

RESIDENCY AGREEMENT

AGREEMENT | ACKNOWLEDGMENTS | POLICIES

REVIEW & SIGN

BRANDYWINE

THE SAVOY

ASSISTED LIVING AND MEMORY CARE

BRANDYWINE by MONARCH COMMUNITIES

5515 LITTLE NECK PKWY | LITTLE NECK, NY 11362
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THE FOLLOWING FORMS MUST BE COMPLETED.

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ENRICHED HOUSING PROGRAM
RESIDENCY AGREEMENT

This Residency Agreement (the "Agreement") is made by and between:

GWC-Savoy, Inc., operator of the assisted living residence known as Brandywine Assisted Living at The Savoy located at 55-15 Little Neck Parkway, Little Neck, NY 11362, ("Operator"), and _____, ("Resident," "You," or "Your"), or_____, ("Resident's Representative," *if applicable*), or _____, ("Resident's Legal Representative, *if applicable*).
This Agreement is entered into as of _____, 20___, ("Effective Date").

RECITALS

A. The Operator is licensed by the New York State Department of Health, ("NYSDOH"), to operate at 55-15 Little Neck Parkway, Little Neck, NY 11362, an Assisted Living Residence ("Residence") known as **Brandywine Assisted Living at The Savoy** as an Enriched Housing Program.

Additional Certifications:

☐ The Operator does not have any additional certifications at this location.

☒ The Operator is also certified to operate an Enhanced Assisted Living Residence ("EALR"), at this location. See Section II.C.1 for more information.

☒ The Operator is also certified to operate a Special Needs Assisted Living Residence ("SNALR), at this location. See Section II.C.2 for more information.

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

AGREEMENT

I. Housing Accommodations and Services.

Beginning on the Effective Date, 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 Living Space**. You may occupy and use apartment #_____, ("Apartment") as identified on Exhibit I: "Identification of Resident's Apartment," subject to the terms of this Agreement. The Apartment occupancy will be indicated on Exhibit I. For purposes of this Agreement, a private apartment at the Residence is one with a single resident while a semi-private apartment may have two (2) residents. Semi-Private apartments include a single bed for each resident and either two (2) or one (1) bathroom shared by the two (2) residents.
2. **Common areas**. Pursuant to regulation at Title 18 of New York Codes, Rules, and Regulations, ("18 NYCRR"), § 485.14(b), coupled with federal regulation at Title 42 of the Code of Federal Regulations § 441.301(c)(5), for at least ten (10) hours per day, between the hours of 9:00 AM and 8:00 PM. You will have access to common areas for scheduled group activities or unscheduled group and/or individual recreation. Specifically, You will be provided with the opportunity to use the general-purpose rooms at the Residence such as lounges, Bistro, game room, library, and any additional common area(s) provided for the use and enjoyment of all residents. Whenever a common area is temporarily unavailable due to maintenance or administrative activities such as staff training, other common areas suitable for recreation will remain available for Your use. Such other common area(s) will be available for Your use twenty-four (24) hours per day, seven (7) days a week.
3. **Furnishings/Appliances Provided by The Operator.** You will be provided the use of the Apartment designated and the fixtures and property of Operator located in the Apartment, including carpeting, window treatment, microwave oven (not applicable to Special Needs), refrigerator, wardrobe/closet, a heating/cooling system with individualized control, and an emergency response system. A list of the furnishings and appliances provided to You by the Operator is attached as Exhibit II: "Furnishings and Appliances provided by the Operator." Upon move-in, You must complete a Furniture Sheet, indicating which furnishings and appliances provided by Operator You accept, and those You decline. See Exhibit III: "Furniture Sheet," attached and incorporated into this Agreement.
4. **Furnishings/Appliances Provided by You.** You may choose to furnish Your Apartment, otherwise Operator will provide furnishings and appliances for Your Apartment on an as needed basis. If You elect to bring personal furnishings or belongings to the Residence, You must complete an Inventory of Your Property being brought to the Residence. Appliances other than a microwave are not permitted in apartments at the Residence. See attached Exhibit IV: "Inventory of Resident's Property" (DSS-3027), attached and incorporated into this Agreement.

B. Basic Services. Pursuant to 18 NYCRR, § 488.7, the following basic services ("Basic Services") will be provided to You, in accordance with Your Individualized Services Plan ("ISP").

1. **Meals and Snacks.** Three (3) nutritionally well-balanced meals per day and snacks are included in Your Basic Rate, per 18 NYCRR § 488.8. The following diets will be available to You if ordered by Your physician and included in Your ISP: (1) Regular ("REG"); (2) No Added Salt ("NAS"); and (3) Consistent Carbohydrate Diet ("CCD"). Access to snacks and drinks is provided to residents by Operator twenty-four (24) hours a day, seven (7) days a week at the Residence, located in common areas or by request.
2. **Activities.** Per 18 NYCRR, § 488.7(f), Operator will provide an organized and diverse 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.** Per 18 NYCRR, § 488.7(g), Operator will provide weekly housekeeping services including vacuuming, dusting of all cleared horizontal surfaces, cleaning of bathroom and changing of Your bed linens.
4. **Linen Service.** When not supplied by the Resident, Operator will provide a minimum of two (2) sheets; one (1) pillowcase, one (1) pillow, at least one (1) blanket, one (1) bedspread, and towels and washcloths, all clean and in good condition per 18 NYCRR, § 488.11(f)(4)(v). Operator will change bed linens once per week and towels twice per week.
5. **Laundry of Your Personal Washable Clothing.** Operator will facilitate washing, drying, and folding of Your personal laundry of up to one full laundry bag (supplied by the Operator) once per week. Dry cleaning services are not included as Basic Services.
6. **Supervision on a 24-hour basis.** Per Title 10 of New York Codes, Rules, and Regulations, ("10 NYCRR"), § 1001.10(g), Operator will provide appropriate staff onsite to provide supervision services in accordance with law. Supervision will include monitoring (response to urgent or emergency needs or requests for assistance on a twenty-four (24) hour a day, seven (7) days a week basis as well as the other components of supervision as specified in law and required by NYSDOH.
7. **Case Management.** Per 10 NYCRR § 1001.10(i), and 18 NYCRR § 488.7(e), Operator will provide case management services in accordance with law. Such case management services will be delivered by appropriate staff and include identification and evaluation of Your needs and interests, information and referral, and coordination with available resources to best address Your identified needs and interests.
8. **Personal Care.** Per 18 NYCRR, § 488.7(c) and 488.9(e)(2), the Operator will provide sufficient staff to perform personal care, including: (1) Wellness checks such as weight and blood pressure monitoring; and (2) Basic assistance with personal care including some assistance with bathing, grooming, dressing, toileting (*if applicable*), ambulation (*if applicable*), transferring (*if applicable*), feeding, medication acquisition, storage and disposal, and assistance with self-administration of medication.

9. **Development of ISP.** At admission, an ISP will be developed to address Resident's needs per Public Health Law § 4659 and 10 NYCRR §§ 1001.2(k), 1001.7(k), and 1001.10(c). This plan will be reviewed and revised every six (6) months and/or whenever ordered by Your physician or as frequently as necessary to reflect Your changing care needs. A copy of a blank ISP is attached as Exhibit V: "Assisted Living Individualized Service Plan" for Your reference.
10. **Customized Support Assessment Program/Level of Care.** For an additional charge, as indicated on the Schedule of Fees, Operator will make available to the Resident personal care services that exceed Level I Basic Services. The Customized Support Assessment Program is designed for Residents who may require a higher Level of Care (e.g., additional hands-on assistance with the activities of daily living). Operator shall determine whether the Resident requires the Customized Support Assessment Program through a comprehensive Level of Care Evaluation ("LOC Evaluation") on admission and at least annually. This Evaluation will be reviewed with the Resident and his/her responsible party will be given the opportunity to review the assessment prior to implementation of the Customized Support Assessment Program. See Exhibit VI: "Level of Care Evaluation."

C. Additional Services. Operator will make available to or arrange for the Resident additional services, or amenities available for an additional or supplemental fee from Operator directly or through arrangements with Operator as set forth on the Schedule of Fees. See Exhibit VII. The Schedule of Fees is subject to the terms and conditions of this Agreement. Operator reserves the right to add or remove additional services upon thirty (30) days prior written notice to the Resident.

D. Licensure/Certification Status. Pursuant to 10 NYCRR § 1001.8(f)(4)(iv), a listing of all providers offering home care or personal care services under an arrangement with Operator, and a description of the licensure or certification status of each provider is set forth in Exhibit VIII: "Residence Providers and Licensure/Certification Status." Such Exhibit will be updated as frequently as necessary.

II. Disclosure Statement

In accordance with 10 NYCRR § 1001.8(f)(4) and (5), GWC-Savoy, Inc., as operator of Brandywine Living at The Savoy, hereby discloses the following, as required by Public Health Law § 4658(3).

A. Consumer Information Guide ("Guide"). The Guide was developed by the New York State Commissioner of Health and is attached as Exhibit IX. Residents are encouraged to reference the Guide as a resource; however, the specific provisions as detailed in the Guide are not incorporated into this Agreement.

B. Operator's Licensure. GWC-The Savoy, Inc. as Operator, is licensed by the NYSDOH to operate the Residence, located at 55-15 Little Neck Parkway, Little Neck, NY 11362, an Assisted Living Residence as well as an Enriched Housing Program.

C. Operator's Additional Certifications. Operator is also certified to operate, at this location, the following programs:

1. **Enhanced Assisted Living Residence ("EALR").** Maximum of 160 persons. Operator is able to serve and accommodate under its EALR Certification residents who are: (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; or (f) skilled nursing services as required by an EALR Resident.
2. **Special Needs Assisted Living Residence ("SNALR").** Maximum of 37 persons. Operator can serve and accommodate under its SNALR Certification residents served under the Assisted Living Residency criteria who have: (a) Cognitive Impairment due to dementia; and/or (b) Behaviors that are not disruptive or dangerous to self or others. Operator is currently approved to accommodate within the EALR and/or SNALR programs only up to the number of persons stated above. If Resident becomes appropriate for either program, and one of those apartments is available, Resident will be eligible to be admitted into the appropriate program. If, however, such apartments are at capacity and there are no vacancies, the Operator will assist Resident, to identify and obtain other appropriate living arrangements in accordance with NYSDOH's regulatory requirements. If Resident becomes eligible for and chooses to receive services in either the EALR or SNALR program within the Residence, it may become necessary for Resident to change apartments at which time Resident, Resident's Representative and/or Resident's Legal Representative must sign a new Residency Agreement or an Addendum to this Agreement.

