

Section G - Item 2

Assisted Living Residency Agreement

Enclosed for approval is the Facility's proposed Assisted Living Residency Agreement, based upon the model agreement issued by the Department. The differences between the enclosed Agreement and the model are:

- 1) Any blanks and "if applicable" options left by the Department were filled in or selected;
- 2) As this Agreement is for an assisted living facility with an enhanced certification, the following provisions relating to special needs certification were deleted:
 - a) Section X (5); and
 - b) Exhibit II (2) [references to SNALR in last 2 sentences deleted].

THE ELIOT AT ERIE STATION
Enhanced Assisted Living Residence
RESIDENCY AGREEMENT

June 29, 2005

MODEL RESIDENCY AGREEMENT

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RESIDENCY AGREEMENT

A. This agreement is made between The Eliot at Erie Station, 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 10-18 John Street, Middletown, New York 10940 an Assisted Living Residence ("The Residence") known as The Eliot at Erie Station and as an Adult Home. The Operator is also certified to operate, at this location, an Enhanced 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/Room.** You may occupy and use a private () or semi-private () room or the room 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 activities rooms.
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/room.

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/room. 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 Services Plan.

1. **Meals and Snacks.** Three [3] nutritionally well-balanced meals per day and two [2] snacks per day are 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: no salt added, no concentrated sweets and other physician ordered diets.
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, and will post a monthly schedule of activities in a readily visible common area of the Residence.
3. **Housekeeping.**
4. **Linen Service.** (towels and washcloths; pillow, pillowcase, blanket, bed sheets, bedspread; all clean and in good condition)
5. **Laundry of Your personal Washable clothing.**
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 assessment of Your needs and interests, information and referral, and coordination with available resources to best address Your identified needs and interests.
8. **Personal Care.** Include some assistance with bathing, grooming, dressing, toileting, ambulation, transferring, feeding, medication acquisition, storage and disposal, assistance with self-administration of medication.
9. **Development of Individualized Service Plan.** The Operator will develop an individualized service plan to address Your needs and will update this Plan every six months or when there has been a significant change in Your condition.

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 the Operator. Such exhibit states who would provide such services or amenities, if other than the Operator.

- D. Licensure/Certification Status.** A listing of all providers offering home care or personal care services under an arrangement with the Operator, and a description of

the licensure or certification status of each provider is set forth in Exhibit I.D. of this Agreement. Such Exhibit will be updated as frequently as necessary.

II. Disclosure Statement

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

III. Fees

A. Basic Rate.

(1) Flat Fee Arrangements

The Resident, Resident's Representative and Resident's Legal Representative agree that the Resident will pay, and the Operator agrees to accept, the following payment in full satisfaction of the Basic Services described in Section I. B. of this Agreement (*the "Basic Rate"*). The Basic Rate as of the date of this agreement is the current SSI rate.

(2) Tiered Fee Arrangements

Any "Tiered" fee arrangements, in which the amount of the Basic Rate depends upon the types of services provided, the number of hours of care provided per week for some type of service and the fees for each "tier" of care, are set forth in detail in Exhibit III.A.2. and made a part of the Agreement. Such exhibit describes the types of services provided, the number of hours of care provided per week for such service, the fees for each "tier" of care, and describes who will be providing care, if other than staff of the Operator.

B. Supplemental, Additional or Community, Fees

A Supplemental or Additional 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 Resident option. In some cases, the law permits the Operator to charge an Additional fee without the express written approval of the Resident (*See section I.E*).

A Community fee is a one-time fee that the Operator may charge at the time of admission. The Operator must clearly inform the prospective Resident what additional services, supplies or amenities the Community fee pays for and what the amount of the Community fee will be, as well as any terms regarding refund of the Community fee. The prospective Resident, once fully informed of the terms of the Community fee, may chose whether to accept the Community fee as a condition of residency in the Residence, or to reject the Community fee and thereby reject residency at the Residence.

Any charges by the Operator, whether a part of the Basic Rate, Supplemental, Additional or Community fees, shall be made only for services and supplies that are actually supplied to the Resident.

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 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 rates, fees or charges.

D. Billing and Payment Terms Payment is due by the first of the month and shall be delivered to the Business Office at the Residence. Failure of the Resident, the Resident's representative or the Resident's legal representative to make payment in a timely manner are grounds for involuntary discharge pursuant to section XIII of this Agreement.

E. Adjustments to Basic Rate or Additional or Supplemental Fees

1. You have the right to written notice of any proposed increase of the Basic Rate or any Additional or Supplemental fees not less than thirty (30) 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 care, services or supplies, the Operator may increase such Rate or Fee upon less than thirty (30) 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 an Additional or Supplementary fee upon less than thirty (30) 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 is the current monthly rate. (The total of the daily rate for a one-month period may not exceed the established monthly rate). The [basic] length of time the space will be reserved is one month. A provision to reserve a residential space does not supercede 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 You leave the Residence, the Operator must provide You, Your Resident 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 agrees to offer to establish a personal allowance account for any Resident who receives either Supplemental Security Income (SSI) or Safety Net Assistance (SNA) payments by executing a Statement of Offering (DSS-2853) with You or Your Representative.

You agree to inform the Operator if you receive or have applied for Supplemental Security Income (SSI) or Safety Net Assistance (SNA) funds.

You must complete the following:

I receive SSI funds or I have applied for SSI funds ____

I receive SNA funds or I have applied for SNA funds ____

I do not receive either SSI or SNA funds ____

If You have a signatory to this agreement besides Yourself and if that signatory does not choose to place Your personal allowance funds in a Residence maintained account, then that signatory hereby agrees that he/she will comply with the Supplemental Security Income (SSI) or Safety Net Assistance (SNA) personal allowance requirements.

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 Services Plan. The Operator shall not admit any Resident in need of 24-hour skilled nursing care.
2. The Operator shall conduct an initial pre-admission evaluation of a prospective Resident to determine whether or not 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 Services 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) are chronically chairfast and unable to transfer, or chronically require the physical assistance of another person to transfer; or (b) chronically require the physical assistance of another person in order to walk; or (c) chronically required the physical assistance of another person to climb or descend stairs; or (d) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or (e) 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

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

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

A. You, or Your Resident 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 Supplemental 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 is 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 shall be responsible for assisting Resident with any and all obligations listed above in Paragraphs One (1) through Six (6).

C. The Resident's Legal Representative, if any, shall be responsible for assisting Resident with any and all legal obligations.

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 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 sustains and 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 removed. 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 that assisted living residency agreements 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.

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

_____ personally guarantees payment of charges for Your Basic Rate.

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

(Date)

Guarantor's Signature

Guarantor's Name (Print)

(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.

(Date)

(Guarantor's Signature)

Guarantor's Name (Print)

EXHIBIT I.A.1.

IDENTIFICATION OF APARTMENT/ROOM

Apartment/Room Number: _____

EXHIBIT I.A.3.

FURNISHINGS/APPLIANCES PROVIDED BY OPERATOR

- **Bed, including spring, mattress and pillow**
- **Dresser**
- **Nightstand/Table**
- **Lamp**
- **Chair**
- **Lockable Storage Facility**
- **Closet Space for storage of Resident's clothing**
- **Hinged-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:

Item	Additional Charge	Provided By
Dry Cleaning	Set by Vendor	Outside Vendor
Professional Hair Grooming	Set by Vendor	Outside Vendor
Personal Toilet Articles	Set by Vendor	Outside Vendor
Commissary Goods	Set by Vendor	Outside Vendor
Medical Transportation	Set by Vendor, except when payment is available through Medicare, Medicaid or other third party coverage	Outside Vendor
Cultural/Activities Transportation	Set by Vendor	Outside Vendor
Long Distance Telephone Service	Set by Vendor	Outside Vendor
Local Phone Service	Set by Vendor	Outside Vendor
Air Conditioning (if available)	No Charge	Operator
Cable T.V. (if available)	Set by Vendor	Outside Vendor
Other: Lost Room/Storage Keys	1.50 per key	Operator

EXHIBIT I.D.

