

Community Advisory Committee Quarterly/Annual Visitation Report

County: Trylvania	Facility Type: <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Family Care Home <input checked="" type="checkbox"/> Combination Home <input type="checkbox"/> Nursing Home	Facility Name: <i>Kingsbridge</i>
Visit Date: 8-4-14	Time Spent in Facility: 1 hr 0 min	Arrival Time: 10 : 30 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm
Name of Person Exit Interview was held with:		Interview was held: <input checked="" type="checkbox"/> In-Person

Name: <i>Velina Netherton</i> <i>Trina Riddle</i>	Phone:
Title: <input type="checkbox"/> Check Box <input checked="" type="checkbox"/> Admn. <input checked="" type="checkbox"/> SIC (Supervisor in Charge) <input type="checkbox"/> Other staff	

Committee Members Present: <i>Marty Griffin</i> <i>Madeley Neep</i>	Report Completed by: <i>Marty Griffin</i>
Number of Residents who received personal visits from committee members:	

Resident Rights Information is clearly visible. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Ombudsman contact information is correct and clearly posted. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
The most recent survey was readily accessible. (Required for Nursing Homes Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	Staffing information is posted. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Resident Profile

Comments & Other Observations

1. Do the residents appear neat, clean and odor free? Yes No
2. Did residents say they receive assistance with personal care activities, Ex. brushing their teeth, combing their hair, inserting dentures or cleaning their eyeglasses? Yes No
3. Did you see or hear residents being encouraged to participate in their care by staff members? Yes No
4. Were residents interacting w/ staff, other residents & visitors? Yes No
5. Did staff respond to or interact with residents who had difficulty communicating or making their needs known verbally? Yes No
6. Did you observe restraints in use? Yes No
7. If you did you ask staff about the facility's restraint policies? Yes No

① Most residents were up and moving about

Resident Living Accommodations

Comments & Other Observations

8. Did residents describe their living environment as homelike? Yes No
9. Did you notice unpleasant odors in commonly used areas? Yes No
10. Did you see items that could cause harm or be hazardous? Yes No
11. Did residents feel their living areas were too noisy? Yes No
12. Does the facility accommodate smokers? Yes No
- 12a. Where? Outside only Inside only Both Inside and Outside.
13. Were residents able to reach their call bells with ease? Yes No
14. Did staff answer call bells in a timely & courteous manner? Yes No
- 14a. If no, did you share this with the administrative staff? Yes No

Resident Services

Comments & Other Observations

15. Were residents asked their preferences or opinions about the activities planned for them at the facility? Yes No
16. Do residents have the opportunity to purchase personal items of their choice using their monthly needs funds? Yes No
- 16a. Can residents access their monthly needs funds at their convenience? Yes No
17. Are residents asked their preferences about meal & snack choices? Yes No
- 17a. Are they given a choice about where they prefer to dine? 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

Areas of Concern

Exit Summary

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

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

This Document is a **PUBLIC RECORD**. Do not identify any Resident(s) by name or inference on this form.
Top Copy is for the Regional Ombudsman's Record. Bottom Copy is for the CAC's Records.

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