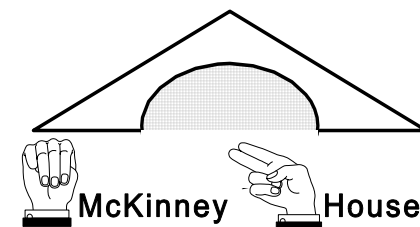


Consumer Handbook and Program Orientation

Piedmont Center for Mental
Health Services
Residential Program



Your case manager's name is:

You are at the McKinney House

Your mailing address and phone number are:

307 Miller Road
Mauldin, SC 29662
(864) 297-5044 – Voice
(864) 297-5130 – TTY
mckhouse.residents@charter.net

Enforcement

The Act is enforced by the:

South Carolina Department of Health and
Environmental Control
Division of Health Licensing and Certification
Office of Health Licensing
2600 Bull Street
Columbia, South Carolina 29201
(803) 737-7202

You may also contact:

Appalachia and Catawba Regional
Ombudsman Program
50 Grand Avenue
P.O. Drawer 6668
Greenville, SC 29606
(864) 242-9733 (voice)
(864) 242-6957 (fax)

Consumer Affairs Representative

The Piedmont Center for Mental Health Services also has a consumer affairs representative who can assist you if there are problems:

Kimberly Fuller
Piedmont Center for Mental Health Services
20 Powderhorn Rd.
Simpsonville, SC 29681
(864) 963-3421 (voice)
(864) 967-8617 (fax)
(864) 967-8835 (tty)
kmf69@dmh.state.sc.us

Non-Retaliation

This facility, by or through its owner, administrator, or operator, or any person subject to the supervision, direction, or control of the owner, administrator, or operator shall not retaliate against a consumer after the consumer or the consumer's legal representative has engaged in exercising rights under the Act by increasing charges, decreasing services, rights, or privileges, or by taking any action to coerce or compel the consumer to leave the facility or by abuse or embarrassing or threatening any consumer in any manner.

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Welcome

Welcome to the Piedmont Center for Mental Health Services Residential Programs. This handbook was created to help orient you to the programs and activities offered through this program. Although there is a lot of information about the program, staff, safety, and rules, always feel free to ask any questions that you might have.

Mission Statement

Our mission is to work with our consumers in improving their quality of life through rehabilitative training in illness, medical management, socially appropriate behaviors, basic living skills and constructive use of leisure time. All our efforts are directed toward enabling our consumers to successfully enter the community.

Philosophy

The underlying principles of the residential programs are designed to encourage consumers' right to self-determination. To that end, consumers will be treated with respect and dignity by all staff members. Consumers will be involved in treatment planning and goal setting and encouraged to be an active participant in the program.

Grievance Procedures

As outlined in the Bill of Rights, each consumer has the right to bring a grievance to the attention of the facility. If the consumer and the staff are unable to resolve the grievance to the satisfaction of the consumer, then the consumer may contact the Facility Client Advocacy Representative to review the grievance. At PCMHS the Client's Advocacy Program Representative is:

Margaret Drake
Piedmont Center for Mental Health Services
20 Powderhorn Rd.
Simpsonville, SC 29681
(864) 963-3421 (voice)
(864) 967-8617 (fax)
(864) 967-8835 (tty)
mmd43@dmh.state.sc.us

You may also contact:

S. C. Department of Mental Health
Client Advocacy Program
P. O. Box 485
Columbia, SC 29202
(803) 734-7740 (voice)
(803) 798-6761 (tty)

10. Allowed to associate and communicate privately with persons of his/her choice and be assured freedom and privacy in sending and receiving mail.
11. Allowed to meet with and participate in activities of social, religious, and community groups at his/her discretion unless medically contraindicated by written medical order.
12. Able to keep and use personal clothing and possessions as space permits unless it infringes on any other resident's rights.
13. Assured privacy for visits of a conjugal nature. Married residents must be permitted to share a room unless medically contraindicated by the attending physician in the medical record.
14. Offered treatment without discrimination as to sex, race, color, religion, national origin, or source of payment.

The Program

Psychosocial Rehabilitation Services

Psychosocial Rehabilitation Services, or PRS for short, is the name of the primary rehabilitative program that is provided in this program. It was developed to support and increase the quality of life and functional abilities of persons with psychiatric disabilities and disorders. By working closely together, staff and consumers hope to develop personal growth, create goals and individual supports, and promote community integration. Some examples of typical classes through PRS include Hair and Skin care, Leisure Skills, Current Events and Decision Making Skills.