LICENSURE/CERTIFICATION STATUS OF PROVIDERS

Agreement between American Certified Special Services ("Certified Home Health Agency" or "CHHA") and The Eliot at Erie Station ALP

The Eliot at Erie Station ALP

And

Americare Certified Special Services

AGREEMENT

This Agreement is entered into this 15 day of February, 2010 between Americare Certified Special Services, Inc., having its principal office at 5923 Strickland Avenue, Brooklyn, New York 11223, hereinafter referred to as the "CHHA", and The Eliot at Erie Station ALP having its principal office at 12 John Street, Middletown NY 10940, hereinafter referred to as "ALP".

SECTION I - PURPOSE

1. The purpose of this Agreement is for the CHHA to provide nursing, physical therapy, occupational therapy and speech therapy services and any other services as certified in the ALP application for the ALP. The CHHA and the ALP bear mutual responsibility for the administration of these services and the decision as to when and by whom services are to be provided.

2. The services will be rendered at the ALP location of 12 John Street, Middletown NY 10940 or at such other locations as may become necessary in the administration of the ALP.

SECTION II - CHHA RESPONSIBILITIES

The CHHA shall:

3. For all services provided by the CHHA, retain full responsibility for obtaining medical orders, establishing the plan of care, reporting to the physician and a designated representative of the ALP any changes or progress and making plans for the services, frequency, hours, and when to terminate, all in the scope of the regular duties of the Registered Nurse.

4. Assist the ALP in assessing the need for services which can be supplied by the ALP.

5. Collaborate with the ALP's administrator regarding any problems which may arise.

6. Notify the ALP of any significant change in scheduled care plans, and otherwise ensure the prompt and timely delivery of the services required.

7. Submit an invoice for payment for the services received by the ALP's patients to the ALP.

8. Conduct and administer a comprehensive program for recruitment of persons to provide services under this Agreement.

9. Insure that each person who applies for employment by it in whatever job category meets the minimum health requirements established by the ALP and the CHHA for such personnel, including physical examination, tuberculosis and rubella testing, and requirements as to selection and training as specified by applicable federal and state law and the policies, procedures, and standards of the ALP. The CHHA shall assure that all staff provided hereunder are (i) in good health, (ii) have completed medical assessments and immunizations as required by law, (iii) possess current NYS professional license, registration, current clinical education, and/or credentialing as applicable, and (iv) have character and professional references and/or other proof of satisfactory skills and qualifications on file with the CHHA, for review by the ALP upon request.

10. Provide, upon the request from the ALP and to the extent that they are available, such personnel as the ALP may specify for assignments.

11. Prepare and keep such records and data as may reasonably be required, and maintain daily reports for statistical and billing purposes. Upon request, CHHA will make available to ALP the personnel files and any other records pertaining to the provision of services to the residents/patients of the ALP.

12. All CHHA personnel shall remain employees or agents of the CHHA and are not employees of the ALP. Therefore, the CHHA shall pay all wages, salaries and other costs of the personnel and insurance compliance with all applicable federal, state and local withholding tax and Social Security regulations, Workers Compensation, and with all recording and reporting requirements. (Certificate of Insurance attached). The ALP engages CHHA as an independent contractor to provide the professional services described herein, and it is expressly understood by the parties that neither CHHA nor its employees shall be considered agents, partners, joint ventures, or employees of the ALP for any purpose whatsoever.

13. Insure that CHHA personnel abide by all policies and practices of the ALP during the performance of their responsibilities under this agreement.

14. The CHHA shall make its staff available for attendance at case conferences at the request of the ALP.

15. Notwithstanding any other provisions in this contract, the CHHA remains responsible for: (a) ensuring that any service provided pursuant to this contract complies with all pertinent provisions of federal, and state and local statutes, rules and regulations, (b) planning, coordinating, and ensuring the quality of all services provided; and (c) ensuring adherence to the plan of care established for patients. The CHHA retains sole authority for the admission and discharge of patients into its care.

16. Maintain liability insurance covering the services to be rendered pursuant to this agreement. The coverage is no less than \$1,000,000/\$2,000,000.

Deleted: ¶

17. CHHA will conduct a reassessment of the resident no later than 45 days after the date of admission of the resident. In addition, reassessments must be conducted as frequently as required and at least every six months to respond to changes in the resident's condition and to obtain access to necessary and appropriate services for the resident.

SECTION III - ALP RESPONSIBILITIES

18. ALP will conduct a pre-assessment screening.

19. Following pre-assessment, ALP will refer residents to the CHHA for a nursing assessment and periodic reassessments, every six months, as needed due to hospitalization and/or change in level of care (transfer to outside facility)

20. ALP personnel will complete all residents' records and related documentation required in a timely and professional manner consistent with the policies of the ALP and the CHHA.

21. The residents' records remain the property of the ALP however the CHHA may keep a copy of the documentation it performs on behalf of the ALP

22. Notwithstanding any other provision of this contract, the ALP remains responsible for:

- (a) ensuring that any services provided pursuant to this contract comply with all pertinent provisions of federal, state and local statutes, rules and regulations;
- (b) ensuring the quality of all services provided by the ALP; and
- (c) ensuring adherence by all staff of the ALP's plan of care established for residents.

SECTION IV - MUTUAL RESPONSIBILITIES

The CHHA and ALP shall:

23. Designate a person within each agency who shall have responsibility for coordination of services.

24. Consult and cooperate on a continuing basis with each other in the establishment of mutually acceptable standards and procedures for selection, training and assignment of personnel, handling of requests for service, billing procedures and other matters incidental to the carrying out of the provisions and purposes of this Agreement.

25. Not discriminate or permit discrimination against any employee, applicant or resident/patient on the grounds of age, race, color, relations, handicap, sex or national origin in any manner prohibited by the laws of the United States or the State of New York.

26. Maintain the confidentiality and privacy of the resident/patient records. When dealing with Human Immunodeficiency Virus (HIV) information, it is understood that this information has been disclosed from confidential records which are protected by state law. State law prohibits making further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

27. In the event that the Secretary of Health and Human Services or the Comptroller General of the United States, or their representatives determines that this contract is a contract as described in Section 1861 (v)(1)(I) of the Social Security Act, the parties agree that until the expiration of four years after the furnishing of services pursuant to this agreement, the parties shall make available, upon written request to the parties of the Secretary of Health and Human Services, or upon the request of the Comptroller General of the United States, or their duly authorized representatives, this contract and any books, documents and records of the parties that are necessary to certify the nature and extent of costs paid by the parties pursuant to this agreement. If the parties carry out any of the duties of the agreement through a subcontract with a value or cost of Ten Thousand Dollars (\$10,000.00) or more over a twelve month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four years after furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary of Health and Human Services or the Comptroller General of the United States, or their duly authorized representatives, the subcontract and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

28. Confidentiality. Both parties agree to adhere to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the federal HIPAA privacy regulations 45 C.F.R. parts 160 and 164.

29. Each party hereto shall have access, upon reasonable request, to the clinical records of the other as may be necessary in the performance of this Agreement.

Each party shall retain its books and records related to the performance of this Agreement for a period of not less than seven (7) years after the date of the last service performed under this Agreement by the CHHA for the ALP.

SECTION V - TERM AND PAYMENT

30. The term of this Agreement shall be one year, and shall commence on the date the ALP is licensed to begin operations by the New York State Department of Health. This Agreement shall be automatically renewed for successive one-year periods, unless one party notifies the other of its intention not to renew not less than thirty days prior to the expiration date. The ALP will pay the CHHA the fee of \$2.25 per day per ALP resident then in residence, for all services provided under this Agreement, with payment due within ~~60~~ ⁴⁵ days of invoice date. *HS MK (N2)*

31. This Agreement ~~may be terminated~~ by either party without cause on thirty (30) days' written notice to the other, delivered to the address for the parties first listed in this Agreement, by overnight mail or personal delivery.

32. This Agreement may be terminated by either party at any time, for cause. The term "cause" shall be: (i) material and substantial breach of this Agreement; (ii) loss or suspension of any license or government approval to conduct the business that is the subject of the Agreement; (iii) finding by any government agency that this Agreement violates any state or federal laws, or written opinion by either party's legal counsel that this Agreement or relationship is or is likely to be found to be in violation of applicable federal or state laws; (iv) failure to provide services or a reasonable quality of services; (v) failure to adhere to applicable patient-care standards, or standards or rules governing billing and payment for services; or (vi) cessation of or serious disruption in the business relationship between the parties, or of either party, whether due to bankruptcy, liquidation, or otherwise.

