Bella Vista
Business Plan

1. Overview/Objective

Bella Vista in a **partnership** with **Alameda County Housing Support Services** provides housing to persons with a diagnosis of mental illness with a limited income. **Bella Vista**, a **non-medical facility**, provides a stable home-like environment for clients in need of housing and support.

Bella Vista is dedicated to providing quality care and supervision to our Adult clients. We provide around the clock staffing seven days a week to provide service and assistance to our residents in daily living activities and needs. The facility is licensed by the California State Department of Social Services, Community Care Licensing to provide services for persons with Ambulatory status who are 59 years old and below.

Bella Vista is located in Hayward, California where the weather is perfect. The facility is located in a quiet and safe neighborhood. Resident rooms are semi-private. All the residents' rooms are furnished to meet the individual taste(s) of the occupant(s). The facility is supplied with an existing sprinkler system, fire alarm system and a fire alarm monitoring service. The Building#1 (1659 D St) facility has an existing sprinkler system, fire alarm system and fire alarm monitoring service. The Building#2 (1641 D St) facility has an existing fire alarm system, as-is no sprinkler system. We provide a variety of activities and we allow the residents to choose the activity for the day. We have an indoor open spaces that are available to residents like Library area (reading, current events), TV Room area (tv news, movie time), Dining area (can also be utilized as a game room, coffee time, stretching exercise, activities like board games, arts & crafts, puzzle). We also have an outdoor sitting spaces that can be utilized for leisure activity, relaxing, reading, sitting or walking, occasional picnic. Area will be managed by the staff on-duty and accessible to all clients with no-restrictions. The surrounding community affords the residents safe, easily accessible areas for recreation, shopping, attending church, medical and dental offices, etc. We are dedicated to providing a safe, sanitary, peaceful and supportive environment for our residents.

Our goal is to assist each individual in living as full as resourceful a life as his/her abilities permit, and to provide a care and assistance to maintain their stay in the "Greater Community". We achieve these goals by maintaining each individual's physical health and abilities at the highest level possible for the greatest length of time their individual aging process will allow.

The Licensee/Administrator is ultimately responsible for the overall facility management.

2. Profile of Bella Vista (Adult Residential Facility – Non-Medical Facility)

Property Detail

Bella Vista located in Hayward, California is comprised of 2 buildings (Building#1 area: Approx 6,302.1 SF and Building#2 area: Approx 3,022.8 SF). The Building#1 is a one story bldg. that can provide housing for 26 clients, and Building#2 is a two story bldg. that can house an additional 16 clients. Both buildings will house the same type of clients. Each building will have a sufficient staffing to accommodate each building client's need. But each building residents are welcome to travel and socialize back and forth with each other. There is ample parking for 16 vehicles (15 standard parking and 1 van accessible parking).

Licensure

Bella Vista is licensed by the Department of Social Services, Community Care Licensing (CCLD) as an Adult Residential Facility (ARF). This type of licensure is not regarded as a healthcare facility, but rather a social-based non-medical facility.

Client Capacity

The licensure and fire clearance allow for a total of 42 ambulatory clients.

Hours of Operation

The facility is open and operational 7 days a week 24 hours a day.

Basic Services Provided

The facility provides services that promote, to the extent possible, independence and self-direction for all persons admitted. All clients shall be encouraged to participate fully as their conditions permit in daily living activities both at the facility and in the community.

Services included:

- Oversight of personal and supportive services
- Assist with self-administration of medication, as prescribed by the treating physician.
- Provide three meals per day plus snacks
- Weekly housekeeping and laundry
- All supplies and equipment necessary to meet the needs of the resident, that are not medical or personal, are provided by facility.
- Arrange for public transportation, activities and community resources
- Access to supportive services Alameda County Behavioral Health Services
- Arranging transportation to meet the client's mental health needs and for participation in planned programs.
- Encouraging the client to take increasing responsibility for the client's own treatment by

supporting self-established goals and the use of support and treatment.

- Encouraging the client's use of public transportation, use of leisure time in a constructive manner, and maintenance of adequate hygiene and grooming.
- Assisting the client to learn social relationship skills, such as communication with others and the appropriate expression of feelings.
- Participating with County and County-Contracted staff in meetings in the facility.
- Assisting the client in developing skills of budgeting, personal shopping, monetary transactions, menu planning, and shopping for, and the preparation of, basic meals with the goal of supporting clients to move toward greater living independence over time.
- Supporting and encouraging the client to identify and secure more independent living arrangements over time through a variety of strategies including, but not limited to, supporting affordable housing applications, cultivating relationship with potential housemates, and fostering the development of community living skills.
- Supporting and encouraging clients to pursue educational and employment opportunities.
- Supporting and encouraging clients to increase their financial independence and personal assets.
- Supporting and encouraging clients to address substance use disorders including, but not limited to, nicotine and alcohol dependence.
- Providers will provide, at a minimum, weekly verbal and monthly written vacancy updates to their designated HSP liaison. Written vacancy updates on a County-provided template will be due to their designated HSP liaison on the 5th of each month.
- Providers with County-designated beds agree that the County is the sole placement authority for usage of beds contracted for by this County.
- Bella Vista will have the placement authority for beds that are not county-designated. However, for this facility, max capacity of 42 beds will be contracted to Alameda County and 42 beds will become a County-designated beds and County will have the placement authority for the 42 beds.
- Relationship with Alameda County: Currently, I am a Service Provider with Alameda County Housing Support Program since 2015. I have an Adult Residential Care Home in City of Oakland who is currently contracted with them. Due to the shortage of care home for the clients I currently served, I decided to expand in City of Hayward which is the Bella Vista proposed facility. Currently, Alameda County HSP is keeping an eye with Bella Vista proposed facility and waiting patiently for it to get approve so Bella Vista can be contracted with them also. Robert Ratner (Housing Support Director) has been very supportive to me on the Bella Vista proposed facility.

See attached Alameda County Housing Support Program Letter (Attachment#7)

Clientele

- Clients accepted for admissions can be adults age 18 to 59.
- Clients have been evaluated by mental health professional to determine suitability for admission, based on their overall physical and mental status.
- Client are ambulatory and require general oversight of personal and supportive services.
- The facility provides services to clients with deficits in self-help skills, life skills, and diagnosis of mental illness or mental disorder.

Client Daily Schedule

Daily Operations: Schedule would not differ on the weekends.

See attached Sample Daily Schedule (Attachment #1)

Transportation Policy

Clients are not expected to have their own vehicles. Client's case manager and Case Management Program Team are responsible for means of transportation for their client's Medical, Psychiatric and Dental appointment. The public transportation are also available for client's use. Clients will also receive information on access to all other public transportation. The facility will provide transportation for those residents who do not have independent arrangements. Staff will assist in arranging the transportation when needed.

Case Management/Mental Health Professionals

The facility has no on-site case management. All case management is provided and coordinated with Alameda County Behavioral Health Services.

Each client has an assigned case worker or mental health social worker, per Alameda County Behavior Health Services. Client case workers and/or social workers arrange on site facility visits with the client. The licensee shall maintain records of mental health provider site visit in client records.

Facility Visiting Policy

The facility visiting hours are from 9AM to 8PM. Visiting is encouraged, there is no restriction on the client's right to receive visitors. Administration understands the value and need for visitors in maintain psychological and emotional wellbeing. The client can use the house phone for local calls. The facility keeps a daily log of visitors signing in & out of the facility. Guests and visitors are not allowed to stay overnight in a resident room.

3. Personnel and Staff Planning

Personnel Protocol

This facility will adhere to all local, state and federal labor regulations which include but not limited to:

- California minimum wage
- California Worker's Rights
- Alleged adult abuse training and mandated reporting
- State and Federal Department of Labor postings and requirements.
- Applicable Cal/OSHA safety posting.

Hiring Policy

This facility will only hire individual's that are qualified and competent. All staff will meet all requirements for the job considered for employment. Enough staff are always employed and scheduled to provide client required care and supervision. The staff schedule is comprised of three work shifts: daytime, evening and graveyard.

Staffing Ratio/Schedule

1659 D Street (Building#1)

Monday thru Sunday, at all times there are three direct care staff at 1659 during day and evening shift and two direct care staff on duty for the graveyard shift, one cook for daily meals. If additional staff are required based on client needs, the licensee will add appropriate staff.

1641 D Street (Building#2)

Monday thru Sunday, at all times there are two direct care staff at 1641 D Street for the day and evening shift and one direct staff scheduled for the graveyard shift, one cook for daily meals. If additional staff are needed based on client need, the licensee will add appropriate staff. Other staff that provide support services include housekeeping/laundry and cook.

Staff Qualifications and Training

Direct Care Staff Qualifications

- At least 18 years of age
- High School diploma or GED equivalent

- First Aid Certified
- CPR Certified
- Criminal Record Background Clearance thru Live Scan to meet CCLD requirements
- Current California Driver License
- Ability to speak and understand English
- Must be in good mental and physical health verified by a Physician. This shall include Health Screening Report (LIC503) and TB Clearance done not more than six (6) months prior to or seven (7) days of employment.
- In-Service Training
    - Housekeeping, sanitation and infection control principles
    - Knowledge of good nutrition, food preparation, storage and menu planning.
    - How to recognize signs of illness and the need for medical intervention.
    - Crisis prevention and/or verbal de-escalation
    - Alleged abuse
    - Personal Rights
    - Facility policies and procedures
    - Mental Illness and Services
    - Knowledge of community resources
    - Assisting residents with their medication administration
    - Resident medication management – see training guide

Medication Policy

A designated staff person will be responsible for assisting clients with self-administration of medications. The medications will be stored under lock and key. Centrally stored medications will be in place that is not accessible to persons other than the staff responsible for the supervision of the centrally stored medications. Medications will be issued as prescribed, no person other than the dispensing pharmacist can alter the prescription label. Medications are prepared in bubble packs, a written record of all centrally stored medication will be maintained, medication records will be kept for 3 years, medications to have all CCLD required information, upon termination of services with the resident – medications is to be given to the client or his/her responsible party. In other cases, medications will be disposed of by the facility administrator and one other staff. Records with signature will be kept at least three years.