Skills Training and Development

Skills Training and Development, or STAD for short, is the name used to describe the type of support provided to people living within our residential services who need wrap-around support in order to stay out of the hospital. STAD is used to describe activities by staff and consumers to develop the resources and skills needed to live in the community. It can include any number of different activities including family contact, skills development groups, conflict resolution and medication management.

Other Programs

In addition to the services provided within our residential programs, consumers may also receive services from the Rainbow or Sunshine Club Houses which provide independent living skills programming. Consumers who are interested in employment may work with the employment specialist or with the South Carolina Department of Vocational Rehabilitation to identify potential employment sites or develop vocational skills.

Consumer Expectations

1. Consumers are expected to be an active participant in the management of their illness. This means becoming a part of the treatment team and expressing personal goals, needs, and problems.
2. Consumers are expected to be on time and participate in all group activities except when medically unable.
3. Consumers are expected to smoke only in designated areas.
4. Consumers are expected to develop and maintain good personal hygiene.
5. Consumers are expected to develop and maintain positive working relationships with peers and staff.

4. Each resident or his/her legal guardian has the right to refuse to participate in experimental research.
5. A resident may be transferred or discharged only for medical reasons, for the welfare of the resident, for the welfare of other residents, or for nonpayment and must be given notice of not less than 30 days.
6. Each resident or his/her representative may manage his/her personal finances unless the facility has been delegated in writing to carry out this responsibility, in which case, the resident must be given a quarterly report of his/her account.
7. Each resident must be free from mental and physical abuse and free from chemical and physical restraints except those restraints ordered by a physician.
8. Assured security in storing personal possessions and confidential treatment of his/her personal and medical records and may approve or refuse their release to any individual outside the facility, except in the case of his/her transfer to another health care institution or as required by law or third-party payment contract.
9. Assured that s/he will not be required to perform services for the facility that are not for therapeutic purposes as identified in his/her plan of care.

Consumer's Rights

Bill of Rights

Federal and State laws include a Bill of Rights for all consumers receiving mental health treatment services. Act #118 of the South Carolina Acts of 1985 provides for the following rights:

1. Prior to or at the time of admission to this facility, each resident or his/her representative must be given by the facility a written and oral explanation of the rights, grievance procedures, and enforcement provisions of the Act.
2. Each resident and his/her representative must be informed in writing of available services and related charges, including all charges not covered under federal or state programs, or by other third party payers, or by the facility's basic per diem rate. Each resident and his/her representative must be informed in writing of any subsequent changes.

AT ALL TIMES:

3. Each resident or his/her legal guardian will receive from his/her physician a complete and current description of his/her diagnosis, plan for treatment, and prognosis in terms which s/he is able to understand.

The Facilities

At present, the PCMHS operates three residential care facilities. In addition, supported apartments and a HomeShare program are available. The other two residential program are specialized programs working with individuals in Columbia. The McKinney House is a facility owned by the Mental Health Association of Greenville County and operated by the PCMHS. The McKinney House is named for J. Charlie McKinney, the first Executive Director of the South Carolina Association of the Deaf. This program is especially designed to meet the needs of persons who are both deaf and mentally ill. There is one building which houses both offices and ten resident rooms, including a large common room, a kitchen and a dining area. The residential care facility is licensed by the Department of Health and Environmental Control as a Community Residential Care Facility.

Street and Mailing Address:

McKinney House
307 Miller Road
Mauldin, South Carolina 29662
(864) 297-5044 (voice)
(864) 297-5130 (tty)
(864) 297-8969 (fax)

mckinneyhouse@charter.net

The Consumers

Consumers must be over 18 years of age at the time of admission and capable of participating in daily activities and completing all self-care activities. Consumers must meet the criteria for needing supportive residential services, including the presence of a serious and persistent mental illness and have had repeated or extended admissions to inpatient psychiatric facilities. All facilities are fully accessible, but consumers must be capable of independent transfer and exit in the event of an emergency. It is the practice and policy of the Piedmont Center for Mental Health Services to accept admissions and provide services to consumers without discrimination because of race, religion, national origin, gender, sexual preference, age, political affiliation, or physical disability.

