

**EVERGREEN PLACE, ENHANCED,  
ASSISTED LIVING & MEMORY CARE  
RESIDENCY AGREEMENT**

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## RESIDENCY AGREEMENT

This agreement (“Agreement”) is made between Evergreen Place at Brockport Inc. (the “Operator”), (the “Resident” or “You”), \_\_\_\_\_ (the “Resident’s Representative”, if any) and \_\_\_\_\_ (the “Resident’s Legal Representative”, if any).

### RECITALS

**A.** The Operator is licensed by the New York State Department of Health to operate at 90 West Avenue, Brockport, New York 14420, an Assisted Living Residence (the “Residence”) known as Evergreen Place, Enhanced, Assisted Living & Memory Care and as an Enriched Housing program. The Operator is also certified to operate, at this location, an Enhanced Assisted Living Residence and/or Special Needs Assisted Living Residence.

**B.** You have requested to become a Resident at the Residence and the Operator has accepted your request.

### AGREEMENTS

#### **I. Housing Accommodations and Services.**

Beginning on \_\_\_\_\_, (insert beginning date of residency), the Operator shall provide the following housing accommodations and services to You, subject to the other terms, limitations and conditions contained in this Agreement. This Agreement will remain in effect until amended or terminated by the parties in accordance with the provisions of this Agreement.

#### **A. Housing Accommodations and Services**

- 1. Your Apartment.** You may occupy and use a Studio ( ). One-Bedroom ( ), or ( ) Companion Apartment identified on Exhibit I.A.1., subject to the terms of this Agreement.

2. **Common areas.** You will be provided with the opportunity to use the general-purpose rooms at the Residence such as lounges and all other common areas. You will be able to use the common areas at the Community between the hours **of 7am and 8pm** for scheduled group activities or unscheduled group or individual recreation. Whenever a common area is temporarily unavailable for maintenance or administrative activities such as staff training, other common areas suitable for recreation will remain available for resident use.

3. **Furnishings/Appliances Provided By The Operator**

Attached as Exhibit I.A.3. and made a part of this Agreement is an Inventory of furnishings, appliances and other items supplied by the Operator in Your Apartment.

4. **Furnishings/Appliances Provided by You**

Attached as Exhibit I.A.4. and made a part of this Agreement is an Inventory of furnishings, appliances and other items supplied by You in your Apartment. Such Exhibit also contains any limitations or conditions concerning what type of appliances may not be permitted (e.g., due to amperage concerns, etc.)

**B. Basic Services**

The following services (“Basic Services”) will be provided to You in accordance with your Individualized Service Plan:

1. **Meals and Snacks.** We will furnish three nutritionally well-balanced meals per day with one snack available in Assisted Living and two snacks

available in Memory Care. However, snacks are available 24 hours a day and included in Your Basic Rate. The following modified diets will be available to You if ordered by Your physician and included in Your Individualized Service Plan: Pureed, Ground, and Chopped. At a minimum, one hot meal will be provided daily, either at midday or in the evening. Food and beverages will also be available in the front lounge areas during non-meal times.

2. **Activities.** The Operator will provide a program of planned activities, opportunities for community participation and services designed to meet Your physical, social and spiritual needs. The Operator will post a monthly schedule of activities in a readily visible common area of the Residence.
3. **Housekeeping.** We will provide light housekeeping on an as-needed basis, but no less than once a week.
4. **Linen Service.** We will launder your bed linens on an as-needed basis, but no less than once a week.
5. **Laundry of Your Washable clothing.** We will launder your personal belongings on an as-needed basis, but no less than once a week.
6. **Supervision on a 24-hour basis.** The Operator will provide appropriate staff on-site to provide supervision services in accordance with law. Supervision will include monitoring (a response to urgent or emergency needs or requests for assistance on a 24-hour a day, seven days a week basis) as well as the other components of supervision as specified in law.

7. **Case Management.** The Operator will provide appropriate staff to provide case management services in accordance with law. Such case management services will include identification and evaluation of Your needs and interests, information and referral, and coordination with available resources to best address Your identified needs and interests.
8. **Personal Care.** Personal care services available to all ALR residents include some assistance with personal hygiene (including dressing, bathing, and grooming), assisting with self-administration of medications, and as otherwise needed by the individual to carry out the activities of daily living, maintain good health, and participate in the ongoing activities of the enriched housing program. Services for each resident are detailed in the residents' Individualized Services Plan (ISP). Detailed fees for personal care services are included in this Agreement's rate or fee schedule.
9. **Development of Individualized Service Plan An Individualized Service Plan** will be developed to address The resident's needs. This plan will be reviewed and revised every six(6) months and whenever ordered by the Resident's physician or as frequently as necessary to reflect the changing care needs of the Resident.

**C. Additional Services.**

Exhibit I.C., attached to and made a part of this Agreement, describes in detail, any additional services or amenities available for an additional, supplemental or community fee from the Operator directly or through arrangements with a third-party vendor. Such exhibit states who would provide such services, if other than the Operator.

**D. Licensure/Certification Status With the Operator**

This Residence does not offer home care or personal care services under an arrangement with any third party-provider. If such arrangement shall occur in the future, a listing of all providers, offering home care or personal care services under an arrangement with the Operator, with a description of the licensure or certification status of each provider will be set forth in Exhibit I.D. of this Agreement as an amendment. Such Exhibit will be updated as frequently as necessary.

**II. Disclosure Statement**

The Operator is disclosing information required under Public Health Law Section 4658 (3). Such disclosures are contained in the Disclosure Statement at Exhibit II, attached to and made part of this Agreement.

**III. Fees**

**A. Basic Rate**

**(1) Flat Fee Arrangements**

Assisted Living Residences are permitted to charge for services on a flat fee basis, where all Basic Services in Section I B. are included in a single fee, or a tiered fee basis, where charges for Basic Services in Section I B. are determined by the type of services provided or the number of hours of care provided. This is referred to as the “Basic Rate”. This community/residence operates with a flat fee or tiered fee Basic Rate.

**(2) Tiered Fee Arrangements**

Any “Tiered” fee arrangements, in which the amount of the Tiered Rate depends upon the type of services provided and the fees for each “tier” of care, are set forth in detail in Exhibit III.A. and assessed using the Evaluation Form as set forth in detail in Exhibit XVIII., both exhibits made a

part of this Agreement. Such Exhibit describes the types of services provided and the fees for each “tier” of care, and describe who will be providing care, if other than staff of the Operator.

## **B. Supplemental, Additional or Community Fee**

The Residency Agreement includes a description of supplemental and additional fees from the Operator directly or through arrangements with the Operator, stating who provides such services if not the Operator, and provide a detailed explanation of the services and amenities covered by the rates, fees or charges. See Exhibit III. C.

A Supplemental fee is a fee for service, care or amenities that is in addition to those fees included in the Basic Rate

A Supplemental fee must be at the Resident’s option. Any charges for supplemental fees by the Operator shall be made only for services and supplies that are actually supplied to the Resident.

An additional fee can be charged if included in the fee schedule and selected by the resident. In some cases, the law permits the Operator to charge an additional fee without the express written approval of the Resident (See Section III E)

Community fee is a one-time fee that the Operator may change at the time of Admission. The operator must clearly inform the prospective Resident what the amount of the Community fee will be as well as any terms regarding refunds of the Community fee. The prospective Resident, once fully informed of the terms of the Community fee, may choose whether to accept the Community fee as a condition of residency in Evergreen Place Enhanced Assisted Living and Memory Care or

to reject the Community fee and thereby reject residency at Evergreen Place Enhanced Assisted Living and Memory Care.

**C. Rate or Fee Schedule**

Attached as Exhibit III. C and made a part of this Agreement is a rate or fee schedule, covering both the Basic Rate, Tiered Level of Service Fee, and any Additional, Supplemental or Community Fees, for services, supplies and amenities provided to You, with a detailed explanation of which services, supplies and amenities are covered by such rate fees or charges. The amount of the one-time community fee is \$ 4,500.00. The community fee is non-refundable.

**D. Billing and Payment Terms**

Payment is due by 1<sup>st</sup> calendar day of the month and shall be delivered to the Concierge Desk or mailed to Evergreen Place, Enhanced, Assisted & Memory Care, 90 West Avenue, Brockport, New York 14420. The Residence shall charge a two hundred and fifty-dollar (\$250.00) late Fee for any payment made after the fifth (5th) day of the month. In the event the Resident, Resident's Representative or Resident's legal representative, as applicable, is no longer able to pay for services provided for in this Agreement or additional services or care needed by the Resident, the Operator may issue a notice of termination, as more fully described in Section XIII.

**E. Adjustments to Basic Rate, Additional or Supplement Fees**

1. You have the right to written notice of any proposed increase of the Basic Rate or any Additional or Supplement Fees not less than forty-five (45) days prior to the effective date of the rate or Fee increase, subject to the exceptions stated in paragraphs 3, 4 and 5 below.
2. Since a Community Fee is a one-time Fee, there can be no subsequent increase in a Community Fee charged to You by the Operator, once You have been admitted as a Resident.

3. If You, or Your Resident Representative or Legal Representative agree in writing to a specific Rate or Fee increase, through an amendment of this Agreement, due to Your need for additional level of care, services or supplies, the Operator may increase such Rate or Fee upon less than forty-five (45) days written notice.
4. If the Operator provides additional care, services or supplies upon the express written order of Your primary physician, the Operator may, through an amendment to this Agreement, increase the Basic Rate or and Additional or Supplemental fee upon less than forty-five (45) days written Notice.
5. In the event of any emergency which affects You, the Operator may assess additional charges for Your benefit as are reasonable and necessary for services, material, equipment and food supplied during such emergency.

#### **F. Bed Reservation**

The Operator agrees to reserve a residential space as specified in Section I.A.1 above in the event of Your absence. The charge for this reservation fee is \$ \_\_\_\_\_ per \_\_\_\_\_. (The total of the daily reservation charge rate for a one-month period may not exceed the established monthly rate). There is no limit on the number of days the Residence will hold your bed reservation so long as You continue to pay the Basic Rate. A provision to reserve a residential space does not supersede the requirements for termination as set forth in Section XIII of this Agreement. You may choose to terminate this Agreement rather than reserve such space but must provide the Operator with any required notice.

#### **IV. Refund/Return of Resident Monies and Property**

Upon termination of this Agreement or at the time of Your discharge, but in no case more than three business days after Your discharge from the Residence, the Operator must provide You, Your

Representative, or Legal Representative or any person designated by You with a final written statement of Your payment and personal allowance accounts at the Residence.

The Operator must also return at the time of Your discharge, but in no case more than three business days any of Your money or property which comes into the possession of the Operator after Your discharge. The Operator must refund on the basis of a per diem proration any advance payment(s) which You have made.

If You die, the Operator must turn over Your property to the legally authorized representative of Your estate. If You die without a Will and the whereabouts of Your next-of-kin is unknown, the Operator shall contact the Surrogate's Court of the County wherein the Residence is located in order to determine what should be done with property of Your estate.

**V. Transfer of Funds or Property to Operator**

If You wish to voluntarily transfer money, property or things of value to the Operator upon admission or at any time, the Operator must enumerate the items given or promised to be given and attach to this Agreement a listing of the items given to be transferred. Such listing is attached as Exhibit V. and is made a part of this Agreement. Such listing shall include any agreements made by third parties for Your benefit.

**VI. Property or items of value held in the Operator's custody for You.**

If, upon admission or any other time, You wish to place property or things of value in the Operator's custody and the Operator agrees to accept the responsibility of such custody, the Operator must enumerate the items so placed and attach to this Agreement a listing of such items. Such listing is attached as Exhibit VI. of this Agreement.

**VII. Fiduciary Responsibility**

If the Operator assumes management responsibility over Your funds, the Operator shall maintain such funds in a fiduciary capacity to You. Any interest on money received and held for You by the Operator shall be Your property.

**VIII. Tipping**

The Operator must not accept, nor allow Residence staff or agents to accept, any tip or gratuity in any form for any services provided or arranged for as specified by statute, regulation or Agreement.

**IX. Personal Allowance Accounts**

The Operator does not hold personal allowance accounts for Residents. Residents are responsible for managing their own personal funds.

**X. Admission and Retention Criteria for an Assisted Living Residence**

1. Under the law which governs Assisted Living Residences (Public Health Law Article 46-b), the Operator shall not admit any Resident if the Operator is not able to meet the care needs of the Resident, within the scope of services authorized under such law, and within the scope of services determined necessary within the Resident's Individualized Service Plan. An operator shall not exclude an individual on the basis of an individual's mobility impairment and shall make reasonable accommodations to the extent necessary to admit such individuals, consistent with federal, state, and local laws.
2. The Operator shall conduct an initial pre-admission evaluation of a prospective Resident to determine whether the individual is appropriate for admission.

3. The Operator has conducted such evaluation of Yourself and has determined that You are appropriate for admission to this Residence, and that the Operator is able to meet Your care needs within the scope of services authorized under the law and within the scope of services determined necessary for You under Your Individualized Service Plan.
4. If You are being admitted to a duly certified Enhanced Assisted Living Residence, the additional terms of the “Enhanced Assisted Living Residence Addendum” will apply.
5. If You are being admitted to a Special Needs Assisted Living Residence, the “Special Needs Assisted Living Residence Addendum” will apply.
6. If You are residing in a “Basic” Assisted Living Residence and Your care needs subsequently change in the future to the point that You require either Enhanced Assisted Living Care or 24-hour skilled nursing care, You will no longer be appropriate for residency in this Basic Residence. If this occurs, the Operator will take the appropriate action to terminate this Agreement, pursuant to Section XIII of the Agreement. However, if the Operator also has an approved Enhanced Assisted Living Certificate, has a unit available, and is able and willing to meet Your needs in such unit, You may be eligible for residency in such Enhanced Assisted Living unit.
7. Enhanced Assisted Living Care is provided to persons who desire to continue to age in place in an Assisted Living Residence and who: (a) chronically require the physical assistance of another person in order to walk; or (b) chronically required the physical assistance of another person

to climb or descend stairs; or (c) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or (d) have chronic unmanaged urinary or bowel incontinence.