D. The owner of the real property upon which the Residence is located is HCRI Emerald Holdings, LLC. The mailing address of such real property owner is 4500 Dorr St., Toledo, Ohio 43615. The following individual is authorized to accept personal service on behalf of such real property owner: Tom Foos. The registered agent for service of process in Ohio is CSC- Lawyers Incorporating Service, 50 West Broad Street, Suite 1800, Columbus, OH 43215 and in New York it is Corporation Service Company, 80 State Street, Albany, NY 12207.

E. The Operator of Brandywine Assisted Living at The Savoy is GWC-Savoy, Inc. The mailing address of the Operator is 55-15 Little Neck Parkway Little Neck, NY 11362. The following individual is authorized to accept service on behalf of the operator: Xenia Balkaran, Executive Director, 55-15 Little Neck Parkway Little Neck, NY 11362.

F. The Operator does not hold any ownership in excess of 10% (whether a legal or beneficial interest) in any entity that provides care, material, equipment or other services to residents of the Residence.

G. No other entity that provides care, material, equipment, or other services to the residents of the Residence holds any ownership in the Operator.

H. All residents have the right to receive services from any provider, regardless of whether the Operator has an arrangement with the provider.

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

J. Public funds may be used for payment of residential, supportive, or home health services, including but not limited to, availability of Medicare coverage of home health services. However, **residency at the Residence is one hundred percent (100%) private pay**, and thus its charges may exceed the amount of public funds available to the Resident.

K. The NYSDOH's toll-free telephone number for reporting of complaints regarding the services provided by Operator is 1-866-893- 6772, or regarding Home Care Services is 1-900-628-5972.

L. 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. The NYSLTCOP web site is www.ombudsman.state.ny.us.

M. The local Long Term Care Ombudsman Program can be reached at (929) 719-4373.

III. Fees

A. Basic Rate: *Select all that apply:*

☐ The Resident ☐ The Resident's Legal Representative

☐ The Resident's Representative ☐ Other: _____

agree(s) that they will pay, and the Operator agrees to accept, the following payment in full satisfaction of the Basic Services described in Section B of this Agreement ("Basic Rate"). As of the date of this Agreement, the Resident's Basic Rate is $_____ (per month). Resident's Basic Rate does not include additional services or amenities or increased personal care services as determined by the Resident's ISP or LOC Evaluation.

B. Tiered Fee Arrangements. Operator of Brandywine Assisted Living at The Savoy uses tiered fee arrangements, in that the Resident's total Monthly Rate will depend upon the types of services provided, and/or the number of hours of care provided per week for some types of services and the fees for each "tier" of care (referred to as "Levels of Care") are set forth in detail in Exhibits VII and VIII. The additional charges depending on the Resident's assessed Level of Care are provided in the Schedule of Fees.

C. Supplemental, Additional or Community Fees. Per 10 NYCRR § 1001.8(f)(4), this Agreement includes a description of supplemental, additional, or community fees from the Operator directly or through arrangements with the Operator, stating who provides such services if not the Operator, and provide a detailed explanation of the services and amenities covered by the rates, fees, or charges. Any charges for supplemental fees by Operator, whether a part of Resident's Monthly Rate, Additional Fees, or Community Fee, shall be made only for services and supplies that are actually supplied to the Resident.

1. **Additional Fees.** An "Additional Fee" is a fee for service, care or amenities that is in addition to those fees collected for the Resident's Basic Rate. Additional Fees include charges for personal care that goes beyond the services included in the Basic Rate but are prescribed by the Resident's ISP or LOC Evaluation.
2. **Community Fee.** A "Community Fee" is a one-time, non-refundable fee that the Operator may charge and is payable at the time of admission. The Community Fee is equal to the Resident's Monthly Rate, is non-refundable as of the thirtieth (30th) day of residency and is not applied towards the Resident's Monthly Rate or any other future charges. Community Fees are used for capital improvements to the Residence, which may include, without limitation, upgrades to common areas and interior and exterior improvements. You may choose whether to accept the Community Fee as a condition of residency at the Residence or to reject the Community Fee and thereby reject residency at the Residence.

D. Rate or Schedule of Fees

1. **Schedule of Fees.** Attached as Exhibit VII and made a part of this Agreement is a Schedule of Fees, covering both the Resident's Summary of Fees, including Your Basic Rate and any Community Fee and/or Additional Fees, for services, supplies, and amenities provided to You, and the Community Fee Schedule which outlines Additional Services and associated fees. If Operator provides You any of the Additional Services, You (or individual(s) designated in Section III.A) will pay to the Operator the charge for such Additional Services set forth in the Schedule of Fees. All charges for Additional Services, if any, are billed monthly by the Operator and are due on the first (1st) calendar day of the month following the statement date. If any services are provided by third parties, the third parties will bill You directly and You will be solely responsible for payment of those charges. Operator will not be responsible for payment for any services provided to You by third parties.
2. **Fees for Increase in Level of Care.** If Operator provides You with any of the Additional Services as determined to be necessary by his/her LOC Evaluation or otherwise necessary for You to remain at the Residence, You will pay to the Operator the charge for such Additional Services as set forth in the Schedule of Fees. All charges for Additional Services, if any, are billed monthly by the Operator and are due on the first (1st) calendar day of the month following the statement date. If any services are provided by third parties, the third parties will bill You directly and You will be solely responsible for payment of those charges. Operator will not be responsible for payment for any services provided to You by third parties.
3. **Monthly Rate.** Your Monthly Rate will include the Basic Rate for Basic Services as well as charges for additional services, care, or amenities that you elect to receive (e.g., phone service, cable television) or require per Your LOC Evaluation (e.g., increased personal care services).

IV. Billing and Payment Terms

In accordance with 10 NYCRR § 1001.8(f)(4)(xiv), the following information is presented:

A. Deposit. Prior to admission, Operator requires a non-interest bearing, fully refundable one-thousand-dollar ($1,000.00) deposit ("Deposit") to secure a reservation for the Apartment. Should a decision be made for any reason by any party that results in the Resident not taking up residency in the Residence, the Deposit is refundable within thirty (30) days. The Deposit will be applied toward the first month's rent upon the Resident's move-in.

B. Payment. Payment of Your Monthly Rate is due by the first (1st) calendar day of the month billed. Operator will provide You with a monthly statement itemizing fees, charges, and payments received and indicating any balances due.

C. Late Fees. You may be assessed a late fee in the amount indicated on the Schedule of Fees, which will not exceed 1.5% per month, for any fees that are not paid by the fifth (5th) calendar day of each month. You will pay the full amount of costs and expenses allowable by law that are incurred by Operator in collecting any amounts past due under this Agreement, including reasonable attorneys' fees and court costs, if assigned by a court.

D. Nonpayment. In the event You (or the individual(s) designated in Section III.A) are no longer able to pay for services provided for pursuant to this Agreement or additional services or care needed by You, Operator may issue a notice of termination, as more fully described in Section XIII of this Agreement.

E. Adjustments to Basic Rate or Additional Fees

1. **Right to Notice.** Per 10 NYCRR § 1001.8(b)(2)(xvi), You have the right to written notice of any proposed increase of the Basic Rate or any Additional or Supplemental fees not less than forty-five (45) days prior to the effective date of the rate or fee increase, except as provided in the following section.
2. **Immediate Need for Increased Care.** If the Resident (or the individual(s) designated in Section III.A) agree in writing to a specific rate or fee increase, through an amendment of this Agreement, due to Resident's need for additional care, services or supplies, the Operator may increase such rate or fee upon less than forty-five (45) days' notice, as detailed in the paragraphs below.
   - **a.** If Operator provides additional care, services, or supplies upon the express written order of the Resident's primary physician, the Operator may, through an amendment to this Agreement, increase the Basic Rate or any charges for necessary adjustments to Resident's Level of Care upon less than forty- five (45) days written notice.
   - **b.** In the event of any emergency which affects the Resident, the Operator may assess additional charges for the Resident's benefit as are reasonable and necessary for services, material, equipment, and food supplied during such an emergency.
   - **c.** If the Resident requires care outside of the Residence following a Level of Care increase, the Operator will provide credits to any increases in Level of Care charges, as indicated on the Schedule of Fees, after Resident has been out of the Residence for medical reasons after a fourteen (14) day period.
3. **Community Fee.** Since a Community Fee is a one-time fee, there can be no subsequent increase in a Community Fee charged to You by Operator once You have been admitted as a Resident.

F. Bed Reservation. Per 18 NYCRR, § 488.5(c)(7)(xvii), Operator agrees to reserve the Apartment as specified in Exhibit I, in the event of Your absence, the charge for this reservation is Your prorated Monthly Rate. The total of the daily rate for a one-month period may not exceed the established monthly rate. The length of time the space will be reserved will be agreed upon by You (or Your Representative) and Operator, based on the circumstances of Your absence. A provision to reserve an Apartment does not supersede the requirements for termination as set forth in this Agreement. You may choose to terminate this Agreement rather than reserve such Apartment but must provide Operator with any required notice.

V. Operator's Fiduciary Responsibilities

A. Refund/Return of Resident Monies and Property. Per 10 NYCRR § 1001.8(f)(4)(xvi), upon termination of this Agreement or at the time of Your discharge, but in no case more than three (3) business days after You leave the Residence, Operator must provide You, Your Representative, Your Legal Representative, or any other person designated by You with a final written statement of Your payment(s) and/or outstanding charges. Operator must also return at the time of Your discharge, but in no case more than three (3) business days after Your discharge, any of Your property which comes into the possession of the Operator after Your discharge. The Operator must refund on the basis or 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.

