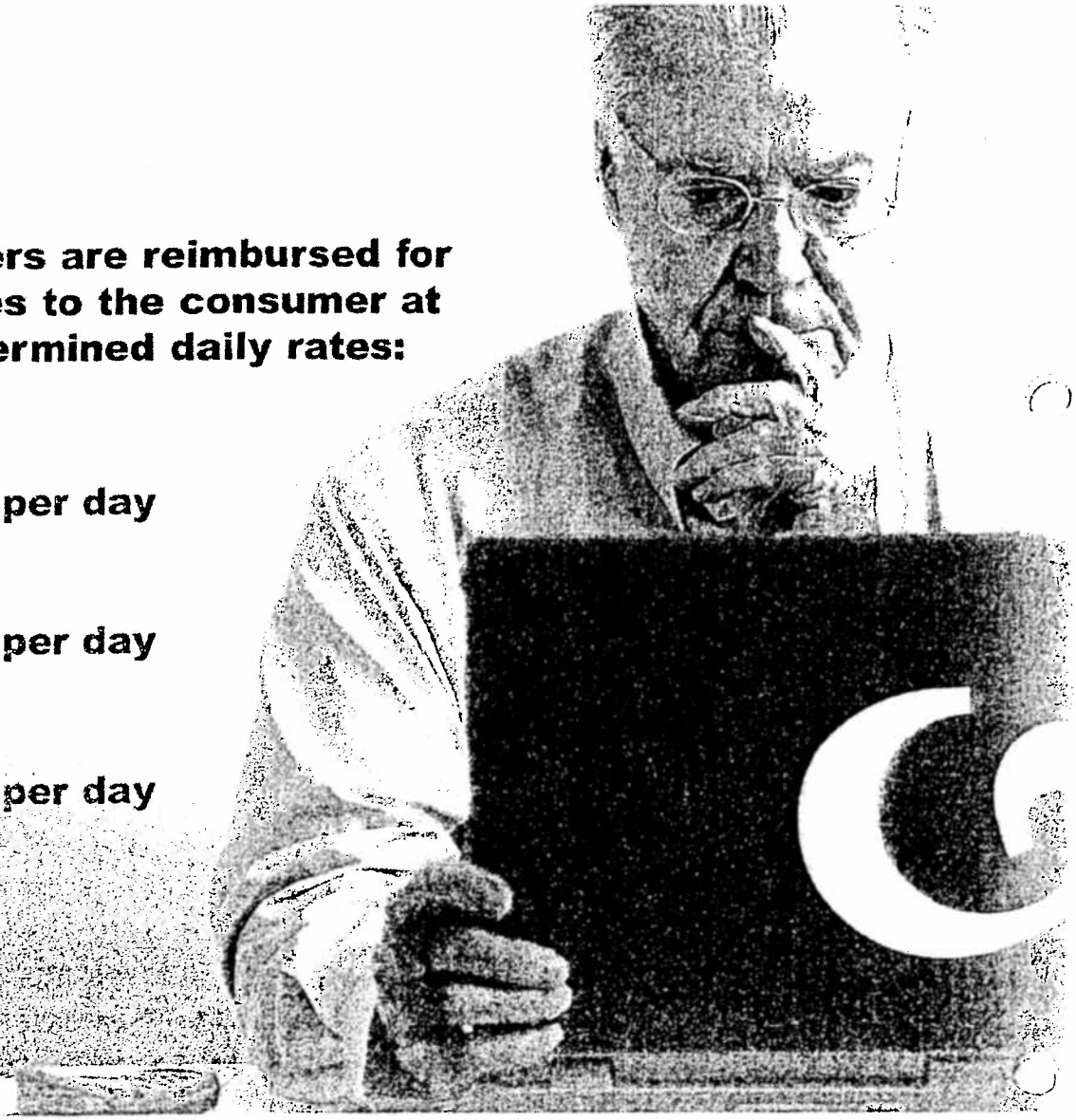

**Providers are reimbursed for services to the consumer at predetermined daily rates:**

**Tier 1**
**$49.98 per day**

**Tier 2**
**$60.00 per day**

**Tier 3**
**$69.98 per day**