8. Enhanced Assisted Living Care may also be provided to certain persons who desire to continue to age in place in an Assisted Living Residence and who are assessed as requiring 24-hour skilled nursing care or medical care and who meet the conditions stated in the Enhanced Assisted Living Residence Addendum.

#### **XI. Rules of the Residence - Resident Handbook**

Attached as Exhibit XI., and made a part of this Agreement, are the Rules of the Residence in the Resident Handbook. By signing this Agreement, You and Your Representative agree to obey all reasonable Rules of the Residence and the Resident Handbook.

#### **XII. Responsibilities of Resident, Resident's Representative and Resident's Legal Representative**

A. You, Your Representative or Legal Representative to the extent specified in this Agreement, are responsible for the following:

1. Payment of the Basic Rate and any authorized Additional and agreed-to Supplement or Community Fees as detailed in this Agreement.
2. Supply of personal clothing and effects.
3. Payment of all medical expenses including transportation for medical purposes, except when payments are available under Medicare, Medicaid or other third party coverage.

4. At the time of admission and at least once every twelve (12) months, or more frequently if a change in condition warrants, providing the Operator with a dated and signed medical evaluation that conforms to regulations of the New York State Department of Health.
5. Informing the Operator promptly of change in health status, change in physician, or change in medications.
6. Informing the Operator promptly of any change of name, address and/or phone number.

**B.** The Resident's Representative, and/or Legal Representative as appropriate, shall be responsible for the following in the event the condition of the Resident requires such assistance, and upon our request:

1. Participating with our associates in evaluating Resident's needs and in planning an appropriate plan for Resident's care;
2. Maintaining Resident's welfare and fulfilling Resident's obligations under the Residency Agreement;
3. Assisting the Operator in relocating Resident following termination and removing the Resident's property;
4. Assisting in the Resident's transfer to a hospital, nursing home, or other facility in the event that Resident requires care we do not offer;
5. Making necessary arrangements for funeral services and burial in the event of death.

### **XIII. Termination and Discharge**

This Residency Agreement and residency in the Residence may be terminated in any of the following ways:

1. By mutual Agreement between You and the Operator;
2. Upon 30 days' notice from You or Your Representative to the Operator of Your intention to terminate the Agreement and leave the facility;
3. Upon 30 days written notice from the Operator to You, Your Representative, Your next of kin, the person designated in this Agreement as the responsible party and any person designated by You. Involuntary termination of a Residency Agreement is permitted only for the reasons listed below, and then only if the Operator initiates a court proceeding and the court rules in favor of the Operator.

The grounds upon which involuntary termination may occur are:

1. You require continual medical or nursing care which the Residence is not permitted by law or regulation to provide;
2. If Your behavior poses imminent risk of death or imminent risk of serious physical harm to You or anyone else;
3. You fail to make timely payment for all authorized charges, expenses and other assessments, if any, for services including use and occupancy of the premises, materials, equipment and food which You have agreed to pay under this Agreement. If Your failure to make timely payment resulted from an interruption in Your receipt of any public benefit to which You are entitled, no involuntary termination of this Agreement can take place unless

the Operator, during the thirty-day period of notice of termination, assists You in obtaining such public benefits or other available supplemental public benefits. You agree that You will cooperate with such efforts by the Operator to obtain such benefits.

4. You repeatedly behave in a manner that directly impairs the well-being, care or safety of Yourself or any other Resident, or which substantially interferes with the orderly operation of the Residence;
5. The Operator has had his/her operating certificate limited, revoked, temporarily suspended or the Operator has voluntarily surrendered the operation of the facility;
6. A receiver has been appointed pursuant to Section 461-f of the New York State Social Services Law and is providing for the orderly transfer of all residents in the Residence to other residences or is making other provisions for the Residents' continued safety and care.

If the Operator decides to terminate the Residency Agreement for any of the reasons stated above, the Operator will give You a notice of termination and discharge, which must be at least 30 days after delivery of notice, the reason for termination, a statement of Your right to object and a list of free legal advocacy resources approved by the New York State Department of Health.

You may object to the Operator about the proposed termination and may be represented by an attorney or advocate. If You challenge the termination, the Operator, in order to terminate, must institute a special proceeding in court. You will not be discharged against Your will unless the court rules in favor of the Operator.

While legal action is in progress, the Operator must not seek to amend the Residency Agreement in effect as of the date of the notice of termination, fail to provide any of the care and services required by Department regulations and the Residency Agreement, or engage in any action to intimidate or harass You. Both You and the Operator are free to seek any other judicial relief to which they may be entitled.

The Operator must assist You if the Operator proposes to transfer or discharge You to the extent necessary to assure, whenever practicable, Your placement in a care setting which is adequate, appropriate and consistent with Your wishes.

#### **XIV. Transfer**

Notwithstanding the above, an Operator may seek appropriate evaluation and assistance and may arrange for Your transfer to an appropriate and safe location, prior to termination of a Residency Agreement and without 30 days' notice or court review, for the following reasons:

1. When You develop a communicable disease, medical or mental condition, or sustain an injury such that continual skilled medical or nursing services are required;
2. In the event that Your behavior poses an imminent risk of death or serious physical injury to him/herself or others; or
3. When a Receiver has been appointed under the provisions of New York State Social Services Law and is providing for the orderly transfer of all Residents in the Residence to other residences or is making other provisions for the Residents' continued safety and care.

If You are transferred, in order to terminate Your Residency Agreement, the Operator must proceed with the termination requirements as set forth in Section XIII of this Agreement, except

that the written notice of termination must be hand delivered to You at the location to which You have been moved. If such hand delivery is not possible, then the notice must be given by any of the methods provided by law for personal service upon a natural person.

If the basis for the transfer permitted under parts 1 and 2 above of this Section no longer exists, You are deemed appropriate for placement in this Residence and if the Residency Agreement is still in effect, You must be readmitted.

**XV. Resident Rights and Responsibilities**

Attached as Exhibit XV and made a part of this Agreement is a Statement of Resident Rights and Responsibilities. This Statement will be posted in a readily visible common area in the Residence. The Operator agrees to treat You in accordance with such Statement of Resident Rights and Responsibilities.

**XVI. Complaint Resolution**

The Operator's procedures for receiving and responding to Resident grievances and recommendations for change or improvement in the Residence's operations and programs are attached as Exhibit XVI. and made a part of this Agreement. In addition, such procedures will be posted in a readily visible common area of the Residence. The Operator agrees that the Residents of the Residence may organize and maintain councils or such other self-governing body as the Residents may choose. The Operator agrees to address any complaints, problems, issues or suggestions reported by the Residents' Organization and to provide a written report to the Residents' Organization that addresses the same. Complaint handling is a direct service of the Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman is available to identify, investigate and resolve Your complaints in order to assist in the protection and exercise of Your rights.

## **XVII. Miscellaneous Provisions**

1. This Agreement constitutes the entire Agreement of the parties.
2. This Agreement may be amended upon the written Agreement of the parties; provided however, that any amendment or provision of this Agreement not consistent with the statute and regulation shall be null and void.
3. The parties agree this Agreement and related documents executed by the parties shall be maintained by the Operator in files of the Residence from the date of execution until three years after the Agreement is terminated. The parties further agree that such agreements and related documents shall be made available for inspection by the New York State Department of Health upon request at any time.
4. Waiver by the parties of any provision in this Agreement which is required by statute or regulation shall be null and void.

***Signatures on the next page.***

**XVIII. Agreement Authorization**

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

Dated: \_\_\_\_\_  
(Signature of Resident)

Dated: \_\_\_\_\_  
(Signature of Resident’s Representative)

Dated: \_\_\_\_\_  
(Signature of Resident’s Legal Representative)

Dated: \_\_\_\_\_  
(Signature of Operator or the Operator’s  
Representative)

**Optional Personal Guarantee of Payment**

Personal Guarantee of Payment Per regulation at Title 10 of New York Codes, Rules, and Regulations at section 1001.8(f)(4)(xvii), the Operator cannot mandate that a resident or other person agree to a guarantor of payment as a condition of admission unless the Operator has reasonably determined on a case-by-case basis, that the prospective resident would lack either the current capacity to manage financial affairs and/or the financial means to assure payments due under this Residency Agreement.

Insert Name \_\_\_\_\_, personally, guarantees payment of charges for Your Basic Rate.

Insert Name \_\_\_\_\_, personally, guarantees payment of charges for the following services, materials, or equipment, provided to You, that are not covered by the Basic Rate:

Services, materials, or equipment not covered in the Basic Rate for which the Guarantor is responsible

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Guarantor's Signature

\_\_\_\_\_  
Guarantor's Name (Print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Copy of Driver's License Attached

**Optional Guarantor of Payment of Public Funds**

If You have a signatory to this Agreement besides Yourself and that signatory controls all or a portion of Your public funds (SSI, Safety Net, Social Security, Other), and if that signatory does not choose to have such public funds delivered directly to the Operator, then the signatory hereby agrees that he/she will personally guarantee continuity of payment of the Basic Rate and any agreed upon charges above and beyond the Basic Rate from either Your Personal Funds (other than Your Personal Needs Allowance), or SSI, Safety Net, Social Security or other public benefits, to meet Your obligations under this Agreement.

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Guarantor's Signature

---

Guarantor's Name (Print Name)

**EXHIBIT I.A.1**

**IDENTIFICATION OF APARTMENT**

**YOU HAVE AGREED TO RESIDE IN APARTMENT NUMBER \_\_\_\_\_.**

**Check appropriate blank:**

**THIS APARTMENT IS \_\_\_\_\_ STUDIO \_\_\_\_\_ ONE BEDROOM LOCATED  
IN ASSISTED LIVING;**

**OR**

**THIS APARTMENT IS \_\_\_\_\_ STUDIO \_\_\_\_\_ ONE BEDROOM LOCATED  
IN MEMORY CARE.**

**EXHIBIT I.A.3**

**FURNISHINGS/APPLIANCES PROVIDED BY OPERATOR**

When not supplied by the Resident, Operator will provide:

Bed, Mattress and Box Spring (in good repair)

Nightstand

Lamp

Chair

Table

Lockable storage facilities for personal articles and medications which cannot be removed at will

Dresser

Closet or Wardrobe

Telephone (Community provides connections for telephone landline service in each unit for all residents. Community will provide landline telephone if requested. Fee for telephone landline service is at Resident expense).

Dishes, glasses, utensils

Bathing soap and toilet tissue

Linens such as towels and washcloths: pillow, pillowcases, bed sheets, blanket, bed spread all clean and in good condition

Household supplies: paper towels

A hinged, lockable entry door

**EXHIBIT I.A.4**

**FURNISHINGS/APPLIANCES PROVIDED BY YOU**

**EXHIBIT I.C**

**ADDITIONAL SERVICES, SUPPLIES, OR AMENITIES**

The following services, supplies, or amenities are available from the Operator directly or through arrangements with the Operator for the following additional charges. All third-party fees are paid directly by You to the service provider. These fees are in addition to the Basic Rate, Level of Care Fees, and Community Fee.

| <b>Item</b>                                       | <b>Supplemental Fee</b>                                                                 | <b>Provided By</b>                                                                |
|---------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Dry Cleaning                                      | Paid directly by the Resident to the dry cleaner                                        | Local dry-cleaning service of Resident's choice                                   |
| Professional Hair Grooming                        | Paid directly to the Beautician in the Residence                                        | Licensed Beautician in-house or Your choice outside of the Residence              |
| Medical Transportation                            | \$1.00 mile over 10-miles per Trip. The first 10-miles are included in Your Basic Rate. | Residence van (third party transport may be used with fee set by the third party) |
| Cultural and Other Occasional Off-Site Activities | May have a fee associated with the activity which varies by activity                    | Residence                                                                         |
| Local & Long-Distance Telephone Service           | At resident expense with phone provider                                                 | Telephone Companies available are Spectrum and Frontier                           |
| Cable T.V.                                        | At resident expense with cable provider                                                 | Cable Company available is Spectrum                                               |
| Internet Service                                  | At resident expense with provider                                                       | Spectrum                                                                          |

|                           |                                                                                       |                                                                                                |
|---------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Pets                      | One-time non-refundable fee of \$300.00 and \$30.00<br>Paid monthly per Pet Agreement | Billed by the Residence and paid monthly per policy. See Exhibit XVII.                         |
| Newspaper                 | At resident expense with newspaper company                                            | Rochester Democrat and Chronicle                                                               |
| Replacement Apartment Key | At resident expense \$10.00                                                           | Paid to the Residence at the time the key is replaced.                                         |
| Guest/Visitor Meals       | At resident's expense or the expense of their guest or visitor.                       | Paid at the time of the meal or billed to the resident. Each guest or visitor meal is \$ _____ |

**EXHIBIT I.D**

**LICENSURE/CERTIFICATION STATUS OF PROVIDERS**

**NONE.**

**EXHIBIT II**  
**DISCLOSURE STATEMENT**

Evergreen Place at Brockport Inc. (“the Operator”) as operator of Evergreen Place, Enhanced, Assisted Living & Memory Care (“the Residence”), hereby discloses the following, as required by Public Health Law Section 4658 (3).

1. The Consumer Information Guide developed by the Commissioner of Health is hereby attached to this Exhibit II, Disclosure Statement.

2. The Operator is licensed by the New York State Department of Health to operate 90 West Avenue, Brockport, NY 14420, an Assisted Living Residence as well as an Enriched Housing Program.