B. Tipping. Operator must not accept, nor allow the 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.

C. Personal Allowance Accounts. Operator does not offer Personal Allowance Accounts.

D. Safekeeping Accounts. Operator offers "Safekeeping Accounts," wherein the Operator may hold small amounts of cash in a safe/envelope, for the Resident to use at his/her discretion if they so choose to create such accounts.

VI. Admission and Retention Criteria for an Assisted Living Residence

The following is made known per 10 NYCRR §1001.8(f)(4)(xii):

A. Public Health Law Article 46-b. Under the law which governs Assisted Living Residences (Public Health Law Article 46- b), Operator shall not admit any Resident if 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 ISP. Operator shall not admit any Resident in need of twenty-four (24) hour skilled nursing care. Operator shall not exclude an individual on the basis of an individual's mobility impairment and shall make reasonable accommodations to the extent necessary to admit such individuals, consistent with federal, state and local laws.

B. Pre-Admission Evaluation. Operator shall conduct an initial pre-admission evaluation of a prospective Resident to determine whether or not the individual is appropriate for admission. Operator has conducted such evaluation of Yourself and has determined that You are appropriate for admission to this Residence, and that 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 per Your ISP.

C. Change of Care/Transfer to EALR. If Your care needs change in the future to the point that You require either Enhanced Assisted Living Care or twenty-four (24) hour skilled nursing care, You will no longer be appropriate for residency in this Residence. If this occurs, the Operator will take the appropriate action to terminate this Agreement, pursuant to Section IX below. However, if Operator also has an approved Enhanced Assisted Living Certificate, has an apartment available, and is able and willing to meet Your needs in such apartment, You may be eligible for residency in such Enhanced Assisted Living apartment.

D. EALR. 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. The EALR Addendum is attached hereto as Exhibit XV.

1. 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.
2. 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 twenty-four (24) hour skilled nursing care or medical care and who meet the conditions stated in the “Enhanced Assisted Living Residence Addendum.”

E. SNALR. If You are being admitted to a Special Needs Assisted Living Residence, the "Special Needs Assisted Living Residence Addendum" will apply. The SNALR Addendum is attached hereto as Exhibit XVI.

VII. Rules of the Residence

Attached as Exhibit XII. and made a part of this Agreement are the Rules of the Residence. By signing this agreement, You, Your Representative, and/or Your Legal Representative agree to obey all Rules of the Residence.

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

You (or the individual(s) designated in Section III.A) to the extent specified in this Agreement, are responsible for the following:

A. Payment of the Basic Rate and any authorized Additional Fees and Community Fees as detailed in this Agreement.

B. Supply of personal clothing and effects.

C. Payment of all medical expenses including transportation for medical purposes, except when payments is available under Medicare, Medicaid, or other third-party coverage.

D. At the time of admission and at least once every twelve (12) months, or more frequently if a change in condition warrants, providing Operator with a dated and signed medical evaluation that conforms to regulations of NYSDOH.

E. Promptly informing Operator of changes in Your health status, physician(s), and/or medications.

F. Promptly informing Operator of changes of name, address and/or phone number of Your Representative and/or Your Legal Representative.

IX. Termination and Discharge

In accordance with 10 NYCRR § 1001.8(f)(4)(xiii), this Residency Agreement and residency at Brandywine Living at The Savoy may be terminated in any of the following ways:

A. Termination by Both or Either Party.

1. By mutual agreement between You, Your Representative, or Your Legal Representative and Operator;
2. Upon thirty (30) days written notice from You, Your Representative, or Your Legal Representative to Operator of Your intention to terminate this Agreement and leave the Residence;
3. Upon thirty (30) days written notice from Operator to You, Your Representative, Your Legal Representative, Your next of kin, and/or the individual(s) designated in Section III.A of this Agreement.

B. Involuntary Termination (Discharge). Involuntary termination of a Residency Agreement is permitted only for the reasons listed below, and then only if Operator initiates a court proceeding and the court rules in favor of Operator:

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, the Resident or anyone else;

3. If 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 Operator, during the thirty (30) day period of notice of termination, assists You in obtaining such public benefits or other available supplemental public benefits. You agree to cooperate with such efforts by 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. Operator has had their operating certificate limited, revoked, temporarily suspended or Operator has voluntarily surrendered the operation of the Residence; and/or
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' safety and care.

C. Notice. If Operator decides to terminate this Agreement for any of the reasons stated above, Operator will give You a notice of termination and discharge, which must be at least thirty (30) days after delivery of notice, the reason for termination, a statement of Your right(s) to object, and a list of free legal advocacy resources approved by NYSDOH.

D. Resident's Recourse. The following paragraphs include additional information regarding Resident's recourse in the event Operator seeks to terminate this Agreement:

1. You may object to Operator about the proposed termination and may be represented by an attorney or advocate. If You challenge the termination, 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 Operator.
2. While legal action is in progress, 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 NYSDOH regulations and the Residency Agreement, or engage in any action to intimidate or harass You.
3. You and Operator are free to seek any other judicial relief to which you may be entitled. Operator must assist You, if 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.

X. 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 thirty (30) days' notice or court review, for the following reasons:

A. When You, the Resident develop a communicable disease, medical or mental condition, or sustains and injury such that continual skilled medical or nursing services are required.

B. In the event that Your behavior poses an imminent risk of death or serious physical injury to him/herself of others; or 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, Operator must proceed with the requirements as set forth in Section IX of this Agreement, except that the written notice of termination must be hand delivered to You at the location to which You have been transferred. 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.

C. If the basis for the transfer permitted under parts l 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.

XI. Rights and Responsibilities of Residences in Assisted Living Residences

Attached as Exhibit XI and made a part of this Agreement is a statement of "Rights and Responsibilities of Residents in Assisted Living Residences" ("Statement"). This Statement will be posted in a readily visible common area in the Residence. Operator agrees to treat You in accordance with such Statement.

XII. Complaint Resolution

A. Resident Grievance Policy and Procedures. Operator's policy and 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 XII and made a part of this Agreement. In addition, such procedures will be posted in a readily visible common area of the Residence. Please refer to regulation at 10 NYCRR § 1001.8(f)(4)(xiii),

B. Resident Councils. Operator agrees that the residents of the Residence may organize and maintain councils or such other self-governing bodies as the residents may choose. Operator agrees to address any complaints, problems, issues, or suggestions reported by the residents' organization(s) and to provide a written report to the residents' organization(s) that addresses the same.

C. Ombudsman Program. 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.

XIII. Pets

A. Permitted Pets. Cats and small dogs are permitted to reside in the Resident's apartment with Operator's/Operator's Representatives' pre-approval.

B. Pet Restrictions. The following breeds of dogs are not permitted to be kept as pets by residents: (a) Chows; (b) German Shepherds; (c) Pit bulls; and (d) Rottweilers. Additionally, pets exceeding eighteen (18) inches in height, or thirty (30) pounds, regardless of species or breed are not permitted.

C. Pet Addendum. If You wish to bring a pet to the Residence, please review and complete the Pet Addendum included with this Agreement as Exhibit XVI "Pet Policies and Addendum." The Pet Addendum contains important information regarding the Residence's pet policies and the Resident's responsibilities.

XIV. Miscellaneous Provisions

The following provisions are made part of this Agreement:

A. This Agreement constitutes the entire Agreement of the parties.

B. 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.

C. The parties agree that assisted living residency agreements and related documents executed by the parties shall be maintained by Operator in files of the Residence from the date of execution until three (3) years after the Agreement is terminated. The parties further agree that such agreements and related documents shall be made available for inspection by NYSDOH upon request at any time.

D. Waiver by the parties of any provision in this Agreement which is required by statute or regulation shall be null and void.

E. Operator recommends that You maintain Your own health, personal property, liability, automobile (*if applicable*) and other insurance coverage in appropriate amounts. You acknowledge that Operator is not an insurer of Your person or property. Operator will not be liable to You for any personal injury or property damage suffered by You or Your agents, guests, or invitees unless caused by the negligence or misconduct of Operator or its employees or agents.

F. You hereby grant Operator permission to use photographs or videos of You taken during your residency at the Residence for internal activities and events or for medical purposes. You must complete the "Photography Release," attached as Exhibit XVI, indicating whether You choose to grant Operator such permission.

G. Any notices to be given under this Agreement will be deemed to have been properly given when delivered personally or when mailed by certified mail, return receipt requested, postage prepaid, addressed as follows:

If to the Resident: Addressed to the Apartment or such other address as You may designate by written notice to Operator.

If to the Operator: Addressed to the attention of the current Executive Director at Operator's address.

H. This Agreement is not assignable by You without prior written consent of Operator.

I. You will be liable and responsible for all obligations referenced in this Agreement, whether these obligations are monetary or otherwise, and where this Agreement has been executed by You, Your Representative, Your Legal Representative, and/or other individual(s) as designated in Section III.A of this Agreement, or where a separate Responsible Party Agreement has been executed by a third party; said third party and/or Responsible Party and You will be jointly and severally liable and responsible for all of Your obligations under this Agreement.

XV. Agreement Authorization

We, the undersigned, reflect all parties to be charged under this Agreement per Title 10 of New York Codes, Rules, and Regulations at Section 1001.8(f)(2)(i), have read this Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

Resident Signature	Print Name	Date
Resident's Representative Signature (*if applicable*)	Print Name	Date
Resident's Legal Representative Signature (*if applicable*)	Print Name	Date
Operator/Operator's Representative's Signature	Print Name	Date

XVI. Personal Guarantee of Payment (*Optional*)

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

I,_____, personally, guarantee payment of charges for Resident's Basic Rate.

I,_____, personally, guarantee payment of charges for the following services, materials, or equipment, provided to Resident, that are not covered by the Basic Rate, including but not limited to, the services/care required pursuant to the Level of Care required as determined by the Resident's Individualized Service Plan and/or any other additional services actually rendered to Resident.

_____

Guarantor's Signature Print Name Date

Exhibit I.

