

ASSISTED LIVING DISCLOSURE STATEMENT

The purpose of this Disclosure Statement is to empower consumers by describing a facility's policies and services in a uniform manner. This format gives prospective residents and their families consistent categories of information from which they can compare facilities and services. By requiring the Disclosure Statement, the department is not mandating that all services listed should be provided, but provides a format to describe the services that are provided.

The Disclosure Statement is not intended to take the place of visiting the facility, talking with residents, or meeting one-on-one with facility staff. Rather, it serves as additional information for making an informed decision about the care provided in each facility.

INSTRUCTIONS TO THE FACILITY

1. Complete this Disclosure Statement according to the care and services that your facility provides. You may not amend the statement, but you may attach an addendum to expand on your answers.
2. Provide copies of and explain this Disclosure Statement to anyone who requests information about your facility.

Facility Name	License No.	Average No. Residents	Telephone No.
Address (Street, City, State, ZIP)			
Manager			Date Disclosure Statement Completed
Completed By:		Title	

The Assisted Living Licensure Standards are available for review at all assisted living facilities.
A copy of the most recent survey report may be obtained from facility management.

To register a complaint about an assisted living facility, contact:
Texas Department of Human Services at 1-800-458-9858.

I. PRE-ADMISSION PROCESS

A. Indicate services which are not offered by your facility:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Assistance in transferring to/from wheelchair | <input type="checkbox"/> Medication injections | <input type="checkbox"/> Oxygen administration | <input type="checkbox"/> Behavior management for verbal aggression |
| <input type="checkbox"/> Bladder incontinence care | <input type="checkbox"/> Feeding residents | <input type="checkbox"/> Special diets | <input type="checkbox"/> Behavior management for physical aggression |
| <input type="checkbox"/> Bowel incontinence care | <input type="checkbox"/> Intravenous (IV) therapy | | |
| <input type="checkbox"/> Other: _____ | | | |

B. What is involved in the pre-admission process?

- | | | | | |
|--|---|---|--------------------------------------|--|
| <input type="checkbox"/> Facility tour | <input type="checkbox"/> Family interview | <input type="checkbox"/> Medical records assessment | <input type="checkbox"/> Application | <input type="checkbox"/> Home assessment |
| <input type="checkbox"/> Other: _____ | | | | |

C. What services and/or amenities are included in the base rate?

- | | | |
|--|---|--|
| <input type="checkbox"/> Meals (____ per day.) | <input type="checkbox"/> Temporary use of wheelchair/walker | <input type="checkbox"/> Select menus |
| <input type="checkbox"/> Housekeeping (____ days per week.) | <input type="checkbox"/> Barber/beauty shop | <input type="checkbox"/> Licensed nurse (____ hours per day.) |
| <input type="checkbox"/> Activities program (____ days per week.) | <input type="checkbox"/> Special diet | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Incontinence care | <input type="checkbox"/> Personal laundry | |
| <input type="checkbox"/> Transportation (specify): _____ | | |
| <input type="checkbox"/> Other: _____ | | |

D. What additional services can be purchased?

- | | | |
|---|--|--|
| <input type="checkbox"/> Beauty/barber services | <input type="checkbox"/> Injections | <input type="checkbox"/> Minor nursing services provided by facility staff |
| <input type="checkbox"/> Incontinence care | <input type="checkbox"/> Companion | <input type="checkbox"/> Home health services |
| <input type="checkbox"/> Incontinence products | <input type="checkbox"/> Transportation to doctor visits | |
| <input type="checkbox"/> Other: _____ | | |

E. Do you charge more for different levels of care? Yes No

II. ADMISSION PROCESS

A. Does the facility have a written contract for services? Yes No

B. Is there a deposit in addition to rent? Yes No
If yes, is it refundable? Yes No
If yes, when? _____

C. Do you have a refund policy if the resident does not remain for the entire prepaid period? Yes No
If yes, explain: _____

D. What is the admission process for new residents?
 Doctors' orders Residency agreement History and physical Deposit/payment
 Other: _____

E. Does the facility have provisions for special resident communication needs?
 Staff who can sign for the deaf Services for persons who are blind
 Other (explain): _____