The Operator is also certified to operate at this location an Enhanced Assisted Living Residence and/or Special Needs Assisted Living Residence. This additional certification may permit individuals who may develop conditions or needs that would otherwise make them no longer appropriate for continued residence in a Basic Assisted Living Residence to be able to continue to reside in the Residence and to receive either Enhanced Assisted Living services or Special Needs Assisted Living services, as long as the other conditions of residency set forth in this Agreement continue to be met.

The Operator is currently approved to provide:

- a. Enhanced Assisted Living services for up to a maximum of 80 persons.
- b. Special Needs Assisted Living services for up to a maximum of 34 persons.

The Operator will post prominently in the Residence, on a monthly basis, the then-current number of vacancies under its Enhanced Assisted Living Services and/or Special Needs Assisted Living program.

**It is important to note the Operator is currently approved to accommodate within the Enhanced Assisted Living and Special Needs Assisted Living programs only up to the numbers of persons stated above.** If You become appropriate for Enhanced Assisted Living Services or Special Needs Assisted Living Services, and one of those units is available, You will be eligible to be admitted into the Enhanced Assisted Living or Special Needs Assisted Living unit (or program). If, however, such units are at capacity and there are no vacancies, the Operator will assist You and Your Representative to identify and obtain other appropriate living arrangements in accordance with New York State's regulatory requirements. If You become eligible for and choose to receive services in Enhanced Assisted Living Residence or Special Needs Assisted Living Residence program within this Residence, it may be necessary for You to change Your apartment within the Residence.

3. The owner of the real property upon which the Residence is located is Welltower Pegasus Landlord, LLC. The mailing address of the owner of the real property is 4500 Dorr Street, Toledo, OH 43615. The following individual is authorized to accept personal service on behalf of such real property owner is Matthew McQueen, General Counsel, at Welltower Pegasus Landlord, LLC., 4500 Dorr Street, Toledo, OH 43615.

4. The Operator of the Residence is Evergreen Place at Brockport Inc.. The mailing address of the Operator is 90 West Avenue, Brockport, NY 14420. The following individual is authorized to accept personal service on behalf of the Operator: Legal Affairs Manager, c/o Pegasus Senior Living, LLC, 17330 Preston Road, Suite 240B, Dallas, TX 75252

5. List any ownership interest in excess of 10% on the part of The Operator (whether a legal or beneficial interest), in any entity which provides care, material, equipment or other services to residents of the Residence.

NONE

6. List any ownership interest in excess of 10% (whether legal or beneficial interest) on the part of any entity which provides care, material, equipment or other services to residents of The Residence, in the Operator.

NONE

7. As a resident of this Residence, we believe that you have the freedom of choice to select your personal health care providers and other third parties to provide the services we provide. You are not bound to utilize our internal services, as our services are in place as a convenience to You.

8. Residents shall have the right to choose their health care providers, notwithstanding any other agreement to the contrary.

9. If a resident is unable to pay (in full) the balance of this Residence's charges, the Residence will assist the resident in securing placement at another facility, pursuant to applicable law and regulation. Public funds are available to certain individuals with limited income for the payment of residential, supportive, or health services. Public funds include but are not limited to Medicare. This Residence does not accept public funds.

10. The New York State Department of Health's toll-free telephone number for reporting of complaints regarding the services provided by The Assisted Living Operator is 1-866-893-6772.

11. The New York State Long Term Care Ombudsman Program (NYSLTCOP) provides a toll-free number 1-855-582-6769 to request an Ombudsman to advocate for the resident. 585-287-6414 is the Local LTCOP telephone number. The NYSLTCOP web site is [www.ltcombudsman.ny.gov](http://www.ltcombudsman.ny.gov).

# **CONSUMER INFORMATION GUIDE: ASSISTED LIVING RESIDENCE**

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## INTRODUCTION

This consumer information guide will help you decide if an assisted living residence is right for you and, if so, which type of assisted living residence (ALR) may best serve your needs.

There are many different housing, long-term care residential and community based options in New York State that provide assistance with daily living. The ALR is just one of the many residential community-based care options.

The New York State Department of Health's (DOH) website provides information about the different types of long-term care at [www.nyhealth.gov/facilities/long\\_term\\_care/](http://www.nyhealth.gov/facilities/long_term_care/).

More information about senior living choices is available on the New York State Office for the Aging website at [www.aging.ny.gov/ResourceGuide/Housing.cfm](http://www.aging.ny.gov/ResourceGuide/Housing.cfm).

A glossary for definitions of terms and acronyms used in this guide is provided on pages 10 and 11.

## WHAT IS AN ASSISTED LIVING RESIDENCE (ALR)?

An Assisted Living Residence is a certified adult home or enriched housing program that has additionally been approved by the DOH for licensure as an ALR. An operator of an ALR is required to provide or arrange for housing, twenty-four hour on-site monitoring, and personal care services and/or home care services in a home-like setting to five or more adult residents.

ALRs must also provide daily meals and snacks, case management services, and is required to develop an individualized service plan (ISP). The law also provides important consumer protections for people who reside in an ALR.

ALRs may offer each resident their own room, a small apartment, or a shared space with a suitable roommate. Residents will share common areas, such as the dining room or living room, with other people who may also require assistance with meals, personal care and/or home care services.

The philosophy of assisted living emphasizes personal dignity, autonomy, independence, privacy, and freedom of choice. Assisted living residences should facilitate independence and helps individuals to live as independently as possible and make decisions about how they want to live.

## WHO OPERATES ALRs?

ALRs can be owned and operated by an individual or a for-profit business group or corporation, a not-for-profit organization, or a government agency.

## PAYING FOR AN ALR

It is important to ask the ALR what kind of payment it accepts. Many ALRs accept private payment or long term care insurance, and some accept Supplemental Security Income (SSI) as

the primary method of payment. Currently, Medicaid and Medicare will NOT pay for residing in an ALR, although they may pay for certain medical services received while in the ALR.

Costs vary among ALRs. Much of the variation is due to the types and level of services provided and the location and structure of the residence itself.

## **TYPES OF ALRs AND RESIDENT QUALIFICATIONS**

There are three types of ALRs: Basic ALRs (ALR), Enhanced ALRs (EALR), and Special Need ALRs (SNALR). The services provided, offered or permitted vary by type and can vary from residence to residence. Prospective residents and their representatives should make sure they understand the type of ALR, and be involved in the ISP process (described below), to ensure that the services to be provided are truly what the individual needs and desires.

*Basic ALR:* A Basic ALR takes care of residents who are medically stable. Residents need to have an annual physical exam, and may need routine medical visits provided by medical personnel onsite or in the community.

Generally, individuals who are appropriately served in a Basic ALR are those who:

- Prefer to live in a social and supportive environment with 24-hour supervision;
- Have needs that can be safely met in an ALR;
- May be visually or hearing impaired;
- May require some assistance with toileting, bathing, grooming, dressing or eating;
- Can walk or use a wheelchair alone or occasionally with assistance from another person, and can self-transfer;
- Can accept direction from others in time of emergency;
- Do not have a medical condition that requires 24-hour skilled nursing and medical care; or
- Do not pose a danger to themselves or others.

The Basic ALR is designed to meet the individual's social and residential needs, while also encouraging and assisting with activities of daily living (ADLs). However, a licensed ALR may also be certified as an Enhanced Assisted Living Residence (EALR) and/or Special Needs Assisted Living Residence (SNALR) and may provide additional support services as described below.

***Enhanced ALR (EALR):*** Enhanced ALRs are certified to offer an enhanced level of care to serve people who wish to remain in the residence as they have age-related difficulties beyond what a Basic ALR can provide. To enter an EALR, a person can "age in place" in a Basic ALR or enter directly from the community or another setting. If the goal is to "age-in-place," it is important to ask how many beds are certified as enhanced and how your future needs will be met.

People in an Enhanced ALR may require assistance to get out of a chair, need the assistance of another to walk or use stairs, need assistance with medical equipment, and/or need assistance to manage chronic urinary or bowel incontinence.

An example of a person who may be eligible for the Enhanced ALR level of care is someone with a condition such as severe arthritis who needs help with meals and walking. If he or she later becomes confined to a wheelchair and needs help transferring, they can remain in the Enhanced ALR.

The Enhanced ALR must assure that the nursing and medical needs of the resident can be met in the facility. If a resident comes to need 24-hour medical or skilled nursing care, he/she would need to be transferred to a nursing facility or hospital unless all the criteria below are met:

- a) The resident hires 24-hour appropriate nursing and medical care to meet their needs;
- b) The resident's physician and home care services agency decide his/her care can be safely delivered in the Enhanced ALR;
- c) The operator agrees to provide services or arrange for services and is willing to coordinate care; and
- d) The resident agrees with the plan.

***Special Needs ALR (SNALR):*** Some ALRs may also be certified to serve people with special needs, for example Alzheimer's disease or other types of dementia. Special Needs ALRs have submitted plans for specialized services, environmental features, and staffing levels that have been approved by the New York State Department of Health.

The services offered by these homes are tailored to the unique needs of the people they serve. Sometimes people with dementia may not need the more specialized services required in a Special Needs ALR, however, if the degree of dementia requires that the person be in a secured environment, or services must be highly specialized to address their needs, they may need the services and environmental features only available in a Special Needs ALR. The individual's physician and/or representative and ALR staff can help the person decide the right level of services.

An example of a person who could be in a Special Needs ALR, is one who develops dementia with associated problems, needs 24-hour supervision, and needs additional help completing his or her activities of daily living. The Special Needs ALR is required to have a specialized plan to address the person's behavioral changes caused by dementia. Some of these changes may present a danger to the person or others in the Special Needs ALR. Often such residents are provided medical, social or neuro-behavioral care. If the symptoms become unmanageable despite modifications to the care plan, a person may need to move to another level of care where his or her needs can be safely met. The ALR's case manager is responsible to assist residents to find the right residential setting to safely meet their needs.

### *Comparison of Types of ALRs*

|                                                                                                                                                         | <b>ALR</b> | <b>EALR</b> | <b>SNALR</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------|--------------|
| Provides a furnished room, apartment or shared space with common shared areas                                                                           | X          | X           | X            |
| Provides assistance with 1-3 meals daily, personal care, home care, housekeeping, maintenance, laundry, social and recreational activities              | X          | X           | X            |
| Periodic medical visits with providers of resident choice are arranged                                                                                  | X          | X           | X            |
| Medication management assistance                                                                                                                        | X          | X           | X            |
| 24 hour monitoring by support staff is available on site                                                                                                | X          | X           | X            |
| Case management services                                                                                                                                | X          | X           | X            |
| Individualized Service Plan (ISP) is prepared                                                                                                           | X          | X           | X            |
| Assistance with walking, transferring, stair climbing and descending stairs, as needed, is available                                                    |            | X           |              |
| Intermittent or occasional assistance from medical personnel from approved community resources is available                                             | X          | X           | X            |
| Assistance with durable medical equipment (i.e., wheelchairs, hospital beds) is available                                                               |            |             | X            |
| Nursing care (i.e. vital signs, eye drops, injections, catheter care, colostomy care, wound care, as needed) is provided by an agency or facility staff |            | X           |              |
| Aging in place is available, and, if needed, 24 hour skilled nursing and/or medical care can be privately hired                                         |            | X           |              |
| Specialized program and environmental modifications for individuals with dementia or other special needs                                                |            |             | X            |

## HOW TO CHOOSE AN AIR

**VISITING ALRs:** Be sure to visit several ALRs before making a decision to apply for residence. Look around, talk to residents and staff and ask lots of questions. Selecting a home needs to be comfortable.

Ask to examine an “open” or “model” unit and look for features that will support living safely and independently. If certain features are desirable or required, ask building management if they are available or can be installed. Remember charges may be added for any special modifications requested.

It is important to keep in mind what to expect from a residence. It is a good idea to prepare a list of questions before the visit. Also, taking notes and writing down likes or dislike about each residence is helpful to review before making a decision.

**THINGS TO CONSIDER:** When thinking about whether a particular ALR or any other type of community-based housing is right, here are some things to think about before making a final choice.

**Location:** Is the residence close to family and friends?

**Licensure/Certification:** Find out the type of license/certification a residence has and if that certification will enable the facility to meet current and future needs.

**Costs:** How much will it cost to live at the residence? What other costs or charges, such as dry cleaning, cable television, etc., might be additional? Will these costs change?

**Transportation:** What transportation is available from the residence? What choices are there for people to schedule outings other than to medical appointments or trips by the residence or other group trips? What is within safe walking distance (shopping, park, library, bank, etc.)?

**Place of worship:** Are there religious services available at the residence? Is the residence near places of worship?

**Social organizations:** Is the residence near civic or social organizations so that active participation is possible?

**Shopping:** Are there grocery stores or shopping centers nearby? What other type of shopping is enjoyed?

**Activities:** What kinds of social activities are available at the residence? Are there planned outings which are of interest? Is participation in activities required?

**Other residents:** Other ALR residents will be neighbors, is this a significant issue or change from current living arrangement?

**Staff:** Are staff professional, helpful, knowledgeable and friendly?

**Resident Satisfaction:** Does the residence have a policy for taking suggestions and making improvements for the residents?

**Current and future needs:** Think about current assistance or services as well as those needed in several years. Is there assistance to get the services needed from other agencies or are the services available on site?

If the residence offers fewer Special Needs beds and/or Enhanced Assisted Living beds than the total capacity of the residence, how are these beds made available to current or new residents? Under what conditions require leaving the residence, such as for financial or for health reasons? Will room or apartment changes be required due to health changes? What is the residence's policy if the monthly fee is too high or if the amount and/or type of care needs increase?

**Medical services:** Will the location of the facility allow continued use of current medical personnel?

**Meals:** During visit, eat a meal. This will address the quality and type of food available. If, for cultural or medical reasons, a special diet is required, can these types of meals be prepared?