4. Emergency Disaster and Client Emergency Protocol

Emergency Disaster Plan

This facility maintains an emergency disaster plan that meets the requirements of H&S Code 1569.695 which includes but Is not limited to evacuation procedures, plan for the facility to be self-reliant for a period not less than 72 hours following an emergency or disaster, able to communicate with local emergency personnel, has access to emergency information to check on emergency routes to be used if an evacuation and relocation is necessary and has appropriate transportation needed for an evacuation.

Protocol and response to a client emergency

The staff has been properly trained to recognize any early sign of illness and distress a client may have and when it is necessary to seek professional help and assistance. All staff have received first-aid and CPR training.

The facility has first aid supplies, and/ or first aid kit approved by the Red Cross to handle minor emergencies. The facility has on hand a current first aid manual. There is always adequate privacy for administering first aid to clients.

All staff have been trained on what to do in case of a client emergency. The staff will refer to the posted list of name, address and telephone number of each emergency agency to call in the event of an emergency, including but is not limited to the crisis center, fire department, ambulance, paramedics, police and medical doctors. The name, address and phone number of each resident's physician, dentist and responsible party is also readily available.

Medical Emergency Protocol

If the client suffers illness or injury certain procedures will be followed:

- Client will be immediately checked for signs of obvious injuries. If indicated Administer First AID or CPR accordance with Red Cross Training.
- Client's physician is contacted to inform of the circumstances. If the client has medication prescribed for a medical condition that has become acute, the medication will be given to the client.
- Client's case worker is contacted to inform of the circumstance.
- If it appears the injury requires further care or on advice from the physician, the client will be transported to the nearest hospital, emergency room or physician office to be medically evaluated.
- If the injury is life threatening or severe 911 will be called. An incident Report will be filed with the licensing office.

- If the client needs to be transferred to an emergency room and/or hospital, the facility staff will follow the procedure of contacting the client physician, family member or case worker as well as prepare a copy of the client's records including insurance information, Medicare/Medi-Cal numbers and medication records.

See attached Complete In Case of Emergency Guidelines (Attachment #2)
After the staff contacts 911, and if the administrator is not at the facility during a medical emergency, the staff shall contact her immediately.

Client Emergency Intervention Plan

The facility emergency intervention plan is designed to provide staff with the techniques and training to intervene and de-escalate a client experiencing a behavioral crisis. The purpose of the intervention is designed to protect the client, as well as any other individuals nearby who's physical safety, is compromised.

If the client is acting in an aggressive dangerous manner and the Intervention is not successful in the de-escalation the client, and you and your client's safety is threatened 911, and 5150 steps should be taken. Alameda County Department Behavioral Health Care Services Mental has available a Psychiatric Mobile Response Team. The team consists of a law enforcement officer and mental health clinician. The team can assist with the intervention as well as imitate a 5150 hold.

See attached Complete Emergency Intervention Plan (Attachment #3)

5. Security Plan

The facility is surrounded by wrought iron and brick enclosure There are gates at the main entrance and driveway. For the safety of both clients and staff there are video cameras at each facility exit. The exterior facility exits are open during the daytime hours but locked by 10pm. After 10pm clients will need to ring the bell for staff to open the exterior exit door. Also, the indoor main exits of the facility have a door chime alarm in-placed and will be activated at 10pm to alert staff for anyone going in and out after 10pm. Clients have no restrictions to come and go from the facility. Clients will sign out to notify the staff if they decide not to return to the facility at night. No additional devices will be installed at this time.

See attached Sign-in and Out Log (Attachment #4)

6. Neighborhood Complaint Policy

Bella Vista takes all complaints seriously and makes it a priority to respond to complainants as soon as possible and in a respectful manner

- Neighbors within 500 feet radius from the facility will be provided a facility contact person for addressing questions, concerns or complaints. Any other requirements by planning shall be complied with.

Neighborhood Complaint Protocol

- The administrator will be notified of any complaint (within 24 hours) and promptly investigate the manner.
- A formal written reply detailing how the administrator can resolve or address the concern/issue will be sent within 48 hours following the initial telephone contact.
- Always respond to the complainant in a reasonable amount of time, and be sure the response addresses their complaint. If the complaint is reasonable, acknowledge this and explain any program adjustments you are making. If the complaint is unfounded, explain why.
- When a complaint is received, ensure that staff follow the neighborhood complaint policy protocol as outlined in the facility's program statement.
- Field complaints in a positive way. If a neighbor complains, legitimately or not, take action immediately, quickly offer to remedy the situation if it is within your power to do so.
- Designate one person to be the community liaison. Staff on site may do "Band-Aid interventions," but getting a complaint to your designee person allows for proper follow-up, consistency of response and control.
- Provide mediation training to the person assigned to deal with complaints.
- At the monthly staff meeting held the last Friday of each month, the administrator addresses the status of any pending complaint and discusses the issues and concerns with the staff as appropriate.

Immediate/time-sensitive

For any type of disturbance such as clients engaging in aggressive, threatening or disruptive behavior the licensee shall contact the client case worker, police if necessary and complete an incident report to be submitted to Community Care Licensing Division (LIC624) The licensee shall provide the complainant a copy of the incident and/or police report.

Long-Term or Continuing Issues

For any type of excessive noise, traffic, trash or loitering, the licensee shall take a pro-active approach to keep complainant or concerned neighbors apprised of continued efforts to reduce or eliminate any on-going problems impacting the neighborhood.

Staff Conduct

Staff members are an extension of the Residential Care Home facilities. Staff will be train to demonstrate courteous, professional behavior at all times. Consider some of the following rules for staff conduct:

- Observe all vehicle safety and driving laws at all times.
- Be aware of parking around the care home; don't park in a manner that may cause concern to the neighbors.
- Be sure that the residents are properly supervised in the community.
- The attitude of staff in the care home sets the tone for the behavior of the residents. If staff respond to neighbors in a defensive or aggressive manner when complaints or questions are raised about the facility, developing a congenial relationship will be unlikely. Staff and residents should adopt the position that they are a part of the community.
- Be an overall good neighbor. Take walks around the block. See the neighbors and let them see you. Build relationships on a personal level as much as your time allows.

Client Conduct

The clients in the facility are community members and should be encouraged to participate in neighborhood events or outdoor activities. Part of caregiver role is to help residents prepare for outside activities including appropriate apparel and appearance.

The following are some suggestions to ensure the clients are also good neighbors:

- Keep the volume of stereos and television at a level that does not disturb the neighbors.
- Encourage clients to use sidewalks and refrain from walking on neighbor's property.
- Encourage clients to exchange greetings with neighbors who appear receptive to this.
- Encourage clients to dress appropriately and use appropriate language.

Maintenance

Maintenance is the essence of "good neighborliness" The appearance of the property is often considered a direct reflection of every other aspect of your care home. Good maintenance of the home may also reassure neighbors that our facility and the clients are equally well cared-for and supervised.

- Each home should be physically maintained in a manner that does credit to the neighborhood.
- Employing a landscape maintenance to handle the facility lawn care. This will help on maintaining the appearance of the yard, while building a relationship with the neighbor.
- Conduct monthly inspections of the facility and recognize the staff for their efforts to make the home presentable and attractive.
- Adhere to community standards for landscaping, painting and décor.

Attachment:

1. Sample Daily Schedule
2. In Case of Emergency Guidelines
3. Emergency Intervention Plan
4. Sign-in and out log
5. Medication Management and Training Guide
6. Resource Guide for Central County
7. Alameda County Housing Support Program Letter

Sample Daily Schedule of Care -- Monday through Friday*

Time	Activity	Activity Detail	Location	Skills	Notes
6AM-7AM	Wake-up Bathing	Make-up bed Selecting clothing Run bath water Get Towels Wash & Dry Body	Client room/ Bathroom	Self- Care	
7AM-8AM	Dressing Grooming	Put on clothes/shoes Brush and comb hair Brush teeth Hang towel Put away toiletries	Bathroom	Self-Care	
8AM-9AM	Breakfast	Wash hands Assist with meal preparation Eat Meal Clean up as eating area	Kitchen/dining	Independent Living	
9AM-3PM*	Daily Activities	Various	Outside programs Vocational Training	Independent Living Life Skills	
10AM-11AM	Indoor Activities	TV News, Current Events Stretching exercises Board Games, puzzles Reading	Lounge Area	Recreation	
12PM-1PM	Lunch	Wash hands Assist with meal preparation Eat Meal Clean up as eating area	Kitchen/dining	Independent Living	
1PM-2PM	Interaction with staff	Group discussion Topic of the day	Lounge	Social Communication skills	

2PM-4PM	Outdoor Leisure activity	Balance exercise Free time Patio activities Movie of the Day	Patio Lounge	Recreational social communication	
5:00PM-5:30PM	Dinner Preparation	Wash hands Help with dinner setup Set table	Kitchen/dining	Independent living Life skills	
5:30PM-6:30PM	Dinner	Eat dinner Interaction Clean up	Kitchen dining	Social Life skills	
7PM-8PM	Free time	Watch TV Video Read Free time	Family Room	Social Leisure recreations	
8PM-9PM	Free time snack bathing	Client choice	Various	Self-care Independent living	
9PM-10PM	Bedtime	Get ready for bed Get pajamas Bathroom Brush teeth Go to bed	Client room Bathroom	Self-care	

IN CASE OF EMERGENCY

1) **CALL 911.** Speak slowly and be prepared to give the following information:
   - WHAT HAPPENED TO THE CLIENT: Give a brief description on condition, if known what caused it. Keep profile handy for more information on the client.

   - THE EXACT ADDRESS: 1641 or 1659 D Street Hayward, CA 94541 (located in the corner of D Street and 7th Street)

   - YOUR TELEPHONE NUMBER: 510-677-6561

   - IDENTIFY YOUR SELF: Care Provider

   - ARE THERE ANY MORE PEOPLE INVOLVED? (If none, go to next step)

   DO NOT HANG UP FIRST.