IDENTIFICATION OF RESIDENT'S APARTMENT

RESIDENT NAME _____APARTMENT #:_____

APARTMENT TYPE

☐ Studio

☐ One Bedroom Apartment

☐ Two Bedroom Apartment

APARTMENT OCCUPANCY

☐ Semi-Private (Shared)

☐ Private

LICENSE CATEGORY

Enriched Housing Program

☐ ALR Assisted Living Residence

☐ EALR Enhanced Assisted Living Residence

☐ SNALR Special Needs Assisted Living Residence

Resident/Representative Legal Representative Initials _____

Exhibit II.

FURNISHINGS/APPLIANCES PROVIDED BY OPERATOR

As a resident of an Enriched Housing Program, in accordance with Section 488.11(f) of Title 18, New York Codes Rules, and Regulations, Operator will provide you with the following:

1. Basic furniture and household items, appropriate to size and function and intended for common use.
2. A standard, single bed in good repair, a chair, a lamp, a nightstand.
3. Lockable storage facilities for personal articles and medication which cannot be removed at will if the individual room or apartment is not equipped with a lock.
4. Individual dresser and closet space for the storage of resident clothing.
5. Household supplies and equipment including soap and toilet tissue.
6. Shaded light fixtures.
7. One telephone (if requested).
8. Dishes, glasses, utensils, table.
9. Access to radios and television sets.
10. Household linens including, at a minimum, a pillow, a pillowcase, two sheets, blankets, a bedspread, towels and washcloths.

Exhibit III.

Furniture Sheet

RESIDENT NAME:_____APARTMENT #:_____

MOVE-IN DATE:_____

Please indicate which furnishings provided by the Operator You wish to accept or decline:

	Accept	Decline
Bed	☐	☐
Nightstand	☐	☐
Dresser (chest of drawers)	☐	☐
Chair	☐	☐
Lamp	☐	☐
Linens	☐	☐
Other:_____	☐	☐
Other:_____	☐	☐

I,_____, agree the furniture being provided is property of and owned by the Operator and is strictly for use during my residency. There is no charge for the furniture during this time. I am responsible for returning all property at the time my residency terminates. If at the time of move-out any of the furniture is missing, I will be responsible for the cost of replacement. In addition, I will be responsible for the replacement of furniture that is damaged above and beyond normal wear and tear.

_____

Resident Signature Print Name Date

_____

Resident's Representative's Signature *(if applicable)* Print Name Date

_____

Resident's Legal Representative's Signature (*if applicable*) Print Name Date

_____

Operator/Operator's Representative's Signature Print Name Date

Exhibit IV.

NEW YORK STATE DEPARTMENT OF HEALTH
Division of ACF/Assisted Living Surveillance

Adult Care Facility Inventory of Resident Property

FACILITY NAME: _____ **OPERATING CERTIFICATE NUMBER:** _____

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

Exhibit V.

Assisted Living Individualized Service Plan

Resident Name: _____ ☐ Female ☐ Male

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 - Nursing				
☐ Lab Test				
☐ Pacemaker				
☐ Dialysis				
☐ Skilled Nursing, Treatments &/or Education	☐ Injection ☐ Insulin ☐ Other – Type _____ ☐ Dressing ☐ Other _____			
☐ Specialists (eg podiatrist, chiropractor)	Specify_____ –			
☐ Medical Equipment	☐ Independent ☐ Type WALKER_____ ☐ 1+ Assist *(requires more than intermittent assistance with equipment – EALR required)*			
☐ Pain Management	N/A			
☐ Other	☐ health prevention ☐ aide-level health related activities ☐ other – specify_____ _ ☐ N/A_____			
Rehabilitation	☐PT ☐ OT ☐ Speech Therapy ☐ Other: _____			
Nutritional				
	☐Regular ☐ NAS ☐ NCS ☐ Chopped as needed ☐ Soft ☐ Dietary Supplement Specify: ALLERGY:	☐ Meals ☐ Snacks		☐ Chewing Difficulty ☐ Swallowing Difficulty ☐ Other: _____
Fluid Restrictions/	☐ None			

Activity – Check all applicable	Services to be provided:	Frequency	By Whom	Comments
Encouragement	☐ 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 *(chronically unwilling or unable to participate, with help from staff, so that cleanliness and sanitation can be maintained - EALR required)*			
Skin Care	☐ None ☐ Location & Type: _____			
Dressing	☐ Independent ☐ Coordinate ☐ Upper ☐ Lower ☐ Other _____			
Medications	☐ Self ☐ Assist			
Transfer	☐ Independent ☐ 1+ Assist *(chronically chairfast and/or chronically needs one person assist to transfer – EALR required)*			
Mobility	☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☐ Crutches ☐ Escort: _____ ☐ 1+ Assist *(chronically needs one person to assist to walk or to climb/descend stairs- EALR required)*			
Falls Risk Reduction	☐ No Known History ☐ Other: _____			
Respiratory Therapy & Oxygen	☐ None ☐ Self-managed ☐ Type: _____			
Equipment	☐ None ☐ Self-managed ☐ Prosthesis ☐ Braces ☐ Other _____			

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 *(~~requires SNALR~~)* ☐ Environmental modifications ☐ Supervision/Monitoring			
Sensory	☐ None ☐Hearing ☐ Vision ☐ Speech ☐ Other: _____			
Mental Health **N/A**	☐ Diagnosis: _ ☐ Treatment Required ___Yes ___No ☐ 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	Assitance with access to financial benfits (i.e. Medicare, Medicaid, Social Security, Veteran's Admin., Pensions, etc.) ☐ Managed Independently ☐ Assistance of family, resident rep. or legal rep. Specify: CHILDREN ☐ Need assistance of ALR staff Specify: _____			

Other Comments: _____

.

Enriched Housing Program-ALR addendum

Activity	Services to be provided:	Frequency	By Whom	Changes/Comments
Instrumental Activities of Daily Living				
❑ Transportation	❑ independent, drives own car or accesses transportation on own & chooses to do so ❑ wants or needs someone to drive them, but does not require an escort ❑ must be accompanied by an escort ❑ requires special transportation specify _____			
❑ Laundry	❑ is able & chooses to do own laundry ❑ is able & chooses to do light laundry, but wants/needs assistance with heavy laundry ❑ needs or chooses ALR to do all laundry			
❑ Housekeeping	❑ is able & chooses to do all housekeeping tasks in room/apartment ❑ is able & chooses to do light housekeeping, but wants/needs assistance with heavier cleaning tasks Specify _____ ❑ needs or chooses ALR to do all housekeeping			
❑ Shopping	❑ is able & chooses to shop on their own & carry or transport packages on their own ❑ is able & chooses to do light shopping on their own, but wants/needs assistance with major shopping Specify _____ ❑ needs or chooses ALR staff or other person (i.e. family member) to do all of their shopping			
❑ Ability to use telephone	❑ Independent-has phone & dials numbers and answers calls without assistance ❑ has specially adapted phone and dials numbers and answers calls without assistance ❑ chooses or needs ALR staff to help them make calls or make the calls on their behalf			

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: _____

Executive Director

Case Manager/EIT

Exhibit VI.

DATE : _____ REASON : _____

Resident Name:

_____

Date of Birth:

ADVANCE DIRECTIVE:

Gender: _____ Room #: _____ Language: _____ Race: _____

Age: _____ Product: _____ Religion: _____ Ethnicity _____

☐ ALCOHOL USE	☐ INCONTINENT	☐ DIABETIC	HAIR COLOR:	EYE COLOR:

Health Profile

PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____

CHRONIC DIAGNOSIS: _____

RECENT SURGERIES: _____

DIET: _____

FOOD ALLERGIES: _____

MEDICAL ALLERGIES: _____

Vaccinations & Tests

COVID-19 STATUS:

Manufacturer: _____

Dose 1 Date: _____ Dose 2 Date: _____

PNEUMOCOCCAL PNEUMONIA STATUS:

Test Date, if applicable: _____

Denial Reason: _____

INFLUENZA STATUS:

Test Date, if applicable: _____

Denial Reason: _____

TB STATUS:

Test Date, if applicable: _____

Mental Health Status *(Answer as: Good, Fair, or Poor)*

REMOTE: _____ RECENT: _____ ATTENTION SPAN: _____

Assistive/Adaptive Devices

HEARING AID: _____ DENTURES: _____

OTHER DEVICES:

NOTES: _____

Sensory/Functional/Communication Limitations

VISION:	AMBULATION:	HEARING:	SPEECH:	SMELL:
☐ Normal	☐ Ambulatory			
☐ Glaucoma	☐ Non-Ambulatory			
☐ Cataracts	☐ Bedridden			
☐ Macular Degeneration				

1. ADLs

1. Orientation

CHOOSE ONE OR MORE

- ☐ Resident is ORIENTED to person, place and time and requires no staff assistance to reorient or redirect.
- ☐ Resident is NOT always oriented to time, or place, or person but does not currently require staff assistance for reorientation and/or redirection.
- ☐ Resident is NOT always oriented to time, or place, or person and DOES require staff assistance for reorientation and/or redirection.
- ☐ Resident is NOT oriented to person, place, and time and requires EXTENSIVE staff assistance including redirection.

2. Hearing

CHOOSE ONE

- ☐ No, Resident does not wear any hearing devices.
- ☐ Resident does not use a hearing device, but is hard of hearing.
- ☐ Resident has hearing device, but refuses to use and/or wear.
- ☐ Resident DOES use a hearing device or devices and is INDEPENDENT with use.
- ☐ Yes, Resident uses hearing device and requires STAFF ASSISTANCE with placing, cleaning, and removing/changing batteries. (0.5 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or from HOSPICE.

3. Vision

CHOOSE ONE OR MORE

- ☐ Resident has adequate vision without the use of a vision aide at this time.
- ☐ Resident has adequate vision with the assistance of glasses, contact lenses, or other vision device and is INDEPENDENT with use.
- ☐ Resident has adequate vision with the assistance of glasses, contact lenses, or other vision device and requires staff ASSISTANCE with use. (0.5 pts.)
- ☐ Resident has glaucoma, cataracts, macular degeneration or other visual diagnosis.
- ☐ Resident is legally blind
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or from HOSPICE.
- ☐ Resident has poor or impaired vision and does not wear glasses or contact lenses.