**Communication:** If English is not the first language and/or there is some difficulty communicating, is there staff available to communicate in the language necessary? If is difficulty hearing, is there staff to assist in communicating with others?

**Guests:** Are overnight visits by guests allowed? Does the residence have any rules about these visits? Can a visitor dine and pay for a meal? Is there a separate area for private meals or gatherings to celebrate a special occasion with relatives?

**WHO CAN HELP YOU CHOOSE AN ALR?** When deciding on which ALR is right, talk to family members and friends. If they make visits to the residences, they may see something different, so ask for feedback.

Physicians may be able to make some recommendations about things that should be included in any residence. A physician who knows about health needs and is aware of any limitations can provide advice on your current and future needs.

Before making any final decisions, talking to a financial advisor and/or attorney may be appropriate. Since there are costs involved, a financial advisor may provide information on how these costs may affect your long term financial outlook. An attorney review of any documents may also be valuable. (e.g., residency agreement, application, etc.).

## **ADMISSION CRITERIA AND INDIVIDUALIZED SERVICE PLANS (ISP)**

An evaluation is required before admission to determine eligibility for an ALR. The admission criteria can vary based on the type of ALR. Applicants will be asked to provide results of a physical exam from within 30 days prior to admission that includes a medical, functional, and mental health assessment (where appropriate or required). This assessment will be reviewed as part of the Individualized Service Plan (ISP) that an ALR must develop for each resident.

The ISP is the “blueprint” for services required by the resident. It describes the services that need to be provided to the resident, and how and by whom those services will be provided. The ISP is developed when the resident is admitted to the ALR, with the input of the resident and his or her representative, physician, and the home health care agency, if appropriate. Because it is based on the medical, nutritional, social and everyday life needs of the individual, the ISP must be reviewed and revised as those needs change, but at least every six months.

## APPLYING TO AN ALR

The following are part of entering an ALR:

**An Assessment:** Medical, Functional and Mental: A current physical examination that includes a medical, functional and mental health evaluation (where appropriate or required) to determine what care is needed. This must be completed by a physician 30 days prior to admission. Check with staff at the residence for the required form.

**An application** and any other documents that must be signed at admission (get these from the residence). Each residence may have different documents. Review each one of them and get the answers to any questions.

**Residency Agreement** (contract): All ALR operators are required to complete a residency agreement with each new resident at the time of admission to the ALR. The ALR staff must disclose adequate and accurate information about living in that residence. This agreement determines the specific services that will be provided and the cost. The residency agreement must include the type of living arrangements agreed to (e.g., a private room or apartment); services (e.g., dining, housekeeping); admission requirements and the conditions which would require transfer; all fees and refund policies; rules of the residence, termination and discharge policies; and resident rights and responsibilities.

An Assisted Living Model Residency Admission Agreement is available on the New York State Health Department’s website at: [http://www.nyhealth.gov/facilities/assisted\\_living/docs/model\\_residency\\_agreement.pdf](http://www.nyhealth.gov/facilities/assisted_living/docs/model_residency_agreement.pdf).

Review the residency agreement very carefully. There may be differences in each ALR’s residency agreement, but they have to be approved by the Department. Write down any questions or concerns and discuss with the administrator of the ALR. Contact the Department of Health with questions about the residency agreement. (See number under information and complaints)

**Disclosure Statement:** This statement includes information that must be made known to an individual before signing the residency agreement. This information should include: licensure, ownership, availability of health care providers, availability of public funds, the State Health Department toll-free number for reporting complaints, and a statement regarding the availability and telephone numbers of the state and local long-term care ombudsman services. The disclosure statement should be reviewed carefully.

**Financial Information:** Ask what types of financial documents are needed (bank statements, long term care insurance policies, etc.). Decide how much financing is needed in order to qualify

to live in the ALR. Does the residence require a deposit or fee before moving in? Is the fee refundable, and, if so, what are the conditions for the refund?

***Before Signing Anything:*** Review all agreements before signing anything. A legal review of the documents may provide greater understanding. Understand any long term care insurance benefits. Consider a health care proxy or other advance directive, making decision about executing a will or granting power of attorney to a significant other may be appropriate at this time.

***Resident Rights, Protection, and Responsibilities:*** New York State law and regulations guarantee ALR residents' rights and protections and define their responsibilities. Each ALR operator must adopt a statement of rights and responsibilities for residents, and treat each resident according to the principles in the statement. For a list of ALR resident rights and responsibilities visit the Department's website at [http://www.nyhealth.gov/facilities/assisted\\_living/docs/resident\\_rights.pdf](http://www.nyhealth.gov/facilities/assisted_living/docs/resident_rights.pdf). For a copy of an individual ALR's statement of rights and responsibilities, ask the ALR.

## LICENSING AND OVERSIGHT

ALRs and other adult care facilities are licensed and inspected every 12 to 18 months by the New York State Department of Health. An ALR is required to follow rules and regulations and to renew its license every two years. For a list of licensed ALRs in NYS, visit the Department of Health's website at

[www.nyhealth.gov/facilities/assisted\\_living/licensed\\_programs\\_residences.htm](http://www.nyhealth.gov/facilities/assisted_living/licensed_programs_residences.htm).

## INFORMATION AND COMPLAINTS

For more information about assisted living residences or to report concerns or problems with a residence which cannot be resolved internally, call the New York State Department of Health or the New York State Long Term Care Ombudsman Program. The New York State Department of Health's Division of Assisted Living can be reached at (518) 408-1133 or toll free at 1-866-893-6772. The New York State Long Term Care Ombudsman Program can be reached at 1-800-342-9871.

## Glossary of Terms Related to Guide

**Activities of Daily Living (ADL):** Physical functions that a person performs every day that usually include dressing, eating, bathing, toileting, and transferring.

**Adult Care Facility (ACF):** Provides temporary or long-term, non-medical, residential care services to adults who are to a certain extent unable to live independently. There are five types of adult care facilities: adult homes, enriched housing programs, residences for adults, family-type homes and shelters for adults. Of these, adult homes, enriched housing programs, and residences for adults are overseen by the Department of Health. Adult homes, enriched housing programs, and residences for adults provide long-term residential care, room, board, housekeeping, personal care and supervision. Enriched housing is different because each resident room is an apartment setting, i.e. kitchen, larger living space, etc. Residences for adults provide the same services as adult homes and enriched housing except for required personal care services.

**Adult Day Program:** Programs designed to promote socialization for people with no significant medical needs who may benefit from companionship and supervision. Some programs provide specially designed recreational and therapeutic activities, which encourage and improve daily living skills and cognitive abilities, reduce stress, and promote capabilities.

**Adult Day Health Care:** Medically-supervised services for people with physical or mental health impairment (examples: children, people with dementia, or AIDS patients). Services include: nursing, transportation, leisure activities, physical therapy, speech pathology, nutrition assessment, occupational therapy, medical social services, psychosocial assessment, rehabilitation and socialization, nursing evaluation and treatment, coordination of referrals for outpatient health, and dental services.

**Aging in Place:** Accommodating a resident's changing needs and preferences to allow the resident to remain in the residence as long as possible.

**Assisted Living Program (ALP):** Available in some adult homes and enriched housing programs. It combines residential and home care services. It is designed as an alternative to nursing home placement for some people. The operator of the assisted living program is responsible for providing or arranging for resident services that must include room, board, housekeeping, supervision, personal care, case management and home health services. This is a Medicaid funded service for personal care services.

**Disclosure Statement:** Information made known to an individual before signing the residency agreement. This information should include: licensure, ownership, availability of health care providers, availability of public funds, the State Health Department toll-free number for reporting complaints, and a statement regarding the availability and telephone numbers of the state and local long-term care ombudsman services.

**Health Care Facility:** All hospitals and nursing homes licensed by the New York State Department of Health.

**Health Care Proxy:** Appointing a health care agent to make health care decisions for you and to make sure your wishes are followed if you lose the ability to make these decisions yourself.

**Home Care:** Health or medically related services provided by a home care services agency to people in their homes, including adult homes, enriched housing, and ALRs. Home care can meet many needs, from help with household chores and personal care like dressing, shopping, eating and bathing, to nursing care and physical, occupational, or speech therapy.

**Instrumental Activities of Daily Living (IADL's):** Functions that involve managing one's affairs and performing tasks of everyday living, such as preparing meals, taking medications, walking outside, using a telephone, managing money, shopping and housekeeping.

**Long Term Care Ombudsman Program:** A statewide program administered by the New York State Office for the Aging. It has local coordinators and certified ombudsmen who help resolve problems of residents in adult care facilities, assisted living residences, and skilled nursing facilities. In many cases, a New York State certified ombudsman is assigned to visit a facility on a weekly basis.

**Monitoring:** Observing for changes in physical, social, or psychological well being.

**Personal Care:** Services to assist with personal hygiene, dressing, feeding, and household tasks essential to a person's daily living.

**Rehabilitation Center:** A facility that provides occupational, physical, audiology, and speech therapies to restore physical function as much as possible and/or help people adjust or compensate for loss of function.

**Supplemental Security Income (SSI):** A federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing and shelter. Some, but not all, ALRs may accept SSI as payment for food and shelter services.

**Supervision:** Knowing the general whereabouts of each resident, monitoring residents to identify changes in behavior or appearance and guidance to help residents to perform basic activities of daily living.



**State of New York  
Department of Health**

**EXHIBIT III.A**

**TIERED FEE ARRANGEMENTS**

Tiered fees are determined at the time of conducting an evaluation of the Resident's individualized service needs. The evaluation form provides a point system that allows the Residence to identify the services specifically for each resident's unique needs. The Evaluation Resident Form is attached as Exhibit XVIII. Tiered fee arrangements are not used for residents residing in memory care.

**EXHIBIT III.B**

**SUPPLEMENTAL, ADDITIONAL, OR COMMUNITY FEE**

We require a one-time non-refundable Community Fee in the amount of \$4,500.00 to be paid at the time this Agreement is signed. The Community Fee is a one-time fee charged by the Operator at the time of admission. The Community Fee is non-refundable. The Community Fee, once collected, is non-refundable and there are no other specific conditions for refunds or any additional conditions regarding the fee or its refundability. Once informed of the Community Fee, the prospective resident may choose whether to accept the Community Fee as a condition of residency or to reject the Community fee and thereby reject residency at the residence.

Pet Fees include a one-time non-refundable fee of \$300.00 and \$30.00 paid monthly per Pet Agreement. See attached Exhibit XVII.

Other fees collected by the Residence are found in Exhibit I. C. and Exhibit III. C.

**EXHIBIT III.C**

**FEE SCHEDULE**

Your initial monthly fees:

**A. Basic Monthly Fee for Assisted Living and Enhanced Assisted Living Residence**

**EALR**

|                                         |            |
|-----------------------------------------|------------|
| Studio (274 square feet)                | \$3,625.00 |
| One Bedroom Apartment (462 square feet) | \$4,735.00 |

Tiered Monthly Fee \$ \_\_\_\_\_

*SEE EXHIBIT III A 2 (TIERED FEE ARRANGEMENT) AND EXHIBIT XVIII (EVALUATION FORM)*

|                               |           |
|-------------------------------|-----------|
| Level Zero 0 to 5 points      | No charge |
| Level One 6 to 15 points      | \$ 400.00 |
| Level Two 16 to 30 points     | \$ 800.00 |
| Level Three 31 to 45 points   | \$1600.00 |
| Level Four 46 to 60 points    | \$2000.00 |
| Level Five 61 points and over | \$2400.00 |

**B. Basic Monthly Fee for Special Needs Assisted Living (Memory Care) (SNALR)**

|                                                              |           |
|--------------------------------------------------------------|-----------|
| Studio (274 square feet)                                     | \$4725.00 |
| Companion (shared apartment) (462 square feet)               | \$3685.00 |
| (Note that there are no one bedroom apartments in the SNALR) |           |

Basic Monthly Fee includes Individualized Services as determined in the Evaluation Form Exhibit XVIII. All Enhanced Assisted Living Residence services are included in the Special Needs Assisted Living Residence rates..

Supplemental Services Fees: \$ \_\_\_\_\_

*See Exhibit III.B.*

Total Monthly Fee: \$ \_\_\_\_\_

**PLUS, ONE-TIME COMMUNITY FEE \$4,500.00**

**EXHIBIT V**

**TRANSFER OF FUNDS OR PROPERTY TO OPERATOR**

**EXHIBIT VI**

**PROPERTY/ITEMS HELD BY OPERATOR FOR YOU**

**SEE FOLLOWING ATTACHED NY DOH-5194**

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**Adult Care Facility Assisted Living**

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by BQA  
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**Adult Care Facility Inventory of Resident Property**

**FACILITYNAME:**\_\_\_\_\_

**OPERATING CERTIFICATE NUMBER:**\_\_\_\_\_

|                    |          |                               |                                              |                |                           |                   |
|--------------------|----------|-------------------------------|----------------------------------------------|----------------|---------------------------|-------------------|
|                    |          |                               | RESIDENT NAME                                | INVENTORY DATE | DATE RETURNED TO RESIDENT | RESIDENT INITIALS |
| ITEM               | QUANTITY | ESTIMATED \$ VALUE (if known) | DESCRIPTION                                  |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
|                    |          |                               |                                              |                |                           |                   |
| RESIDENT SIGNATURE |          | DATE                          | AUTHORIZED FACILITY REPRESENTATIVE SIGNATURE | DATE           |                           |                   |
| X                  |          |                               | X                                            |                |                           |                   |

**EXHIBIT XI**

**RULES OF THE RESIDENCE**

**SEE THE ATTACHED RESIDENT HANDBOOK**

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# ***RESIDENT HANDBOOK***

## ***Evergreen Place, Enhanced, Assisted Living & Memory Care***

**WELCOME TO YOUR EVERGREEN PLACE, ENHANCED,  
ASSISTED LIVING & MEMORY CARE COMMUNITY!**

Dear New Resident,

Welcome to Evergreen Place, Enhanced, Assisted Living & Memory Care! We value you, your family, and the trust you are placing in us. Thank you for the opportunity to be of service to you. We are confident you will find living with us the source for an inspiring and rewarding life, a place to live, and to call your home.