   RETURN TO THE CLIENT. (If needed, another staff should have stayed with the client).

   In case of Injury:
   - How did the client hurt himself/herself?
   - Be able to tell WHERE, HOW BIG and HOW BAD the wound or injury is?

2) **NOTIFY** the client's primary physician, case manager, family member/conservator and CCLD.
3) **COMPLETE** an Incident Report and send to CCLD within 7 days.

WHAT TO TELL THE PHYSICIAN/MEDICAL PERSONNEL

GUIDELINES:

1) Describe how the client looks? (Client looks pale, can not answer questions, very weak)
2) Has there been a change in behavior? (Was very active before, suddenly became silent and not getting up from the chair, drooling)
3) Can the client say if anything is wrong or if he hurts?
4) What time did you notice that he/she behaved differently?
5) Has the client been eating or drinking? Any change in appetite?
6) Any unusual complaint – vomiting, loose stools, problem urinating?
7) Check temperature, pulse and blood pressure, if possible.
8) Be aware if client has had a similar complaints before.
9) Report any allergies that the client has
10) Be able to provide list of medications taken by the client (on the client's profile).
11) Keep the client's profile on hand. It will help you answer questions better.

EMERGENCY INTERVENTION PROCEDURES
Bella Vista

2013 California Code
Health and Safety Code - HSC
Division 1.5. use of seclusion and behavioral restraints in facilities
1180.4

Emergency Intervention Plan
The facility emergency intervention plan is designed to provide staff with the techniques and training to intervene and de-escalate a client experiencing a behavioral crisis. The purpose of the intervention is designed to protect the client, as well as any other individuals nearby who's physical safety, is compromised. The techniques may be employed in the facility as well as public settings. Criteria to implement the plan include danger to self, danger to others and or the violation of the rights of others. The plan is rooted in the idea that techniques are employed in the least restrictive manner.

Emergency Intervention Procedures are designed to de-escalate a client without harm or injury. Emergency procedures are not specified in the clients IPP or behavior plan prepared by the behaviorist. The Emergency Plan is a separate and unique document for the facility that justifies and application of seclusion and restraint as a last resort.

Restraints are different from manual prompts. Restraints are to be used only when there is an emergency event and are never part of the client's behavior plan. Manual prompts are utilized as part of the emergency intervention and may also be part of the client's IPP or behavior plan.

An emergency is defined as a behavior that is a clear and present danger to self or others. The intensity and potential for harm caused by the behavior require the temporary application of manual restraint and sections. The Emergency Intervention Plan outlines the methods to apply these techniques in a way that respects the dignity of the client and protects their civil and personal rights.

Advanced Directive (see Advanced Directive attachment)
Each resident shall have an advanced directive that specifies preferred emergency intervention techniques to be used in de-escalation including seclusion and restraint. (see Advanced Healthcare Directive Attachment). The Advanced Healthcare Directive as it pertains to emergency intervention applies to an emergency event that may happen at the residence or health care setting such as a psychiatric hospital. If the resident is hospitalized, the advanced directive will accompany the resident to the hospital. The licensee shall honor the client's advance directive unless it violates statue or regulation, or it impinges upon the health or safety of the client or another person.

Early Warning Signs and History

Critical to emergency intervention and de-escalation is the early identification of warning signs, triggers, and precipitants that cause a person to escalate and become aggressive to self or others. The foundation of successful de-escalation of aggression is the identification of early signs that occur before the behavioral crisis. Each client is different and signals these early signs differently. Historical information regarding past incidents of aggression is pivotal in discovering what early signs are unique for each client. The licensee will gather information on each client with a potential for aggressive behavior through history. Historical information is culled from medical and psychiatric reports, former residential placement, day programs as well as family.

Residents with a known history of aggression will also be carefully assessed to determine if there are any medical conditions or physical disabilities or limitations that would place the person at greater risk during restraint and seclusion. Any history of trauma including sexual or physical abuse will be assessed and specified in the client emergency intervention plan.

Staff Qualifications

Bella Vista shall contract with a behavior consultant. The consultant shall provide staff training based on PART Professional Assault Response Training.

PART is designed to assist staff with a means of identification and appropriate response to potentially assaultive/aggressive situations. PART focuses on prevention by teaching the concept that all behavior is communication. If staff can identify and respond to behavior, they may be able to prevent escalation to a potentially dangerous situation. Hands-on techniques are also trained to keep everyone safe when preventative measures are not successful, and dangerous behaviors do occur.

Only staff who receive training from the Behavior Consultant assigned to the facility will be considered qualified to implement emergency intervention techniques. Job titles of staff who can implement emergency intervention techniques include Direct Support Professional and House Manager.

Manual Prompts

Restraints are to be used only when there is an emergency event and are never part of the client's behavior plan. Manual prompts are NOT the same as restraints. Manual prompts may be detailed as part of the client's behavior plan. In the context of Emergency, Intervention manual may be used as a technique to restrain an individual against their will and choice.

Manual prompts are never considered aversive or illegal unless the client is verbally or physically resisting such prompting. If the client requires a great deal of manual prompting to accomplish a task, staff will provide that much prompting to de-escalate the behavior. Manual prompt becomes restraint when the client states or physically refuses to cooperate, and the behavior crisis escalates. At this point manual prompt become restraint. Restraints are considered aversive and illegal. Restraint is allowed only the behavior manifested by the client is a danger to sell others or compromise the racists of others. Without these conditions, there is no justification for restraint. Manual prompts occur in a gradual hierarchy that includes:

1. Gesture Prompt - signals are given to the client as a reminder to do something, such as pointing to the dishwasher or the bathroom.

2. Verbal Prompt - a direct verbal instruction is informing the client what you wish for them to do.

3. Tactile Prompt - a physical touch, such as putting your hand on their back to signal the client to move in that direction while also using the verbal prompt to inform them of your intention.

4. Physical Prompt - giving physical assistance and guidance to get the client started on something you are asking them to do when they do not respond and do not resist.

5. Guided Performance - providing complete physical assistance in helping the client accomplish a task that they don't know how to do or are not motivated to do themselves.

6. Restraint - providing the client with physical prompts they do not wish to receive and are resisting and escalating because of your efforts.

Rights and Prompts

Prompts are normally used on a regular basis with most clients to achieve success in independent living skills and reduction of undesirable behaviors. Restraints are never used unless part of the emergency intervention plan.

Clients are free individuals who have all the same rights and privileges of all other individuals unless they are conserved. Conservatorship of a client-specified especially which rights are controlled are controlled by the conservator. A conservatorship never justifies abusive practices that violate the right to be free from pain. Social norms of courtesy and respect are always present in the implementation of manual prompts and restraint. Restrain always occurs in a manner that avoids placing the client or anyone else near danger.

The primary goal of emergency intervention and possibly restrain is to assist the client to regain control and independence. The goal is never to punish or withhold rights of an individual who is already suffering from a behavioral crisis.

Physical Contact and Intervention

Avoid using physical intervention unless there is a clear and present danger of physical injury. Physical altercations are dangerous to both the client and staff. Seek the position of defense when involved in a violent episode. The position of defense is the position of advantage. Staff should never be in a posture of attack toward the client.

Staff should always use their weight and leverage against the client's strength. Avoid efforts to overpower or out-muscle the client. When there is a choice, always grasp the client by the clothing rather than the flesh. Clothing affords a better grip.
Grasp the limbs at points just above the joints. This affords better leverage and minimizes the risk of joint injury.

When containing clients against the wall or on the floor, hold them with their face to the surface. This restricts their mobility and allows the client some mobility. The goal of physical intervention procedures is to help the client regain self- control, not impose rigid external control.

Use space to your advantage. Try to minimize the space available to the client and maximize the space available to the staff. Use teamwork to your advantage. The person with the best contact with the client at the moment should be allowed to lead the team. All should move at once when the signal is given.

Once contact has been made, don't let go until all agree that it is safe. If forced to let go, warn other team members. Assemble enough team members to do the job effectively and safely and keep other staff out of the way. Five persons are the maximum that can work together effectively. Others can be used for crowd control, moving furniture, opening doors, etc. Staff should not attempt to intervene unless there are not enough trained and capable team members.

More than One Client

If more than one client is suffering from a behavioral crisis and requires intervention best practice is to separate as quickly as possible the two clients. Effort should be made to move each client to a separate low-key stimulus environment. Often events with more than one client are a physical fight in which one client is the aggressor and the other a victim. A triage sort should be employed to assign more staff to the client who is experiencing a more severe crisis. More staff should be called to assist in any complex crisis event involving more than one client. If more staff are not available and is it is not possible to successfully implement de-escalation techniques 911 or the psychiatric mobile response team should be contacted. 911 should only be called if he client is a clear and present danger to him or herself.

Client Types of Aggression and Assault

There are three basic types of assaultive/aggressive clients that may be encountered in any given setting. Anti-social personalities are not in included in this scheme. Anti- social or sociopathic individual engage in aggression as a calculation to intentionally harm others. Anti-social types should not be in any public programs where they have access to innocent individuals and should be referred out. The three types are:

Frightened Client: A person who is extremely frightened of being killed or hurt within the next few minutes.

The Frenzied Client: A violently frustrated person who is ready to destroy anything he/she can put his/her hands on.

The Client Having A Temper Tantrum: A person who is upset and ready to use violence to get what he/she wants.

Table 1 below describes the characteristics of each of the above types of assaultive clients, their symptoms, and the recommended approach to use when confronting each type of individual in an escalation cycle.

