Texas Dept. of Aging and Disability Services

Form **3647**
November 2004

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.
Crazy Water Retirement Hotel	123941	70	940-327-5800

Address (Street, City, State, ZIP)	
401 N. Oak Ave., Mineral Wells, Texas 76067	
Manager	**Date Disclosure Statement Completed**
Jennifer Lewis	12/14/2009
Completed By:	**Title**
Charles V. Miller Jr	President

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 Aging and Disability Services at 1-800-458-9858.

I. PRE-ADMISSION PROCESS

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

- ☒ Assistance in transferring to/from wheelchair
- ☐ Bladder incontinence care
- ☐ Bowel incontinence care
- ☐ Medication injections
- ☐ Feeding residents
- ☒ Intravenous (IV) therapy
- ☐ Oxygen administration
- ☐ Special diets
- ☒ Behavior management for verbal aggression
- ☒ Behavior management for physical aggression
- ☐ Other: _____

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

- ☒ Facility tour
- ☒ Family interview
- ☐ Medical records assessment
- ☒ Application
- ☐ Home assessment
- ☐ Other: _____

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

- ☒ Meals (_____ per day.)
- ☒ Housekeeping (_____ days per week.)
- ☒ Activities program (_____ days per week.)
- ☒ Incontinence care
- ☒ Transportation (specify): _____
- ☐ Other: _____
- ☐ Temporary use of wheelchair/walker
- ☐ Barber/beauty shop
- ☒ Special diet
- ☒ Personal laundry
- ☒ Select menus
- ☐ Licensed nurse (hours per day.)
- ☐ Injections

D. What additional services can be purchased?

- ☒ **Beauty/barber services**
- ☐ **Incontinence care**
- ☒ **Incontinence products**
- ☐ **Injections**
- ☐ **Companion**
- ☐ **Transportation to doctor visits**
- ☐ **Minor nursing services provided by facility staff**
- ☒ **Home health services**
- ☐ **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**
- ☒ **Drug stabilization**
- ☐ **Other:** _____
- ☒ **Unacceptable physical or verbal behavior**
- ☒ **Resident requires services the facility does not provide**

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

- ☒ **24 hour nursing care**
- ☐ **Assistance in transferring to and from wheelchair**
- ☒ **Behavior management for verbal aggression**
- ☒ **Behavior management for physical aggression**
- ☐ **Other:** _____
- ☐ **Sitters**
- ☐ **Bowel incontinence care**
- ☐ **Bladder incontinence care**
- ☒ **Intravenous (IV) therapy**
- ☐ **Medication injections**
- ☐ **Feeding by staff**
- ☐ **Oxygen administration**
- ☐ **Special diets**

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:** 4 **hours** ☐ **Review of resident service plan** ☒ **On the job training with another employee:** 16 **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): Monthly 1 hour

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

RN and Home Health Agencies

E. What type of training do volunteers receive?

☒ **Orientation:** 4 **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:

Silver Notes

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?..... $300.00

VIII. STAFFING PATTERNS

A. What are the qualifications of the manager?

Assisted Living Certification

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? Monthly

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?

Leisure Life Management, LTD
6206 Evergreen St.
Houston, TX 77081
713-830-5500
713-830-5501 fax

SHIFT TIMES AND STAFFING PATTERNS AT THE FACILITY

Full-Time Personnel

SHIFTS (Enter the hours of each of your facility's shifts.)	NUMBER OF STAFF PER SHIFT						
	R.N.s	L.V.N.s	Attendants	Medication Aides	Activity Workers	Universal Workers	Other Workers
6:00 am - 2:00 pm		1	1			3	
2:00 pm -10:00 pm			1			3	
10:00 pm - 6:00 am			1				
8:00 am - 5:00 pm					1	7	

Part-Time Personnel

SHIFTS (Enter the hours of each of your facility's shifts.)	NUMBER OF STAFF PER SHIFT						
	R.N.s	L.V.N.s	Attendants	Medication Aides	Activity Workers	Universal Workers	Other Workers