As you join our Community, We promise to provide you with an engaging environment that will renew and refresh your body and soul. Designed to keep pace with the active lifestyles of our residents, Evergreen Place, Enhanced, Assisted Living & Memory Care provides a stimulating environment full of quality amenities, opportunities for lifelong learning, and personal well-being. This is a place to rekindle existing and establish new friendships.

We are here to provide you the freedom to live the life you desire. Our core values of compassion, dignity, and choice are at the heart of everything we will do. We pledge to consistently provide you with outstanding personal service that will enrich your life every day.

Evergreen Place, Enhanced,  
Assisted Living & Memory Care.

Chris Hollister  
Co-Founder and President

## **YOUR LIFE...YOUR CHOICE**

Evergreen Place, Enhanced, Assisted Living & Memory Care is dedicated to the highest quality of service delivery to our residents with a sense of warmth, compassion, individual pride and Company spirit. Our goal is to provide You with individualized services in a home-like setting so Your lifestyle remains as self-sufficient, dignified and private as possible. Services and activities are available to maintain or improve Your capabilities, with an emphasis on Your choices and abilities rather than differences and/or disabilities. No person may be discriminated against because of their race, color, religion, sex, national origin, age, sexual orientation, disability, military status or any other reason prohibited by federal, state or local laws. At the Community, We practice the spirit of the Resident Rights, which are included in Your Residency Agreement.

This Resident Handbook provides a brief overview of miscellaneous topics related to the Residence. Please keep this handbook close at hand for future reference as it is incorporated as part of the Residency Agreement.

## **MEET OUR COMMUNITY ASSOCIATES**

You should become familiar with the Community Associates who are employed at the Community. We encourage You to get acquainted with Our Community Associates and to share any concerns and/or questions You may have with Our Executive Director.

### **Executive Director**

The Executive Director serves as Your main resource at the Community, with his/her office located at the front of the building. He/she is responsible for overseeing all of the operations and Community Associates. Please direct any questions You have about policies, services, personnel and/or maintenance to the Executive Director. Questions related to fees, charges, mail or monthly statements should also be referred to this individual. In addition, the Executive Director may be contacted in regard to concerns about personal issues, relationships with other Residents or issues involving family. Any problems not resolved to satisfaction by other Community Associates should be brought to the attention of the Executive Director immediately.

The Executive Director works closely with the Community Business Office Manager and/or Assistant Director, the Life Enrichment/Resident Program Coordinator, Sales Director and the Memory Care Manager.

### **Health & Wellness Director**

The Health & Wellness Director, who is a licensed nurse, oversees Your assessments, medication assistance, medical treatments and the coordination of Residents' doctor appointments and/or other services not provided by the Community Associates. Any questions about personal services, medications, medical treatments or other health-related concerns should be directed to the Wellness Director and/or the Executive Director if the Wellness Director is unavailable.

## **Resident Care Partners**

The Resident Care Partners are responsible for providing all personal care services to Residents at the Community. These community Associates are trained by the Executive Director and the Health & Wellness Director. The primary goal of the Resident Care Partner is to provide quality services to You through Your individual assessment and service plan.

Resident Care Partners are available 24 hours a day to provide personal services that You need, including assistance with activities such as dressing, personal hygiene and bathing, assistance with medication and some routine health-related tasks. All community Associates work as a team, in conjunction with Your physicians and/or other outside care providers, to ensure that comprehensive and quality services are provided to You.

The Resident Care Partners also strive to maintain a clean and aesthetically pleasing environment by assisting with laundry and housekeeping services. You may direct any questions You have regarding housekeeping/laundry schedules or operations to the Executive Director or a community Associate if the Executive Director is temporarily unavailable.

Maintenance Director All maintenance operations, building equipment, and building repairs are the responsibility of the Maintenance Director at the Community. If You should require any maintenance, You may bring Your request to the attention of the Executive Director or the Maintenance Director. You may also give this request to any Community Associate if the Executive Director and Maintenance Director are temporarily unavailable.

## **CASE MANAGER**

The Case Manager of the Residence shall carry out the functions specified in section 1001.10(i) of the NY DOH licensing regulations to include: shall assist the resident in arranging such services, if necessary, and, as part of the residence's case management responsibility, shall be responsible for coordinating the care the residence provides or arranges with the care provided by such other service providers. The Case Manager will be a registered professional or licensed practical nurse,

## ***Meal Services***

The Dining Services Director and Assistant Cook are responsible for providing You with tasty, nourishing and well-balanced meals. Please let these community Associates or the Executive Director know if You have any menu suggestions and/or a concern about any aspect of the meal services operation. You should also notify the Wellness Director or the Executive Director if You would like to speak personally with a dietitian.

## ***Volunteers***

Volunteers play an important role at the Community. They are involved in a variety of activities, such as walking, reading or visiting one-on-one with Residents. Volunteers may also participate in many of the group activities offered at the Community (e.g. by leading a cooking group or playing bingo).

### ***Emergency Response System***

Emergency call systems are available in all apartments to provide You with communication with Community Associates. We will make every effort to respond to requests for assistance as quickly as possible. ***Please use the system for emergencies only. Do not use the emergency call system for help with general matters such as turning Your television on, assisting You in making a phone call, or finding out what time it is.*** Apartments and common areas are also equipped with smoke detectors and sprinkler systems for Your protection. In addition, the building has a security system and controlled access on outside doors to provide security.

### **Housekeeping and Laundry**

Included in Our basic services, Community Associates clean Resident apartments once a week. A typical weekly cleaning includes changing the bed linens, vacuuming and cleaning the bathroom and kitchen, and dusting furniture. Talk with Your Executive Director to request more frequent cleaning.

Personal laundry and linen service is available on a weekly basis. Laundry is picked up and returned in a reasonable timeframe set by the Community.

Please be aware that the Community Associates do not hand launder, iron, or mend Your personal laundry. If these services or other laundry services are needed and/or desired, please discuss this with Your Executive Director.

### **Activities**

We make every effort to arrange individual and group social and recreational events to provide You with opportunities to participate in intellectual, physical, and spiritual activities. Typically, activities are included in Your basic fees; however, You will be notified in advance if there is an additional fee to participate in an event. The Associates distribute and post a monthly schedule that outlines the upcoming activities. We encourage You to participate in the activity planning process by expressing Your personal preferences and to discuss any concerns or suggestions that You may have about activities with Your Executive Director.

### **Common Areas**

Common areas of the building, including the dining room, sitting areas, library living room, and designated smoking area, provide You with opportunities for socialization and recreation. Most communities offer amenities such as a hair salon, life enrichment center and outdoor patio conveniently located for Your use. You and Your guests may use these common areas so long as You and Your guests do not disturb or disrupt the enjoyment of other residents or interfere with the operations of the Community. If necessary, guests will be asked to leave if they do not cease inappropriate behavior when requested by Community Associates.

### **Paying Your Monthly Statement**

Monthly statements are mailed to Residents around the 25th of each month, and payment is due on the 1st of the following month. Bills may be mailed or paid in person at the Concierge desk,

which is located at the front of the building or mailed to the Community at 90 West Avenue, Brockport, New York 14420. ***Rent paid after the fifth (5th) of the month is considered late; a late fee of \$250.00 will be charged according to the terms of Your Residency Agreement or as allowed under state law.*** You will be notified of late and/or non-payment fees immediately.

### **MISCELLANEOUS BEAUTY/BARBER SHOP**

A beauty salon is located within the Community, which offers hair services to men and women. Contact Your Executive Director about business hours to set up an appointment and to learn more about services offered and charges.

### **COMPLIMENTS/SUGGESTIONS/CONCERNS/GRIEVANCES**

We encourage You to express Your opinions about the Community, the Community Associates and/or the services offered so that We can continue to serve You better. There are many ways that You can communicate Your suggestions, questions, compliments and/or concerns to the Executive Director:

- Join the Resident Council – It meets on a regular basis and provides a venue for You to discuss Your opinions and/or provide Associate with input.
- Communicate directly with the Executive Director – Contact the Executive Director who will work with You to effectively address Your matters as soon as they arise.
- Plan a Formal Meeting with the Executive Director – We encourage You to schedule a conference and/or a service plan meeting.
- Provide Compliments/Suggestions/Concerns in Writing – Ask Your Executive Director where to drop off said letter.
- Follow the state grievance rules that is provided to You in Your residency agreement, if applicable.

You should be contacted about Your opinions in an efficient and timely manner. If You feel the Executive Director has not addressed Your thoughts appropriately, please contact the Vice President of Operations for the Company. We encourage You to let us know who You are so that We can work with You to resolve any concerns You may have; however, You may also write or call us anonymously and leave Your concerns. You may do this by writing or calling the number listed below:

Evergreen Place,  
Enhanced, Assisted  
Living & Memory Care  
90 West Ave  
Brockport, NY 14420

Or call Our phone number: (585) 637.3140

You also have the right to contact the state Ombudsman and/or licensure agency, whose numbers should be visibly posted in the Community, or may be obtained from the Executive Director. No complainant, witness or Resident will be subject to retaliation for expressing his/her thoughts. We welcome Your opinions and look forward to hearing from You.

## **CONFIDENTIALITY**

We keep a separate business and health record for You that contains medical and other personal information. Your information is kept safe and confidential. The local and/or state licensing agency, as well as other governmental agencies have the authority to examine Your records without any prior or follow-up notice to You. Your privacy rights are further explained in the state's Resident's Rights. No resident or legal representative will be able to inspect or receive a copy of Your records without prior notice.

## **EVACUATIONS & EMERGENCY PREPAREDNESS**

In the event of a natural disaster and/or hazardous weather conditions, the Community will arrange for evacuation, lodging and care, if necessary. This Community has an emergency preparedness plan and will make it available to You as required under state law.

## **FIRE SAFETY**

The Community is designed to meet the standards for fire protection and safety. Thus, the building is equipped with overhead smoke detectors and safety equipment.

Fire Drills are held as required under state law. We recommend that You participate to the extent possible so that You know what to do in the event of a fire. This means that You may have to move from one area of the building to another or exit the building from time to time. Some state regulations require that You participate in fire drills. We recommend that You contact Your Executive Director about the state fire safety requirements that apply to You or any other questions that You may have.

## **KEYS**

Apartment keys are issued to You at the time of move-in. If You lose or misplace a key, please notify a Community Associate immediately. The cost of replacing your keys are listed in Your Residency Agreement. You will be required to return keys to the Community at the time You no longer reside within the Community.

## **NEWSPAPERS**

Residents may have papers delivered to the building. Please arrange for your personal subscription if You desire to receive a newspaper. You may pick up the papers at the Concierge desk, or We can plan to have Your paper delivered to Your apartment.

## **PARKING**

There are limited parking spaces available on the premises. If You own a car, please contact the Executive Director about parking availability and the Community policy related to parking.

## **PETS**

Pets are welcome at the Community (such as a cat, small dog or bird) under conditions defined by the policy and agreement between You and the Residence.

## **RIGHT OF ENTRY TO YOUR APARTMENT**

Community Associates are authorized to enter Your apartment at reasonable times for reasonable purposes such as housekeeping, to respond to emergencies, and maintenance as needed. Community Associates will make every effort to give You notice before entering Your apartment, except in an emergency or after having made several attempts to notify You.

In addition, the local and/or state licensing agency representative may, after providing proper identification and stating the purpose of his or her visit, enter and inspect the entire Community, including Your apartment, at any time without any advance notice.

## **SAFETY**

For Your safety and the safety of others, You may not keep the following items in Your apartment:

- Firearms, ammunition and/or other weapons
- Dangerous flammable items, such as gasoline or kerosene, or explosives of any kind
- Illegal drugs
- Space heaters
- Other potentially hazardous substances or objects not specified but that could cause harm to You or others
- Cleaning chemicals must be in a secured area.

## **PROHIBITED ITEMS IN MEMORY CARE OR AS DIRECTED BY YOUR PHYSICIAN**

In order to ensure the safety of Our Your loved one, as well as other Residents who are confused and may wander, We ask that You follow the list of items below when moving into Our secure Memory Care or if You are directed by your physician.

Please do not bring the following items into the Memory Care area or into an apartment where a Memory Care resident resides.

- Knives/Scissors or any other sharp instrument (including nail clippers, nail files, sewing items or knitting needles, etc.)
- Razors for shaving (may have electric razors)
- Silverware items

- Household cleaners in any form
- Mouthwashes that are alcohol based
- Hairdryers/Curling irons
- Clothing irons
- Extension cords
- Throw rugs
- Nail polish or remover
- Any medications (prescription or over the counter) If ordered by the physician, please give to the Community Associate giving meds for safekeeping.
- Electric appliances (need approval from ED prior to bringing these items)

Please remember that this is only a short list and other items may be dangerous residents as well. As a general rule You should avoid bringing items that have the potential to cause harm to the Resident. Should You have any questions regarding any items to bring, please contact the Wellness Director or the Executive Director.

### **SMOKE FREE POLICY**

We are pleased to announce that We offer a smoke free Community. We are confident that this policy will enhance the health and well-being of all that live and work in the Community. This policy affects both new Residents and current Residents.

Smoking is strictly prohibited near or at entrances or exits, in or about any other Resident's apartment that objects to smoke, as well as the outdoors of the Community in non-smoking areas and in any vehicle owned or operated by the Community. If You choose to smoke outside, please ask the Executive Director where the Community has designated the outside smoking area. This area meets state standards in regard to fire proof receptacle, fire resistant furniture and has accessibility to a fire extinguisher.