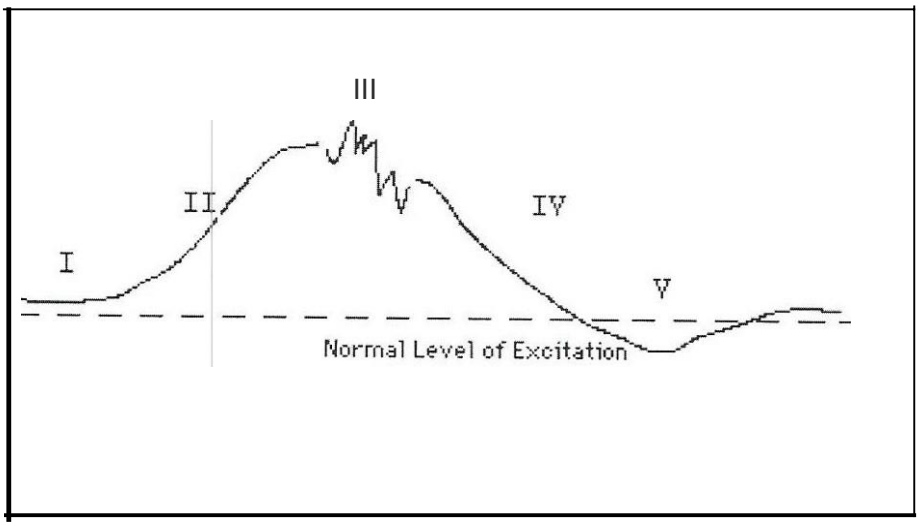
Table 1

The Three Types of Assaultive Clients

Behavior	Symptom	Recommendation
Fright/Fear Extremely frightened, scared of being hurt or killed in the very near future.	Pale skin color Defensive posture Rapid shallow breathing yes, wide open, pupils dilated Defensive gestures	**Reduce Perceived Threat** Keep voice calm and reassuring Open posture, 8-12 feet distance, palms up gestures Reassuring, protective words
Frenzied Violent frustrated; may destroy anything within reach.	! Attack posture Heavy rapid breathing Eyes narrowed, focused Threatening gestures Flushed skin tone (pink)	**Communicate Control** Quiet, controlled voice Command posture Stand directly in front just out of reach Palm down gestures Firm words Set limits
Temper Tantrum (uproar) Very upset and ready to use violence to get own way in the situation.	Diffuse agitation Usually follows a pattern Produces confusion "Gimme" issue Object or person-oriented violence	**Avoid Playing Games** Keep distance, disapproving voice Closed posture Stand at eye level; face client No gestures Withdraw eye contact Words: Demand calm before addressing the issue

Assault follows a predictable pattern of excitation as noted in the graph below. This pattern has five distinct phases (see Figure 1).

Figure 1



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I The Triggering Phase
11. The Escalation Phase
111. The Crisis Phase
IV. The Recovery Phase
V. Post-Crisis Phase

The Responsibility Continuum

External Factors are Responsible For Assault	<:- - - - - - - - - - - - >	Internal Factors are Responsible for Assault

The goal of de-escalation is to address the crisis in the first phase. Staff must be trained in identifying the early signs of an oncoming episode. The guidelines for action on the various phases of the assault cycle are as follows:

Cycle of Escalation
All assault crisis paradigms recognize a predictable cycle that moves through the following sequence:

Phase I: Triggering or Stimulus Phase
There can be many environmental triggers or biological states that disrupt the client's normal state of being. Possible antecedents in the environment may include noise, temperature, disruption in routine, texture of clothing, the presence of people, or demand to engage in a task.

Biological antecedents may include, headache, hunger, fatigue, gastrointestinal distress, toothache or other physical states. A client in this condition can usually be diverted to another task or activity that will interrupt the escalation into a full crisis episode. Hence diversion tactics are recommended to a less demanding situation temporarily. Try to get the client away from the current situation.

Phase II: Escalation Phase
Agitation anxiety and irritability are often present at this stage and may be evidence of pacing, scanning and or a tightening of the body posture. Verbal behaviors at this phase may include repetitive questions, talking loudly and possibly complaints.

A client in this stage will usually give definite signs of the sources of the agitation. Diverting the client at this point may itself cause an escalation and hence is not recommended. The problem-solving approach is recommended attempting to remove the source of the agitation.

Phase III: Crisis Phase
It is in the crisis phase when the client's behavior presents a clear threat to self or others and may require physical intervention. The least restrictive method is to geographically contain the client in one area of the facility and move all other clients to another area. If this is not possible, staff should move the client as far away as possible to a safe area away from other clients. As the client's behavior escalates more restrictive methods are used to protect the acting-out client as well as others the hierarchy of restrictive approaches is listed below:

Crisis Communication: The least restrictive method is to use verbal mediation and reassurance that you will help the client resolve the problem. This step will continue with all other steps which follow until the problem has been resolved. Staff must communicate confidence that the problem will be resolved and that the client is safe. Staff will also firmly communicate that violent behavior is not appropriate and is not allowed.

Geographical Containment: Geographical containment is used if the verbal communication does not resolve the site. The staff places themselves between the client and everyone else and between the exit and the client without any physical intervention. Verbal mediation and reassurance continue to be used at this stage to halt the escalating behavior become a a more serious episode.

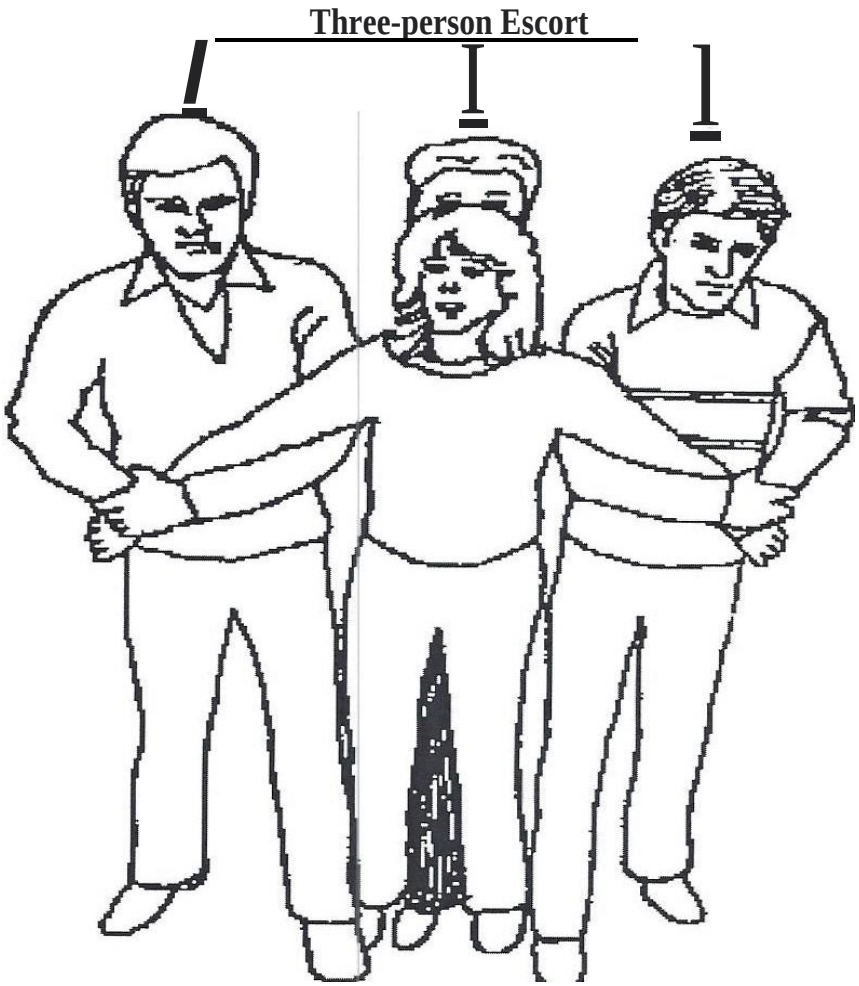
One Man, Two Man, or Three-Man Escort: This procedure consists of one or more staff members physically removing and escorting the client to a safe area. For a One-Man procedure, the staff must get behind the client, grab the shirt/blouse in the middle of the back and twist to secure a good grip, grab the pant belt area with the other hand, push the upper torso forward and steer with the mid-drift portion while walking forward to a safe area.

A **Two Man Escort** consists of one staff member on each side of the client. Each staff member is to place their arms under the client's arm, securing the shoulder, while holding the client's arm just above the elbow with the other hand, hugging it close to their body.

The Three-Man Escort is essentially utilizing both above procedures consecutively.

Physical Containment: This is where the client is physically held against the nearest wall, facing it, until calm. The holds are again identical to the above procedures. If possible, before attempting any restraints to the wall or floor, staff should attempt to go to the nearest couch and sit with the person while maintaining the same holds with the additional move of placing your leg over their legs from both sides to prevent flailing and kicking. This is particularly important for a client with tracheotomies since pushing against the wall or floor could obstruct their breathing.

Two Man, or Three-Man Restraint: This procedure consists of physically laying the client flat on the floor face down and holding them until calm. Using the same holds, the staff is to place their legs in front of the client and move forward, breaking the fall by stopping with their knee, then proceeding to lay flat on the ground; (see figure below).



Two Person Escort

The **One-Man Restraint** is never recommended. Staff should at least have two if not three people to attempt prone containment, especially if the client is larger than the staff. When staff is in a position where they cannot get away, the staff is to deflect the attack, move around them and attempt to get help from another staff. Make sure to keep your eyes and focus on the assaultive client and not let them get to other clients standing by. Instruct any other clients to leave the area and continue calling for help from other staff.

Visual Checks

Whenever manual restraint is required staff will continuously make a visual check to ensure, only the techniques as specified in this emergency plan are utilized. Any staff the either participate in, approve or provide visual checks of the manual restraint or seclusion will have a minimum of sixteen hours of emergency intervention training and be certified for having successfully completed the training.

Time Limits

No Manual restraint or seclusion will be employed for more than 15 consecutive minutes unless the licensee complies with Section 85322(e)(6);

Unless discontinued sooner, at 15 consecutive minutes after the initiation of a manual restraint or seclusion, staff shall discontinue the manual restraint or seclusion.

The only exception to the 15-minute limitation above shall be when there is a continued need to protect the immediate health and safety of the client or others from risk of imminent serious physical harm, and the certified administrator obtains concurrent approval for every exception.

