ENHANCED ASSISTED LIVING ADDENDUM TO RESIDENCY AGREEMENT

Heather Heights of Pittsford
160 W. Jefferson Rd. Pittsford, NY 14534

This is an addendum to a Residency Agreement made between Heather Heights of Pittsford, Inc. (the "Operator"), _____, (the "Resident or you"), _____, (the "Resident's Representative"), and _____, (the "Resident's Legal Representative"). Such Residency Agreement is dated _____.

This addendum adds new sections and amends, if any, only the section specified in this Addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Agreement. This Addendum must be attached to the Residency Agreement between the parties.

Enhanced Assisted Living Certificates
The operator is currently certified by the New York State Department of Health to provide Enhanced Assisted Living at **HEATHER HEIGHTS OF PITTSFORD,** located at **160 WEST JEFFERSON ROAD, PITTSFORD, NY 14534.**

Physician Report:
You have submitted to the Operator a written report from your physician, which report states:

a. Your Physician has physically examined you within the last month prior to your admission into this Enhanced Assisted Living Residence.
b. You are not in need of 24- hour skilled nursing care of medical care which would require placement in a hospital or nursing home

Request for and Acceptance of Admission
You have requested to become a Resident at this Enhanced Assisted Living Residence, (the "Residence") and the Operator has accepted your request.

Specialized Programs Staff Qualifications and Environmental Modifications
The following services will be provided to You in the Enhanced Assisted Living Residence (check all that apply):

☐ Physical assist with transfers including assistance in the use of a transfer belt or mechanical lift.
☐ Physical assist with ambulation
☐ Wheelchair transportation
☐ Physical assistance with toileting / toileting schedule
☐ Physical assistance with dressing
☐ Showering Assistance
☐ Assist with meals by prompting and cuing
☐ Behaviors that can be managed with continuous interventions
☐ Oxygen Management – including Pulse Ox, CPAP and BiPAP

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☐ Foley catheter Care – empty, monitoring function, changing of night / day bags
☐ Ostomy Care – emptying, monitoring function, changing of appliance
☐ Incontinence Management
☐ Intramuscular & Subcutaneous Injectable Medications / Diabetic Reporting by a licensed nurse
☐ Assistance with Medication Administration
☐ Wanderguard
☐ Other/Additional (*Type below)*

_____

Staffing levels will be maintained in compliance with all applicable laws and regulations appropriate for the level of care needed to provide required supervision and perform all the tasks necessary to meet the Residents' needs. The enhanced program will be staffed with personal care aides and licensed nurses to provide supervision and meet the needs of Residents at all times. The staffing plan will be adjusted to meet the needs and census of Residents enrolled in the enhanced program. There is a comprehensive activities program with an activities staff that plans and conducts activities designed to promote Residents' activity in the Residence.

- Nursing Services and Oversight
- Case Management
- Increased staffing matrix based on resident needs
- Additional training provided to direct care staff including Personal Care Services, first aid and body mechanics to effectively and respectfully meet the needs of persons retained in the Residence. The training includes methods on assisting with mobility impairments and, for licensed staff, delivering the available nursing services detailed and applicable in this Addendum.
- Some services may be required to have outside nursing in place to oversee; Foley care and placement, or other skilled services. Cost associated with additional services is not included in your rate.
- In addition to the environmental provisions made and described in the Residency Agreement, Environmental modifications such as; upgraded sprinkler system, specialized toilet seats, and grab bars in bathrooms are available to the Resident.

Based on the physical assessment completed, your fees associated with these Enhanced services are $_____ per day. This assessment will be completed every 6 months, when physician requests or there is a change in resident's condition or needs change to review care level needs.

Aging in Place

The Operator has notified you that, while the Operator will make reasonable efforts to facilitate your ability to age in place according to your Individualized Service Plan, there may be a point reached where your needs cannot be safely or appropriately met at the Residence: If this occurs, the Operator will communicate with you regarding the need to relocate to a more appropriate setting, in accordance with law.

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If 24 hour Skilled Nursing or Medical Care is needed

If you reach the point where you are in need of 24-hour skilled nursing care or medical care that is required to be provided by a hospital, nursing home or facility licensed under the New York State Mental Hygiene Law, the Operator will initiate proceedings for the termination of Your Residency Agreement and to discharge You from residency, UNLESS each of the following conditions are met:

a. You hire appropriate nursing, medical or hospice staff to care for your increased needs; AND
b. Your Physician and a home care services agency both determine and document that with the provision of such additional nursing, medical or hospice care you can be safely cared for in the Residence, and would not require placement in a hospital, nursing home or other facility licensed under Public Health Law Article 28 or Mental Hygiene Law Article 19, 31 or 31; AND
c. The Operator agrees to retain you as a Resident and to coordinate the care provided by the operator and the additional nursing, medical or hospice staff; AND
d. You are otherwise eligible to reside at the Residence.

Addendum Agreement Authorization

We, the undersigned, have read the EALR Addendum Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Date: _____ _____
Resident

Date: _____ _____
Resident's Representative

Date: _____ _____
Resident's Legal Representative

Date: _____ _____
Operator or Operator's Representative

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