All visitors and guests of new and current Residents must observe this smoke free policy and smoke only in designated areas.

We understand the addictive nature of smoking and the use of other tobacco products. We will make every effort to assist with referral to or recommend a smoking cessation program to Residents who elect to stop smoking. If You have questions or concerns regarding the smoke free policy, please contact the Executive Director.

### **GUESTS AND VISITORS**

Resident guests and visitors are always welcome and are encouraged to visit at their convenience. We do ask that all visitors be considerate of other Residents when visiting the Community (e.g. by recognizing that some Residents prefer to retire early in the evening). To provide a safe and secure environment for Residents, We ask that all visitors sign in/out at the front of the Community when they arrive and leave the building. We also ask Residents to plan with the Executive Director if guests are expected to stay overnight. This also allows us to know who is in the building should an emergency arise. We have the right to ask visitors to leave and/or discontinue visits to the

Community if these individuals are disrupting the peace and enjoyment of other residents, threatening Your safety, or interfering with the operation of the Community.

We also encourage Your family and friends to visit and dine with You any time. Please notify the Dining Services Director of guest meals 24 hours in advance, if possible. A nominal cost is charged for each guest meal and may be paid for directly in the Executive Director's office or charged to Your monthly bill. Please contact Your Executive Director in order to coordinate guest meals and payment.

### **WHEN PLANNING ON BEING AWAY FROM THE COMMUNITY**

Should the Resident at any time plan to leave the Community for a period of 24 hours or longer, the Resident is required prior to leaving the Community to notify and inform the Executive Director or the Director of Health and Wellness of the date of departure and the date of return to the Community.

**EXHIBIT XV**

**RIGHTS AND RESPONSIBILITIES OF RESIDENTS IN ASSISTED LIVING  
RESIDENCES**

RESIDENT'S RIGHTS AND RESPONSIBILITIES SHALL INCLUDE, BUT NOT BE LIMITED TO THE FOLLOWING:

(A) EVERY RESIDENT'S PARTICIPATION IN ASSISTED LIVING SHALL BE VOLUNTARY, AND PROSPECTIVE RESIDENTS SHALL BE PROVIDED WITH SUFFICIENT INFORMATION REGARDING THE RESIDENCE TO MAKE AN INFORMED CHOICE REGARDING PARTICIPATION AND ACCEPTANCE OF SERVICES;

(B) EVERY RESIDENT'S CIVIL AND RELIGIOUS LIBERTIES, INCLUDING THE RIGHT TO INDEPENDENT PERSONAL DECISIONS AND KNOWLEDGE OF AVAILABLE CHOICES, SHALL NOT BE INFRINGED;

(C) EVERY RESIDENT SHALL HAVE THE RIGHT TO HAVE PRIVATE COMMUNICATIONS AND CONSULTATION WITH HIS OR HER PHYSICIAN, ATTORNEY, AND ANY OTHER PERSON;

(D) EVERY RESIDENT, RESIDENT'S REPRESENTATIVE AND RESIDENT'S LEGAL REPRESENTATIVE, IF ANY, SHALL HAVE THE RIGHT TO PRESENT GRIEVANCES ON BEHALF OF HIMSELF OR HERSELF OR OTHERS, TO THE RESIDENCE'S STAFF, ADMINISTRATOR OR ASSISTED LIVING OPERATOR, TO GOVERNMENTAL OFFICIALS, TO LONG TERM CARE OMBUDSMEN OR TO ANY OTHER PERSON WITHOUT FEAR OF REPRISAL, AND TO JOIN WITH OTHER RESIDENTS OR INDIVIDUALS WITHIN OR OUTSIDE OF THE RESIDENCE TO WORK FOR IMPROVEMENTS IN RESIDENT CARE;

(E) EVERY RESIDENT SHALL HAVE THE RIGHT TO MANAGE HIS OR HER OWN FINANCIAL AFFAIRS;

(F) EVERY RESIDENT SHALL HAVE THE RIGHT TO HAVE PRIVACY IN TREATMENT AND IN CARING FOR PERSONAL NEEDS;

(G) EVERY RESIDENT SHALL HAVE THE RIGHT TO CONFIDENTIALITY IN THE TREATMENT OF PERSONAL, SOCIAL, FINANCIAL AND MEDICAL RECORDS, AND SECURITY IN STORING PERSONAL POSSESSIONS;

(H) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE COURTEOUS, FAIR AND RESPECTFUL CARE AND TREATMENT AND A WRITTEN STATEMENT OF THE SERVICES PROVIDED BY THE RESIDENCE, INCLUDING THOSE REQUIRED TO BE OFFERED ON AN AS-NEEDED BASIS;

(I) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE OR TO SEND PERSONAL MAIL OR ANY OTHER CORRESPONDENCE WITHOUT INTERCEPTION OR

INTERFERENCE BY THE OPERATOR OR ANY PERSON AFFILIATED WITH THE OPERATOR;

(J) EVERY RESIDENT SHALL HAVE THE RIGHT NOT TO BE COERCED OR REQUIRED TO PERFORM WORK OF STAFF MEMBERS OR CONTRACTUAL WORK.

(K) EVERY RESIDENT SHALL HAVE THE RIGHT TO HAVE SECURITY FOR ANY PERSONAL POSSESSIONS IF STORED BY THE OPERATOR;

(L) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE ADEQUATE AND APPROPRIATE ASSISTANCE WITH ACTIVITIES OF DAILY LIVING, TO BE FULLY INFORMED OF THEIR MEDICAL CONDITION AND PROPOSED TREATMENT, UNLESS MEDICALLY CONTRAINDICATED, AND TO REFUSE MEDICATION, TREATMENT OR SERVICES AFTER BEING FULLY INFORMED OF THE CONSEQUENCES OF SUCH ACTIONS, PROVIDED THAT AN OPERATOR SHALL NOT BE HELD LIABLE OR PENALIZED FOR COMPLYING WITH THE REFUSAL OF SUCH MEDICATION, TREATMENT OR SERVICES BY A RESIDENT WHO HAS BEEN FULLY INFORMED OF THE CONSEQUENCES OF SUCH REFUSAL;

(M) EVERY RESIDENT AND VISITOR SHALL HAVE THE RESPONSIBILITY TO OBEY ALL REASONABLE REGULATIONS OF THE RESIDENCE AND TO RESPECT THE PERSONAL RIGHTS AND PRIVATE PROPERTY OF THE OTHER RESIDENTS;

(N) EVERY RESIDENT SHALL HAVE THE RIGHT TO INCLUDE THEIR SIGNED AND WITNESSED VERSION OF THE EVENTS LEADING TO AN ACCIDENT OR INCIDENT INVOLVING SUCH RESIDENT IN ANY REPORT OF SUCH ACCIDENT OR INCIDENT;

(O) EVERY RESIDENT SHALL HAVE THE RIGHT TO RECEIVE VISITS FROM FAMILY MEMBERS AND OTHER ADULTS OF THE RESIDENT'S CHOOSING WITHOUT INTERFERENCE FROM THE ASSISTED LIVING RESIDENCE; AND

(P) EVERY RESIDENT SHALL HAVE THE RIGHT TO WRITTEN NOTICE OF ANY FEE INCREASE NOT LESS THAN FORTY-FIVE DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE OF THE FEE INCREASE; PROVIDED, HOWEVER, PROVIDING ADDITIONAL SERVICES TO A RESIDENT SHALL NOT BE CONSIDERED A FEE INCREASE PURSUANT TO THIS PARAGRAPH; AND

(Q) EVERY RESIDENT OF AN ASSISTED LIVING RESIDENT THAT IS ALSO CERTIFIED TO PROVIDE ENHANCED ASSISTED LIVING AND/OR SPECIAL NEEDS ASSISTED LIVING SHALL HAVE A RIGHT TO BE INFORMED BY THE OPERATOR, BY A CONSPICUOUS POSTING IN THE RESIDENCE, OR AT LEAST A MONTHLY BASIS, OF THE THEN-CURRENT VACANCIES AVAILABLE, IF ANY, UNDER THE OPERATOR'S ENHANCED AND/OR SPECIAL NEEDS ASSISTED LIVING PROGRAMS.

WAIVER OF ANY OF THESE RESIDENT RIGHTS SHALL BE VOID. A RESIDENT CANNOT LAWFULLY SIGN AWAY THE ABOVE-STATED RIGHTS AND RESPONSIBILITIES THROUGH A WAIVER OR ANY OTHER MEANS.

## **EXHIBIT XVI**

### **OPERATOR'S PROCEDURE:** **RESIDENT GRIEVANCES AND RECOMMENDATIONS**

In the event a Resident and/or Resident's responsible party (on behalf of the Resident) and/or Legal Representative (on behalf of the Resident) has a grievance (or complaint) regarding the Community, staff, or its services, the following steps can be taken to resolve the grievance or complaint:

Step 1: - Discuss the grievance with the Associate and Executive Director or at any scheduled Resident Council meeting. The Resident Council can make recommendations to the Executive Director, if it deems appropriate. The Executive Director will respond verbally within 5 days of receipt of the grievance.

Step 2: If the grievance is not resolved, submit the grievance in writing to the Executive Director. The Executive Director will respond within fourteen (14) days of receipt of the grievance. Grievance forms are located on the table outside of the Activity Room. Forms may also be submitted anonymously by dropping them into the suggestion box located on the table outside the Activity Room.

Step 3: If the grievance is still not resolved, mail a written copy of the grievance to the Regional Director of Operations for Evergreen Place, PSL Associates, Community Support Center, 17330 Preston Road, Suite 240B, Dallas, TX 75252. The Regional Director of Operations should respond within fourteen (14) days of receipt of the grievance.

Step 4: Should the grievance still not be resolved submit the written grievance to the President, PSL Associates, Community Support Center, 17330 Preston Road, Suite 240B, Dallas, TX 75252. The decision of the President shall be final.

You and/or Your Resident Representative and/or Legal Representative may file a grievance with any governmental official, the New York State Department of Health, or to any other person at any point in this process. If requested, a community representative should in forwarding the written grievance to the appropriate address and contact person.

**Residents, their responsible parties, and/or Legal Representatives may submit grievances without fear of reprisal.**

**EXHIBIT XVII**  
**RESIDENT PET POLICY & AGREEMENT**

There is a non-refundable fee of \$300.00 per pet and a monthly fee of \$30.00 per month. The following rules are for the protection all of our Residents, associates, guests, property and other pets.

1. Pets are allowed in the common areas only when entering or exiting the building. The animal must be on a leash or in a pet carrier.
2. Pets are not to exceed 40 pounds and must always be under the Resident's control.
3. Residents are responsible for removing animal waste from the grounds and responsible for all damages caused by the pet anywhere on the premises and for injuries to any individuals whatsoever.
4. Residents will learn of complaints about their pet in writing and the corrective action needed. Failure to comply is a violation of the residency agreement and may be grounds to terminate the residency agreement.
5. This Residence requires licensing and proper vaccination of all pets. Proof of license and vaccination must be submitted to the Executive Director prior to move-in. The Executive Director has the sole discretion of deciding whether any pet is appropriate to live in the Residence.
6. All pets must wear a nametag and local license that includes appropriate identification to return the dog and cat if it becomes lost. All pets must be microchipped.
7. Each Resident is responsible for all care of their pet without assistance. Pet care is not a service provided by the Residence.
8. If pest infestation occurs, the facility will exterminate the apartment at the expense of the Resident. If the Resident's pet causes pest infestation in other apartments, the Resident owning the pet will be responsible for all costs related to the infestation. Any relocation costs to any Resident will be at the sole expense of the Resident owning the pet.
9. All local and State regulations regarding animal control, care, abuse and/or neglect are always to be adhered to; pet owners must have an individual available in case the Resident cannot take care of their pet if ill or away from the Residence.

|                                                                                                                                                                                    |                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| _____<br>Resident/Legal Representative and Date<br>RESIDENT NAME: _____<br>TYPE OF PET: _____<br>AGE: _____ WEIGHT: _____<br>NAME AND PHONE NUMBER OF BACK-UP PET CARETAKER: _____ | _____<br>Residence Representative and Date<br>APT# _____<br>NAME: _____<br>_____<br>NAME OF VET: _____ PHONE: _____<br>VET PAPERS ATTACHED |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|

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by BQA  
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2026.05.05  
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**EXHIBIT XVIII**

