

20  
7-28

# Community Advisory Committee Quarterly/Annual Visitation Report

County: <i>Pennsylvania</i>	Facility Type:		Facility Name: <i>Transylvania Mission Hospital</i>	
	<input type="checkbox"/> Adult Care Home	<input type="checkbox"/> Family Care Home		
Visit Date: <i>6-9-14</i>	<input checked="" type="checkbox"/> Combination Home	<input type="checkbox"/> Nursing Home		
Time Spent in Facility: <i>1</i> hr <i>0</i> min	Arrival Time: <i>12</i> : <i>20</i> am <input checked="" type="checkbox"/> pm			

Name of Person Exit Interview was held with: \_\_\_\_\_ Interview was held  In-Person

Name: *Erica Dodd* Phone: \_\_\_\_\_

Title: Check Box  Admn.  SIC (Supervisor in Charge)  Other staff

Committee Members Present: *Diana Brown / Madeline D. Meyer* Report Completed by: *Marty Giff*

Number of Residents who received personal visits from committee members: \_\_\_\_\_

Resident Rights Information is clearly visible.  Yes  No Ombudsman contact information is correct and clearly posted.  Yes  No

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

Resident Profile	Comments & Other Observations
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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. So, did you ask staff about the facility's restraint policies?  Yes  No

Resident Living Accommodations	Comments & Other Observations
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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
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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

*NA*  
*NA*  
*NA*  
*NA*

**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.

NO

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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