33. If terminated, the parties may not re-enter into this Agreement until the end of the current one-year term.

SECTION VI

MISCELLANEOUS

34. This Agreement and any attachments constitute the entire contract between the parties, and may be changed or modified only by a subsequent written agreement.

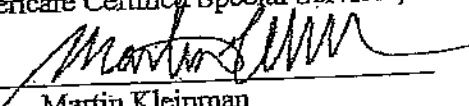
35. Neither party shall assign or transfer any interest in this Agreement without the prior written consent of the other party. Any assignment, transfer, or subcontract shall be attached together with the consent to this Agreement and made a part thereof.

37. The CHHA shall name the ALP as an additional insured on its professional liability insurance policy.

IN WITNESS WHEREOF, the parties hereto have set their hands on the dates indicated below:

Americare Certified Special Services, Inc.

By:


Martin Kleinman

Title: PRES & CEO

Date

2/4/10

The Elliot at Erie Station ALP

By:


Eric Newhouse

Title:

Date

CEO

2.15.10

EXHIBIT II

DISCLOSURE STATEMENT

The Eliot Management Group, LLC ("The Operator") as operator of The Eliot at Erie Station ("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 as Exhibit D-1 of this Agreement.
2. The Operator is licensed by the New York State Department of Health to operate at 10-18 John Street, Middletown, New York 10940 an Assisted Living Residence as well as an Adult Home. The Operator is also certified to operate at this location an Enhanced Assisted Living Residence. These additional certifications 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 Enhanced 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 56 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 programs.

It is important to note that The Operator is currently approved to accommodate within The Enhanced Assisted Living program only up to the numbers of persons stated above. If You become appropriate for Enhanced Assisted Living Services, and one of those units is available, You will be eligible to be admitted into the Enhanced Assisted Living unit (or program). If

however, such units are at capacity and there are no vacancies, the Operator will assist You and Your representatives 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 the Enhanced Assisted Living Residence program within this Residence, it may be necessary for You to change your (room, unit, apartment) within the Residence.

3. The owner of the real property upon which the Residence is located is Erie Property Group, LLC. The mailing address of such real property owner is 386 Route 9, Suite 203, Monsey, New York 10952. The following entity is authorized to accept personal service on behalf of of such real property owner: Israel Orzel, Managing Member, Erie Property Group, LLC, 386 Route 9, Suite 203, Monsey, New York 10952.
4. The Operator of the Residence is The Eliot Management Group, LLC. The mailing address of the Operator is 386 Route 59, Suite 203, Monsey, New York 10952. The following entity is authorized to accept personal service on behalf of the Operator: Eric E. Newhouse, Managing Member, The Eliot Management Group, LLC, 386 Route 59, Suite 203, Monsey, New York 10952.
5. The Operator does not have any ownership interest in excess of 10% (whether a legal or beneficial interest) in any entity which provides care, material, equipment or other services to residents of the Residence.
6. No entity which provides care, material, equipment or other services to residents of The Residence has an ownership in excess of 10% (whether legal or beneficial interest) in the Operator.
7. All residents have the right to receive services from any provider, regardless of whether the operator of this residence has an arrangement with the provider.

8. Residents shall have the right to choose their health care providers, notwithstanding any other agreement to the contrary.
9. All residents should be aware that public funds for the payment of residential, supportive or home health services are available for eligible individuals, including but not limited to Medicare coverage of home health services.
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 or regarding Home Care Services is 1-800-628-5972.

The New York State Long Term Care Ombudsman Program (NYSLTCOP) provides a toll free number 1-800-342-9871 to request an Ombudsman to advocate for the resident. (716) 878-2385 is the Local LTCOP telephone number. The NYSLTCOP web site is www.ombudsman.state.ny.us.

(revised 10/17/03)

EXHIBIT III.A.2.

TIERED FEE ARRANGEMENTS

None.

EXHIBIT III.B.

SUPPLEMENTAL, ADDITIONAL OR COMMUNITY FEES

None.

EXHIBIT III.C

RATE OR FEE SCHEDULE

Basic Rate for SSI Eligible Residents:	SSI Rate
Private Pay Semi-Private Room Rate:	\$1,500
Private Pay Private Room Rate:	\$2,800

EXHIBIT V.

TRANSFER OF FUNDS OR PROPERTY TO OPERATOR

(List of any funds or property voluntarily transferred to the Facility, if applicable)

EXHIBIT VI.

PROPERTY/ITEMS HELD BY OPERATOR FOR YOU

(List of property voluntarily placed in the custody of the Facility, if applicable)

EXHIBIT X.I.

RULES OF THE RESIDENCE

See Attached

RULES OF CONDUCT

1. Residents are encouraged to help keep their rooms neat and clean.
 2. Residents must maintain their rooms and personal belongings in an orderly and safe manner, according to Fire and Health codes.
 3. Residents are encouraged to attend all recreational activities, within the facility, if not attending a community based (outside) recreational program.
 4. Residents keeping medications in their room must have documentation from their physician attesting to the fact that they are capable of self administering their medication and it must be kept locked in their locker. Residents must inform administration when they are seeing any doctors other than those who come to the facility.
 5. Residents should see the physician, when requested to do so, by the Case Manager and/or Administrator.
 6. Residents should take all medications prescribed by physicians.
 7. Resident's general behavior and demeanor must be respectful towards peers and staff.
 8. Residents should maintain their personal hygiene and cleanliness, including bathing/showering regularly. Personal assistance will be provided if needed or requested.
 9. Residents should give their dirty clothing to staff for washing on a regular basis, unless they are utilizing an outside facility and/or are doing their own wash with staff supervision.
 10. Residents must inform the Receptionist of all overnight visits. They must provide enough advanced notification for any needed medicine to be prepared. Residents must take the prepared medication at the appropriate time(s) as per the prescriptions.
 11. Residents must permit designated staff to enter their room for housekeeping and maintenance.
 12. The Eliot has no responsibility for lost or stolen items left outside their lockable storage area except that the Operator is responsible for any lost or stolen items caused by acts or omissions by the Operator's employees, agents or contractors. Valuables should be kept in lockable storage.
 13. The Eliot will maintain personal belongings for 2 weeks after date of discharge. Clients must make arrangements to retrieve personal belongings prior to this period. The Eliot will not bear any responsibility for personal items after this time frame.
 14. The Building is smoke free. Residents may smoke anywhere outside the building. Residents causing any building deterioration through unauthorized smoking will be held financially accountable. Any smoke-related paraphernalia such as ashtrays, etc., will be removed from residents' suites.
 15. Under no circumstances are Alcohol, Drugs or Drug paraphernalia permitted in the Residence. Any Alcohol, Drugs or Drug Paraphernalia that is found anywhere in the residence, including suites, will be confiscated and destroyed.
 16. Under no circumstances may food be stored in Residents' suites.
 17. Cooking appliances are not permitted in Resident rooms.
 18. Extension cords are not permitted in Resident rooms and, if found, will be confiscated.
 19. Heating appliances such as portable heaters are not allowed in Resident rooms.
 20. Under no circumstances are weapons of any kind or form permitted in the Residence. Any weapons found anywhere in the Residence, including suites, will be confiscated and either destroyed or turned over to the police department.
 21. Residents will be financially responsible for any deliberate damage or vandalism.
- I understand and agree to abide by The Eliot's Rules and Regulations.

(Resident's Signature)

Date

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 THIRTY DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE OF THE FEE INCREASE; PROVIDED, HOWEVER, THAT IF A RESIDENT, RESIDENT'S REPRESENTATIVE OR LEGAL REPRESENTATIVE AGREES IN WRITING TO A SPECIFIC RATE OR FEE INCREASE THROUGH AN AMENDMENT OF THE RESIDENCY AGREEMENT DUE TO THE RESIDENT'S NEED FOR ADDITIONAL CARE, SERVICES OR SUPPLIES, THE OPERATOR MAY INCREASE SUCH RATE OR FEE UPON LESS THAN THIRTY DAYS WRITTEN NOTICE.

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 PROCEDURES: RESIDENT GRIEVANCES
AND
RECOMMENDATIONS

SEE ATTACHED

Grievance Recommendation Procedure

In an effort to keep The Eliot at Erie Station a pleasant and comfortable place to live, we would like to share your concerns with us. The following has been developed to receive and respond to grievances and recommendations for change or improvement in the home by our residents.