**SEE THE ATTACHED EVALUATION FORM**

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Resident

Community / Division

Apartment

Category

MoveIn Date

Date of Birth

Primary Language

Physician

Food Allergies

Drug Allergies

Diagnoses  
Advance Directives

| Category                                                                                                     | Not | Frequency | Levels                         | Score |  |
|--------------------------------------------------------------------------------------------------------------|-----|-----------|--------------------------------|-------|--|
| <b>Orientation (Select only One)</b>                                                                         |     |           | <b>Cognitive/Psycho-Social</b> |       |  |
| 1 Resident is oriented to person, place and time                                                             |     |           | 0                              |       |  |
| 2 Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation. |     |           | 3                              |       |  |
| <b>Wandering Behavior (Select only One)</b>                                                                  |     |           | <b>Cognitive/Psycho-Social</b> |       |  |
| 3 Resident does not wander                                                                                   |     |           | 0                              |       |  |
| 4 Wanders in public areas, but not intrusive                                                                 |     |           | 3                              |       |  |
| 5 Wanders intrusively, but easily redirected                                                                 |     |           | 5                              |       |  |

| Category                                                                                                                                     | Not | Frequency | Levels                         | Score |  |
|----------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------|--------------------------------|-------|--|
| <b>Behaviors (Select all that apply either frequently or continuously)</b>                                                                   |     |           | <b>Cognitive/Psycho-Social</b> |       |  |
| 6 Resident does not exhibit present or past behavioral issues                                                                                |     |           | 0                              |       |  |
| 7 Resident has non active but history of behavioral issues                                                                                   |     |           | 0                              |       |  |
| 8 Resident has active behavioral issues.                                                                                                     |     |           | 2                              |       |  |
| 9 Non Compliant / Refusals                                                                                                                   |     |           | 3                              |       |  |
| 10 Depression-feeling of hopelessness                                                                                                        |     |           | 0                              |       |  |
| 11 Altered sleep cycle                                                                                                                       |     |           | 10                             |       |  |
| 12 Agitation: anxious; fluctuates emotionally                                                                                                |     |           | 12                             |       |  |
| 13 Impaired decision-making skills; reality disorientation.                                                                                  |     |           | 12                             |       |  |
| <b>Communication (Select only One)</b>                                                                                                       |     |           | <b>Cognitive/Psycho-Social</b> |       |  |
| 14 Resident can communicate independently                                                                                                    |     |           | 0                              |       |  |
| 15 Needs assistance to make and receive calls                                                                                                |     |           | 1                              |       |  |
| 16 Difficulty communicating. Requires additional employees attention and/or assistance with adaptive device                                  |     |           | 4                              |       |  |
| <b>Life Enrichment Activities/Socialization (Select)</b>                                                                                     |     |           | <b>Cognitive/Psycho-Social</b> |       |  |
| 17 Resident is independent in life enrichment and socialization activities                                                                   |     |           | 0                              |       |  |
| 18 List Top 5 Life Enrichment choices of resident.                                                                                           |     |           | 0                              |       |  |
| 19 Consistent resistance to life enrichment and socialization activities (Check Behaviors Section; Also select another Item in this Section) |     |           | 0                              |       |  |
| 20 Requires encouragement and reminders regarding life enrichment and socialization activities                                               |     |           | 1                              |       |  |
| 21 Needs daily assistance and supervision with consistent redirection in activities/events. Exhibits short attention span                    |     |           | 4                              |       |  |
|                                                                                                                                              |     |           |                                |       |  |

| Category                                                                               | Not | Frequency | Levels                                                 | Score |  |
|----------------------------------------------------------------------------------------|-----|-----------|--------------------------------------------------------|-------|--|
| <b>Smoking (Select only One)</b>                                                       |     |           | <b>Cognitive/Psycho-Social</b>                         |       |  |
| 22 Resident is a non-smoker currently                                                  |     |           | 0                                                      |       |  |
| 23 Resident can smoke independently in designated areas                                |     |           | 0                                                      |       |  |
| <b>Dressing And Grooming (Select all that apply)</b>                                   |     |           | <b>Activities Of Daily Living/Physical Functioning</b> |       |  |
| 24 Resident is independent with all dressing and grooming tasks                        |     |           | 0                                                      |       |  |
| 25 Resident is independent in oral care                                                |     |           | 0                                                      |       |  |
| 26 Resident is resistant to assistance planned (Check Behaviors Section of Assessment) |     |           | 0                                                      |       |  |
| 27 Requires reminders for dressing and grooming                                        |     |           | 0                                                      |       |  |
| 28 Requires reminders for oral care                                                    |     |           | 0                                                      |       |  |
| 29 Staff to set up grooming and dressing items                                         |     |           | 2                                                      |       |  |
| 30 Requires physical assist with oral care                                             |     |           | 3                                                      |       |  |
| 31 Requires physical assist with dressing and grooming                                 |     |           | 8                                                      |       |  |
| 32 Requires stand by assist with dressing and grooming                                 |     |           | 8                                                      |       |  |
| 33 Requires two persons to assist with dressing                                        |     |           | 20                                                     |       |  |

| Category                                                                                                                                 | Not | Frequency | Levels                                                 | Score |  |
|------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------|--------------------------------------------------------|-------|--|
| <b>Sensory Assistive Devices (Select all that apply)</b>                                                                                 |     |           | <b>Activities Of Daily Living/Physical Functioning</b> |       |  |
| 34 Resident does not use sensory devices                                                                                                 |     |           | 0                                                      |       |  |
| 35 Wears and cares for eyewear independently                                                                                             |     |           | 0                                                      |       |  |
| 36 Wears and cares for hearing aids independently                                                                                        |     |           | 0                                                      |       |  |
| 37 Wears and cares for dentures independently                                                                                            |     |           | 0                                                      |       |  |
| 38 Resident is resistant to assistance planned (Check Behaviors Section of Assessment)                                                   |     |           | 0                                                      |       |  |
| 39 Requires reminders and/or assistance locating and/or caring for eyewear                                                               |     |           | 1                                                      |       |  |
| 40 Requires reminders and/or assistance locating and/or caring for hearing aids                                                          |     |           | 1                                                      |       |  |
| 41 Requires reminders and/or assistance locating and/or caring for dentures                                                              |     |           | 2                                                      |       |  |
|                                                                                                                                          |     |           |                                                        |       |  |
| <b>Bathing (Select all that apply)</b>                                                                                                   |     |           | <b>Activities Of Daily Living/Physical Functioning</b> |       |  |
| 42 Resident baths independently                                                                                                          |     |           | 0                                                      |       |  |
| 43 Resident is resistant to assistance planned (Check Behaviors Section of Assessment; Also Need to select another Item in this Section) |     |           | 0                                                      |       |  |
| 44 Resident needs reminders for bathing                                                                                                  |     |           | 0                                                      |       |  |
| 45 Staff to set up bathing supplies                                                                                                      |     |           | 2                                                      |       |  |
| 46 Requires stand by assist for shower                                                                                                   |     |           | 5                                                      |       |  |
| 47 Requires physical assist for shower                                                                                                   |     |           | 5                                                      |       |  |
| 48 Requires two employees to assist with showering                                                                                       |     |           | 10                                                     |       |  |
| 49 Requires employees assistance with whirlpool                                                                                          |     |           | 10                                                     |       |  |
| 50 Requires two employees to assistance with whirlpool                                                                                   |     |           | 16                                                     |       |  |
|                                                                                                                                          |     |           |                                                        |       |  |
|                                                                                                                                          |     |           |                                                        |       |  |

| Category                                                                                                                                 | Not | Frequency | Levels                                                 | Score |  |
|------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------|--------------------------------------------------------|-------|--|
| <b>Bathroom Assistance (Select need/assistance and supply program choice)</b>                                                            |     |           | <b>Activities Of Daily Living/Physical Functioning</b> |       |  |
| 51 Resident is continent of bowel and bladder and manages independently                                                                  |     |           | 0                                                      |       |  |
| 52 Resident is resistant to assistance planned (Check Behaviors Section of Assessment; Also Need to select another Item in this Section) |     |           | 0                                                      |       |  |
| 53 Is incontinent of bowel and/or bladder and manages protective and/or assistive devices independently                                  |     |           | 0                                                      |       |  |
| 54 Resident will use the Incontinence supply program 1.                                                                                  |     |           | 0                                                      |       |  |
| 55 Resident will use the Incontinence supply program 2.                                                                                  |     |           | 0                                                      |       |  |
| 56 Resident will use the Incontinence supply program 3.                                                                                  |     |           | 0                                                      |       |  |
| 57 Requires occasional reminders to go to the bathroom                                                                                   |     |           | 0                                                      |       |  |
| 58 Requires reminders for bathroom or protective garment usage                                                                           |     |           | 2                                                      |       |  |
| 59 Has intermittent episodes of incontinence with employees assistance required                                                          |     |           | 2                                                      |       |  |
| 60 Requires regular employees assistance in managing bowel and/or bladder care                                                           |     |           | 10                                                     |       |  |
| 61 Requires two employees to assist with bathroom assistance                                                                             |     |           | 15                                                     |       |  |
| <b>Special Needs Care (Select)</b>                                                                                                       |     |           | <b>Activities Of Daily Living/Physical Functioning</b> |       |  |
| 62 Resident is resistant to assistance planned (Check Behaviors Section of Assessment; Also Need to select another Item in this Section) |     |           | 0                                                      |       |  |
| 63 Resident manages independently (colostomy, catheter, bedside commode, etc.)                                                           |     |           | 0                                                      |       |  |
| 64 Requires set up to manage colostomy, catheter, bedside commode, etc.                                                                  |     |           | 1                                                      |       |  |
| 65 Requires physical assistance to manage colostomy, catheter, bedside commode, etc.                                                     |     |           | 3                                                      |       |  |

| Category                                                                                                                                 | Not | Frequency | Levels                          | Score |  |
|------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------|---------------------------------|-------|--|
| <b>General Mobility (Select only One - but Resistance does not count as your choice)</b>                                                 |     |           | <b>Mobility/Transfer/Escort</b> |       |  |
| 66 Resident is independent in mobility                                                                                                   |     |           | 0                               |       |  |
| 67 Resident is resistant to assistance planned (Check Behaviors Section of Assessment; Also Need to select another Item in this Section) |     |           | 0                               |       |  |
| 68 Requires reminders to use assistive devices                                                                                           |     |           | 3                               |       |  |
| 69 Requires assistance of 1 person transferring                                                                                          |     |           | 3                               |       |  |
| 70 Requires employees to escort you or push your wheelchair because of a physical limitation                                             |     |           | 6                               |       |  |
| 71 Two person assistance required for transfer                                                                                           |     |           | 50                              |       |  |
| <b>Assistive Devices (Select all that apply)</b>                                                                                         |     |           | <b>Mobility/Transfer/Escort</b> |       |  |
| 72 Cane                                                                                                                                  |     |           | 0                               |       |  |
| 73 Walker                                                                                                                                |     |           | 0                               |       |  |
| 74 Manual wheelchair                                                                                                                     |     |           | 0                               |       |  |
| 75 Electric wheelchair or scooter                                                                                                        |     |           | 0                               |       |  |
| <b>Incidents (Select only One [Falls])</b>                                                                                               |     |           | <b>Mobility/Transfer/Escort</b> |       |  |
| 76 Resident has had no falls                                                                                                             |     |           | 0                               |       |  |
| 77 Resident has had 1 fall within last 3 months                                                                                          |     |           | 5                               |       |  |
| 78 Resident has had more than 1 fall in the last 3 months                                                                                |     |           | 10                              |       |  |
|                                                                                                                                          |     |           |                                 |       |  |
|                                                                                                                                          |     |           |                                 |       |  |
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|                                                                                                                                          |     |           |                                 |       |  |

| Category                                                                                     | Not | Frequency | Levels                           | Score |  |
|----------------------------------------------------------------------------------------------|-----|-----------|----------------------------------|-------|--|
| <b>Diet (Select all that apply)</b>                                                          |     |           | <b>Nutrition/Dining Services</b> |       |  |
| 79 Resident is on a regular diet                                                             |     |           | 0                                |       |  |
| 80 Resident has had recent unplanned change in weight                                        |     |           | 1                                |       |  |
| 81 Resident uses nutritional supplements                                                     |     |           | 1                                |       |  |
| 82 Resident is on a special diet. (Limited concentrated sweets; No added salt)               |     |           | 0                                |       |  |
| 83 Requires texture modified preparation (pureed, soft, cutting meat, thickened liquid, etc) |     |           | 0                                |       |  |
|                                                                                              |     |           |                                  |       |  |
| <b>Dining (Select all that apply)</b>                                                        |     |           | <b>Nutrition/Dining Services</b> |       |  |
| 84 Independent in dining                                                                     |     |           | 0                                |       |  |
| 85 Resident is resistant to assistance planned Check Behaviors Section of Assessment         |     |           | 0                                |       |  |
| 86 Resident needs reminders for meals                                                        |     |           | 1                                |       |  |
| 87 Requires assistance with set up of meal (opening packets, buttering bread)                |     |           | 1                                |       |  |
| 88 Uses adaptive devices for dining                                                          |     |           | 1                                |       |  |
| 89 Resident requires verbal prompts to intake meals                                          |     |           | 2                                |       |  |
| 90 Additional Tray Service                                                                   |     |           | 2                                |       |  |
| 91 Needs physical assist with eating                                                         |     |           | 15                               |       |  |
|                                                                                              |     |           |                                  |       |  |
| <b>Acute Illness Needs (Select all that apply)</b>                                           |     |           | <b>Health Related Services</b>   |       |  |
| 92 Flu                                                                                       |     |           | 0                                |       |  |
| 93 Pneumonia                                                                                 |     |           | 0                                |       |  |
| 94 Lesion                                                                                    |     |           | 0                                |       |  |
| 95 Bronchitis                                                                                |     |           | 0                                |       |  |
| 96 Pressure Ulcer                                                                            |     |           | 0                                |       |  |
| 97 Others (Describe)Write in Notes                                                           |     |           | 0                                |       |  |
|                                                                                              |     |           |                                  |       |  |
|                                                                                              |     |           |                                  |       |  |

| Category                                                                                                       | Not | Frequency | Levels                         | Score |  |
|----------------------------------------------------------------------------------------------------------------|-----|-----------|--------------------------------|-------|--|
| <b>Skin (Select all that apply)</b>                                                                            |     |           | <b>Health Related Services</b> |       |  |
| 98 Resident Skin is intact and no issues. Resident is independent in preventative skin care.                   |     |           | 0                              |       |  |
| 99 Resident is not cognitively or Physically capable of preventative skin care and will need assistance.       |     |           | 2                              |       |  |
| 100 Resident has acute skin care needs. (describe)                                                             |     |           | 3                              |       |  |
| 101 Resident has chronic skincare needs. (describe)                                                            |     |           | 3                              |       |  |
| <b>Medication Assistance (Select)</b>                                                                          |     |           | <b>Health Related Services</b> |       |  |
| 102 Resident is completely independent with self medication administration with accompanying physicians orders |     |           | 0                              |       |  |
| 103 Resident Uses Packaging from non Community pharmacy and Community Standard Packaging.                      |     |           | 0                              |       |  |
| 104 Requires employees assist/administer medications                                                           |     |           | 0                              |       |  |
|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |
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|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |
|                                                                                                                |     |           |                                |       |  |