The administrator's approval shall be documented in the client record within 24 hours and include an explanation of why it was necessary for the manual restraint or seclusion to go over 15 minutes, including a description of the client's imminently dangerous behavior.

The certified administrator mentioned in Section 85322(e)(6)(A)1. above shall not be a participant in the manual restraint.

Emergency Intervention are Not Behavior Intervention Strategies

Do not attempt to use any of these procedures as intervention strategies to teach clients new skills. These are **Emergency Procedures Only.** Clients amid a behavior crisis are not capable of learning conflict resolution or other coping skills. Learning only occurs in when the client conflicts free state.

When employing physical restraint only the use of necessary force is used. As the client becomes calm the staff should you relax their physical grip? The staff should always continue to reassure and speak to the client using resource and empathy. The amplitude and emotions communicate in the client's voice is a good indicator of stress. If the client continues to show signs of distress it may be too early let, go. Staff should loosen their loosen their only when it is clear through verbal and physical behavior that the client is no longer dangerous to self or others.

Post Crisis - Reintegration

When the client is no longer in crisis and has returned to their baseline level of functioning the goal is to reintegrate the client into their routine. This is best achieved by adopting a nonjudgmental attitude and making available the clients preferred activities.

Documentation

Whenever restraint is utilized staff must complete SIR and forward copies to Community Gare Licensing as well as APS if appropriate. Restraint is a violation of the client's rights and must be reported with a follow-up to determine if the procedure was justified and how to prevent the behavior crisis from happening again.

Monthly log
A monthly log will be maintained with the name of each client for which manual restrain was used. The date and time of the manual restraint or seclusion will be recorded along with the time duration of the restraint or seclusion. The names of all staff who participated in the restraint and seclusion will be included in the log.

The log will specify the outcome of the emergency intervention including injury and death. If an injury did occur the entry will indicate if the injury is serious as defined by Health and Safety Code 1180.5 (b)

The serious injury" means a significant impairment of the physical condition such as determined by qualified medical personnel, and includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs.

Manual Restraint or Seclusion Review
The administrator or the administrator's designee shall conduct a clinical and quality review by conducting a debriefing meeting as soon as possible or within 24 hours of the manual restraint incident. The meeting shall include:

The client (participationof the client is voluntary).
The staff involved in the incident if reasonably available.
A client representative if available and requested by the client m by Health and Safety Code section 1'180.5

Criteria for Modification or Termination of Emergency Plan
If it is determined through implementation that the existing plan is not relevant or effective in addressing the aggressive incident, then the emergency plan will be reviewed. A regular review of SIR incidents may reveal a pattern that suggests that certain elements of the plan may need to be revised. For example, it may be determined that some types of prompts are effective than others. This information is invaluable in making modifications in the future.

Criteria for Assessing Resources to Meet Needs of Client
If the Emergency Plan has been implemented with a client and found not to be effective the facility may not have the resources to meet the needs of that client.

Criteria for Assess Emergency Services
Emergency intervention to assist staff in an emergency intervention is provided through **Alameda County Behavioral Health 800-491-9099**

If the client is acting in an aggressive dangerous manner and the Intervention is not successful in the de-escalation the client, and you and your client's safety is threatened 911, and 5150 steps should be taken. **Alameda County Department Behavioral Health Care Services Mental** has available a **Psychiatric Mobile Response Team**. The team consists of a law enforcement officer and mental health clinician. The team can assist with the intervention as well as imitate a 5150 hold.

Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Mobile Crisis Team
(510) 981-5254

Expected Outcome
The expected outcome of the emergency intervention is to de-escalate the resident to a psychological and physical state that existed before the crisis. Operationally this means the resident is no longer experiencing a behavior crisis and no longer considered a danger to self or others.

Bella Vista
Sign in/Out Log

Date	Client name	Time departing from the facility	Destination	Name of person(s) accompanying the client/phone no.	Estimated time client will be returning to the facility	Actual time client returned to the facility

1. **Client arrives with medication:**
   - Contact the physician(s) to ensure that they are aware of all medications currently taken by the client/resident.
   - Verify medications that are currently taken by the client/resident and dispensing instructions.
   - Inspect containers to ensure the labeling is accurate.
   - Log medications into The Centrally Stored Medication and Destruction Record (LIC 622).
   - Discuss medications with the client/resident or the responsible person/authorized representative
   - Store medications in a locked compartment.
2. **Medication is refilled:**
   - Communicate with the physician or others involved (for example, discusser payment of medications, who will order the medications, etc. with the responsible person.)
   - Never let medications run out unless directed to by the physician.
   - Make sure refills are ordered promptly.
   - Inspect containers to ensure all information on the label are correct.
   - Note any changes in instructions and/or medication (for example, change in dosage, change to generic brand, etc.)
   - Log medication when received on the LIC 622.
   - Discuss any changes in medications with the client/resident, responsible person/authorized representative and appropriate staff.
3. **A dosage is changed between refills:**
   - Obtain written documentation of the change from the physician or document the date, time, and person talked to in client's/resident's record.
   - Record change in medication record.
   - Discuss the change with client/resident and/or responsible person/authorized representative.
4. **Medication is permanently discontinued:**
   - Confirm with the physician. Obtain written documentation of the discontinuation from the physician document the date, time, and person talked to in clients/resident's record.
   - Discuss the discontinuation with the client/resident and/or responsible person/authorized representative.
   - Have a facility procedure (i.e., card file/card ex. notebook, and/or a flagging system) to alert staff to the discontinuation.
   - Destroy the medications. Medication must be destroyed by the facility administrator or designee and one other adult who is not a client/resident.
   - Sign the medication destruction record/log. (The reverse side of LIC 622, Centrally Stored Medication Record may be used for this purpose.
5. **Medications are temporarily discontinued ("dc") and/or placed on hold:**
   - Medications temporarily discontinued by the physician may be held by the facility.
   - Discuss the change with client resident and/or responsible person/authorized representative.
   - Obtain a written order from the physician to HOLD the medication, or document in the client's/residents file the date, time, and name of person talked to regarding the HOLD order.
   - Record discontinuation and restart date in medication record.
   - Without altering the label, mark or identify in a consistent manner medication containers that have HOLD orders.
   - Be sure to contact the physician after the discontinuation/hold order expires to receive new instructions regarding the use of the medication.

6. **Medication reaches expiration date**:
   - Check containers regularly for expiration dates.
   - Communicate with physician and pharmacy promptly if a medication expires.
   - Do not use expired medications. Obtain a refill as soon as possible if needed.
   - Over-the-counter medications and ointments also have expiration dates (for ointments the expiration date is usually at the bottom of the tube).
   - Destroy expired medications according to regulations. Log/record the destruction of prescription medications as required. The
   - LIC 622 may be used for this purpose.

7. **Client transfers, dies, or leaves medication behind:**
   - All medications, including over-the-counters, should go with client/resident when possible.
   - If the client/resident dies, prescription medications must be destroyed.
   - Log/record the destruction as required using LIC form 622.
   - Document when medication is transferred with the client/resident. Obtain the signature of the person accepting the medications (i.e., responsible person/authorized representative.)
   - Maintain medication records for at least 1 year (CCF) section 80075 (n)(7),(0).

8. **Client missed or refused medications:**
   - Client can be forced to take any medication.
   - Missed/refused medications must be documented in the client's/resident's
   - medication record and the prescribing physician contacted immediately.
   - Notify the responsible person/authorized representative.
   - Refusal of medications may indicate changes in the client/resident that require a reassessment of his/her needs. Continued refusal of medications may require the client's/resident's relocation from the facility.

9. **Medications need to be crushed or altered:**
   a. Medications may be crushed or altered to enhance swallowing or taste, but never to disguise or "slip" them to a client/resident without his or her knowledge.
   b. The following written documentation must be in the client/residents file if the medication is to be crushed or altered:
      - A physician order specifying the name and dosage of the medication to be crushed.
      - Verification of consultation with a pharmacist or physician that the medication can be safely crushed, identification of foods and liquid that can be mixed with the medications, and instructions for crushing or mixing medications
      - A form consenting to crushing the medication signed by the client/resident. If the client/resident has a conservator with authority over his /her medical decisions, the consent form must be signed by that conservator.

10. Medications are PRN or "as needed"

Facility staff may assist the client /resident with self-administration of his/her prescription and nonprescription PRN medication, when:

a. The client's/resident's physician has stated in writing that the client/resident can determine and clearly communicate his/her need for a prescription or - nonprescription PRN medication.
b. The physician provides a signed, dated, written order for the medication on a prescription blank or the physician's business stationery which is maintained in the client's/resident's file.
c. The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription labels display this information.

Facility staff may also assist the client/resident with self-administration of his/ her nonprescription PRN medication if the client cannot determine his/her need for a nonprescription PRN medication, but can communicate his/her symptoms clearly when:

a) The clients/ resident physician has stated in writing that the client/resident cannot determine his/her need for nonprescription medication but can communicate his /her symptoms clearly.
b) The client's physician provides a signed, dated written order on a prescription blank or the physician's business stationary which is maintained in the client's /residents file.
c) The written order identifies the name of the client/resident, the name of the PRN medication, instructions regarding when the medication would be stopped, and an indication when the physician should be contacted for reevaluation.
d) The physician order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum dosage to be given in a 24 hours period. Most nonprescription medication labels display this information.
e) A record of each dose is maintained in the client's/resident's record and includes the date, time, and dosage taken, and the clients/resident's response.