1. A resident Grievance/Suggestion form will be available at the front desk.
2. If you wish to bring your concern to us confidentially, please write them down and place them in our suggestion box located in the lobby. Responses to Confidential Grievances will be given to the President of the Resident Council within five (5) business days.
3. Grievances are to be made to the Administrator, Assistant Administrator or Case Manager.
4. An individual or group grievance may be submitted to your Resident Council Representative or presented through the resident council. The Administrator/Assistant Administrator following the meeting will submit a written response to the Resident Council. Verbal grievances may be given at the meeting if requested or available.
5. Within five (5) business days, for:
 - a. An individual grievance, an individual meeting will be held.
 - b. A group grievance, a group conference will be held, with the Administrator/Assistant Administrator to discuss the details of the grievance or suggestion, and an attempt to work out a solution to the concern.
6. A copy of the determination made by the Administrator/Assistant Administrator will be given to the resident or residents in writing.

We will treat each concern seriously and work with you to improve the quality of life in your home.

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

This is an addendum to a Residency Agreement made between
The Eliot at Erie Station (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 The Eliot at Erie Station located at 10-18 John Street, Middletown, New York 10940.

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 Representative)

Dated: _____
(Signature of Resident's Legal Representative)

Dated: _____
(Signature of Operator or Operator's Representative)

Section G - Item 3

Admission and Discharge Policies

ADMISSIONS POLICY

Purpose:

To create a framework for reviewing a potential resident's suitability and eligibility for admission to the Assisted Living Residence under the criteria established by the NYS Department of Health regulations and guidelines.

Policy & Procedures:

1. The Facility has an obligation to provide care within the facility's financial and clinical capabilities, mission, and standards of practice while complying with all State laws and regulations.
2. Applicants will be evaluated for admission suitability by the Administrator and Case Manager to ensure that the applicant's care needs are within the scope of services authorized under Public Health Law Article 46-b, without discrimination on the basis of age, race, color, religion, sex, marital status, national origin, handicap, sexual orientation, or disabilities.
3. All Applicants and/or their representative(s) will be given a tour of the facility and a pre-admission interview with the Facility designee.
4. During the interview, the Applicant will be given the following:
 - Admission Agreement
 - Resident Rights
 - Facility Rules and Regulations as they pertain to Residents
 - Resident Disclosure Statement(s), as applicable
 - Shown a copy of the most recent NYS Department of Health Inspection Report
5. Acceptance to the Facility is based upon the reasonable expectation that the applicant's medical and social needs can be adequately met by the Facility. Applicants are accepted for admission only after the Facility's designee has reviewed the following list of documentation and determined that the applicant meets all NYS Department of Health regulations pertaining to suitability for admission to this Assisted Living Facility:
 - Medical evaluation (DOH-3122, or approved substitute)
 - Mental health evaluation (if required)
 - Personal Data and Resident Evaluation (DOH-4397)
 - Interview with Facility designee
 - Application for Admission
 - Pre-Admission Evaluation
 - Any other Facility required forms
6. The Applicant or any other persons designated by the applicant will be notified of the Facility's admission decision.
7. An initial Individualized Service Plan (ISP) will be developed for each resident utilizing the information initially obtained from Admission Evaluation materials to address the individual's unique medical, nutritional, rehabilitative, functional,

and cognitive needs. The ISP will be updated every six (6) months or whenever a significant change in condition occurs.

8. For those residents who become ineligible for retention by an Assisted Living Residence, but who may be eligible for retention under the Facility's Enhanced Assisted Living Residence certification, the Facility shall undertake an individualized evaluation to determine whether (1) the Facility has the capability of addressing the Resident's enhanced needs; and (2) the feasibility of providing such services, taking into account the Facility's staffing and budgetary status.

DISCHARGE POLICY

Purpose:

To provide an established procedure for the discharge of residents who are deemed inappropriate for continuing occupancy under NYS Department of Health regulations and guidelines.

Policy & Procedures:

1. The Facility has an obligation to retain only those residents who require services the Facility is permitted to provide under New York State laws and regulations.
2. An involuntary discharge of a resident may occur for the following reasons:
 - The resident requires continual medical or nursing care outside the licensed scope of this Assisted Living Facility.
 - The resident's behavior poses imminent risk of death or serious physical harm to himself or another.
 - The resident fails to make timely payment for all authorized charges, expenses and/or other assessments the resident has agreed to pay pursuant to the resident's admission agreement.
 - The resident repeatedly behaves in a manner that directly impairs the well-being, care or safety of himself or any other resident or which substantially interferes with the operation of the facility.
 - Or for any other reason provided by law.
3. If an involuntary discharge is necessary, a Notice of Discharge complying with all New York State laws and regulations will be issued to the resident and/or the resident's designee at least thirty (30) days prior to discharge.
4. The Administrator and the Case Manager are responsible for all discharge procedures.

Section G - Item 4

Pre-Admission Evaluation and Evaluation Update process

Pre-Admission Evaluation and Evaluation Update Process

1. The evaluation will be completed by the Facility Designee, which may be the Case Manager/Admissions Representative, Administrator, or Residence Service Director.
2. The Facility Designee will conduct a face to face interview with the potential resident and (if applicable) the resident representative.
3. Charting/medical review will be done and will include a review of DOH Form 3122 (medical evaluation) and a mental health evaluation when appropriate.
4. A Personal Data and Resident Evaluation Form (DOH 4397), a copy of which is attached, will also be completed and reviewed. This form will be updated annually and as needed if conditions change.
5. The pre-admission evaluation will, if possible, be completed within thirty (30) days of the referral or request for admission. Medical (and Mental Health evaluations if resident has a diagnosed mental illness) will be completed no less than once every twelve (12) months and as needed if conditions change.
6. The information will be used for eligibility decisions and kept in a confidential file.
7. All referrals will be made based on the needs of the applicant. When it is assured that the potential resident's needs can be met the Administrator or Facility Designee will accept the resident for admission.

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

Reason for evaluation: ☐ Pre-admission ☐ Annual ☐ 6-Month Review of ISP ☐ Change in physical/functional status.

ADMISSION / DISCHARGE INFORMATION

Date: _____ County: _____

Admitted from: ☐ Own Home ☐ Hospital ☐ NH ☐ OMH

Other (specify): _____

Address Admitted from (Street, City, State, Zip): _____

Resident's Admission Sponsor (if any): _____

Discharge Date: _____ Discharge to: ☐ Own Home ☐ Hospital ☐ NH ☐ OMH

☐ Other (Specify): _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge: _____

SECTION 1: PERSONAL DATA

Date of Birth: ____/____/____ Gender: ☐ M ☐ F SSN: _____
Status: _____
Month Day Year Married Single Divorced Widowed Partner

NOTIFY IN CASE OF EMERGENCY

Name _____
Relationship _____
Telephone Number (s) _____
Address _____
City _____ State _____ Zip _____

ATTENDING PHYSICIAN Phone: _____

Name _____
Address _____
City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____
Specialty _____ Phone: _____
Address _____
City _____ State _____ Zip _____
Name _____
Specialty _____ Phone: _____
Address _____
City _____ State _____ Zip _____

HEALTH INSURANCE

Insurer _____ ID # _____
Medicaid No. _____
Medicare No. _____
Prescription Drug Plan (if any) _____
Plan ID # _____
Other Health Care Coverage _____

Pharmacy(ies) _____
Phone _____ Phone _____
Address(es) _____
City _____ State _____ Zip _____

AREA HOSPITAL / CLINIC OF CHOICE

Name _____
Address _____

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____

Address (if different from ALR): _____

Resident's Representative: _____
Relationship: _____
Address: _____

Phone: Home _____
Work _____
Cell _____

Significant Other: _____
Relationship: _____
Address: _____

Phone: Home _____
Work _____
Cell _____

Significant Other: _____
Relationship: _____
Address: _____

Phone: Home _____
Work _____
Cell _____

Significant Other: _____
Relationship: _____
Address: _____

Phone: Home _____
Work _____
Cell _____

Residential Background (born/raised, lived most of life): _____

Occupational/Educational Background: _____

Religious Affiliation (if any): _____ Place of Worship: _____ Phone: _____

Health Care Proxy: ☐ Yes ☐ No _____ DNR: ☐ Yes ☐ No
(Name)

Power of Attorney: ☐ Yes ☐ No _____ Living Will: Yes ☐ No ☐
(Name)