F. Is there a trial period for new residents? Yes No
If yes, how long? _____

III. DISCHARGE/TRANSFER

A. What could cause temporary transfer to specialized care?
 Medical condition requiring 24 hour nursing care Unacceptable physical or verbal behavior
 Drug stabilization Resident requires services the facility does not provide
 Other: _____

B. The need for the following services could cause permanent discharge:

<input type="checkbox"/> 24 hour nursing care	<input type="checkbox"/> Sitters	<input type="checkbox"/> Medication injections
<input type="checkbox"/> Assistance in transferring to and from wheelchair	<input type="checkbox"/> Bowel incontinence care	<input type="checkbox"/> Feeding by staff
<input type="checkbox"/> Behavior management for verbal aggression	<input type="checkbox"/> Bladder incontinence care	<input type="checkbox"/> Oxygen administration
<input type="checkbox"/> Behavior management for physical aggression	<input type="checkbox"/> Intravenous (IV) therapy	<input type="checkbox"/> Special diets
<input type="checkbox"/> Other: _____		

C. Who would make this discharge decision?
 Facility Manager Other: _____

D. Do families have input into these discharge decisions? Yes No

E. Is there an avenue to appeal these decisions? Yes No

F. Do you assist families in making discharge plans? Yes No

IV. PLANNING AND IMPLEMENTATION OF CARE (check all that apply)

A. Who is involved in the service plan process?

- Resident Family member Activity directory Attendants Manager
 Licensed nurses Social worker Dietary Physician
 Other: _____

B. Does the service plan address the following?

- Medical needs Nursing needs Activities of daily living Psychosocial status Nutritional status Dental Status
 Other: _____

C. How often is the service plan assessed?

- Monthly Quarterly Annually As needed
 Other: _____

D. How many hours of structured activities are scheduled per day?

- 1-2 Hours 2-4 Hours 4-6 Hours 6-8 Hours 8 + Hours

E. What types of programs are scheduled?

- Music program Arts program Crafts Exercise Cooking
 Other: _____

F. Who assists with or administers medications?

- RN LVN Medication aide Attendant
 Other: _____

V. CHANGE IN CONDITION ISSUES

What special provisions do you allow for aging in place?

- Sitters Additional services agreements Hospice Home health—If so, is it affiliated with your facility? Yes No
 Other: _____

VI. STAFF TRAINING

A. What training do new employees receive?

- Orientation: _____ hours Review of resident service plan On the job training with another employee: _____ hours
 Other: _____

B. Is staff trained in CPR? Yes No
If no, please explain why you do not require CPR training: _____

C. How much ongoing training is provided and how often? (Example: 30 minutes monthly): _____

D. Who gives the training and what are their qualifications?

E. What type of training do volunteers receive?

- Orientation: _____ hours On the job training
 Other: _____

F. In what type of endeavors are volunteers engaged?

- Activities Meals Religious services Entertainment Visitation
 Other: _____

G. List volunteer groups involved with the facility:

VII. PHYSICAL ENVIRONMENT

A. What safety features are provided in your building?

- Emergency call system Fire alarm system Built according to NFPA Life Safety Code, Chapter 12, Health Care
 Sprinkler system Wander Guard or similar system Built according to NFPA Life Safety Code, Chapter 21, Board and Care
 Other: _____

B. Does the facility's environment include the following?

- Plants Pets Vegetable/flower gardens for use by residents
 Other: _____

C. Are the residents allowed to have:

- Plants Pets- If so, is a deposit required? Yes No How much?..... \$ _____

VIII. STAFFING PATTERNS

A. What are the qualifications of the manager?

B. Please list the facility's normal 24-hour staffing pattern on:

1. the attached chart; or
2. a separate attachment which explains your facility's unique staffing policies and patterns. _____

IX. RESIDENTS' RIGHTS

A. Do you have a Resident's Council? Yes No
How often does it meet? _____

B. Do you have a Family Council? Yes No
How often does it meet? _____

C. Does the facility have a formal procedure for responding to resident grievances and suggestions for improvement? Yes No
Is there a Grievance Committee? Yes No
Is there a Suggestion Box? Yes No

D. How can the company that owns the facility be contacted?