| Category                                                                                                        | Not | Frequency | Levels                         | Score |  |
|-----------------------------------------------------------------------------------------------------------------|-----|-----------|--------------------------------|-------|--|
| <b>Medication/Treatments (Select all that apply)</b>                                                            |     |           | <b>Health Related Services</b> |       |  |
| 105 Resident is resistive to assistance planned                                                                 |     |           | 0                              |       |  |
| 106 Resident monitors Blood sugars independently                                                                |     |           | 0                              |       |  |
| 107 Resident is independent in insulin use                                                                      |     |           | 0                              |       |  |
| 108 Resident wears TED Hose manages independently                                                               |     |           | 0                              |       |  |
| 109 Resident uses medication other than oral (creams, eye drops, inhalers, patch etc) independently             |     |           | 0                              |       |  |
| 110 Resident has state allowed skin wounds managed independently or by Third Party Provider                     |     |           | 0                              |       |  |
| 111 Resident uses nebulizers independently                                                                      |     |           | 0                              |       |  |
| 112 Requires employees to assist with Blood sugar monitoring                                                    |     |           | 1                              |       |  |
| 113 Resident takes PRN medications                                                                              |     |           | 1                              |       |  |
| 114 Requires employees to assist/administer nebulizer treatments                                                |     |           | 1                              |       |  |
| 115 Resident uses Oxygen independently                                                                          |     |           | 1                              |       |  |
| 116 Resident has scheduled monitoring of VS or weights connected to medication pass.                            |     |           | 1                              |       |  |
| 117 Requires employees to assist/administer medication other than oral (creams, eye drops, inhalers, patch etc) |     |           | 1                              |       |  |
| 118 Requires regular labwork for medication monitoring                                                          |     |           | 1                              |       |  |
| 119 Requires employees to assist/administer insulin                                                             |     |           | 2                              |       |  |
| 120 Requires medications crushed                                                                                |     |           | 2                              |       |  |
| 121 Requires employees assistance with Oxygen use                                                               |     |           | 2                              |       |  |
| 122 Resident needs assistance with TED hose                                                                     |     |           | 3                              |       |  |
| 123 Resident uses psychotropic medications                                                                      |     |           | 3                              |       |  |
|                                                                                                                 |     |           |                                |       |  |
|                                                                                                                 |     |           |                                |       |  |

| Category                                                                                                                                                                                                    | Not | Frequency | Levels                                   | Score |                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------|------------------------------------------|-------|----------------|
| <b>Third Party Provider Services (Select all that apply)</b>                                                                                                                                                |     |           | <b>Health Related Services</b>           |       |                |
| 124 Resident utilizes Hospice                                                                                                                                                                               |     |           | 1                                        |       |                |
| 125 Resident utilizes Private sitters                                                                                                                                                                       |     |           | 1                                        |       |                |
| 126 Resident utilizes Home Health                                                                                                                                                                           |     |           | 1                                        |       |                |
|                                                                                                                                                                                                             |     |           |                                          |       |                |
| <b>General (Select all that apply)</b>                                                                                                                                                                      |     |           | <b>Laundry and Housekeeping Services</b> |       |                |
| 127 Resident utilizes base service Laundry (1 linen 1 personal)                                                                                                                                             |     |           | 0                                        |       |                |
| 128 Resident utilizes base service Housekeeping (1 x per week)                                                                                                                                              |     |           | 0                                        |       |                |
|                                                                                                                                                                                                             |     |           |                                          |       |                |
| <b>Transportation (Choose all that apply)</b>                                                                                                                                                               |     |           |                                          |       | <b>General</b> |
| 129 Resident is independent in transportation for scheduled needs and arrangements. Resident will not need accompaniment in Emergency transportation situations. This includes family taking responsibility |     |           | 0                                        |       |                |
| 130 Resident Will need a companion for scheduled appointments -                                                                                                                                             |     |           | 0                                        |       |                |
| 131 Resident will need a companion for emergent transportation events                                                                                                                                       |     |           | 0                                        |       |                |
| 132 Resident will need assistance in arranging transportation for scheduled needs                                                                                                                           |     |           | 2                                        |       |                |
|                                                                                                                                                                                                             |     |           |                                          |       |                |
| <b>Pet Care (Choose one)</b>                                                                                                                                                                                |     |           |                                          |       | <b>General</b> |
| 133 Resident has a pet and is independent in its care.                                                                                                                                                      |     |           | 0                                        |       |                |
| 134 Resident has a pet and will need assistance in pet care.                                                                                                                                                |     |           | 0                                        |       |                |
|                                                                                                                                                                                                             |     |           |                                          |       |                |
| <b>Miscellaneous assistance (Choose all that apply)</b>                                                                                                                                                     |     |           |                                          |       | <b>General</b> |
| 135 Resident will need paperwork assistance monthly for insurance submittal.                                                                                                                                |     |           | 0                                        |       |                |
| 136 Resident will need assistance managing funds. (only in states where Required) ONLY IN STATES WHERE REQUIRED                                                                                             |     |           | 0                                        |       |                |
|                                                                                                                                                                                                             |     |           |                                          |       |                |

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## Evaluation Resident Form (PGSL Evergreen Place Evaluation Form)

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| Category                                                                    | Notes | Frequency | Levels                         | Score |  |
|-----------------------------------------------------------------------------|-------|-----------|--------------------------------|-------|--|
| <b>State Required evaluation (States requiring state evaluation)</b>        |       |           | <b>Health Related Services</b> |       |  |
| 137 The resident will be in a Kansas Pegasus Senior living community        |       |           | 0                              |       |  |
| 138 The resident will be in a New York Pegasus community.                   |       |           | 0                              |       |  |
| Resident Signature _____<br>Date _____                                      |       |           |                                |       |  |
| Responsible Party Signature (If Applicable) _____<br>Date _____             |       |           |                                |       |  |
| Community Executive Director/Administrator Signature _____<br>Date _____    |       |           |                                |       |  |
| Community Wellness/Resident Services Director Signature _____<br>Date _____ |       |           |                                |       |  |

**ENHANCED ASSISTED LIVING RESIDENCE**  
**ADDENDUM TO**  
**RESIDENCY AGREEMENT**

This is an addendum to a Residency Agreement made between Evergreen Place at Brockport 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 sections 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.

I. Enhanced Assisted Living Certificates

The Operator is currently certified by the New York State Department of Health to provide Enhanced Assisted Living at Evergreen Place, Enhanced, Assisted Living and Memory Care, located at 90 West Avenue, Brockport, NY 14420.

II. Physician Report

You have submitted to the Operator a written report from Your physician, which report states that:

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

III. 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.

IV. Specialized Programs, Staff Qualifications and Environmental Modifications

Attached as EALR # 1 and made a part of this Agreement is a written description of:

- Services to be provided in the Enhanced Assisted Living Residence;
- Staffing levels;
- Staff education and training work experience, and any professional affiliations or special characteristics relevant to serving persons in the Enhanced Assisted Living Residence; and
- Any environmental modifications that have been made to protect the health, safety and welfare of persons in the Residence.

V. 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.

VI. 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 a facility licensed under the Mental Hygiene Law, the Operator will initiate proceedings for the termination of this 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 Articles 19, 31, or 32; AND
- c. The Operator agrees to retain You as 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.

VII. Addendum Agreement Authorization

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

Dated: \_\_\_\_\_

\_\_\_\_\_  
*(Signature of Resident)*

Dated: \_\_\_\_\_

\_\_\_\_\_  
*(Signature of Resident's Legal Representative)*

Dated: \_\_\_\_\_

\_\_\_\_\_  
*(Signature of Operator or Operator's Representative)*

**EARL # I**

**ENHANCED ASSISTED LIVING RESIDENCE  
ADDENDUM TO RESIDENCY AGREEMENT**

The below adds new sections to the Evergreen Place, Enhanced, Assisted Living & Memory Care Community Residency Agreement (“Agreement”). All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with the Agreement. This Agreement must be attached to the Agreement between the parties.

1. **Enhanced Assisted Living Certificate** The Operator is currently certified by the New York State Department of Health to provide Enhanced Assisted Living located at 80 West Avenue, Brockport, NY 14420 (“Community”).

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

a. Your physician has physically examined you within the last month prior to Your admission to the Community; and

b. You are not in need of 24-hour skilled nursing care or medical care requiring placement in a hospital or nursing home.

3. **Request for and Acceptance of Admission** You or Your Legal Representative have request to become a Resident at this Community and the Operator has accepted your request for residency.

4. **Specialized Programs, Staff Qualifications & Environmental Modifications** include:

a. Services to be provided in the Enriched Assisted Living Residence:

|                                   |                                             |
|-----------------------------------|---------------------------------------------|
| Oxygen therapy                    | Ostomy care                                 |
| Blood Pressure checks             | Insulin administration                      |
| Indwelling catheter care          | Enema administration                        |
| Nebulizer treatment               | Foley catheter care                         |
| Treating skin tears and abrasions | Suprapubic catheter care                    |
| One and two-person transfers      | Transdermal patch applications              |
| Blood glucose monitoring          | Temperature, pulse & respiration monitoring |
| Care of casts, braces & splints   |                                             |

Staffing levels will be maintained in compliance with all applicable laws and regulations and will be adjusted to meet the acuity needs of the Residents in the enhanced program. The staffing plan includes the presence of a licensed Registered Nurse that will be on the premises for a minimum of forty (40) hours per week with additional nursing coverage provided by a licensed practical nurse.

Resident Care Aides will be provided specialized training to enable each to respond to the enhanced needs of Residents. These trainings will be provided by a Registered Nurse licensed by the State of New York having experience in Adult Education/Learning.

Enhanced Assisted Living Residents live throughout the Community. The entire Community is equipped with a sprinkler system, emergency call bells in all Resident apartments and bathrooms, smoke corridors, and supervised smoke detection systems for resident safety.

5. Aging in Place

The Operator has notified You that, while the Operator will make reasonable efforts to facilitate Your ability to age in place and remain in the Community according to your Personal Service Plan, there may be a time when Your needs cannot be safely or appropriately met at the Community. If this occurs, the Operator will communicate with You regarding the need to relocate to a more appropriate residential or nursing setting, in accordance with law.

6. When 24 Hour Skilled Nursing or Medical Care is Needed

If You reach the time when you are in need of 24 hour skilled nursing or medical care that is required to be provided by a hospital, nursing home, or a facility licensed under the Mental Hygiene Law of New York. the Operator will initiate the termination of this Agreement and to discharge You from the Community, 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 Community, and would not require placement in a hospital, nursing home, or other facility licensed under Public Health Law Article 28 or Mental Hygiene Law Articles 19, 31, or 32; 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.

7. Addendum Agreement Authorization We, the undersigned, have read this Addendum and the Agreement, and have received a duplicate copy of each, and agree to abide by its terms and conditions.

Dated: \_\_\_\_\_  
*(Signature of Resident)*

Dated: \_\_\_\_\_  
*(Signature of Resident's Legal Representative)*

Dated: \_\_\_\_\_  
*(Signature of Operator or Operator's Representative)*

**SPECIAL NEEDS ASSISTED LIVING  
RESIDENCE ADDENDUM TO  
RESIDENCY AGREEMENT**

This is an addendum to a Residency Agreement made between Evergreen at Brockport 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 sections 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.

I. Special Needs Assisted Living Certification.

The Operator is currently certified by the New York State Department of Health to provide Special Needs Assisted Living at Evergreen Place, Enhanced, Assisted Living, and Memory Care, located at 90 West Avenue, Brockport, New York 14420.

II. Request for and Acceptance of Admission

You or Your Resident Representative or Legal Representative have requested that You become a Resident at this Special Needs Assisted Living Residence (the “Residence”) and the Operator has accepted such request.

III. Specialized Programs, Staff Qualifications and Environmental Modifications

Attached as Exhibit S.N.#1 and made a part of this Agreement is a written description of:

- Specialized services to be provided in the Special Needs Residence;
- Staffing levels

- Staff education and training and work experience, and professional affiliations or special characteristics relevant to serving persons with specific special needs;
- Any environmental modifications that have been made to protect the health, safety and welfare of Residents.

IV. Addendum Agreement Authorization.

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

Dated: \_\_\_\_\_  
*(Signature of Resident)*

Dated: \_\_\_\_\_  
*(Signature of Resident's Legal Representative)*

Dated: \_\_\_\_\_  
*(Signature of Operator or Operator's Representative)*

SN#1

## Special Needs Assisted Living

### Specialized Services

- Programing developed specifically for individuals with cognitive decline to encourage brain health.
- Staff trained to understand and provide support for people living with dementia
- Smaller environment to help reduce anxiety
- Programming meets each resident where they are in the moment, using current skills to support a successful experience.
- Secured Environment

### Staffing Levels

Staffing levels will be maintained in compliance with all applicable laws, regulations and minimum standards. Staffing will be adjusted to meet the acuity levels of the residents who have been admitted into the program.

Staffing includes NYS Certified Home Health Aides, Resident Care Aides and Medication Technician's.

Staffing plan includes the presence of a licensed Registered nurse who will be on premises for a minimum of 40 hours per week and provides on-call support for the facility 24/7.

Additional nursing coverage is provided by a Licensed LPN.

### Staff Training

Resident Care Aides and Home Health will be provided with any specialized training to meet the ongoing needs of our SNALR residents.

Ongoing in servicing and training is provided by professional organizations and licensed and/or certified professionals who specialize in Alzheimer's and Dementias.

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Resident)

Dated: \_\_\_\_\_  
*(Signature of Resident’s Legal Representative)*

Dated: \_\_\_\_\_  
*(Signature of Operator or Operator’s Representative)*