The Staff

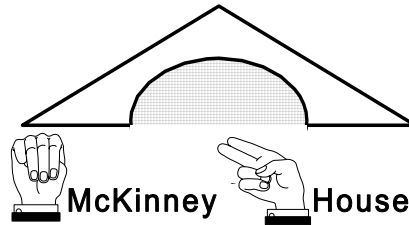
The Mental Health staff at each program is comprised of mental health professionals, clinical counselors and therapeutic assistants. At the McKinney House, mental health assistants provide round-the-clock coverage. The clinical counselors and therapeutic assistants conduct RPT activities up to five hours a day, for five to six days a week. The mental health professionals provide counseling, case management and community liaison services.

Admission

Admissions to the PCMHS residential programs are coordinated by the PCMHS.

For admission to the McKinney House, contact:

Steve Quam
Rehabilitation Program Coordinator
McKinney House
307 Miller Road
Mauldin, South Carolina 29662
(864) 297-5044 (voice)
(864) 297-5130 (tty)
(864) 297-8969 (fax)
mckhouse.admin@charter.net



307 Miller Road ❖ Mauldin, SC, 29662
864-297-5044 (Voice) ❖ 864-297- 5130 (TTY) ❖ 864-297-8969 (Fax)

Resident Agreement

THIS AGREEMENT entered into this day, _____, by and between the MCKINNEY HOUSE, hereinafter referred to as the "Facility" and _____, hereinafter referred to as the "Resident".

WHEREAS, the Facility is licensed as a Community Residential Care Facility, #CRC778 by the South Carolina Department of Health and Environmental Control Regulation Number 61-84, Standards for Licensing for Community Residential Care Facilities, to provide maintenance and care to the disabled or aged adult who is desirous of residing in the Facility:

NOW THEREFORE, the parties hereby do mutually agree as follows:

1. The Facility will provide the following services:
 - a. Private room. Bed and Bath linens.
 - b. Three balanced meals per day. Two snacks per day.
 - c. Special diets will be prepared when ordered by the Physician.
 - d. Laundry Facilities for personal laundry.
 - e. Planned activities and recreation.
 - f. Staff on duty 24 hours per day for assistance and supervision.
 - g. Administration of medications per Physician's orders.
 - h. Staff will assist with personal care as needed.
 - i. Arranging for or assisting with arrangements of medical or dental care.
 - j. Transportation to local doctor, dentist, and local shopping.

- k. Assistance with the arrangements for transportation for Medical Services outside the local area. If arrangements cannot be made or the resident would prefer that transportation be provided by the Facility, the Facility will provide transportation at a cost of thirty cents (0.30) per mile.
 - l. Assistance with arranging transportation to the Church of your choice.
 2. The Resident agrees to the following financial arrangements for care:
 - a. The amount to be paid shall be \$878.00 monthly, payable in advance. The first month will be charged at a pro-rated amount, when applicable. Subsequent months are due and payable on the first day of each month and shall be received no later than the fifth (5th) day of the month.
 - b. A resident whose account is 60 days in the arrears may be discharged for nonpayment. A thirty (30) day written notice will be given to the resident for nonpayment discharge.
 - c. There will be no adjustment for any period that the Resident is away from the Facility on personal leave or hospitalization.
 - d. A thirty (30) day written notice will be given for any changes in the monthly charges or any other changes in the financial arrangements.
 - e. If a Resident is discharged or transferred to another Residential Care facility before the end of the month, a refund based on the daily rate will be given to the Resident. When such a refund is due, such refund shall be provided to the resident within 60 days.
3. The Facility will maintain records acknowledging monthly charges and payments. Upon request, the Facility will provide a statement quarterly which will show the charges and payments for the previous quarter. The Facility will not send monthly invoices or statements for services rendered.
4. The Facility agrees that if any personal funds are held by the Facility only for safekeeping on behalf of the Resident, a written accounting for monies received and disbursed, showing current balance, shall be maintained. Such funds and such accounting shall be made available to the Resident and/or representative quarterly. The balance of such funds shall be returned to the Resident upon discharge from the Facility.
5. The Resident agrees to abide by Facility's Rules and Regulations, (a copy of the Rules and Regulations, signed by the Resident, shall be attached to and become a part of this agreement.)