11. Medications are injectables:

a) Injections can only be administered by the client/resident or by a licensed medical professional. Licensed medical professional includes Doctors *of* Medicine (M.D.), Registered Nurses (R.N.), and Licensed Vocational Nurses (L.V.N.) or a Psychiatric Technician (P.T.). P.T.s can only administer subcutaneous and intramuscular injections to clients/residents with developmental or mental disabilities and in accordance with a physician's order.
b) Family members are not allowed to draw up or administer injections unless they are licensed medical professionals.
c) Facility personnel who are not licensed medical professionals cannot draw up or administer injections.
d) Licensed medical professionals may not administer medications/insulin injections that have been pre-drawn by another licensed medical professional.
e) Injections administered by a licensed medical professional must be provided in accordance with the physician's orders.

f) The physician's medical assessment must contain documentation *of* the need for injected medication.
g) If the client/resident does administer his/her own injections, physician verification *of* the client's/resident's ability to do so must be in the file.
h) Sufficient amounts *of* medications. test equipment, syringes, needles, and other supplies must be maintained in the facility and stored properly.
i) Syringes and needles should be disposed of in a "container for sharps", and the container must be kept inaccessible to clients/residents (locked).
j) Only the client/resident or the licensed medical professional can mix medications to be injected or fill the syringe with the prescribed dose.
k) Insulin and other injectable medications must be kept in the original containers until the prescribed single dose is measured into a syringe for immediate injection.
l) Insulin or other injectable medications may be packaged in pre-measured doses in individual syringes prepared by a pharmacist or the manufacturer.
m) Syringes may be pre-filled under the following circumstances:
n) Client can self-administer pre-filled syringes prepared by a registered nurse, pharmacist or drug manufacturer.
o) The registered nurse (R.N.) must not set up insulin syringes for more than seven days in advance.

12. Over-the-counter (OTC) medications, including herbal remedies, aspirin, cold medications, may be dangerous.

a) They must be centrally stored to the same extent that prescription medications are centrally stored.
b) Over-the-counter medication(s) that are given on a PRN basis must meet all PRN requirements. (See section #10)
c) Physicians must approve the use of all OTC medications that are or may be taken by the client/resident on a regular basis (e.g., aspirin for heart condition, vitamins, etc.) as well as those used on a PRN basis.
d) Client's/resident's name should be on the over-the-counter medication container when: (1) it is purchased for that individual's sole use; (2) it is purchased by client's/resident's family or (3) the client's/resident's personal funds were used to purchase the medication.

13. Set up to pour medications:

a. Have clean, sanitary conditions. (i.e., containers. counting trays, pill cutters, pill crushers and storage/setup areas.)
b. Pour medications from the bottle to the individual clients/resident's cup/utensil to avoid touching or contaminating medication.
c. Medications must be stored in their original containers and not transferred between containers.
d. The name of the client/resident should be on each cup/utensil used in the distribution of medications.

14. Assisting with medications (passing):

a. Staff dispensing medications need to ensure that the client/resident swallows the medication (not "cheeking" the medication); mouth checks are an option for staff.

b. Cups or envelopes containing medications should not be left unattended in the dining room, bathrooms, bedrooms or anywhere in the facility.

c.

15. Staff who handle medications.

a. All staff who assist in dispensing medication will receiving training in medication procedures.
b. Training will ensure that staff know what they are expected to do (i.e., keys, storage, set up, clean-up, documentation, notification, etc.)
c. Staff will be trained in which procedures can and cannot be done (i.e., injections, enemas, suppositories, etc.)

16. Medications are received or destroyed:

a. Every prescription medication that is centrally stored or destroyed in the facility must be logged.
b. A record of prescription medications that are disposed of in the facility must be maintained for at least 3 years.
c. A record of centrally stored medications for each client/resident must be maintained for at least 1 year.

17. Medications are prepackaged:

a. Prepackaged medications (bubble packs, trays, cassettes, etc.) are allowed if they are packed and labeled by a pharmacy.
b. Licensees and/or facility staff cannot remove discontinued medications from customized medication packages.
c. Multi-dose packages must be returned to the pharmacy for changes in doses or discontinuation of a medication.
d. The facility will obtain a waiver from the licensing office if medications are to be returned to the pharmacy for disposal.

18. Sample medications are used:

a. Sample medications may be used if given by the prescribing physician.
b. Sample medications must have all the information required on a regular prescription label except pharmacy name and prescription number.

19. Transferring medications for home visits, outings, etc.

a. When a client resident leaves the facility for a short period of time during which only one dose of medication is needed, the facility may give the medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, client's name, name of medication(s), and instructions for administering the dose.
b. If client/resident is to be gone for more than one dosage period, the facility may:

Give the full prescription container to the client/resident, or responsible person/authorized representative,
or

Have the pharmacy either fill a separate prescription or separate the existing prescription into two bottles,
or
Have the client's/resident's family obtain a separate supply of the medication for use when the client/resident visits the family.

c. If it is not safe to give the medications to the client/resident, the medications must be entrusted to the person who is escorting the client/resident off the facility premises.
d. If medications are being sent with the client/resident off the facility premises, check the Physician's Report (LiC 602 or 602a) to ensure that they are given only to clients/residents whose doctors have indicated that they may control their own medications.
e. Always have the person entrusted with the medications sign a receipt which identifies the number and type of medications sent out and returned.

20. House medications/stock supplies of over-the-counter medications are used:

a. Centrally stored, stock supplies of over-the-counter medications may be used.
b. The licensees cannot require clients/residents to use or purchase house supply medications.
c. Clients/residents may use personal funds to purchase individual doses of OTC medications from the licensee's stock if each dose is sold at the licensee's cost and accurate written records are maintained of each transaction.
d. All regulations regarding the use of OTC medications must be followed (see section #12).
e. Be sure to verify that the clients/resident's physician has approved the use of the OTC before giving him/her a dose from the house supply.

f. The date and time and name of the person who gave the medication. .The client's/resident's response to the medication.
g. Lay staff may perform vital sign readings as long as the readings are not used to determine a need for medication.

21. Clients using emergency medication(s) (e.g., nitroglycerin, inhaler, etc.) Clients who have a medical condition requiring the immediate availability of emergency medication may maintain the medication in their possession if all the following conditions are met:

a. The physician has ordered the PRN medication and has determined and documented in writing that the client/resident can determine his/her need for a dosage of the medication and that possession of the medication by the client/resident is safe.
b. This determination by the physician is maintained in the individual's file and available for inspection by Licensing.
c. The physician's determination clearly indicates the dosage and quantity of medication that should be maintained by the client/resident.
d. Neither the facility administrator nor the Department has determined that the medications must be centrally stored in the facility due to risks to others or other specified reasons.
e. If the physician has determined it is necessary for a client/resident to have medication immediately available in an emergency but has also determined that possession of the medication by the client/resident is dangerous, then that client/resident may be inappropriately placed and may require a higher level of care.

22. Blood pressure and pulse readings. The following persons can take blood pressure and pulse readings to determine the need for medications:

a. The client when his/her physician has stated in writing that the

Client's physically and mentally capable of performing the procedure.

b. A physician or registered nurse.
c. A licensed vocational nurse under the direction of a registered nurse or physician.
d. A psychiatric technician under the direction of a physician, surgeon, psychiatrist, or registered nurse.
e. The licensee must ensure that the name of the skilled professional who takes the client's vital signs is documented.

23. . Clients need assistance with the administration of ear, nose and eye drops:

a. The client must be unable to self-administer his/her own eye, ear or nose drops due to tremors, failing eyesight or other similar conditions.
b. The clients condition must be chronic and resistant to sudden change (stable), or temporary in nature and expected to return to a condition normal for the client/resident.
c. The clients Individual Services Plan (RCF-CI) must state that he/she cannot self-administer his/her own drops.
d. The client's physician must document in writing the reasons that the client/resident cannot self-administer the drops, the stability of the medical condition and must provide authorization for the staff to be trained to assist the client/resident.
e. Staff providing the client with assistance must be trained by a licensed professional and names of trained staff must be maintained in the staff files. This training must be completed prior to providing the service, must include hands-on instruction in general and client/resident specific procedures, and must be reviewed and updated by the licensed professional at least annually or more often if the condition changes.
f. Staff must be trained by a licensed professional to recognize objective symptoms observable by a lay person and to respond to the client's/resident's health problem.
g. Staff must be trained in and follow universal precautions and any other procedures recommended by the licensed professional.
h. Written documentation outlining the procedures to be used in assisting the client/resident with the drops and all aspects of care to be performed by the licensed professional and facility staff must be maintained in the clients/resident's file.
i. Prior to providing ongoing client/resident assistance with drops, facility staff should consider the use of assistive devices, such as an eye cup, which would enable the client/resident to self-administer the drops.

24. Medications need to be stored:

a. All medications, including over-the-counters, must always be locked.
b. All medications must be stored in accordance with label instructions (refrigerate, room temperature, out of direct sunlight, etc.).
c. Medication in refrigerators needs to be locked in a receptacle, drawer, or storage containers as metal may rust.)
d. If one client/resident is allowed to keep his/her own medications, the medications need to be locked to prevent access by other clients.