Burial Instructions: _____

Can the individual speak, read and/or write in English? ☐ Yes ☐ No If No, indicate dominant language: _____

Verbal Expression/Speech (check all that apply):

Easily Understood ☐ Yes ☐ No Difficulty finding words or expressing self ☐ Yes ☐ No
Slurred or mumbled speech ☐ Yes ☐ No Understands directions ☐ Yes ☐ No

SPEECH: Does the resident have a speech defect / impairment? ☐ Yes ☐ No

If yes, describe: _____

DENTAL: _____

VISION: Glasses: ☐ Yes ☐ No Glaucoma: L ☐ R ☐ Legally Blind: L ☐ R ☐
Contact Lenses: ☐ Yes ☐ No

Comments: _____

HEARING: Does the patient have a hearing deficit? ☐ Yes ☐ No Hearing Aid: L ☐ R ☐

Comment(s): _____

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

SECTION 3: CUSTOMARY ROUTINE

Sleeping routine: Preferred wake up time: _____ Napping routine: _____
Preferred bedtime: _____ Nighttime sleep pattern: _____

Comments: _____

Bathing routine: Prefers ☐ Bath ☐ Shower Frequency: _____

Comments: _____

Eating routine: Food preferences: _____
Food dislikes: _____

Comments: _____

Daily Events: (check all that apply) ☐ Goes out _____ days a week (Specify 1 - 7) ☐ Stays busy with hobbies, reading, fixed daily routine
☐ Spends most time alone ☐ Contact with relatives/close friends _____ days per week (Specify 1 - 7)
☐ Spends most time watching TV ☐ Usually attends church, synagogue etc.
☐ Prefers small group activities ☐ Prefers large group activities

Comments: _____

SECTION 4: CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? (Obtained from Med. Eval. DOH - 3122) ☐ Yes ☐ No
Is the resident continent of bowel function? (Obtained from Med. Eval. DOH - 3122) ☐ Yes ☐ No

IF ANSWER IS "NO" TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Urinary Incontinence		Bowel Incontinence	
☐ Less than once a week ☐ Several times a week ☐ Daily	☐ Day Only ☐ Night only ☐ Day and night	☐ Less than once a week ☐ Several times a week ☐ Daily	☐ Day only ☐ Night only ☐ Day and night
Current management techniques		Current management techniques	
☐ Prompting/reminding defers incontinence ☐ Timed voiding defers incontinence ☐ Uses incontinence pads/adult diapers: ☐ Day only ☐ Night only ☐ Day and night Catheter (specify type) _____ Comments: _____ Self-manage continence? ☐ Yes ☐ No		☐ Uses incontinence pads/adult diapers: ☐ Day only ☐ Night only ☐ Day and night Comments: _____ Self-manage continence? ☐ Yes ☐ No	

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

SECTION 5: PHYSICAL FUNCTION

TASK	LEVEL OF ASSISTANCE	COMMENTS
Eating: (Ability to feed self meals and snacks)	☐ Independent: Able to feed self independently with or without assistive device. ☐ Intermittent Assistance: Requires minimal, intermittent supervision and/or assistance. ☐ Continual Assistance: Requires constant assistance and/or supervision throughout meal. ☐ Total Assistance: Unable to feed self, needs to be fed. Unable to take nutrients orally, requires enteral nutrition.	Dentures Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No Chewing difficulties ☐ Yes ☐ No Difficulty swallowing ☐ Yes ☐ No Modified consistency ☐ Yes ☐ No Specify _____ Comments: _____
Ambulation: (Ability to safely walk and move about once in a standing position)	☐ Independent: Walks and climbs and descends stairs independently with or without assistive device. ☐ Intermittent Assistance: Walks and climbs and descends stairs with minimal, intermittent assistance and/or supervision. ☐ Continual Assistance: Walks and climbs and descends stairs with constant supervision and/or assistance. ☐ Total Assistance: Chairfast or bedfast. Requires total assistance for mobility.	☐ Wheelchair ☐ Walker ☐ Quad cane ☐ Cane ☐ Other: _____ Falls within the last 3 months? ☐ Yes ☐ No Frequency #: _____ Injury: _____ Comments: _____
Transferring: (Moving from bed to chair, on/off toilet, in/out of shower or tub)	☐ Independent: Able to transfer independently with or without assistive device. ☐ Intermittent Assistance: Transfers with minimal human assistance and/or supervision. ☐ Continual Assistance: Unable to transfer but can bear weight and pivot when transferred by at least one other person. ☐ Total Assistance: Chairfast or bedfast, unable to transfer, pivot, bear weight or turn self in bed.	Comments: _____

PROSTHESIS: ☐ No ☐ Yes (describe) _____
 AMPUTATION: ☐ No ☐ Yes (describe) _____
 PODIATRIC: Does the resident have podiatric concerns requiring treatment or which impair ability to ambulate or transfer?
☐ No ☐ Yes (describe) _____

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Toileting: (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing)	☐ Independent: Able to toilet independently with or without assistive device. ☐ Intermittent Assistance: Able to toilet with minimal intermittent assistance and/or supervision. ☐ Continual Assistance: Able to toilet with constant assistance and/or supervision. ☐ Total Assistance: Unable to toilet. Requires total assistance with toileting.	Ostomy ☐ Yes ☐ No Comments:
Bathing: (Getting in and out of tub or shower, washing and drying entire body)	☐ Independent: Able to bathe or shower independently with or without assistive device. ☐ Intermittent Assistance: Able to bathe or shower w/minimal intermittent assistance and/or supervision. ☐ Continual Assistance: Able to bathe or shower with constant assistance and/or supervision. ☐ Total Assistance: Unable to use shower or tub. Bathed in bed or at bedside.	Comments:
Dressing: (Getting clothes from closets and drawers, dressing and undressing upper/lower body including buttons, snaps, zippers, socks and shoes)	☐ Independent: Able to dress and undress independently with or without assistive device. ☐ Intermittent Assistance: Able to dress and undress with minimal, intermittent assistance and/or supervision. ☐ Continual Assistance: Requires assistance throughout the dressing and undressing process. ☐ Total Assistance: Requires another person to dress and undress upper and lower body.	Comments:
Grooming: (Washing face, hair care, shaving, teeth/denture, fingernail care, eyeglasses care)	☐ Independent: Able to groom self independently with or without assistive device. ☐ Intermittent Assistance: Requires grooming utensils to be set up and placed within reach. ☐ Continual Assistance: Requires assistance throughout the grooming process. ☐ Total Assistance: Depends entirely upon someone else for grooming.	Comments:
Transportation: (Physical and mental ability to safely use a car, taxi, or public transportation [bus, train, subway])	☐ Independent: Able to independently drive a regular or adapted car; OR uses a regular or handicap accessible public bus, train or subway. ☐ Independent: But requests facility perform task. ☐ Intermittent Assistance: Able to ride in a car only when driven by another person; AND/OR due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway. ☐ Continual Assistance: Able to ride in a car only when driven by another person; OR able to use a bus or handicap van, train or subway only when assisted or accompanied by another person. ☐ Total Assistance: Unable to ride in a car, taxi, bus or van, and requires transportation by ambulance.	Comments:

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Laundry: (Ability to do own laundry --to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand)	☐ Independent: Able to independently take care of all laundry tasks. ☐ Independent: But requests facility perform task. ☐ Intermittent Assistance: Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry. ☐ Continual Assistance: Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry. ☐ Total Assistance: <u>Unable</u> to do any laundry.	Comments:
Housekeeping: (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks)	☐ Independent: Able to independently perform all housekeeping tasks. ☐ Independent: But requests facility perform task. ☐ Intermittent Assistance: Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently; <u>AND/OR</u> able to perform housekeeping tasks with intermittent assistance or supervision from another person. ☐ Continual Assistance: <u>Unable</u> to consistently perform any housekeeping tasks unless assisted by another person throughout the process. ☐ Total Assistance: Unable to effectively participate in any housekeeping tasks.	Comments:
Shopping: (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery)	☐ Independent: Able to plan for shopping needs and independently perform shopping tasks, including carrying package. ☐ Independent: But requests facility perform task. ☐ Intermittent Assistance: Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping. ☐ Continual Assistance: <u>Unable</u> to go shopping alone, but can go with someone to assist; <u>OR</u> unable to go shopping but is able to identify items needed, place orders, and arrange for home delivery. ☐ Total Assistance: Needs someone to do all shopping and errands.	Comments:
Ability to use a Telephone: (Ability to answer the telephone, dial numbers, and <u>effectively</u> use the telephone to communicate)	☐ Independent: Able to dial numbers and answers calls appropriately and as desired. ☐ Independent: But requests facility perform task. ☐ Intermittent Assistance: Able to use a specially adapted telephone (i.e., large numbers on the dial pad, teletype phone for the deaf) and call essential numbers; able to answer the telephone and carry on a normal conversation but has difficulty with placing calls; able to answer the telephone only some of the time or is able to carry on only a limited conversation. ☐ Continual Assistance: Unable to make calls or answer the telephone at all, but can listen if assisted with equipment. ☐ Total Assistance: Totally unable to use the telephone. Requires someone else to make calls.	Comments:

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

SECTION 6: COGNITIVE IMPAIRMENT SCREEN

Cognitive Functioning: Individual's current level of alertness, orientation, comprehension, concentration and immediate memory.

