COMMONWEALTH OF KENTUCKY
Cabinet for Families and Children
Department for Community Based Services

DSS-277A
(R 4-99)

PERSONAL CARE HOME SEMI-ANNUAL ASSESSMENT

A. IDENTIFYING DATA
Facility Name ___________________________ Number of Beds ______ Phone ___________________________
Address ___________________________ Administrator ___________________________
____________________________________ Owner ___________________________

B. FACILITY ASSESSMENT (circle appropriate responses)
1. Housekeeping standards: Excellent Good Fair Poor
   If yes, elaborate________________________

2. Staffing or administrative changes? Yes No
   If yes, elaborate________________________

3. Changes in physical environment? Yes No
   If yes, elaborate________________________

4. Activities available to residents? Yes No
   List: __________________________

5. Nutrition: Times of Meals Breakfast ______ Lunch ______ Dinner ______ Snack ______
   Meals observed (include date)________________________
   Do Meals appear adequate and well-balanced? Yes No

6. Unpleasant Odors? Yes No
   If yes, elaborate________________________

7. Phone available to residents? Yes No
8. Since last assessment: Any DSS-284's? Yes No
   Any Protective Service Investigations Yes No
9. Any In-Service Training for staff? Yes No
   List: __________________________

10. Deaths occurring since last assessment? Yes No
    Comments __________________________

11. Is there a Resident Council? Yes No

C. RESIDENT OVERVIEW (circle appropriate responses)
1. Number of Guardianship Residents________________________

2. Did you note any residents being restrained? Yes No
   If yes, was restraint ordered by physician? Yes No

3. Did you note any residents who was non-ambulatory? Yes No
D. RESIDENT INTERVIEWS (circle appropriate responses)
   1. List the names four (4) residents interviewed:

   ____________________________________________________________

   2. Is any problem consistently identified by residents interviewed? Yes No
      If yes, explain ____________________________________________________________
      ____________________________________________________________
      ____________________________________________________________
      ____________________________________________________________
      ____________________________________________________________
      ____________________________________________________________

E. COMMENTS AND RECOMMENDATIONS INCLUDING DSS INVOLVEMENT AND FUTURE PLANS

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

F. DATE OF NEXT ASSESSMENT ________________________________

   WORKER'S SIGNATURE ___________________________ DATE ___________________________

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DSS-277A
PERSONAL CARE HOME SEMI-ANNUAL ASSESSMENT

The Semi-Annual Assessment for PCH, DSS-277A, is to provide a periodic uniform assessment of the home, operator and selected residents, to assist the worker in identifying problems or service needs.

PROCEDURES:

The initial DSS-277A is to be completed within six (6) months of the date of licensure and every six months thereafter. The initial assessment to the PCH shall establish baseline information about the home and selected residents. Changes noted by the worker are of particular importance in subsequent visits. The worker shall not function as a licensing or regulatory agent. However, if the worker observes conditions which appear to be in violation of PCH regulations, a DSS-284 is to be completed and forwarded to Licensing and Regulations.

ALL SECTIONS ARE TO BE COMPLETED AT EACH ASSESSMENT

A. IDENTIFYING DATA:

Enter the appropriate information.

B. FACILITY ASSESSMENT:

1. Observe housekeeping standards and circle appropriate response.

2. Note staffing or administrative changes which may effect resident care.

3. Changes may be positive or negative and may effect the safety or comfort of residents. Examples: new A/C, new paint, carpet; uncomfortable temperatures.

4. List activities available to residents; both those provided by the facility and offered outside the facility.

5. Enter times of meals, any meals observed and date and assessment of food served.

6. Note any unpleasant odors which may include disinfectant, pesticide, urine or stale cooking odors.

7. Indicate if phone is available to residents.

8. Indicate if any DSS-284 or Protective Service Investigations have been completed.

9. List any training that has been provided to enhance staff's ability to provide care.

10. List any death(s) and cause(s), if known.