6. A Resident may bring his/her personal possessions such as radios, TV's, tape players, etc. as space allows and/or determined by the Administrator. All personal items other than clothing and personal care items must be approved by the Administrator and meet existing standards and regulations before they may be brought into the Facility.
7. The Resident should bring enough clothing to adequately meet his/her needs, but should not bring more clothing that can be kept neatly in the closet space provided. The Facility will not be responsible for any damage to the Resident's personal furnishings, or the loss of personal property, including money.
8. The Facility would prefer that Resident not keep more than Ten (\$10.00) dollars in their possession. The Administrator will keep in the Facility safe any monies or valuables the Resident may wish to put in safekeeping. A receipt will be given to the Resident for anything that is put in the Facility's safe.
9. The Facility will not be responsible for any injury incurred in an altercation with another resident.
10. The Resident and/or representative acknowledges that he/she has received a copy of and has had explained to him/her the following:
 - (A) Bill of Rights for Residents of Long-term Care Facilities (Act No. 118, May 31, 1985).
 - (B) The Grievance Procedure of the Facility for implementing the Resident's Bill of Rights.

IN WITNESS, whereby the parties have caused this agreement to be executed by their official signatures hereunder duly authorized.

Representative of Facility	Title	Date
----------------------------	-------	------

Client's Signature	Date
--------------------	------

Representative of Client	Date
--------------------------	------

rev. 05-03-05

Piedmont Center for Mental Health services Adult Application

Name: _____ Date of Birth: _____ Telephone #: _____

Address: _____ Social Security #: _____

Name of nearest relative or contact in case of an emergency: _____
Address and phone Number: _____

1. Have you have received mental health treatment before? Yes No
If yes; where, when and why were you treated? _____

2. Have you ever been treated in a psychiatric hospital before? Yes No
If yes; where, when and why were you treated? _____

3. What do you want help with? _____

4. How will you know when you are ready to stop treatment? _____

5. What are your preferences for treatment? _____

6. What do you like to do? _____

7. What do you do well? _____

8. Have your parents or other family members had emotional problems? Yes No
If yes; where, when and why were they treated? _____

9. What is your present occupation?	10. What was the longest period of time you have worked at any job?
11. How long have you had your present job?	12. How many jobs have you had in the past year?

13. How many times have you been married?	14. How old were you when you first married?
15. How many children do you have?	16. What are your children's ages?

Please list those living in your home:

Name	Age	Relationship

What is your church/religious affiliation? _____

Please check any that have happened to you in the last year:

- | | |
|---|--|
| <input type="checkbox"/> Lost money or property | <input type="checkbox"/> Legal Problems |
| <input type="checkbox"/> Lost, quit, fired, or retired from job | <input type="checkbox"/> Marital Problems |
| <input type="checkbox"/> Engagement or marriage in your family | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Birth or adoption of a child | <input type="checkbox"/> Attempted suicide |
| <input type="checkbox"/> Family member moved in or out of household | <input type="checkbox"/> Problems eating or sleeping |
| | Other _____ |
| <input type="checkbox"/> Worry over family problems | _____ |
| <input type="checkbox"/> Pregnancy or abortion | _____ |
| <input type="checkbox"/> Sex problems | _____ |

Have any of the following happened to you? If yes, check all that apply to you and indicate how old you were when they took place:

- | | |
|--|---|
| <input type="checkbox"/> Death of a close relative or spouse () | <input type="checkbox"/> Long-term physical illness of a family member () |
| <input type="checkbox"/> Divorce of parents () | <input type="checkbox"/> Suicide of a significant person () |
| <input type="checkbox"/> Separation of parents () | <input type="checkbox"/> Murder of a significant person () |
| <input type="checkbox"/> Desertion of a parent () | <input type="checkbox"/> Mental illness of an immediate family member (hospitalization) () |
| <input type="checkbox"/> Desertion of a spouse () | |
| <input type="checkbox"/> Sexual assault () | |

- Have you ever felt the need to cut down on your drinking? Yes No
- Have you ever been annoyed by criticism of your drinking? Yes No
- Have you ever felt guilty about your drinking? Yes No
- Do you ever take an eye opener in the morning to get started? Yes No