4. Ambulation/Mobility

CHOOSE ONE

- ☐ Resident is INDEPENDENT and is able to move around the community independently with or without assistive device.
- ☐ Resident requires REMINDERS assistance for ambulation and mobility needs.
- ☐ Resident is requires SET-UP and/or CUEING ASSISTANCE with ambulation and/or mobility needs for the duration of the task.
- ☐ Resident requires STANDBY assistance with ambulation and/or mobility needs.
- ☐ Resident requires assistance with PROPEL of WHEELCHAIR to dining/activities. (4 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of one staff member for ambulation and mobility needs due to physical or cognitive impairments. (3 pts.)
- ☐ Resident requires an EXTENSIVE ASSISTANCE with ambulation and/or mobility including the assistance of TWO staff members (non weight bearing status) (8 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or from HOSPICE for mobility/ambulation/escort assistance.

5. Transfers and Bed Mobility

CHOOSE ONE

- ☐ Resident is INDEPENDENT with transfers and bed mobility needs.
- ☐ Resident requires REMINDERS to initiate transfers but can complete independently.
- ☐ Resident requires STANDBY assistance from staff as guidance for transferring from chairs and/or bed. Resident can move or step feet for pivot.
- ☐ Resident requires PHYSICAL ASSISTANCE from staff to transfer due to cognitive or physical limitations OR requires full-body lifts (would also include resistance to care or re-direction needs). Resident is independent with bed mobility. (3 pts.)
- ☐ Resident requires EXTENSIVE assistance from staff to transfer including two staff members and/or a mechanical lift. (8 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or from HOSPICE for transfers and bed mobility.

6. Skin Integrity

INSTRUCTIONS: Select all that apply.

CHOOSE ONE OR MORE

- ☐ Resident has no current skin issues or skin evaluation score is no risk; Resident's skin intact.
- ☐ Resident has a current skin concern such as rash, skin tear or bruising and requires MONITORING
- ☐ Resident has present edema/swelling in lower extremities, upper extremities, or abdomen and requires MONITORING
- ☐ Resident has present ulcer or open areas and requires regular staff INTERVENTION to assist with current skin condition.
- ☐ Resident has a Stage 2 wound or venous stasis wound or unstageable wounds, significant history of wounds/wound care
- ☐ Resident has a Stage 3 or higher wound
- ☐ Other

7. Grooming and Hygiene

INSTRUCTIONS: Consider resident's level of assistance needed with grooming routine including brushing hair, putting on make-up, routine hygiene, shaving, etc.

CHOOSE ONE OR MORE

- ☐ Resident is INDEPENDENT and does not require reminders or assistance with grooming tasks.
- ☐ Resident requires REMINDERS to perform grooming tasks. (1 pts.)
- ☐ Resident requires SET-UP/CUING assistance to complete grooming tasks. (3 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of 1 staff member to complete grooming tasks. (5 pts.)
- ☐ Resident requires EXTENSIVE assistance with grooming tasks (including 2 staff members and/or an extended period of time due to behaviors)
- ☐ Assistance with shaving
- ☐ Assistance with makeup
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE for grooming and hygiene assistance.
- ☐ Resident uses dentures and requires assistance with cleaning and/or insertion.

8. Bathing/Showering Assistance

CHOOSE ONE

- ☐ Resident will receive one shower per week
- ☐ Resident will receive more than one shower per week.

8a. Bathing/Showering - Once Per Week

CHOOSE ONE

- ☐ Resident is INDEPENDENT and does NOT require assistance with bathing or showering. Resident completes all tasks related to bathing without hands-on help or reminders from staff (getting into and out of the shower, wash/dry self)
- ☐ Resident requires REMINDERS for bathing/showering (1 pts.)
- ☐ Resident requires SET-UP/CUING assistance for showers/bathing. Resident can initiate or complete the service on their own (placing towels, soap, shampoo, in reach). (3 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of 1 staff member for showering/bathing. (7 pts.)
- ☐ Resident requires EXTENSIVE assistance with showering/bathing (including 2 staff members and/or an extended period of time due to behaviors) (9 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE for bathing/showering assistance.

8b. Bathing/Showering - More Than Once Per Week

CHOOSE ONE

- ☐ Resident is INDEPENDENT and does NOT require assistance with bathing or showering. Resident completes all tasks related to bathing without hands-on help or reminders from staff (getting into and out of the shower, wash/dry self)
- ☐ Resident requires REMINDERS for bathing/showering (1 pts.)
- ☐ Resident requires SET-UP/CUING assistance for showers/bathing. Resident can initiate or complete the service on their own (placing towels, soap, shampoo, in reach). (3 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of 1 staff member for showering/bathing. (7 pts.)
- ☐ Resident requires EXTENSIVE assistance with showering/bathing (including 2 staff members and/or an extended period of time due to behaviors) (9 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE for bathing/showering assistance.

9. Bathing/Showering Additional Assistance

INSTRUCTIONS: Does the resident require any of the following additional bathing services?

CHOOSE ONE OR MORE

- ☐ None
- ☐ Additional showers above three times per week (5 pts.)
- ☐ Fully assisted daily bathing at sink (non-shower day) (5 pts.)

10. Dressing Assistance

CHOOSE ONE

- ☐ Resident is INDEPENDENT with dressing and can complete all tasks related to dressing and undressing without hands-on help or reminders from the staff (e.g. changing into and out of shirt, pants, undergarments, socks, and shoes).
- ☐ Resident requires REMINDERS for dressing.
- ☐ Resident requires SET-UP/CUING assistance for dressing tasks. Resident can initiate or complete the task on their own (e.g. placing clothes, undergarments, shoes and socks in reach. Resident may need help with hooking bra, socks and/or tying shoes). (1 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of 1 staff member for the duration of the service (e.g. putting on/ taking off clothes, undergarments, socks other than compression hose, shoes). (4 pts.)
- ☐ Resident requires EXTENSIVE assistance with dressing (including 2 staff members and/or an extended period of time due to behaviors). (7 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE for dressing assistance.

11. Compression Hose/Dressing Devices

INSTRUCTIONS: Select all that apply:

CHOOSE ONE OR MORE

- ☐ None
- ☐ Resident wears compression/TED hose and is INDEPENDENT with putting them on, taking them off, and cleaning them.
- ☐ Resident uses another adaptative device (contracture brace, leg/eye prosthesis, mastectomy support bra, etc.) and is INDEPENDENT with use
- ☐ Resident require staff ASSISTANCE with their compression/TED hose.
- ☐ Resident uses another adaptative device (contracture brace, leg/eye prosthesis, mastectomy support bra, etc.) and requires staff ASSISTANCE with use
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE for their ted hose and/or other adaptative device needs.

12. Toileting

INSTRUCTIONS: When evaluating resident consider the following: ability to locate restroom, manipulate clothing, clean self after toileting, change and dispose of incontinent product, flush toilet, and wash hands.

CHOOSE ONE

- ☐ Resident is INDEPENDENT with toileting needs. Resident can complete all tasks related to toileting without hands-on help or reminders from the staff.
- ☐ Resident requires REMINDERS for toileting.
- ☐ Resident requires SET-UP/CUEING for toileting needs. Resident can initiate or complete the task on their own. (3 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of 1 staff member for the duration of the service (6 pts.)
- ☐ Resident requires EXTENSIVE assistance with toileting (including 2 staff members and/or an extended period of time due to behaviors). (9 pts.)
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE for toileting assistance.

13. Continence

CHOOSE ONE OR MORE

- ☐ Resident is continent of both bowel and bladder.
- ☐ Resident is incontinent of bowel or bladder, but is INDEPENDENT with management.
- ☐ Resident is incontinent of bladder ONLY (even if occasionally incontinent) and requires staff ASSISTANCE.
- ☐ Resident is incontinent of bowel ONLY (even if occasionally incontinent) and requires staff ASSISTANCE.
- ☐ Resident is incontinent of both bowel and bladder and requires staff ASSISTANCE and/or toileting program.
- ☐ Resident uses a bedside commode
- ☐ Resident receives incontinence assistance from a PRIVATE DUTY AIDE, FAMILY, or HOSPICE.

14. Continence Products

CHOOSE ONE

- ☐ Resident does NOT need or use continence products
- ☐ Resident DOES need or wear continence products. Resident is INDEPENDENT with procurement of products through themselves, family, or other third party.
- ☐ Resident DOES need continence products and requires STAFF ASSISTANCE with procurement.
- ☐ Resident is on Medline Incontinent Package 1.
- ☐ Resident is on Medline Incontinent Package 2.

15. Indwelling Urinary Catheter

CHOOSE ONE OR MORE

- ☐ Resident does not have an indwelling urinary catheter.
- ☐ Resident has an indwelling catheter but can manage catheter care and self-cleaning with minimal oversight independently. Resident can change out bags and maintain good hygiene.
- ☐ Resident has a catheter/catheter bag and needs staff assistance to maintain cleanliness.
- ☐ Resident requires sterile catheter irrigations.
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or from HOSPICE.

16. Ostomy Care

CHOOSE ONE

- ☐ Resident does not have an ostomy.
- ☐ Resident has an ostomy and is independent with care.
- ☐ Resident has an ostomy and requires minimal assistance from care manager and/or nurse. Change ostomy bag 1 time weekly and PRN
- ☐ Resident has an ostomy and requires care manager and/or nurse assistance with changing ostomy bag more than 1X weekly and PRN
- ☐ Resident receives assistance from a PRIVATE DUTY AIDE, FAMILY, or from HOSPICE.

17. Housekeeping

CHOOSE ONE OR MORE

- ☐ Resident is INDEPENDENT with housekeeping needs.
- ☐ Resident is INDEPENDENT with housekeeping needs but still prefers staff to handle.
- ☐ Resident receives the community standard WEEKLY housekeeping services.
- ☐ Resident requires/requests DAILY spot cleaning in addition to basic housekeeping.
- ☐ Third party assists with resident's housekeeping needs (family, private duty aide, or hospice).

