

Department of Health
 Continuing Care Branch
 Long Term Care

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RESIDENTIAL CARE FACILITY

Facility Name:		Date:
Mailing Address:		
Phone:		(902)
Fax:		(902)
Owner:		Administrator:
Bed capacity (excluding respite):	No. of approved respite beds:	Date of last licensing visit:

Licensing recommendations and actions taken since last license:	Actions:
1.	
2.	
3.	
4.	

B. RESIDENT INFORMATION

RESIDENT DIAGNOSIS

Please provide the following, based on your current resident population:

<i>Diabetics</i>	<i>No. of residents diet controlled:</i>	
	<i>No. of residents on oral hypoglycemics:</i>	
	<i>No. of residents receiving insulin:</i>	
	<i>Total:</i>	
<i>Dementias</i>	<i>No. of residents diagnosed with ALZHEIMERS:</i>	
	<i>No. of residents diagnosed with other dementias:</i>	
	<i>No. of residents non diagnosed but demonstrating similar symptoms of dementia:</i>	
<i>Specific Diagnosis</i>	<i>No. of residents with HUNTINGTONS:</i>	
	<i>No. of residents with PARKINSONS:</i>	
	<i>No. of residents with ALS:</i>	
	<i>No. Of residents with MS:</i>	
	<i>No. of residents with MD:</i>	
	<i>No. of residents with post traumatic brain injury:</i>	
	<i>No. of residents with spinal cord injury:</i>	
	<i>No. of residents diagnosed with psychiatric illness:</i>	

Please list your five (5) top diagnoses based on frequency:

List any other diagnosis that is of special significance in your facility:

NOTE: (Please complete Appendix I on Resident Information contained in this package)

RESIDENT AGE		
Age Groups	Number of Persons	
	Male	Female
18 - 44		
45 - 64		
65 - 69		
70 - 74		
75 - 79		
80 - 84		
85 - 89		
90 - 94		
95 - 99		
100+ (state age)		

Average age on admission:
Average age of total current population:

RESIDENT CARE (Note: Some may not apply)			
No. of residents with the following:		(Current Information)	
Description	Number	Description	Number
Indwelling Catheters: <ul style="list-style-type: none"> • • • <i>Other</i> 		Gastrostomy: <ul style="list-style-type: none"> • • Jejunostomy <ul style="list-style-type: none"> • • 	

<i>Colostomies:</i> <ul style="list-style-type: none"> • • • 		<i>Oxygen Concentrator</i> <ul style="list-style-type: none"> • • <i>O2 tanks on site:</i> <i>Sizes:</i> <ul style="list-style-type: none"> • 	
<i>Incontinent Residents</i> <i>Type of system used:</i> <ul style="list-style-type: none"> • • 		<i>Tracheostomy</i> <i>Hemodialysis</i> <i>Peritoneal Dialysis</i>	
<i>Skin Breakdown:</i> <ul style="list-style-type: none"> • • 		<i>Brief Description</i>	
<i>RESIDENT CARE DOCUMENTATION</i>			
<i>No. of Level 1:</i>			
<i>No. Of Level 2:</i>			
<i>Method of Resident Care Document:</i>			
<i>Describe:</i>			

C. PHYSICIAN SERVICES

Name of Medical Advisor(s):

Dr.

No. of other general practitioners who service home:

Do physicians see residents on site?

If not, describe process:

If they are mobile, they go to the office.

How are physicians orders obtained and recorded?

Are there any costs incurred by the Home from physicians?

Have all residents been personally seen by a physician in the last 12 months?

D. PHARMACEUTICAL SERVICES

Provide the name and address of the licensed pharmacy providing services for this facility:

Provide the name of the pharmacist who is the usual contact person for regular ongoing communications and on-site visits:

<i>From where are Over The Counter (OTC) drugs purchased?</i>	<i>A. Pharmacy</i>	<i>B. Facility</i>	<i>C. Other</i>
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PACKAGING:

<i>are:</i>	<i>Blister Pack</i>	<i>Rx</i>	<i>in vial</i>	<i>Stock</i>
<i>a) regular scheduled prescriptions for individuals</i>				
<i>b) regular scheduled OTC medications</i>				
<i>c) PRN medications</i>				
<i>d) Stock medications</i>				

Is the pharmacy involved in the removal and disposal of outdated or unused medication from the facility?