Please answer the following questions about yourself:			
1a. Age	1b. Weight	1c. Weight one year ago	1d. Date of last physical
2. Name, address and phone number of family physician:			
3. Have you had:			
Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Areas of numbness	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating habits	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Changes in hair growth	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	“DT’s”	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Ulcers	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems/Hepatitis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual difficulties	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Poor Memory	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Trouble	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sexual Difficulties	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Swelling Ankles	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>
4. Check any of the following allergies which you have:			
<input type="checkbox"/> Drugs (specify)			
<input type="checkbox"/> Food (specify)			
<input type="checkbox"/> Chemicals (specify)			
<input type="checkbox"/> Insects (specify)			
<input type="checkbox"/> Other (specify)			
5. If you have been hospitalized for health problems, give name of hospital, city, state and state where located and when:			
6. List any operations you had and when:			
7. List all medications you are now taking:		Prescribed by:	Non-Prescription Medicine:
8. List all other medications taken in the six months:			

**PIEDMONT CENTER FOR MENTAL HEALTH SERVICES
RESIDENTIAL PROGRAMS
PRE-ADMISSION ASSESSMENT**

I. POTENTIAL RESIDENT PROFILE

Resident's Full Name _____

_____/_____/_____
Date of Birth

Community Residential Care Facility _____

_____/_____/_____
Date of Assessment

Resident's Physical Address _____

Resident's Mailing Address _____

City, State, Zip _____

City, State, Zip _____

Phone Number _____

Educational History: Circle last grade resident has completed.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

II. MEDICAL AND MENTAL HEALTH DIAGNOSES

Medical Diagnoses

Mental Health Diagnoses

III. MEDICATIONS

VII. AMBULATION

No devices [] Uses prosthesis [] Uses cane [] Uses walker [] Uses wheelchair []

Is independently ambulating	_____ yes	_____ no
Needs assistance with transfer	_____ yes	_____ no
Needs assistance to dining and activities	_____ yes	_____ no
Is stable on feet	_____ yes	_____ no
Can climb stairs	_____ yes	_____ no
Can sit and stand	_____ yes	_____ no
Can bend over and pick up objects	_____ yes	_____ no
Receives physical therapy	_____ yes	_____ no
Is able up feet when walking	_____ yes	_____ no

(Circle one)

- 0 pts **Totally Independent** – In ambulation/transfer. May use ambulation aid, but does not require assistance.
- 3 pts **Moderate Assistance** – Regular supervision/instruction is required. Needs assistance to vacate the building
- 5 pts **Significant Assistance** – Requires physical help to transfer/ambulate on a regular basis. Requires escort to dining and activities due to physical handicap (not dementia). Unable to vacate the building without physical assistance
- 7 pts **Total Assistance** – Restriction of movement. May require assistance with walking for routine exercise. Requires more than one staff member for assistance in evacuating building.

VIII. DRESSING/UNDRESSING/GROOMING/HYGIENE FACTORS:

Wears glasses []	Wears dentures []	Wears hearing aids []
Shaves self	_____ yes	_____ no
Dresses self	_____ yes	_____ no
Grooms self (combs own hair)	_____ yes	_____ no
Does hygiene independently (washes face and hands)	_____ yes	_____ no
Dresses appropriately	_____ yes	_____ no
Goes to beauty/barber shop independently	_____ yes	_____ no
Brushes own teeth/dentures	_____ yes	_____ no

(Circle one)

- 0 pts **Totally Independent** – No assistance required. Dresses appropriately.
- 2 pts **Minimal Assistance** – Hands on help once a day (a.m or p.m.)
- 3 pts **Moderate Assistance** – Assistance 2 times per day (a.m. and p.m.) Needs direction and encouragement to dress and undress appropriately.
- 4 pts **Significant Assistance** – Needs assistance in choosing clothing and physical assistance in putting on or taking off clothing. May require clothing change twice daily. Needs assistance sorting clothing.
- 6 pts **Total Assistance** – Physical assistance required with all items of clothing. Requires assistance more than twice daily.