18. Laundry

INSTRUCTIONS: Please note if resident uses any special laundry detergent.

CHOOSE ONE OR MORE

- ☐ Resident is independent with laundry needs.
- ☐ Resident's family completes laundry.
- ☐ Resident receives the community standard laundry services: 1x WEEKLY
- ☐ Resident requires or requests laundry services more often than weekly.
- ☐ Third party assists with resident's laundry needs (family, private duty aide, or hospice).

19. Care Coordination

CHOOSE ONE OR MORE

- ☐ No
- ☐ Yes, Therapy Services
- ☐ Yes, Home Health
- ☐ Yes, Private Duty Services
- ☐ Yes, Hospice
- ☐ Yes, Other - please include details in notes

20. Does the resident require assistance procuring toiletries?

INSTRUCTIONS: If individual is NOT a MC resident skip this section.

CHOOSE ONE OR MORE

- ☐ Staff will order toiletries.
- ☐ Yes, resident is a memory care resident.
- ☐ Family or outside agency will provide toiletries.

2. Medications and Treatments

1. Medications

CHOOSE ONE

- ☐ No, resident is independent with medication management.
- ☐ Yes, resident requires 3 or less med passes per day
- ☐ Yes, resident requires 4 or more med passes per day.
- ☐ Yes, resident has a PRIVATE DUTY AIDE or other OUTSIDE PARTY assist them with medication management.

1a. Self-Administration Safety Screen

INSTRUCTIONS: Complete this review before resident starting self-administration of medication. Person completing assignment will sign along with Resident to verify information contained in these answers.

CHOOSE ONE OR MORE

- ☐ Resident is capable of reading ALL medication label.
- ☐ Resident is capable of interpreting ALL medication labels.
- ☐ Resident can identify and verbalize directions including route, time, dosage, and frequency for each and every medication.
- ☐ Resident can open the medication containers independently.
- ☐ Resident can correctly ingest, apply, or inject medications as necessary.
- ☐ Resident can correctly measure and prepare the medication (including mixing, shaking, and filling).
- ☐ Resident can safely store their medications.
- ☐ The medication dosages and instructions match the physician's orders.
- ☐ Resident will and has been informed to notify nurse of any medication changes.
- ☐ All medications on eMAR and are available for use.
- ☐ Comments (document the resident's ability to self administer medications including visual skills, coordination, problem solving, and memory) in notes.
- ☐ Not applicable
- ☐ Other

2. Medication Ordering and Preferred Pharmacy

CHOOSE ONE OR MORE

- ☐ Resident is INDEPENDENT with their medication ordering needs
- ☐ Resident requires staff assistance with ordering and uses the community's PREFERRED PHARMACY
- ☐ Resident requires staff assistance with ordering and uses a NON-PREFERRED PHARMACY (including the VA)

3. Vital Signs

INSTRUCTIONS: NOT related to Diabetic Management

CHOOSE ONE OR MORE

- ☐ Resident to receive the STANDARD monthly vitals checks.
- ☐ Resident to receive one or more vitals checks MORE than 1x MONTHLY
- ☐ Resident to receive one or more vitals checks PER WEEK
- ☐ Resident to receive one or more vitals checks PER DAY
- ☐ Blood pressure monitoring
- ☐ Weight monitoring
- ☐ Pulse monitoring
- ☐ Other vital sign
- ☐ N/A

3. Health Services

1. Does resident use a CPAP Machine?

INSTRUCTIONS: Include all relevant instructions

CHOOSE ONE

- ☐ No
- ☐ Yes, and resident is independent with application and removal of mask, and maintaining device settings.
- ☐ Yes, and the resident requires staff assistance with application and removal of mask, and maintaining device settings.

2. Does the resident use a BIPAP machine?

CHOOSE ONE

- ☐ No
- ☐ Yes, and the resident is independent with managing the device including safely applying settings, and applying/removing mask.
- ☐ Yes, and the resident requires staff assistance with application and removal of mask, and maintaining device settings.

3. Does resident require any wound care supplies?

CHOOSE ONE

- ☐ No
- ☐ Yes. (Include a description and contact information for ordering.)

4. Does resident require assistance with oxygen usage?

CHOOSE ONE

- ☐ No
- ☐ Yes, and the resident is independent with application and removal of mask, and maintaining device settings.
- ☐ Yes, and the resident requires staff assistance with application and removal of mask, and maintaining device settings.

5. Does resident require assistance with medication management?

CHOOSE ONE

- ☐ No, resident is independent with medication management.
- ☐ No, resident has a caregiver assist them with medication management.
- ☐ Yes, staff will provide medication management including ordering, refilling, storing, administration, transcription of physician orders, and communication with physician office.

6. Does the resident require any IM/SQ injection (other than insulin) provided by a skilled nurse?

CHOOSE ONE

- ☐ No
- ☐ Yes

7. Does resident require Coumadin Management

CHOOSE ONE

- ☐ No, resident does not use Coumadin.
- ☐ Yes, resident is independent with their Coumadin management.
- ☐ Yes, resident requires Coumadin Management by CMA or skilled nurse. This includes scheduling and tracking of blood work and medication changes.

8. Does resident require Diabetic Management for blood sugars or insulin?

CHOOSE ONE

- ☐ No, resident is not diabetic.
- ☐ No, resident is diabetic but is independent with Diabetic Management and does not need to assist with SQ injections, blood sugar testing and recording of blood sugars.
- ☐ Yes, resident has blood sugar checks and/or standing insulin orders daily.
- ☐ Yes, resident has 3 or more blood sugar and/or sliding insulin orders.

9. Does resident require assistance with wound care and/or Ace Wraps?

CHOOSE ONE

- ☐ No, resident's skin is intact. Resident does not have any wounds or open areas and does not require assistance with wound care or Ace Wraps.
- ☐ Yes, the resident requires daily assistance with Ace Wraps, but has no wounds.
- ☐ Resident requires daily dressings by nurse for wound care management.
- ☐ Yes, resident requires wound care, and is performed by a third party (home health, family, OR resident manages independently.)

10. Pain Management Evaluation

INSTRUCTIONS: If pain is reported, for each site list the LOCATION, LEVEL OF PAIN (1-10), and a DESCRIPTION OF THE PAIN (stabbing, burning, sharp, dull, throbbing, etc.); duration and frequency and whether it is continuous or intermittent.

CHOOSE ONE OR MORE

- ☐ Resident is NOT currently showing any signs of pain and/or does not report any pain.
- ☐ Resident IS currently reporting pain.
- ☐ Resident is unable to communicate but IS currently showing signs of pain
- ☐ Other

10a. Pain Management Assistance

INSTRUCTIONS: NOTE STEPS TAKEN TO ALLEIVATE THE PAIN.

CHOOSE ONE

- ☐ Resident independently manages their pain needs.
- ☐ Resident requires staff assistance with pain management (includes both both non-pharmacological and pharmacological interventions)
- ☐ Other

4. Dining and Nutrition

1. Dietary Preferences/Requirements

INSTRUCTIONS: (Optional)

CHOOSE ONE OR MORE

- ☐ Resident on regular diet
- ☐ Resident requires pureed diet.
- ☐ Resident requires an adaptive device i.e. (utensils/dishes/etc.) to assist with dining.
- ☐ Resident is currently taking and/or needs to take meal/nutritional supplements.
- ☐ Resident requires renal diet.
- ☐ Resident requires food to be cut into bite-size pieces.
- ☐ Resident requires staff awareness of food allergies.
- ☐ Resident requires mechanical soft diet modifications.
- ☐ Resident has experienced recent weight loss and/or other nutritional problems.
- ☐ Resident receives dialysis.
- ☐ Resident requires NCS/CCD diet.

2. Dining Assistance

CHOOSE ONE OR MORE

- ☐ Resident is INDEPENDENT with all dining needs. Resident can complete all tasks related to dining without reminders, or hands-on help from staff.
- ☐ Resident request or requires ESCORT assistance to meals (2 pts.)
- ☐ Resident requires PHYSICAL ASSISTANCE of one staff member for dining (Memory Care ONLY). (5 pts.)
- ☐ Resident has a PRIVATE DUTY AIDE and/or HOSPICE agency that assists with dining needs.
- ☐ Resident requires REMINDERS to attend meals.
- ☐ Resident requires SET-UP and/or CUEING assistance for dining. Resident can consume meal without any hands-on help from the staff. (Memory Care Only) (3 pts.)
- ☐ Resident requires EXTENSIVE assistance with dining (Memory Care ONLY) (7 pts.)
- ☐ Dysphagia intervention/assist (6 pts.)

3. Hydration

CHOOSE ONE OR MORE

- ☐ Resident INDEPENDENT with fluid management
- ☐ Staff will encourage resident to drink one glass of liquid at each meal and in between meals
- ☐ Other
- ☐ Resident requires ONE PERSON assistance including hospice
- ☐ Resident requires altered liquidation hydration including honey or thickened

5. Safety and Risk

1. Call System

CHOOSE ONE OR MORE

- ☐ Resident CAN utilize the call system and make needs known.
- ☐ Excessive nurse call usage
- ☐ Resident CANNOT utilize the call system and/or make needs known.
- ☐ Resident resides in Memory Care and does not utilize the call system.

2. Microwave Usage

CHOOSE ONE

- ☐ Resident does not have a microwave or oven in their room
- ☐ Resident does have a microwave or oven in their room and wants to use it independently

2a. Microwave Use Evaluation

CHOOSE ONE OR MORE

- ☐ Resident understands the microwave settings, puts appropriate items in the microwave, does not leave food unattended in the microwave, uses appropriate holders when removing hot items from microwave and cleans up as needed.
- ☐ Resident does not understand microwave settings, has put unsafe items into the microwave, has left food unattended in the microwave, does not clean up as needed when using microwave.

2b. Microwave Safety Evaluation

CHOOSE ONE

- ☐ Resident DOES know what to do if a food item burns and/or catches fire.
- ☐ Resident does NOT know what to do if a food item burns and/or catches fire.