Senior Resource Guide for Central County

Nonprofit and Public Agencies Serving
Castro Valley ● Hayward ● San Leandro ● San Lorenzo
Alameda County Area Agency on Aging
6955 Foothill Boulevard, 3rd Floor, Oakland CA 94605, 1-800-510-2020 / 510-577-3530
http://alamedasocialservices.org (Revised 10/2010)

ADULT DAY CARE/RESPITE (useful web site: www.adsnac.org)

Adult Day Services Network of Alameda County (personalized referrals & community education) ... 510-883-0874
Alzheimer's Services of the East Bay Adult Day Health Care, Hayward ... 510-888-1411
Bay Area Community Services Adult Day Care (serves Hayward), Fremont ... 510-656-7742
Center for Elders Independence (PACE—A Program of All-inclusive Care for the Elderly) ... 510-433-1150
LifeLong Medical Care Adult Day Health Care, East Oakland ... 510-563-4390
St. Peter's Community Adult Day Care, San Leandro ... 510-562-4037

ALCOHOLISM & DRUG ABUSE PREVENTION PROGRAMS

Alameda County Health Care ACCESS (referrals to substance abuse services in Alameda County) ... 1-800-491-9099
Alcoholics Anonymous Central Office, Oakland ... 510-839-8900
CommPre, a program of Horizon Services, Inc.
(Prevention strategies to reduce alcohol and medication misuse among older adults) ... 510-885-8743

ALZHEIMER'S SERVICES

Alzheimer's Association Helpline ... 1-800-272-3900
Alzheimer's Services of the East Bay, Berkeley ... 510-644-8292
Ethnic Elders Care (website focuses on ethnic elders with Alzheimer's and related disorders) www.ethnicelderscare.net
Family Caregiver Alliance (caregiver respite), San Francisco ... 1-800-445-8106
U.C. Davis Alzheimer's Disease Center, Martinez ... 1-925-372-2485

CAREGIVER SUPPORT PROGRAMS

Adult Day Services Network of Alameda County ... 510-883-0874
Alzheimer's Association of Northern California ... 1-800-272-3900
Family Caregiver Alliance ... 1-800-445-8106
Family Education and Resource Center (support for family/caregivers of people with mental illness) ... 510-746-1700
Lincoln Child Center Kinship Support Services Program (grandparent & relative caregivers) ... 510-583-8026
Spectrum Community Services ... 510-881-0300

CASE MANAGEMENT/COORDINATION OF SERVICES FOR HOMEBOUND ELDERS

Bay Area Community Services (BACS) ... 510-271-8843
MSSP (Hayward residents on Medi-Cal) ... 510-574-2041

DISABLED ADULTS SERVICES/PROGRAMS

Alameda County Public Health Department Diabetes Program
(free classes for County residents with Type 2 Diabetes) ... 510-383-5185
American Cancer Society ... 1-800-227-2345
American Diabetes Association ... 510-654-4499
American Heart Association / American Stroke Association ... 510-904-4000
Americans with Disabilities Act (ADA), General Information ... 1-800-949-4232
Aphasia Center of California (services for persons who have had strokes) ... 510-336-0112
Arthritis Foundation ... 1-800-464-6240
Braille & Talking Book Library ... 1-800-952-5666
California Telephone Access Program (CTAP) (accessible phone products/services) ... 1-800-806-1191
... TTY 1-800-806-4474
Community Resources for Independent Living (CRIL) ... 510-881-5743

DISABLED ADULTS SERVICES/PROGRAMS (continued)

DCARA (Deaf Counseling, Advocacy and Referral Agency) 1-866-680-0515
.....TTY 1-877-322-7288
Disability Rights California (formerly Protection & Advocacy, Inc.) 510-267-1200
.....TTY 1-800-649-0154
Hearing and Speech Center of Northern California, San Francisco (testing and product info).... 1-415-921-7658
Lighthouse for the Blind (consumer products), San Francisco 1-415-431-1481
Lions Center for the Blind, Oakland (including services for newly blind seniors) 510-450-1580
MS Friends Support Line (multiple sclerosis peer phone helpline) 1-866-673-7436
National Multiple Sclerosis Society 1-800-344-4867
Parkinson's Institute..... 1-800-786-2958
Wheelchair Breakdown Service (emergency wheelchair transportation and breakdown assistance) 1-877-509-4335
Women's Cancer Resource Center, Oakland..... 510-420-7900

EDUCATION (See also *Senior Centers*)

Castro Valley Adult School..... 510-886-1000
Hayward Adult School..... 510-293-8595
San Leandro Adult School 510-618-4420
San Lorenzo Adult School..... 510-317-4200
U.C. Berkeley (Osher Lifelong Learning Institute – OLLI, www.olli.berkeley.edu)..... 510-642-9934

ELDER ABUSE PREVENTION PROGRAMS

Alameda County Adult Protective Services, Oakland 1-866-225-5277
District Attorney Consumer and Environmental Protection Division – Elder Abuse Unit 510-569-9281
District Attorney Victim/Witness Assistance Division 510-272-6180
Legal Assistance for Seniors (services for persons 60 and older), Oakland 1-800-393-0363

EMERGENCY PREPAREDNESS PROGRAMS

(Note: Contact your local Fire Departments and Offices of Emergency Services)

American Red Cross (preparedness training for groups) 510-595-4459
CARD (Collaborating Agencies Responding to Disasters)
(preparedness training for nonprofit/community agencies) 510-451-3140
Senior Injury Prevention Partnership (discussion groups for older adults)..... 510-577-3535

EMPLOYMENT PROGRAMS

ASSETS Senior Employment Program (for persons 55 and older) 510-238-3535
Eastbay Works One-Stop Business and Career Centers:
Eden Area (24100 Amador St., 3rd Floor, Hayward, 94544) 510-670-5700
SCORE—Service Corps of Retired Employees (provides free business counseling) 510-273-6611
Self-Help for the Elderly – Senior Community Service Employment Program (SCSEP)..... 510-265-8267

END-OF-LIFE PLANNING & ARRANGEMENTS

(Note: Hospice agencies provide support and care services for people facing terminal illness. Contact Senior Information for a list of local hospice agencies.)

Alameda County Bar Association (lawyer referral service-$30 for 30 minute consultation—
pertaining to estate planning, wills and trusts) 510-302-2222
Alameda County Coroner (indigent burial/cremation in case of no next of kin or financial means—
eligibility determined by application)..... 510-268-7300
Alameda County Public Administrator (administers estates of decedents who have no next of kin or
executor) 510-577-1979
Bay Area Funeral Society (consumer education including funeral price survey:
www.bafsweb.org) 510-841-6653
California Advocates for Nursing Home Reform (elder law attorney referral services and information
on Medi-Cal estate recovery) 1-415-974-5171, 1-800-474-1116

END-OF-LIFE PLANNING & ARRANGEMENTS (continued)

California Department of Consumer Affairs' Cemetery and Funeral Bureau
(licenses funeral agencies, publishes consumer guide: www.cfb.ca.gov) 1-800-952-5210
Crisis Support Services of Alameda County (grief counseling, grief support group for seniors).. 1-800-309-2131
Legal Assistance for Seniors (provides workshop on advance health care directive)..... 510-832-3040

ETHNIC / CULTURALLY SPECIFIC SENIOR PROGRAMS

Catholic Charities of the East Bay, Oakland (Immigration and Naturalization Services, Refugee Resettlement Program, Southeast Asian Senior Services) 510-768-3100
Ethnic Elders Care (website focuses on ethnic elders with Alzheimer's and related disorders) www.ethnicelderscare.net
International Institute of the East Bay (immigration legal services)..... 510-451-2846
Jewish Family & Children's Services of the East Bay – Older Adult Services..... 510-558-7800
Lavender Seniors (support services for LGBT—lesbian/gay/bisexual/transgendered—elders) 510-667-9655

FINANCIAL ASSISTANCE (useful websites: www.benefitscheckup.org & www.govbenefits.gov)

Alameda County Social Services Agency:
Eden Area Multi-Service Center (24100 Amador St., Hayward, 94544).. 510-670-6000, 1-800-698-1118
CANHR (California Advocates for Nursing Home Reform), San Francisco
(estate planning for long term care)..... 1-415-974-5171, 1-800-474-1116
CAPI (Cash Assistance Program for Immigrants)..... 510-268-2332, 1-800-648-0954
ECHO Housing (rental assistance; Hayward & San Leandro only)..... 510-581-9380
Social Security / SSI 1-800-772-1213
Veterans Assistance Benefits Counseling (Adult & Aging Services—Hayward Office)..... 510-265-8271

FOOD AND NUTRITION

Home Delivered Meals

S.O.S. Meals on Wheels 510-582-1264

Senior Group Dining ***(congregate meals)***

Hayward Senior Center (Tuesday & Thursday: meals prepared on site)..... 510-881-6766
K.C. Aitken Senior Center (Monday & Wednesday: meals prepared on site) 510-881-6738
Spectrum Community Services (senior community dining; call for list of sites)..... 510-881-0300
Alameda County Community Food Bank 510-635-3663, 1-800-870-3663
Brown Bag Program..... 510-534-8540
Food Stamps 510-670-6000

FRIENDLY VISITORS/TELEPHONE REASSURANCE PROGRAMS

Lavender Seniors (support services for LGBT—lesbian/gay/bisexual/transgendered—elders) 510-667-9655
Senior Center Without Walls (group activities for homebound seniors thru FREE phone conference calls) ... 1-877-797-7299
Senior Services Foundation Friendly Visitor Program 510-347-4620,ext.180
Tele-Care (daily phone calls to people who are homebound or isolated), Alta Bates Medical Center... 510-204-4487

HEALTH INSURANCE PROGRAMS (useful website : www.cahealthadvocates.org)

HICAP (Health Insurance Counseling and Advocacy Program) 510-839-0393
Medi-Cal (Alameda County Social Services Agency):
Eden Area Multi-Service Center (24100 Amador St., Hayward, 94544)..... 510-670-6000
..... 1-800-698-1118
Medicare..... 1-800-633-4227
Alameda County Adult and Aging Services Department:
Medi-Cal Long Term Care (new applicants contact County Medi-Cal Center)..... 510-777-2300, 1-800-698-1118
Medi-Cal Long Term Care (ongoing cases only) 510-577-1900
Medicare Savings Programs (QMB, SLMB, QI-1)..... 510-577-1900
(QMB—Qualified Medicare Beneficiary Program, SLMB—Specified Low-Income Medicare Beneficiary, QI—Qualified Individual)
Uninsured Help Line 1-800-234-1317

HOME IMPROVEMENT PROGRAMS FOR LOW TO MODERATE INCOME HOUSEHOLDS

Alameda County Housing & Community Development 510-670-5398
City of Hayward Housing Conservation Program (Hayward residents only, minor repairs also)..... 510-583-4225
City of San Leandro 510-577-6008

HOUSING ASSISTANCE PROGRAMS

Housing Authorities:
Alameda (County)—Housing Authority of the County of Alameda 510-538-8876
Community Resources for Independent Living (CRIL) (disabled housing assistance) 510-881-5743
ECHO Housing (home seeking, rental assistance, tenant/landlord counseling)..... 510-581-9380
ECHO Housing (reverse mortgage counseling) 510-271-7931
Eden Information & Referral (rental housing information and emergency shelter referrals) 2-1-1
HERA—Housing and Economic Rights Advocates (mortgage counseling)..... 510-271-8443
NID-Housing Counseling Agency (homeowner/foreclosure counseling) 510-268-9792
San Leandro Housing Services Division (information about affordable housing in San Leandro) 510-577-6004