Response:

What is today's date?
(correct, if within 2 days) ☐ Correct ☐ Incorrect

What day of the week is today: ☐ Correct ☐ Incorrect

How old are you? ☐ Correct ☐ Incorrect

When were you born? ☐ Correct ☐ Incorrect

Behaviors of Note (check all that apply):

- | | |
|--|---|
| ☐ Wanders Day / Night | ☐ Sleep disturbance |
| ☐ Confused | ☐ Agitated (repeated vocalizations, screaming, shouting, complaining, moaning, cursing, fidgeting, etc.) |
| ☐ Depressive Feelings | ☐ Anxious |
| ☐ Withdrawn/ Refuses to Socialize | |

Overall Cognitive Functioning (check all that apply):

- ☐ Is alert and oriented, comprehends verbal questions and commands and has accurate recall
- ☐ Requires prompting and redirection, on occasion, to complete tasks
- ☐ Has occasional fluctuation in orientation, memory/alertness
- ☐ Has significant memory loss and is disoriented to person, place and/or time

This screen includes indicators, which are often related to cognitive impairment. This is a screen ONLY and is intended to assist the residence in determining if an individual is appropriate for care in an ALR and/or if the individual should be referred to his/her physician for consultation and/or further evaluation or treatment.

Comments: _____

Facility Name: _____ Date of Evaluation: _____
Resident's Name: _____

SECTION 7: Admission / Level of Care

Current level of care: ☐ Pre-admission ☐ ALR / EHP / AH ☐ Enhanced ALR ☐ Special Needs ALR

ADMISSION DECISION ☐ Not Accepted

ACCEPTED TO: ☐ ALR / AH / EHP ☐ Enhanced ALR ☐ Special Needs ALR

For new admissions, the following documents were provided to the applicant at, or prior to, the admissions interview:

- _____ Consumer Information Guide
- _____ Copy of the admission agreement
- _____ Copy of the statement of resident rights
- _____ Copy of any facility regulations relating to resident activities, office and visiting hours and like information
- _____ Information about the Long-Term Care Ombudsman Program and listing of legal services or advocacy agencies, if made available by the Department
- _____ Personal Allowance Protections (SSI and TA recipients only)
- _____ Most recent Statement of Deficiencies (shown to applicant)

Signature(s) of ALR staff participating in this evaluation.

Name: _____	Title: _____	Date: _____
Name: _____	Title: _____	Date: _____
Name: _____	Title: _____	Date: _____

Signature of Administrator/Case Manager/or ISP Planner: _____ Date: _____

Signature of Individual/Resident: _____ Date: _____

Signature of Resident Representative: _____ Date: _____

Name(s) of others participating in this evaluation.

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

ALL SPACES MUST BE FILLED OUT

Facility Name: _____ Date of Exam: _____

Patient's/Resident's Name: _____ Date of Birth: _____ Sex: _____

Present Home Address: _____
City _____ State _____ Zip _____
Street _____

Reason for evaluation: ☐ Pre-Admission ☐ 12 month ☐ Acute change in patient condition

☐ Other (Describe): _____

MEDICAL REVIEW FINDINGS

Vital Signs: BP: _____ Pulse: _____ Resp: _____ T: _____ Height: _____ ft _____ in. Weight: _____

Primary Diagnosis(s): _____

Secondary Diagnosis(s): _____

Allergies: ☐ None Known Allergies (list): _____

Diet: ☐ Regular ☐ No Added Salt ☐ No Concentrated Sweets ☐ Mechanical Soft ☐ Other: _____

Does the resident have dental health concerns requiring treatment or which may impair chewing/eating? No ☐ Yes ☐

If yes, describe: _____

Tobacco Use: ☐ PPD/Years: _____ Alcohol Use: ☐ Amount/Frequency: _____

Recreational Drug Use: ☐ Describe _____

IMMUNIZATIONS

- ☐ Influenza (Date _____)
☐ Pneumococcal Vaccine (Date _____)
☐ Tetanus Vaccine (Date _____)

SCREENINGS

- ☐ Mammogram (Date _____)
☐ Pap Smear (Date _____)
☐ PSA (Date _____)
☐ Colonoscopy (Date _____)

TUBERCULIN TEST (Required within 30 days prior to admission unless medically contraindicated) ☐ Test is contraindicated

- ☐ TST1: _____ Date placed _____ Date Read _____ mm
☐ TST2: _____ Date placed _____ Date Read _____ mm
☐ QuantIFERON-TB (QFT): _____ Date Placed _____ Date Read _____ mm

Based on my findings and on my knowledge of this patient, I find that the patient _____ IS _____ IS NOT exhibiting signs or symptoms suggestive of communicable disease that could be transmitted through casual contact.

CONTINENCE

- Bladder: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐
Bowel: Yes ☐ No ☐ If no, is incontinence managed? Yes ☐ No ☐

If no, recommendations for management: _____

Patient/Resident Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING (ADL's)

Activity Restrictions: No ☐ Yes ☐ (describe): _____

Dependent on Medical Equipment: No ☐ Yes ☐ (describe): _____

Does the resident need the assistance of another person to perform the following?

Ambulate: No ☐ Yes ☐ Intermittent ☐ Continual ☐ Transfer: No ☐ Yes ☐ Intermittent ☐ Continual ☐

Feeding: No ☐ Yes ☐ Intermittent ☐ Continual ☐ Manage Medical Equipment: No ☐ Yes ☐ Intermittent ☐ Continual ☐

ADDITIONAL SERVICES: ☐ None (List all that are needed. Attach additional sheet if necessary)

Reason	Reason
Physical Therapy ☐ _____	Speech Therapy ☐ _____
Occupational Therapy ☐ _____	Other (Specify) ☐ _____
Home Care: ☐ Nursing ☐ PCA ☐ HHA ☐ Other (describe) _____	

LABORATORY SERVICES: ☐ None

Lab Test	Reason/Frequency	Lab Test	Reason/Frequency
_____	_____	_____	_____
_____	_____	_____	_____

COGNITIVE IMPAIRMENT/MEMORY LOSS

Based on your examination and/or information received from caregivers, do you recommend the patient be screened and/or tested for dementia or another cognitive impairment? (If yes, indicate who will perform screening/testing below)

☐ No ☐ Yes (describe) _____

If yes, testing to be performed by: _____

MENTAL HEALTH ASSESSMENT

Does the patient have a history of or a current mental disability? ☐ Yes ☐ No

Has the patient ever been hospitalized for a mental health condition? ☐ Yes ☐ No

If Yes, describe: _____

Based on your examination, would you recommend the patient seek a mental health evaluation? (If yes, provide referral)

☐ No ☐ Yes Describe: _____

Comments: _____

**ASSISTED LIVING RESIDENCE
MEDICAL EVALUATION**

Patient/Resident Name: _____

Date: _____

Pertinent medical/mental findings requiring follow-up by facility (e.g. skin conditions/acute or chronic pain issues) or any additional recommendations for follow-up: _____

PHYSICIAN CERTIFICATION

I certify that I have physically examined this patient and have accurately described the individual's medical condition, medication regimen and need for skilled and/or personal care services. Based on this examination and my knowledge of the patient, this individual (see Statement of Purpose):

- ☐ IS ☐ IS NOT mentally suited for care in an Adult Home or Enriched Housing Program.
- ☐ IS ☐ IS NOT medically suited for care in an Adult Home or Enriched Housing Program.
- ☐ IS ☐ IS NOT in need of continual acute or long term medical or nursing care or supervision which would require placement in a hospital or nursing home.
- ☐ IS ☐ IS NOT in need of 24-hour skilled nursing care.