3. Sleep Patterns

CHOOSE ONE OR MORE

- ☐ Resident is INDEPENDENT with wake up and nighttime routines and has regular sleep patterns.
- ☐ Resident demonstrates or verbalizes a sleep cycle disturbance/insomnia
- ☐ Resident requires extensive and additional assistance from care manager to get out of bed due to non-compliance.
- ☐ Resident requires/requests a wake up “call” or reminder
- ☐ Yes, resident will receive spot checks twice NIGHTLY for safety.
- ☐ Other

4. Spot checks

CHOOSE ONE OR MORE

- ☐ Resident does NOT require spot checks
- ☐ Resident requires interventions with specific instructions in addition to Q shift spot checks.
- ☐ Yes, resident will receive Q shift spot checks
- ☐ Yes, the resident is a MEMORY CARE resident and will receive hourly spot checks as part of the MEMORY CARE package.

5. Evacuation Level of Assistance

CHOOSE ONE

- ☐ Resident is independent with mobility with or without assistive device; resident has shown no evidence of being resistant to evacuate; resident is alert and oriented; resident is able to follow instructions; resident is aware of the back up plan in case of fire or evacuation; and resident is willing to stay in the evacuated position.
- ☐ Resident is independent with mobility but needs staff VERBAL CUEING assistance with evacuation due to being distracted, hard of hearing, groggy, in need of extra encouragement during a stressful situation, or may need light assistance with their adaptive device.
- ☐ Resident requires the assistance of ONE STAFF for evacuation due to mild resistance to evacuation, difficulty with mobility, maneuvering stairs, getting out of bed, confusion or mental status, lack of understanding of instructions, visual or hearing impairment, or emotionally unstable in stressful situations.
- ☐ Resident requires the assistance of TWO STAFF for evacuation due to strong resistance to being evacuated, inability to ambulate, wheelchair bound, or has wandering extensively during previous fire drills.
- ☐ Unable to determine at this time.

6. Resident use of tobacco, alcohol, and other drugs. Select all that apply

CHOOSE ONE OR MORE

- ☐ Resident does NOT smoke any substance, vape, and has no history of smoking or tobacco or recreational marijuana use.
- ☐ Resident does not currently smoke, vape, or use tobacco but has a HISTORY of using tobacco or recreational marijuana products.
- ☐ Resident has a known history of tobacco and/or recreational marijuana use but is not on oxygen therapy.
- ☐ Resident has a known history of tobacco and/or recreational marijuana use and is currently on OXYGEN therapy.
- ☐ Resident currently or has a history of taking recreational marijuana edibles.
- ☐ Resident does NOT currently use alcohol excessively and does NOT have a known history of alcohol abuse
- ☐ Resident currently uses alcohol AND has a known history of alcohol abuse
- ☐ Resident does not currently use illegal drugs and does not have a known history i.e. heroin, methamphetamines, cocaine, other
- ☐ Resident currently uses illegal drugs OR has a known history i.e. heroin, methamphetamines, cocaine, other
- ☐ Other

7. Psychosocial Issues - History

INSTRUCTIONS: Does resident have a HISTORY with any of the following:

CHOOSE ONE OR MORE

- ☐ No psychosocial issues; resident's emotional states do not create an unusual demand on others.
- ☐ Family has voiced a fear of loved one being "left alone" in ALF. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ NOT capable of independent decision making or exhibits bad judgment. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Dresses in excessive layers of clothing. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Hoarding/squirreling; hiding items. Staff to assist with daily decluttering.
- ☐ Known history or current history of suicidal ideations. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Anxious/paranoid or suspicious tendencies. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Diagnosis of depression OR mental health history OR withdrawn from others. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Demonstrates obsessive/ repetitive tendences or needs repetitive reassurances. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Verbally aggressive and/or inappropriate behaviors. May not be appropriate for ASSISTED LIVING. Coordinate with corporate contact for confirmation.
- ☐ Hallucinations or delusions. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Psychiatric diagnosis that required in-patient treatment. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Demonstrates sexually inappropriate tendencies/history of sexual behaviors/aggressiveness. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Episodes of physical aggression/physical harm to others or self. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Other

8. Psychosocial Issues - Current

INSTRUCTIONS: Does resident CURRENTLY have any of the following:

CHOOSE ONE OR MORE

- ☐ No psychosocial issues; resident's emotional states do not create an unusual demand on others.
- ☐ Family has voiced a fear of loved one being "left alone" in ALF. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ NOT capable of independent decision making or exhibits bad judgment. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Dresses in excessive layers of clothing. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Hoarding/squirreling; hiding items. Staff to assist with daily decluttering.
- ☐ Known history or current history of suicidal ideations. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Anxious/paranoid or suspicious tendencies. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Diagnosis of depression OR mental health history OR withdrawn from others. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Demonstrates obsessive/ repetitive tendences or needs repetitive reassurances. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Verbally aggressive and/or inappropriate behaviors. May not be appropriate for ASSISTED LIVING. Coordinate with corporate contact for confirmation.
- ☐ Hallucinations or delusions. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Psychiatric diagnosis that required in-patient treatment. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Demonstrates sexually inappropriate tendencies/history of sexual behaviors/aggressiveness. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ History of physical aggression/physical harm to others or self. Staff to provide support and safety checks Q shift in addition to spot checks.
- ☐ Other

9. Mental or Behavioral Assistance

INSTRUCTIONS: Based on the resident's current status and history, please select the level of staff assistance that is appropriate.

CHOOSE ONE

- ☐ Resident exhibits socially appropriate interaction with other residents and staff. Resident does NOT need any staff monitoring or intervention for their current or past mental and/or behavioral issues.
- ☐ Resident requires OCCASIONAL (1-3x per DAY) staff redirection and/or reorientation for their current or past mental and/or behavioral issues. (1 pts.)
- ☐ Resident requires FULL STAFF ASSISTANCE with regular (4+ per DAY) redirection and/or reorientation for resident's current or past mental and/or behavioral issues. Resident is easily re-directed back to an activity or meal when they become distracted or lose focus. They do NOT become agitated, upset or appear to have a change in mood based on the staff intervention. (4 pts.)
- ☐ "Sundowns" requiring more interaction from staff. (6 pts.)
- ☐ Resident requires EXTENSIVE (5+ times per day with overnight checks) staff redirection and/or reorientation for their current or past mental and/or behavioral issues. Resident may wander to the point of exhaustion, may ask questions repeatedly, use call bell excessively, becomes anxious agitated, fearful, or changes moods when re-directed. (10 pts.)
- ☐ Resident can become aggressive towards staff or other residents and/or is abusive and combative. (8 pts.)
- ☐ Reflections day program (25 pts.)

6. Fall Risk Evaluation

1. INSTRUCTIONS

INSTRUCTIONS: Evaluate the resident status in the eight clinical condition parameters listed below by assigning the corresponding score which best describes the resident. Add the total points from each question to obtain the TOTAL SCORE.

CHOOSE ONE

- ☐ I have read and understand the instructions.

2. MENTAL STATUS

CHOOSE ONE

- ☐ Oriented x3 (time, place, person) - 0 POINTS
- ☐ Disoriented x1 - 1 POINT
- ☐ Disoriented x2 - 2 POINTS
- ☐ Disoriented x3 - 4 POINTS
- ☐ Wanders - 4 POINTS

3. HISTORY OF FALLS (Past 3 Months)

CHOOSE ONE

- ☐ No Falls in the past 3 months - 0 POINTS
- ☐ 1-2 Falls in the past 3 months - 2 POINTS
- ☐ 3 or More Falls in the past 3 months - 4 POINTS

4. ELIMINATION STATUS

CHOOSE ONE

- ☐ Regularly continent - 0 POINTS
- ☐ Requires regular assist with elimination - 2 POINTS
- ☐ Regularly incontinent - 4 POINTS
- ☐ Gets up at night to void - 4 POINTS

5. VISION STATUS

CHOOSE ONE

- ☐ Adequate (with or without glasses) - 0 POINTS
- ☐ Poor (with or without glasses) - 2 POINTS
- ☐ Legally blind - 4 POINTS

6. GAIT/BALANCE/AMBULATION

INSTRUCTIONS: Indicate appropriate point value for each item that applies.

CHOOSE ONE OR MORE

- ☐ Gait/balance normal - 0 POINTS
- ☐ Balance problem while standing/walking - 1 POINT
- ☐ Decreased muscular coordination/jerking movements - 1 POINT
- ☐ Change in gait pattern when walking (i.e. shuffling) - 1 POINT
- ☐ Requires use of assistive devices (i.e. cane, w/c, walker, furniture) - 1 POINT
- ☐ Wears thick, soft-soled, or ill-fitting shoes - 2 POINTS

7. BP LYING/STANDING

INSTRUCTIONS: **Report results to MD**

CHOOSE ONE

- ☐ NO noted drop between lying and standing - 0 POINTS
- ☐ Drop in SYSTOLIC BP of 20 or More - 4 POINTS
- ☐ Drop in DIASTOLIC BP of 10 or More - 4 POINTS

8. MEDICATIONS

INSTRUCTIONS: Respond below based on the following types of medications: Antihistamines, Antihypertensive, Antiseizure, Benzodiazepines, Diuretics, Hypoglycemic, Insulin, Narcotics, Psychoactive, Sedatives/Hypnotics

CHOOSE ONE OR MORE

- ☐ NONE of these medications taken currently or within the last 7 days - 0 POINTS
- ☐ TAKES 1-2 of these medications currently and/or within the last 7 days - 2 POINTS
- ☐ TAKES 3-4 of these medications currently and/or within the last 7 days - 4 POINTS
- ☐ If resident has had a change in medication and/or change in dosage in the past 5 days, select and score 1 additional point - 1 POINT

9. CHRONIC CONDITIONS

INSTRUCTIONS: Respond below based on the following predisposing conditions: Hypo/Hypertension, Vertigo, CVA, Parkinson's Disease, Loss of limb(s), Seizures, Arthritis, Pain, Fractures, Heart Failure, COPD/Breathing problems, Cancer, Kidney disease, Diabetes, Dementia

CHOOSE ONE

- ☐ None present - 0 POINTS
- ☐ 1-2 present - 2 POINTS
- ☐ 3 or More present - 4 POINTS

10. TOTAL SCORE/FALL RISK LEVEL

INSTRUCTIONS: Add up the total points from the eight previous questions to get the total score and associated Fall Risk Level.
Low Risk: 0-4 Points
Medium Risk: 5-9 Points
High Risk: 10+ Points

CHOOSE ONE

- ☐ LOW Fall Risk (0-4 Points)
- ☐ MEDIUM Fall Risk (5-9 Points)
- ☐ HIGH Fall Risk (10+ Points) (5 pts.)