If No, then describe the current disposal process.

Are medications reordered quarterly?

What is your process?

Method of documentation of medication administration:

Who administers medication?

E. DIETARY

NUTRITIONAL CARE

MENU

Number of cycles:

Is menu posted throughout home?

Are choices made available?

Comments:

Are the Menus reviewed by a Dietitian?

Yes

No

NUTRITIONAL SUPPLEMENTS & SPECIAL DIETS

No. of residents receiving supplements:

Monthly Average:

No. of residents eating in their rooms:

No. and types of special diets:

DINING AREA(S)

No. of dining areas:

No. of meal settings:

*Range of Resident
Meal Hours*

Breakfast

Lunch

Supper

Comments:

KITCHEN

*Preventative Maintenance
Schedule:*

Yes

No

Monthly

Quarterly

<i>Refrigerator/Freezer:</i>	<i>Clean floors, shelves, walls, doors:</i>	
	<i>Food properly covered and labelled:</i>	
	<i>Containers of food stored off floor:</i>	
<i>Types of Audits and Frequency Completed:</i>		
<i>Comments (Examples):</i>		

F. ENVIRONMENTAL SERVICES

HOUSEKEEPING

Are resident rooms clean, tidy and free of clutter? *Yes* *No*

Comments:

Are bedspreads/draperies in good order and repair? *Yes* *No*

Comments:

Are there lingering odours? *Yes* *No*

Comments:

Is soiled laundry self-contained until laundered? *Yes* *No*

Comments:

Are Housekeeping carts clean *Yes* *No*

Are chemicals secured? *Yes* *No*
In utility rooms? *Yes* *No*

Number of housekeeping audits completed *Quarterly* *Yearly*

G. PHYSICAL PLANT

<i>Age of building: years</i>	<i>New additions added with dates:</i>	
<i>Type of structure:</i>		
<i>Square footage:</i>		
<i>No. of levels/floors:</i>	<i>No. of bathrooms:</i>	<i>Are they ventilated?</i>
	<i>No. of tubs/shower rooms:</i>	<i>Yes No</i>
<i>Is there adequate space to implement services?</i>		<i>Yes No</i>
<i>Is there adequate storage space?</i>		<i>Yes No</i>
<i>Comments:</i>		
<i>Type of Heat:</i>		
<i>Air exhaust system:</i>		<i>Yes No</i>
<i>No. of smoking areas:</i>	<i>Residents:</i>	<i>Staff:</i>
<i>Are they ventilated and enclosed?</i>		<i>Yes No</i>
<i>Schedule for painting/decorating:</i>		
<i>Preventative maintenance program:</i>		<i>Yes No</i>
<i>for building</i>	<i>Yes</i>	<i>No</i>
<i>for equipment</i>	<i>Yes</i>	<i>No</i>
<i>What maintenance programs are contracted?</i>		
<i>Regular Inspection</i>		
<i>of electrical appliances</i>	<i>Yes</i>	<i>No</i>
<i>of resident equipment i.e., wheelchairs, lifts, etc.</i>	<i>Yes</i>	<i>No</i>

<i>Is there policy for electrical equipment in resident rooms?</i>	<i>Yes</i>	<i>No</i>
<i>Is there process for reporting/correcting maintenance deficiencies?</i>	<i>Yes</i>	<i>No</i>
<i>Is there process for resident to request maintenance/repairs?</i>	<i>Yes</i>	<i>No</i>
<i>Are doorways, corridors and stairs free from obstacles?</i>	<i>Yes</i>	<i>No</i>
<i>Exit doors have automatic alarms</i>	<i>Yes</i>	<i>No</i>
<i>Residents have easy access to outdoors</i>	<i>Yes</i>	<i>No</i>

H RECREATION SERVICES

Please describe recreation activities:

Are there day programs?

Are there evening/weekend programs?

Please Attach A Copy Of Last Month's Act. Cal.