IX. EATING FACTORS:

Regular Diet []	Diabetic Diet []	Low Salt Diet []	Low Fat Diet []	Other Diet []
Dietary Supplement []	Food allergies [] (Specify in comments)		Calories/day _____	
Weight is health and stable	_____ yes	_____ no		
Has a good appetite	_____ yes	_____ no		
Enjoys eating in dining area	_____ yes	_____ no		
Can make menu selections	_____ yes	_____ no		
Is able to eat without assistance	_____ yes	_____ no		
Can cut food independently	_____ yes	_____ no		
Requires special diet	_____ yes	_____ no		

(Circle one)

- 0 pts **Totally Independent** – No assistance required. Eats regular diet.
- 1 pts **Minimal Assistance** – Needs special diet or supplements, reminders to come to 1 -2 meals a day or assistance with cutting food.
- 2 pts **Moderate Assistance** – Needs reminders to 3 meals a day.
- 5 pts **Significant Assistance** – Needs routine direction to eat. May need supervision of intake. May need monitoring of special diet. Regular inappropriate eating behavior. May require one-to-one assistance with eating.

X. TOILETING FACTORS:

Incontinent Bladder []	Incontinent Bowel []	Wears Briefs []	
Needs grab bars on toilet		_____ yes	_____ no
Is independent in toileting		_____ yes	_____ no
Is able to transfer self to toilet		_____ yes	_____ no
Is under physician care for incontinence		_____ yes	_____ no
Is able to use toilet with a raised seat		_____ yes	_____ no
Incontinent at night or only occasionally		_____ yes	_____ no
Can dispose of protective garments independently		_____ yes	_____ no

(Circle one)

- 0 pts **Totally Independent** – No assistance required. Manages incontinence independently. Empties trash daily.
- 2 pts **Minimal Assistance** – Needs daily emptying of used incontinence products or twice daily emptying trash.
- 3 pts **Moderate Assistance** – Needs toileting reminders several times per day (does not include changing briefs) and 2 – 3 brief changes.
- 5 pts **Significant Assistance** – Management of incontinence; taking to bathroom, assistance with taking briefs off and on; emptying trash.
- 7 pts **Total Assistance** – Requires daily assistance with toileting. Must be reminded/supervised in toileting. Incontinence of bladder and/or bowel and requires assistance with laundry or cleaning. Incontinent and requires bed changes often or assistance with briefs.

XI. BATHING FACTORS:

Prefers tub []	Prefers shower []		
Is entirely independent with bathing		_____ yes	_____ no
Is able to do part of bathing independently		_____ yes	_____ no
Needs reminders to bathe		_____ yes	_____ no
Needs/wants to bathe more than once a day		_____ yes	_____ no
Will accept bathing assistance from opposite sex		_____ yes	_____ no
Is receptive to bathing assistance		_____ yes	_____ no

(Circle one)

- 0 pts **Totally Independent** – No assistance required. Is capable of self medication.
- 2 pts **Minimal Assistance** – Assistance with taking medication 1-3 times a day
- 4 pts **Moderate Assistance** – Assistance with taking medications 4 or more times day.
- 7 pts **Total Assistance** – Is resistive to medication administration and/or receives injections or specially prepared medications more than once a week.

XIII. FINANCIAL FACTORS

Receives SSI []	Receives SSA []	Private Pay []
Has a payee	_____ yes	_____ no
Handles small sums of money (under \$50.00) responsibly)	_____ yes	_____ no
Can budget funds for day/week/month	_____ yes	_____ no
Can add and subtract change and make purchases	_____ yes	_____ no
Can open and maintain own bank account	_____ yes	_____ no
Begs money/sundries from others	_____ yes	_____ no
Can make responsible decisions about paying bills	_____ yes	_____ no

(Circle one)

- 0 pts **Totally Independent** – No assistance required. Is capable of managing own funds.
- 2 pts **Minimal Assistance** – Needs a payee. Can handle two weeks worth of funds without difficulty.
- 4 pts **Moderate Assistance** – Needs funds disbursed 1 – 2 times a week. Needs a payee.
- 5 pts **Significant Assistance** - Needs funds disbursed more than twice a week. Needs assistance with determining costs and funds needed.
- 7 pts **Total Assistance** – Needs staff to make small purchases. Begs or intimidates others to obtain additional funds. Not receptive to assistance with managing finances.

Total Points _____

Completed by: _____

Information provided by: Potential Resident [] Family [] Caregiver [] Other []

Comments:

**PIEDMONT CENTER FOR MENTAL HEALTH SERVICES
ANNUAL EMPLOYEE HEALTH CERTIFICATE**

In accordance with the Minimum Standards for Licensing of Hospitals and Institutional General Infirmaries in South Carolina, Regulation No. 61-16; and the Standards for Licensing of Community Residential Care Facilities, Regulation No. 61-84, every employee of the Piedmont Center for Mental Health Services shall have the following report of tuberculin screening completed on an annual basis.