LEVEL OF CARE RECOMMENDATION: (see Statement of Purpose)

- ☐ Adult Home/Enriched Housing Program/Assisted Living Residence ☐ Enhanced ALR ☐ Special Needs ALR

Name/Title of individual completing form: _____ Date: _____

Physician Signature: _____ Date: _____

STATEMENT OF PURPOSE

Adult Homes (AH), Enriched Housing Programs (EHP), Residences for Adults (RFA), Assisted Living Residences (ALR), Enhanced Assisted Living Residences (EALR) and Special Needs Assisted Living Residences (SNALR) provide 24-hour residential care for dependent adults. They are not medical facilities. Persons in need of constant medical care and medical supervision should not be admitted or retained in these settings because the facility lacks the staff and expertise to provide needed services. Persons who, by reason of age and/or physical and/or mental limitations are in need of assistance with activities of daily living, can be cared for in adult residential care settings listed above.

ALRs with certification to provide:

Enhanced ALR care may serve people who need chronic assistance from another person with ambulation, transfer, ascending / descending stairs; are dependent on medical equipment, have intermittent nursing needs (less than 24 hours a day); or have chronic, unmanaged urinary or bowel incontinence.

Special Needs ALR care may serve people who have a need for a secured environment and/or highly specialized services due to advanced dementia or other special need.

Section G - Item 5

Individualized Service Plan (ISP)

INDIVIDUALIZED SERVICE PLAN POLICY

The ISP (Individualized Service Plan) will be developed for each resident within thirty (30) days of admission by the assisted living case manager in consultation with the resident, the resident's representative, the resident's legal representative, if any, the assisted living operator or designee, the resident's physician and, if applicable, a home care agency (or clinical staff of the assisted living facility, if health care services are provided directly). The case manager will use the information from the admission interview, DOH Form 3122, DOH Form 4397 and any other relevant information regarding the resident's health and care needs to develop the ISP, in conjunction with the recommendations of a physician and health aide, if applicable.

The ISP will be reviewed and, if necessary, revised at least every six months or more frequently as may be necessary to address the resident's changing care needs or if the resident and/or the resident's designated representative request an ISP review. The ISP reviews will be coordinated and completed by the case manager in consultation with the resident's physician, home care staff and or clinical staff of the residence.

The ISP will specify how the assisted living residence will address the resident's needs and include the following elements:

- The type of service or assistance being provided;
- The frequency and duration of the service or assistance being provided;
- Who by title and affiliation is providing the service or assistance;
- Documentation of what action will be taken to address a change in the resident's physical condition, level of physical or cognitive functioning, mental health or behavior, or a change in social activity or daily habits.

Assisted Living Individualized Service Plan

☐ Female ☐ Male

Resident Name: _____

Date: _____

For: ☐ Initial ☐ six months ☐ change of care needs

Note: Services to be provided and by whom: Any additional information or change of care needs on this ISP must be indicated in bold type, capital letters, or by using a different color ink and dated.

Key: N/A = Not Applicable, RA = Resident Aide, N = Nurse, P = Physician, L = Lab Tech, T = Therapist, O = Other

Part 1 – Care Needs

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Comments
Medical				
☐ Lab Test				
☐ Pacemaker				
☐ Dialysis				
☐ Skilled Nursing, Treatments &/or Education	☐ Injection ☐ Insulin ☐ Other – Type _____ ☐ Dressing ☐ Other _____			
☐ Specialists (eg podiatrist, chiropractor)	Specify _____			
☐ Medical Equipment	☐ Independent ☐ Type _____ ☐ 1+ Assist (requires more than intermittent assistance with equipment – EALR required)			
☐ Pain Management				
☐ Other	☐ health prevention ☐ aide-level health related activities ☐ other – specify _____			
Rehabilitation	☐ PT ☐ OT ☐ Speech Therapy ☐ Other: _____			
Nutritional				
Diet – Meal Assist	☐ Regular ☐ NAS ☐ NCS ☐ Chopped as needed ☐ Soft ☐ Dietary Supplement Specify: _____	☐ Meals ☐ Snacks		☐ Chewing Difficulty ☐ Swallowing Difficulty ☐ Other: _____

Name: _____

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Comments
Fluid Restrictions/Encouragement	☐ None ☐ Dietary Supplements _____ ☐ Other Specify: _____			

Functional				
Personal Hygiene	☐ Independent ☐ Shower ☐ Bath ☐ Equipment ☐ Hearing Aide: ☐ R ☐ L ☐ Eyeglasses ☐ Reading ☐ Always Hair: ☐ Shampoo ☐ Grooming ☐ Shave ☐ Teeth Care ☐ Denture Care ☐ Nail Care ☐ Foot Care			
Continence	☐ Independent ☐ Assist with bathroom ☐ Assist with protective garment change ☐ Ostomy Care ☐ Chronic unmanaged incontinence <i>(chronically unwilling or unable to participate, with help from staff, so that cleanliness and sanitation can be maintained - EALR required)</i>			
Medication Care	☐ None ☐ Location & Type: _____			
Dressing	☐ Independent ☐ Coordinate ☐ Upper ☐ Lower ☐ Other _____			
Medications	☐ Self ☐ Assist			
Transfer	☐ Independent ☐ 1+ Assist <i>(chronically chairfast and/or chronically needs one person assist to transfer – EALR required)</i>			
Mobility	☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Crutches ☐ Escort: _____ ☐ 1+ Assist <i>(chronically needs one person to assist to walk or to climb/descend stairs- EALR required)</i>			
Falls Risk Reduction	☐ No Known History ☐ Other: _____			
Respiratory Therapy Oxygen	☐ None ☐ Self-managed ☐ Type: _____			
Equipment	☐ None ☐ Self-managed ☐ Prosthesis ☐ Braces ☐ Other _____			

Name: _____

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Comments
Cognitive				
Orientation	☐ N/A ☐ Remind ☐ Cue ☐ Supervise ☐ Accompany			
Specialized Services	☐ N/A ☐ Dementia Care, Secured Unit (<i>requires SNALR</i>) ☐ Environmental modifications ☐ Supervision/Monitoring			
Sensory	☐ None ☐ Hearing ☐ Vision ☐ Speech ☐ Other: _____			
Mental Health	☐ Type: _____ ☐ Substance Abuse ☐ Coordination with SA provider _____			
Social				
Education & Employment	Desire for continued or future education: ☐ Yes ☐ No If yes, specify: _____ Desire to work or volunteer ☐ Yes ☐ No If yes, specify: _____			
Intellectual	Desire for new or continued intellectual activity ☐ Yes ☐ No If yes, specify: _____			
Recreational	Desire for new or continued recreational activity ☐ No ☐ Yes, Specify: _____ ☐ Need assistance of ALR staff Specify: _____			
Spiritual	Desire for new or continued spiritual activity ☐ No ☐ Yes, Specify: _____ ☐ Need assistance of ALR staff Specify: _____			
Cultural	Desire for new or continued cultural activity ☐ No ☐ Yes, Specify: _____ ☐ Need assistance of ALR staff Specify: _____			
Financial	Assistance with access to financial benefits (i.e. Medicare, Medicaid, Social Security, Veteran's Admin., Pensions, etc.) ☐ Managed Independently ☐ Assistance of family, resident rep. or legal rep. Specify: _____ ☐ Need assistance of ALR staff Specify: _____			

Name: _____

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Other
Comments: _____

Print Name, Title and Organization of Individuals Participating

Resident

Resident's Representative

Resident's Legal Representative (if applicable)

ALR Provider's Representative

Was the Resident's Primary Physician Consulted?