RESIDENT PARTICIPATION

Is there a Resident Council?

Name of President:

Identify opportunities for resident input into program and special event planning:

What percentage of the population is actively involved in programs?

Are resident participation statistics recorded for every program/service?

Is resident participation monitored on an individual basis?

Identify resident linkages with the community:

Indicate ways in which your Home promotes/supports involvement of family members:

Describe Pastoral Care Program:

I. ADMINISTRATION

Is there liability insurance?

Expiry Date:

Amount:

DEPARTMENTAL DIRECTIVES - DO YOU HAVE?

Policy & procedure manuals?

POLICIES

<i>Is there a written policy for:</i>	<i>Yes</i>	<i>No</i>	<i>Date Reviewed</i>	<i>Audited/ Validated</i>
<i>Physical Restraint:</i>				
<i>Resident at Risk</i>				
<i>Smoking - Staff</i>				
<i>Handling Resident Funds</i>				
<i>Personal Use Allowance</i>				
<i>Confidentiality</i>				

STAFF EDUCATION PROFILE (as per Residential Care Facility Guidelines)

The following training is required to meet the minimum standard. Have you & your staff participated in training/workshops in the following areas:

	<i>How Many?</i>	<i>How Many?</i>
<i>Food Handler's</i>	<i>Yes</i>	<i>No</i>
<i>Fire and Life Safety</i>	<i>Yes</i>	<i>No</i>
<i>Medication Awareness</i>	<i>Yes</i>	<i>No</i>
<i>Crisis Intervention</i>	<i>Yes</i>	<i>No</i>
<i>Standard First Aid & CPR</i>	<i>Yes</i>	<i>No</i>
<i>If yes, is training current?</i>	<i>Yes</i>	<i>No</i>
<i>Basic Principles and Practices of Personal Care</i>	<i>Yes</i>	<i>No</i>
<i>Have you/staff successfully completed a formal training course?</i>	<i>Yes</i>	<i>No</i>

Please list with date completed:

Percentage of total staff who have completed Alzheimers Related Dementia course:

List outside educational groups who receive training within your Centre:

How are educational needs identified?

Identify future educational needs for all disciplines:

Is there an orientation program for staff?

J. SAFETY COMMITTEES

FIRE AND LIFE SAFETY ISSUES

Fire Marshal's Report	Date:	Deficiencies:
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Actions to comply:

Emergency lights functioning when tested at time of visit?

Is there a generator?

Does the Facility have a sprinkler system?

If yes, system date:

Is there a Fire and Life Safety Education Program within the Facility?

Who is the person responsible?

Who is responsible for fire drills?

Frequency:

Are there records of staff who:	a) have participated in drills:	
	b) have participated in yearly fire and life safety programs:	

DISASTER PLAN (EMO)

Date of Plan:	Date Submitted:	Date Approved:
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Date of Fan Out Exercise:	Date Exercised:
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HEALTH INSPECTION

Department of Agriculture Health Inspector Report Date:	Deficiencies:
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<i>Was entire facility inspected?</i>	
<i>Is current Eating Establishment License posted?</i>	
<i>Is there a beauty salon?</i>	
<i>Is there a Cosmetology License posted?</i>	<i>Expiry Date:</i>
<i>Is hairdresser's current license posted?</i>	
OCCUPATIONAL HEALTH AND SAFETY	
<i>Is there an Occupational Health and Safety Committee?</i>	
<i>Name of Chairperson:</i>	
<i>Frequency of Committee Meetings:</i>	
<i>Do the minutes of the meetings indicate that the intent of the legislation is being met?</i>	
<i>Are minutes available for staff?</i>	
<i>Occupational Health and Safety Inspection Visit Date:</i>	
<i>Deficiencies:</i>	
WHMIS	
<i>Who is responsible for WHMIS staff education?</i>	
<i>Are all staff trained annually?</i>	
<i>Date of last review/revision of manuals:</i>	
<i>Are MSDS sheets present in required areas?</i>	
<i>Are chemicals safely stored?</i>	
<i>Are chemicals labelled appropriately?</i>	