IN-HOME SERVICES

Alameda County In-Home Supportive Services (IHSS Intake & Client Information Services) 510-577-1800
Alameda County In-Home Supportive Services (IHSS Payroll) 510-577-1877
Community Resources for Independent Living (CRIL) (private pay referrals) 510-881-5743
.....TTY – 510-881-0218
Public Authority (IHSS Registry Referral)..... 510-577-1980
Rapid Response (emergency worker replacement for IHSS consumers) 1-866-397-3689

INJURY PREVENTION

Bay Area Community Services (home modification program)..... 510-271-8843
CommPre, a program of Horizon Services, Inc.
(Prevention strategies to reduce alcohol and medication misuse among older adults) 510-885-8743
Spectrum Community Services (exercise and medication management programs) 510-881-0300
Senior Injury Prevention Partnership (falls prevention and older driver safety discussion groups) 510-577-3535

LEGAL SERVICES

AARP Legal Services Network (will refer AARP members to local lawyers)..... www.aarplsn.com
Alameda County Bar Association / Lawyer Referral Service ($30 fee for ½ hr consultation and referral) 510-302-2222
Alameda County Bar Association / Volunteer Legal Services (free assistance for low-income persons) 510-302-2222
Bay Area Legal Aid, Oakland 1-800-551-5554
CANHR (California Advocates for Nursing Home Reform), San Francisco
(estate planning for long term care, lawyer referral service)..... 1-415-974-5171, 1-800-474-1116
Centro Legal de la Raza (low-cost immigration legal services)..... 510-437-1554
East Bay Community Law Center (for low income persons needing legal advice/counsel) 510-548-4040

Eviction Defense Center 510-452-4541
HERA—Housing and Economic Rights Advocates 510-271-8443
Legal Assistance for Seniors, Oakland (services for persons 60 and older) 510-832-3040
SEEDS Community Resolution Center 510-548-2377
Senior Legal Hotline of Northern California (free legal advice by phone for persons over 60)..... 1-800-222-1753

MEDICAL/DENTAL CLINICS & SERVICES

Alameda-Contra Costa Medical Association (doctor referrals) 510-654-5383
Alameda County Medical Center—Winton Wellness Center 510-266-1700
Chabot College Dental Hygiene 510-723-6900
Davis Street Family Resource Center (RotoCare Clinic) 510-347-4620,ext.135
Denti-Cal (information on limited emergency dental services Medi-Cal may still cover)..... 1-800-322-6384
Home CARES Equipment Recyclers..... 510-251-2273
Southern Alameda County Dental Society (referrals)..... 510-782-5442
Tiburcio Vasquez Health Center 510-471-5880

MEDICAL/DENTAL CLINICS & SERVICES (continued)

U.C. Berkeley School of Optometry Eye Clinic 510-642-2020
University of the Pacific Dental Care Center, Union City 510-489-5200

MENTAL HEALTH/COUNSELING PROGRAMS

Alameda County Health Care ACCESS (referrals to mental health services in Alameda County)..... 1-800-491-9099
Asian Community Mental Health Services, Oakland 510-451-6729
Crisis Support Services of Alameda County (Senior In-Home Counseling; Grief Counseling) 1-800-260-0094
Davis Street Family Resource Center Mental Health Program 510-347-4620, ext.160
Eden Hospital Adult Psychiatric Services 510-889-5016
Family Service Counseling Center (outpatient and crisis response)..... 510-483-6715
La Familia Counseling Service (referrals only) 510-881-5921
Mental Health Association of Alameda County : Family Caregiver Support..... 510-835-0188
Mental Health Advocates (benefits advocacy) 510-835-5532
Patients' Rights Advocates..... 510-835-2505
Suicide Prevention/Crisis Support (24 hr line) 1-800-309-2131

NURSING HOME ASSISTANCE / LONG TERM CARE FACILITIES

(useful web sites: www.calqualitycare.org, www.canhr.org, and www.nursinghomeguide.org)

CANHR (California Advocates for Nursing Home Reform), San Francisco
(advice on nursing home selection; residents' rights advocacy) 1-415-974-5171, 1-800-474-1116
Ombudsman (Alameda County Long Term Care Ombudsman Program) 510-638-6878
……(care facility complaint resolution & advocacy; lists of RCFEs, Residential Care Facilities for the Elderly, and SNFs, Skilled Nursing Facilities)
State of California Community Care Licensing (RCFE Licensing)..... 650-266-8800
State of California Department of Health Services (SNF & Home Health Care Agency Licensing)... 1-800-554-0352

PUBLIC GUARDIAN'S OFFICE (court appointed conservatorships)..... 510-577-1900

SENIOR CENTERS (See also: Ethnic/Culturally Specific Senior Programs)

Castro Valley (17800 Redwood Rd., Castro Valley, 94546) 510-881-6738
Hayward (22325 North 3rd St., Hayward, 94546)..... 510-881-6766
San Leandro, Marina Community Center (15301 Wicks Blvd., San Leandro, 94579)..... 510-577-6080
Senior Center Without Walls (group activities for homebound seniors thru FREE phone conference calls) ... 1-877-797-7299

TRANSPORTATION PROGRAMS AND SERVICES

AC Transit Senior Discount..... 510-891-4706
American Cancer Society—Road to Recovery (transportation program for cancer patients) 1-800-227-2345
BART Senior Discount 510-464-7133
DMV Parking Placards for Disabled Drivers 1-800-777-0133
East Bay Paratransit Service (for those who meet ADA criteria)..... 510-287-5000
Flex Route Shuttle (San Leandro only)..... 510-577-3462
Hayward Paratransit Program (Measure B door to door service, except San Leandro city) 510-583-4230
Travel Information (public transportation information for Bay Area, dial 511)..... 510-817-1717
Travel Training (training on how to use AC Transit and BART):
Senior Group Travel Training (United Seniors of Oakland and Alameda County)..... 510-729-0852
Persons with Disabilities One-on-One Training (Center for Independent Living)..... 510-841-4776

UTILITIES ASSISTANCE

California Lifeline (telephone service discounts)..... 1-866-272-0349
California Telephone Access Program (CTAP) (accessible phone products/services)..... 1-800-806-1191
.....TTY 1-800-806-4474
EBMUD Customer Assistance Program (CAP), Salvation Army (water discounts for low-income EBMUD customers)
..... 510-645-9710
HEAP (energy Assistance for low-income households) 510-881-0300
PG&E CARE (discount on gas/electric bills for qualified low-income households) 1-866-743-2273
PG&E Customer Service—Energy Assistance Programs (medical care baseline service, multi-lingual) 1-800-743-5000

UTILITIES ASSISTANCE (continued)

PG&E Energy Partners (weatherization measures, energy-efficient appliances for qualified low-income PG&E customers) 1-800-989-9744
PG&E REACH, Salvation Army (emergency energy assistance Hayward, Castro Valley, San Lorenzo) 510-581-6444
PG&E REACH, Salvation Army (emergency energy assistance for San Leandro)..... 510-793-6319
Weatherization..... 510-881-0300

VETERANS SERVICES

Veterans Assistance Benefits Counseling (Adult & Aging Services)..... 510-577-3547
Veterans Assistance Benefits Counseling (Adult & Aging Services—Hayward Office)..... 510-265-8271
U.S. Department of Veteran's Affairs Counseling..... 1-800-827-1000

VOLUNTEER OPPORTUNITIES

(See also *Friendly Visitor/Telephone Reassurance* & *Food and Nutrition* categories, etc.)

Alameda County Library Homeword Bound Program (home delivery of library materials)..... 510-745-1491
Coming of Age Bay Area (formerly RSVP)..... 1-888-308-1767
Ombudsman (volunteer advocates for persons in long term care facilities)..... 510-638-6878
Stagebridge (senior actors and storytellers), Oakland 510-444-4755
Volunteer Center of the East Bay..... 510-232-0163

IMPORTANT PHONE NUMBERS

Alameda County Area Agency on Aging Senior Information .. 510-577-3530 / 1-800-510-2020

Alameda-Contra Costa County Medical Association (to locate doctors who accept Medi-Cal) 510-654-5383
Alameda County Library Services to Older Adults (Homeword Bound, Programs for Older Adults, Library Computer Training and more) 510-745-1499
Alameda County Social Services Agency:
Eden Area Multi-Service Center (24100 Amador St., Hayward, 94544).. 510-670-6000, 1-800-698-1118
Contra Costa County Senior Information 1-925-229-8434
Eden Information & Referral..... 2-1-1
Eldercare Locator (information on services outside Alameda County/California)..... 1-800-677-1116
55 Alive Driving Classes: check www.aarp.org for a class near you..... 1-888-227-7669
Immigration Questions: International Institute of the East Bay..... 510-451-2846
MedicAlert Service (for persons with special medical needs; call for information) 1-800-432-5378
Public Authority (IHSS Registry Referral)..... 510-577-1980
Public Authority (Centralized Registry Information Line—for worker application and orientation)... 510-577-5694
Public Authority (IHSS Worker Health Benefits Hotline) 510-777-4201
Public Authority (IHSS Worker and Consumer Training) 510-577-3554
Senior Injury Prevention Partnership (SIPP) 510-577-3535
Social Security / SSI 1-800-772-1213

Other guides available from the Area Agency on Aging upon request:

- Senior Housing Guide
- A Listing of Retirement Residences and Continuing Care Retirement Communities
- Emergency Response Programs
- Employment Assistance and Resources for Older Persons
- Food & Nutrition Resources
- Geriatric Care Management & Other Private Services
- Home Health Care, Home Care, and Hospice Agencies
- Mental Health Agencies
- Placement Agencies
- Senior Centers
- SSI/CAPI
- Utilities Assistance