☐ Yes Indicate physician's name and date: _____
☐ No

Home Care Services Agency Representative (if applicable)

ALR Provider's Representative Signature

Date: _____

Section G - Item 6

House Rules

RULES OF CONDUCT

1. Residents are encouraged to help keep their rooms neat and clean.
 2. Residents must maintain their rooms and personal belongings in an orderly and safe manner, according to Fire and Health codes.
 3. Residents are encouraged to attend all recreational activities, within the facility, if not attending a community based (outside) recreational program.
 4. Residents keeping medications in their room must have documentation from their physician attesting to the fact that they are capable of self administering their medication and it must be kept locked in their locker. Residents must inform administration when they are seeing any doctors other than those who come to the facility.
 5. Residents should see the physician, when requested to do so, by the Case Manager and/or Administrator.
 6. Residents should take all medications prescribed by physicians.
 7. Resident's general behavior and demeanor must be respectful towards peers and staff.
 8. Residents should maintain their personal hygiene and cleanliness, including bathing/showering regularly. Personal assistance will be provided if needed or requested.
 9. Residents should give their dirty clothing to staff for washing on a regular basis, unless they are utilizing an outside facility and/or are doing their own wash with staff supervision.
 10. Residents must inform the Receptionist of all overnight visits. They must provide enough advanced notification for any needed medicine to be prepared. Residents must take the prepared medication at the appropriate time(s) as per the prescriptions.
 11. Residents must permit designated staff to enter their room for housekeeping and maintenance.
 12. The Eliot has no responsibility for lost or stolen items left outside their lockable storage area except that the Operator is responsible for any lost or stolen items caused by acts or omissions by the Operator's employees, agents or contractors. Valuables should be kept in lockable storage.
 13. The Eliot will maintain personal belongings for 2 weeks after date of discharge. Clients must make arrangements to retrieve personal belongings prior to this period. The Eliot will not bear any responsibility for personal items after this time frame.
 14. The Building is smoke free. Residents may smoke anywhere outside the building. Residents causing any building deterioration through unauthorized smoking will be held financially accountable. Any smoke-related paraphernalia such as ashtrays, etc., will be removed from residents' suites.
 15. Under no circumstances are Alcohol, Drugs or Drug paraphernalia permitted in the Residence. Any Alcohol, Drugs or Drug Paraphernalia that is found anywhere in the residence, including suites, will be confiscated and destroyed.
 16. Under no circumstances may food be stored in Residents' suites.
 17. Cooking appliances are not permitted in Resident rooms.
 18. Extension cords are not permitted in Resident rooms and, if found, will be confiscated.
 19. Heating appliances such as portable heaters are not allowed in Resident rooms.
 20. Under no circumstances are weapons of any kind or form permitted in the Residence. Any weapons found anywhere in the Residence, including suites, will be confiscated and either destroyed or turned over to the police department.
 21. Residents will be financially responsible for any deliberate damage or vandalism.
- I understand and agree to abide by The Eliot's Rules and Regulations.

(Resident's Signature)

Date

Served in the Dining Room

Breakfast: 8:00 AM

Lunch: 12:00 PM

Dinner: 5:00 PM

Served in the Dining Room

Afternoon Snacks: 2:30 PM

Evening Snacks: 7:30 PM

Medication Times

Morning Medication: 7:00 AM – 9:30 AM

Afternoon Medication: 10:30 AM – 1:30 PM

Dinner Medication: 3:30 PM – 6:30 PM

Bedtime Medication: 6:30 PM – 9:30 PM

Personal Laundry Schedule

Tuesday Third Floor - Rooms: 315 -337

Thursday Second Floor – Rooms: 228 – 237

Thursday Third Floor –Rooms: 301 -314

Saturday Second Floor – Rooms 208 - 227

Sunday First Floor – Rooms: 101 – 119

Sunday Second floor – Rooms: 201 - 207

All laundry must be placed outside of rooms before breakfast otherwise it will not be picked up.

The laundry is returned the next day.

Visiting Hours

9:00 AM – 8:00 PM

No Visiting during Mealtimes. Visitors are not allowed in the Dining Room.

The Following are Suggestions of The Eliot

NO GIFTS

NO BORROWING ♦ NO LENDING

The Following are the House Rules of The Eliot

NO TIPPING

NO FOOD IN ROOMS

NO ALCOHOL ON THE PREMISES

NO SMOKING IN THE BUILDING

NO DRUGS

NO WEAPONS

NO VISITING DURING MEALS

NO VISITORS ARE ALLOWED IN THE ROOM WITHOUT THE CONSENT OF ALL THE ROOMMATES.

**VIOLATION OF THESE RULES ARE A DIRECT VIOLATION OF YOUR
ADMISSION AGREEMENT**

THE ELIOT

at Erie Station

Welcome Letter

The management and staff of The Eliot at Erie Station extend a hearty welcome to you, a newly arrived resident in our home. Hopefully, you will want to make it your home for many years to come. Your stay here can be rewarding, pleasant, and enjoyable if you will take advantage of the many opportunities available through our broad program of activities. For more specific details, please refer to the activity board in the lobby or feel free to speak to our recreation director with regard to any area of particular interest to you.

This packet is made available to you for your general information and in an effort to assist you to better acquaint yourself and appreciate your new home.

The guidelines listed are in your best interest. We therefore request that you give your wholehearted cooperation and participation in adhering to them.

1. Meals are as follows:
 - a) Breakfast – 8:00 AM
 - b) Lunch – 12:00 PM
 - c) Dinner – 5:00 PM

Meals are served in the Dining Room. Room Service is available upon request in the event that you are not feeling well or if the elevator is temporarily not in service. Coffee, Tea and Snacks are served twice daily in the Dining Room.

2. Snacks are as follows:
 - a) Afternoon – 2:30 PM
 - b) Evening – 7:30 PM

Proper attire is required at all times. Street clothes and casual outfits are appropriate. Pajamas and bathrobes are not permitted at any time. We ask for your full cooperation.

3. Residents are of course, permitted to leave the premises. You must sign the register at the desk prior to leaving and upon return. Should you plan on being away and missing a meal, please notify the office. The doors are locked promptly at 9:00 PM. If you plan on returning later than 9:00 PM, prior arrangements should be made at the reception desk. However, a phone call to The Eliot advising of your late return may save you some inconvenience.
4. Residents are not permitted in the kitchen at any time.
5. Visiting hours are between the hours of 9:00 AM to 8:00 PM. Visitors are not allowed in the Dining Room during meal times.
6. Personal hygiene is very important. Bathing assistance is provided, if needed, by a staff member. At times it might become necessary to remind a resident to bathe, no offense is intended.
7. Perishable foods are not permitted in resident rooms for obvious reasons. Reluctantly, we will, on periodic inspections, remove any food not in

compliance. For the comfort of yourself, and if there is a roommate, as well as for safety purposes, an accumulation of newspapers, magazines and any other flammable materials, beyond the norm, are not permitted and is a direct violation of the facility's safety policy. Clutter cannot be permitted in the rooms, and will not be permitted.

8. Hot plates, portable cookers, toasters, coffeepots and any other cooking appliances are not allowed in resident rooms. Cooking in any form is strictly forbidden.
9. Portable Heaters and heating appliances are not allowed in the facility. Any heating appliance found will be confiscated. Extension cords are not allowed and if found will be confiscated.
10. In the case of two individuals sharing a room, its occupants must share the room in its entirety.
11. Personal laundry is done on a weekly basis. Our staff will take the laundry and it will be returned to you within a day or two. We are not responsible for unmarked, lost or misplaced items. If you have an unmarked article of clothing, which needs to be marked, please inform the front desk and we will mark it. No washing is permitted in the room's lavatory.
12. Fire drills are held a minimum of once a month. All residents, without exception, must participate by the order of the Fire Marshall. Exits are clearly marked for assistance.
13. A very diverse activity program is designed for your enjoyment. Outings, and in house entertainment, is arranged and is displayed on our monthly activity board. Resident council meetings are held once a month. They are designed for your benefit. They provide you to voice any concerns, opinions, complaints and/or compliments that you might have. This meeting is most beneficial to you, the resident.
14. There will absolutely NO smoking in the rooms and bathrooms. This rule is strictly enforced. Violation is a reason for termination of your admission agreement with our facility.
15. Since the majority of our public areas are being cleaned during the night, we ask that you refrain from staying in the lobby or common areas during the hours of 1:00 AM to 6:00 AM.
16. Our dedicated staff is on duty 24 hours a day, every day, to assist you. Should you have any complaint or recommendation concerning a staff member, please present it to administration at any time. We respectfully request of all residents' total cooperation and courtesy towards our staff in return. In doing so, you will find The Eliot at Erie Station a very pleasant home in which you live.