TUBERCULIN SCREENING

_____ received the tuberculin skin test utilizing the
(Name of Individual)

Mantoux method on _____
(Date)

(Test Administered By)

and the results were _____ on _____
(Read in Millimeters) (Date Test Read)

(Test Read By)

CHEST X-RAY NECESSARY ONLY IF PRIOR POSITIVE OR PRESENT TEST IS POSITIVE

_____ received a chest x-ray, if indicated, on _____
(Name of Individual) (Date)

and the results were _____

(Results Verified By)

**PIEDMONT CENTER FOR MENTAL HEALTH SERVICES
PRE-PLACEMENT EMPLOYEE HEALTH CERTIFICATE**

In accordance with the Minimum Standards for Licensing of Hospitals and Institutional General Infirmaries in South Carolina, Regulation No. 61-16; and the Standards for Licensing of Community Residential Care Facilities, Regulation No. 61-84, every new employee of the Piedmont Center for Mental Health Services shall have the following report of physical examination and tuberculin screening completed prior to their first day of employment. The PHYSICAL EXAMINATION must have been completed within twelve (12) months of employment date and the TUBERCULIN SKIN TEST within three (3) months of the employment date. A 2-step tuberculin test is needed for new employees who have not had a tuberculin skin test within the last twelve (12) months.

2nd STEP TUBERCULIN SCREENING

_____ received the tuberculin skin test utilizing the
(Name of Individual)

Mantoux method on _____
(Date)

(Test Administered By)

This test was given 7 to 21 days since the previous test on _____
(Date of Previous Test)

and the results were _____ on _____
(Read in Millimeters) (Date Test Read)

(Test Read By)

CHEST X-RAY NECESSARY ONLY IF PRIOR POSITIVE OR PRESENT TEST IS POSITIVE

_____ received a chest x-ray, if indicated, on _____
(Name of Individual) (Date)

and the results were _____

(Results Verified By)



**A Program of the Piedmont Center for Mental Health Services
307 Miller Road, Mauldin, SC 29662
(864) 297-5044 Voice • (864) 297-5130 TTY • (864) 297-8969 Fax**

McKinney House Rules

1. Smoking is allowed only on the North Patio.
2. No resident of the McKinney House will leave without the knowledge of a staff member or responsible party. A release of responsibility form must be signed when leaving the premises with family and friends.
3. Respect the property of the facility and other residents. Residents are not allowed to damage rooms or furnishings.
4. Observe social courtesies to the staff and other residents, no abusive language or profanity will be tolerated. Abuse of other residents and staff is prohibited.
5. No open food or drinks are allowed in the bedrooms, except where medically necessary. Residents may eat or drink in the living room, dining room, and patio areas. All personal food and drinks will be labeled and kept in the kitchen or refrigerator.
6. A telephone and TTY are available for local and collect long distance calls for private conversations.
7. No alcoholic beverages or intoxicating substances will be allowed on the grounds.
8. All residents must participate in all fire and disaster drills. This is for your safety.
9. Personal items, such as clothing, shampoo, deodorant, etc., shall be paid for by the resident as necessary to maintain proper hygiene.
10. Residents may have a small TV, radio or other personal belongings in their room.

11. No medication of any kind (this included over the counter medications) will be allowed in the room unless you have a physician's order.
12. Residents will be responsible for all medical costs; including medication. Medications are supplied at the facility by the Mauldin Family Pharmacy, unless the resident has an alternative preference, per physician's order. It will be the responsibility of the resident to pay any balance of their account at the pharmacy not paid by third party payers.
13. No contraband such as firearms, slingshots, sticks, knives or other hazardous materials are to be kept in rooms.
14. Residents are responsible for attending all scheduled groups and showing up on time.
15. Cleaning supplies are to be kept in the storage room. No supplies are to be kept in the resident's room. You must ask staff for cleaning supplies.
16. Residents are responsible for the upkeep of their rooms and bathrooms.
17. Residents will be responsible for washing and ironing their own clothes and leaving the laundry room clean.
18. If a resident is their own payee they can choose to keep the money themselves or put it in the safe for safekeeping.
19. No resident is allowed in another resident's room except by invitation.
20. You must pick up cans and paper in the dining area and living areas after eating or drinking. Help keep the home and grounds clean.