FACILITY SELECTION GUIDE

A decision-making tool used during the process of selecting a safe and secure facility for a loved one.

Facility Name: ____

Address: ____

Phone: ____

Resident Capacity: _______________Private Bedrooms: _________Yes ________No

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A. LICENSURE *(check one)*

Facility is: ____ Not Licensed

____ Licensed *(State licensing information available at _____________).*

____ Adult Foster Care

____ Home for the Aged

B. STAFFING

Are criminal background checks completed prior to hiring staff? ____ Yes ____ No

Number of direct care staff on duty: Days/Evenings ___________Overnight _____________

Are staffs required to be awake while on duty, during all shifts? ____ Yes ____ No

Is a nurse (RN or LPN) present in the facility: Days/Evenings? ____ Yes ____ No

Overnight? ____ Yes ____ No

Does staff administer medications? ____ Yes ____ No

C. TRAINING

Training is provided to direct care staff in: *(check all that apply)*

____ Dementia Care

____ First Aid

____ CPR

____ Fire Safety & Emergency Evacuation Procedures

____ Medication Administration

D. SAFEGUARDS

	In Resident Rooms		In Other Areas	
Smoke Detectors	____ Yes	____ No	____ Yes	____ No
Sprinkler Systems	____ Yes	____ No	____ Yes	____ No
Door Alarms	____ Yes	____ No	____ Yes	____ No
Air Conditioning	____ Yes	____ No	____ Yes	____ No

Are alarms audible to staff 24 hours? ___ Yes ___ No

What other forms of supervision/monitoring do you have in place for Individuals with dementia?

____
____
____

E. QUALITY OF LIFE

Are there regular therapy, exercise, and/or social activities at the facility? ____ Yes ____ No

Do you provide a copy of the facilities activities calendar upon request? ____ Yes ____ No

Does the facility provide transportation to activities, appointments, etc.? ____ Yes ____ No

Can resident choose/select/retain: Own Pharmacy? ____ Yes ____ No

Hospice Provider? ____ Yes ____ No

Can residents retain their own physician? ____ Yes ____ No

Is there a care planning process to address each resident's needs and preferences? ____ Yes ____ No

If yes, please describe the process:____
____
____
____
____
____
____
____
____
____
____

F. FEES

Is there a written fee schedule for all costs given to each resident/family member upon request? _____ Yes _____ No

What is the facility's policy for billing a resident during a temporary absence from the facility?

____
____
____
____

Does the facility provide a full refund for any paid interval if the resident leaves the facility permanently for any reason? _____ Yes _____ No

G. DISCHARGE AND GRIEVANCE PROCEDURE

What are your discharge and grievance procedures?

____
____
____
____

Are there circumstances under which the facility will involuntarily discharge or refuse to readmit a resident? _____ Yes _____ No

If yes, please specify: ____
____
____
____

In the event of involuntary discharge, does the facility provide assistance finding another facility? _____ Yes _____ No

If yes, please specify: ____
____
____
____

Does the facility have a written appeal or grievance procedure for: *(please check all that apply)*

_____ Involuntary discharge

_____ Fees and/or billing

_____ Care plan and/or changes to level of care

If so, are the policies given to each resident/family member? _____ Yes _____ No

H. AGENCY CONTACTS

Ombudsman Contact: ____

Licensing Agency Contact: ____

I. NOTES

This guide is dedicated to the memory of Mildred Hadley. Many thanks to the Michigan Campaign for Quality Care whose members made this form a reality.