

# Community Advisory Committee Quarterly/Annual Visitation Report

County: Pennsylvania Facility Type: Assisted Living Facility Name: Cedar Mountain Home

Visit Date: 8/17/17 Time Spent in Facility: 1 hour hr: 1 min: 0 Arrival Time: 1:30 pm : 00 am  pm

Person Exit Interview was held with: Cari Keegan, Exec Director Interview was held with: Cari Keegan In-Person or Phone (Circle):  In-Person  Phone

Interview with Administrator:  O  R SIC (Supervisor in Charge):                      Other Staff: (Name & Title):                     

Committee Members Present: Debbie Felker, Sonna Razaq Report Completed by: Debbie Felker

Number of Residents who received personal visits from committee members: 15

Resident Rights Information are clearly visible:  Y  N Ombudsman contact information is correct and clearly posted:  Yes  No Given a corrected sheet

The most recent survey was readily accessible. (Required for Nursing Homes Only):  Y  N Staffing information is posted:  Yes  No

Resident Profile	Comments & Other Observations
1. Do the residents appear neat, clean and odor free? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<p><i>For the most part but one gentleman sitting outside had an odor and 2 rooms had an odor when you walked in</i></p> <p><i>Not seen</i></p>
2. Did residents say they receive assistance with personal care activities, Ex. brushing their teeth, combing their hair, inserting dentures or cleaning their eyeglasses? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you see or hear residents being encouraged to participate in their care by staff members? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
4. Were residents interacting w/ staff, other residents & visitors? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
5. Did staff respond to or interact with residents who had difficulty communicating or making their needs known verbally? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Did you observe restraints in use? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7. If so, did you ask staff about the facility's restraint policies? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Resident Living Accommodations	Comments & Other Observations
3. Did residents describe their living environment as homelike? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p><i>Not sure</i></p> <p><i>- one call light in a room with 2 people - not close to either bed and not really <del>near</del> reachable -&gt; one in the bathroom see reverse side</i></p>
1. Did you notice unpleasant odors in commonly used areas? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
0. Did you see items that could cause harm or be hazardous? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
1. Did residents feel their living areas were too noisy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
2. Does the facility accommodate smokers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2a. Where? <input type="checkbox"/> Outside only <input type="checkbox"/> Inside only <input type="checkbox"/> Both inside and outside.	
3. Were residents able to reach their call bells with ease? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
4. Did staff answer call bells in a timely & courteous manner? <u>NA</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	
4a. If no, did you share this with the administrative staff? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Resident Services	Comments & Other Observations
i. Were residents asked their preferences or opinions about	

This was discussed with Exec Director, Mrs Keegan  
She stated if someone was sick & not getting  
up, they had extra battery operated  
call bells or lights they put next to  
person's bed or they give them a horn  
She stated staff check on everyone every 2 hours  
and if someone had been in hospital or  
had a fall, they are checked every 30  
minutes.

- the activities planned for them at the facility?
- 16. Do residents have the opportunity to purchase personal items of their choice using their monthly needs funds?  Yes  No
- 17. Can residents access their monthly needs funds at their convenience?  Yes  No
- 17a. Are residents asked their preferences about meal & snack choices?  Yes  No
- 18. Do residents have privacy in making and receiving phone calls?  Yes  No
- 19. Is there evidence of community involvement from other civic, volunteer or religious groups?  Yes  No
- 20. Does the Facility have a Resident's Council?  Yes  No

*A meal is planned - if they do not like it, they can have a sandwich*

*Only 1 or 2*

**Areas of Concern**

Are there resident issues or topics that need follow-up or review at a later time or during the next visit?

**Exit Summary**

Discuss items from "Areas of Concern" Section as well as any changes observed during the visit.

*Just lack of call light for people within reach.*

## Instructions For Completing Community Advisory Committee Quarterly / Annual Visit Worksheet

1. County: List the county in which the facility is located
2. Date: Self-explanatory
3. Facility: List the name of the facility and the type of facility (i.e. nursing, adult care, or combination home)
4. Committee member present: List the names of members who participated in the official quarterly (or annual) visit.
5. Committee met with: Explained on form
6. Report completed by: Include name(s)
7. Overview of residents' status: Explained on form
8. Physical environment: Explained on form
9. Services / Activities / Volunteer involvement: Explained on form
10. State needs: Explained on form
11. Problems: Explained on form
12. Summary of Administrator's or SIC's comments: Self-explanatory
13. Copies: Submit the original copy to the Regional Ombudsman