

# COMMUNITY CARE LICENSING DIVISION

*"Promoting Healthy, Safe and  
Supportive Community Care"*



## Keys to Success

### **Self-Assessment Guide for Residential Care Facilities for the Elderly (RCFE) Pre-Admission Questionnaire**



**CDSS**

CALIFORNIA  
DEPARTMENT OF  
SOCIAL SERVICES

# RESIDENTIAL CARE FACILITY FOR THE ELDERLY

## PRE-ADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist licensees in identifying specific medical and behavioral issues that may affect the placement of and/or services to be provided to prospective residents of Residential Care Facilities for the Elderly (RCFE). The questions on this form should be reviewed with the applicant's responsible party prior to admission to the facility. If the answer to any of the questions on this list is yes; the licensee should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs. It is essential for licensees to ensure, to the extent possible, that the resident's history, medical assessment, prior facility records, if applicable and existing conditions are known and care needs understood prior to admission.

This guide is not intended to be a substitute for reading and understanding the regulations. The regulation section is referenced after each question.

The information on this form supplements the Preplacement Appraisal Information form (LIC 603), but does not replace it. While the information gathered from this form should assist licensees in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Residence:

Own home \_\_\_\_\_ With family \_\_\_\_\_ Board & Care \_\_\_\_\_

Skilled nursing facility \_\_\_\_\_ Hospital \_\_\_\_\_

Reason(s) for Placement in RCFE: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Applicant's Responsible Person, (if applicable) \_\_\_\_\_

**A. INCIDENTAL MEDICAL SERVICES ASSESSMENT**

**YES**      **NO**

**1. Oxygen Administration**

           Does the applicant use oxygen? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(See 87618)

           Does the applicant need assistance? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Exception required. See 87618)

           Does the applicant use liquid oxygen? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Exception required. See 87618(c)(1))

**2. Intermittent Positive Pressure Breathing (IPPB) Machine**

           Does the applicant use an IPPB? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(See 87619)

           Does the applicant need assistance? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87619)

**3. Colostomy/Ileostomy**

           Does the applicant have a colostomy or ileostomy? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87621)

**YES**      **NO**

      Does the applicant need assistance? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Exception required. See 87621)

**4. Enema/Suppository/Fecal Impaction Removal**

      Does the applicant need enemas, suppositories or fecal impaction removal? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87622)

      Does the applicant need assistance? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(See 87622)  
(Procedures must be performed by an Appropriately Skilled Professional [ASP])

**5. Catheter Care**

      Does the applicant have a catheter? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87623)

      Does the applicant need assistance? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Some procedures must be performed by an ASP)

**6. Bowel and Bladder Incontinence**

      Is the applicant incontinent of bowel or bladder? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87625)

**7. Contractures**

      Does the applicant have contractures? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (See 87626)

**YES**      **NO**

      Does the applicant need assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Exception required. See 87626)

      Do the contractures severely affect the applicant's ability to function?  
(If yes, not allowed in an RCFE. See 87626) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**8. Diabetes**

      Does the applicant have diabetes? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (See 87628)

      Does the applicant require assistance with performing or reading  
glucose tests, drawing up injectable medications or administering  
injections? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(See 87628)

(Procedures must be performed by an ASP)

**9. Injections**

      Does the applicant need any injections? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ (See 87629)

      Does the applicant need assistance with drawing up and administering  
the injections? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(See 87629)

(Procedures must be performed by an ASP)

**YES**      **NO**

**10. Healing Wounds**

      Does the applicant have any healing wounds? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Exception required. See 87631)

      Does the applicant have stage 1 or 2 dermal ulcers (bedsores)? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(Exception required. See 87631)

      Does the applicant have stage 3 or 4 dermal ulcers? (If yes, not allowed in an RCFE unless an exception is approved. See 87615)

**11. Bedridden**

      Is the applicant bedridden – unable to reposition or transfer in bed? If yes, please explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(See 87455)

      Is the applicant unable to transfer in and out of bed without assistance? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

      Is the applicant's bedridden status temporary (less than 14 days)? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(See 87455)

      Is the condition permanent or expected to last more than fourteen days? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(See H&S 1569.72)

**YES**    **NO**

**12. Gastrostomy**

- Does the applicant have a gastrostomy? (If yes, not allowed in an RCFE unless an exception is approved. See 87615)

**13. Naso Gastric (NG) Tubes**

- Does the applicant have NG tubes? (If yes, not allowed in an RCFE. See 87615)

**14. Staph Infection**

- Does the applicant have a Staph or other serious infection? (If yes, not allowed in an RCFE unless an exception is approved. See 87615)

**15. Total Care**

- Does the applicant need total care (assistance with ALL activities of daily living-- eating, bathing, dressing, grooming, toileting and transferring)? (If yes, not allowed in an RCFE unless an exception or waiver is approved. See 87615)

**16. Tracheostomies**

- Does the applicant have a tracheostomy? (If yes, not allowed in an RCFE. See 87615)

**17. Hospice**

- Is the applicant currently receiving hospice care? (If yes, please see Self-Assessment Guide on Hospice Care.)

**B. PERSONS WITH DEMENTIA**

**YES**    **NO**

- Does the applicant have Dementia?

- Is the applicant mentally able to respond to an emergency signal or instruction? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(See 87705)

**YES**    **NO**

    Is the applicant mentally unable to respond to an emergency signal or instruction? If yes, explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(See 87705)

**C. BEHAVIORAL ASSESSMENT**

Does the applicant have a history of any of the following behaviors?

**YES**    **NO**

- 1. Physical assaultiveness
- 2. Verbal assaultiveness
- 3. Wandering
- 4. Sexual assaultiveness, molestation or inappropriate sexual activity
- 5. Disruptiveness (screaming, throwing things, argumentative)
- 6. Property destruction
- 7. Careless disposal of smoking materials
- 8. Stealing

If the answer to any of the above is yes, describe the behavior: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Frequency and duration of the behavior(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Approximate date of last occurrence: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What seems to trigger the behavior: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Strategies to deal with the behavior: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have a history of any of the following behaviors?

**YES**      **NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Refusal to take medication              |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Refusal to get medical attention        |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Refusal to bathe or wear clean clothing |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Non-compliance with house rules         |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Self-abuse                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Suicide attempts or suicidal thoughts   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Depression                              |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Alcohol or drug abuse                   |

If the answer to any of the above is yes, describe the behavior: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Frequency and duration of the behavior(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximate date of last occurrence: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What seems to trigger the behavior: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Strategies to deal with the behavior: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**YES**    **NO**

5. Does the applicant use any of the following devices?

- |                          |                          |             |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses     |
| <input type="checkbox"/> | <input type="checkbox"/> | Dentures    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

6. Does the applicant need assistance with any of the following?

<input type="checkbox"/>	<input type="checkbox"/>	Eating. If yes, explain. _____
		_____
		_____
		_____

<input type="checkbox"/>	<input type="checkbox"/>	Bathing. If yes, explain. _____
		_____
		_____
		_____

<input type="checkbox"/>	<input type="checkbox"/>	Dressing. If yes, explain. _____
		_____
		_____
		_____

<input type="checkbox"/>	<input type="checkbox"/>	Grooming. If yes, explain. _____
		_____
		_____
		_____

<input type="checkbox"/>	<input type="checkbox"/>	Toileting. If yes, explain. _____
		_____
		_____
		_____

7. Does the applicant use any of the following?

<input type="checkbox"/>	<input type="checkbox"/>	Cane. If yes, explain.
		_____
		_____
		_____

<input type="checkbox"/>	<input type="checkbox"/>	Crutch. If yes, explain. _____
		_____
		_____
		_____

**YES**    **NO**

    Walker. If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

    Wheelchair. If yes, explain.  
\_\_\_\_\_  
\_\_\_\_\_

    8. Does the applicant have any paralysis? If yes, explain (site, degree, assistance needed) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

    9. Does the applicant require a special diet? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

    10. Does the applicant have any skin condition or history of skin breakdown? If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

    11. Will the applicant require transportation to any appointments or events other than routine local medical appointments? If so, where and how often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant/Responsible Person: \_\_\_\_\_  
*(Signature)*

Date: \_\_\_\_\_

Facility Representative: \_\_\_\_\_  
*(Signature)*

Date: \_\_\_\_\_

Attachments:

**YES**     **NO**