7. Elopement Risk Evaluation

1. Instructions

INSTRUCTIONS: Assess the resident status in the seven clinical areas below by assigning the corresponding score which best describes the resident. Add the numbers from each question to obtain the total score. If the total score is 10 or greater, the resident should be considered at risk for elopement. Prevention protocols should be followed and documented on the care plan.

CHOOSE ONE

- ☐ I read and acknowledge the instructions.

2. Mobility

CHOOSE ONE

- ☐ Needs total assistance - 0 POINTS
- ☐ Propels self/some assist - 2 POINTS
- ☐ Fully ambulatory - 4 POINTS

3. Mental Stability

CHOOSE ONE

- ☐ Alert, oriented x3 - 0 POINTS
- ☐ Disoriented/no wandering - 2 POINTS
- ☐ Wanders aimlessly - 4 POINTS

4. Emotional Status

CHOOSE ONE

- ☐ Happy with placement - 0 POINTS
- ☐ Content with placement - 2 POINTS
- ☐ Voices desire to leave - 4 POINTS

5. History of Elopement Attempts

CHOOSE ONE

- ☐ No attempt - 0 POINTS
- ☐ Voices, but no action - 4 POINTS
- ☐ Had made 1 or more attempts - 10 POINTS

6. Behavior Modification

CHOOSE ONE

- ☐ No behaviors noted - 0 POINTS
- ☐ Behavior redirected - 2 POINTS
- ☐ Difficult to redirect - 4 POINTS

7. Medications (dementia, other brain disorders, any mental illness)

CHOOSE ONE

- ☐ None present - 0 POINTS
- ☐ One present - 2 POINTS
- ☐ Two or more present - 4 POINTS

8. Total Score/Elopement Risk

INSTRUCTIONS: Add the associated points from the seven questions above to obtain the resident's total score.

CHOOSE ONE

- ☐ 0-9 Total Points - Resident is at low/medium risk for elopement and requires regular MONITORING.
- ☐ 10 or More Points - Resident is at HIGH risk for elopement and requires staff assistance through regular INTERVENTIONS.

8. MMSE

1. Orientation: What is the (YEAR) (SEASON) (DATE) (DAY) (MONTH)?

INSTRUCTIONS: Give one point for each correct answer.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points
- ☐ 4 points
- ☐ 5 points

2. Orientation: Where are we (STATE) (COUNTRY) (TOWN) (FACILITY) (FLOOR)?

INSTRUCTIONS: Give one point for each correct answer.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points
- ☐ 4 points
- ☐ 5 points

3. Registration

INSTRUCTIONS: Name 3 objects: 1 second to say each. Then ask the resident all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points

4. Attention and Calculation: Serial 7's

INSTRUCTIONS: Serial 7's (Count backward from 100 by 7s).

1 point for each correct answer. Stop after 5 answers.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points
- ☐ 4 points
- ☐ 5 points

5. Attention and Calculation: Alternate

INSTRUCTIONS: Alternatively, spell "WORLD" backward.

1 point for each correct answer. Stop after 5 answers.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points
- ☐ 4 points
- ☐ 5 points

6. Recall

INSTRUCTIONS: Ask for the 3 objects repeated above from Question 3. Give 1 point for each correct answer.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points

7. Language: Name a pencil and watch

INSTRUCTIONS: Give 1 point for each

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points

8. Language: I would like you to repeat a phrase after me: No ifs, ands or buts

INSTRUCTIONS: Score one point for a correct repetition. Must be exact, e.g. no ifs or buts, score 0).

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point

9. Language: Follow a 3 stage command

INSTRUCTIONS: "Take a paper in your hand, fold it in half, and put it on the floor."

Give 1 point for each

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point
- ☐ 2 points
- ☐ 3 points

10. Language: Read the following and do what it says: CLOSE YOUR EYES

INSTRUCTIONS: Show resident the sentence on sheet.
If resident reads successfully, give 1 point.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point

11. Language: Write a sentence.

INSTRUCTIONS: Time: 30 seconds
Hand the person a pencil and paper (Page 3). Say: Write any complete sentence on that piece of paper (This sentence should contain a noun and a verb).
Score one point. The sentence must make sense. Ignore spelling errors.

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point

12. Language: Copy the design

INSTRUCTIONS: Show resident the following design via link or sheet: [INSERT LINK]

Give 1 point for each

CHOOSE ONE

- ☐ 0 points
- ☐ 1 point

13. Total Score

INSTRUCTIONS: Add the total points from previous questions - maximum of 30.

ANSWER

_____

_____

14. Classification

CHOOSE ONE

- ☐ Less than 10
- ☐ 10-14
- ☐ 15-20
- ☐ 21-26
- ☐ Greater than 26

9. Geriatric Depression Screening

1. Is a geriatric depression screening needed or required?

CHOOSE ONE

- ☐ Yes
- ☐ No

2. Are you basically satisfied with your life?

CHOOSE ONE

- ☐ Yes
- ☐ No (+1)

3. Have you dropped many of your activities and interests?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

4. Do you feel that your life is empty?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

5. Do you often get bored?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

6. Are you in good spirits most of the time?

CHOOSE ONE

- ☐ Yes
- ☐ No (+1)

7. Are you afraid that something bad is going to happen to you?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

8. Do you feel happy most of the time?

CHOOSE ONE

- ☐ Yes
- ☐ No (+1)

9. Do you often feel hopeless?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

10. Do you prefer to stay at home, rather than going out and doing things?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

11. Do you feel that you have more problems with memory than most?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

12. Do you think it is wonderful to be alive now?

CHOOSE ONE

- ☐ Yes
- ☐ No (+1)

13. Do you feel worthless the way you are now?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

14. Do you feel full of energy?

CHOOSE ONE

- ☐ Yes
- ☐ No (+1)

15. Do you feel that your situation is hopeless?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

16. Do you think that most people are better off than you are?

CHOOSE ONE

- ☐ Yes (+1)
- ☐ No

17. Total Score

INSTRUCTIONS: A score greater than or equal to 5 suggests depression

CHOOSE ONE

- ☐ 4 or LESS
- ☐ 5 or MORE

10. Social Profile and Life Enrichment

1. Interests and Hobbies

INSTRUCTIONS: Select all that apply

CHOOSE ONE OR MORE

- ☐ Reading - books, newspapers, magazines, etc.
- ☐ Social gatherings (happy hours, coffee breaks, theme parties, intergenerational gatherings, etc.)
- ☐ Theater / Movies / Live Events
- ☐ Music / Live music / Dancing
- ☐ Gardening
- ☐ Volunteering
- ☐ Religious or Spiritual services / activities / Meditation
- ☐ Political participation / Current Events / News
- ☐ Writing / Journaling / Emotional / Mental Health
- ☐ Painting / Drawing / Sculptures / Crafts
- ☐ Knitting / Crocheting / Sewing / Beading
- ☐ Exercise and Nutrition / Hiking / Walking / Yoga / Pickleball
- ☐ Food / Snacks / Meals
- ☐ Travelling
- ☐ Family time / visits
- ☐ Shopping
- ☐ Intellectual / Continuing education / Lectures
- ☐ Sporting events
- ☐ Games / Board Games / Bingo / Puzzles
- ☐ Technology / Wii / Video Games / Virtual Reality
- ☐ Napping
- ☐ Other

2. Activity Participation

CHOOSE ONE OR MORE

- ☐ Resident prefers 1:1 activities
- ☐ Resident prefers solo activities
- ☐ Resident prefers group activities
- ☐ Resident prefers both group and solo activities
- ☐ Resident prefers daily contact with family/friends
- ☐ Resident prefers attending religious activities
- ☐ Resident requires reminders to attend activities.
- ☐ Requests or requires ESCORT assistance to and from activities
- ☐ Requests or requires assistance while participating in activities
- ☐ Other

3. Transportation

CHOOSE ONE

- ☐ Resident does NOT require/request assistance arranging transportation to medical and non-medical appointments.
- ☐ Resident DOES require/request assistance arranging medical appointments.
- ☐ N/A

11. Acknowledgement

1 Required Questions

* 1. Points - Minutes Equivalence

CHOOSE ONE

- ☐ The point totals on this assessment are equivalent to minutes.

Care Levels and Point Ranges

Level	Point Range
AL	
Basic	0 - 32
Level 1	33 - 59
Level 2	60 - 89
Level 3	90 - 119
Level 4	120 - 148
Level 5	149
MC	
Level 1	0 - 150
Level 2	151 - 180
Level 3	181

Signatures

1.

NAME	TITLE	SIGNATURE	DATE

2.

NAME	RELATIONSHIP	SIGNATURE	DATE

3.

NAME	RELATIONSHIP	SIGNATURE	DATE

SCHEDULE OF FEES (RESIDENT SUMMARY OF FEES)

Resident Name:_____ **Apartment #**_____ **Date:**_____

Social Security Number:_____ **Scheduled Move-in Date:**_____

Fee Summary

Monthly Basic Rate ☐AL ☐MC	$_____
Community Fee (one-time charge; nonrefundable)	$_____
Deposit (applied towards first month's rate)	$_____
Level of Care Fee (*if applicable*)	$_____
Spouse / 2nd Person (*if applicable*)	$_____
Respite Fee (*if applicable*)	$_____
MONTHLY TOTAL	**$_____**

Billing / Mailing Address:

Name:_____

Phone number: _____

Email Address: _____

Address:_____
(House # and Street) (City) (State) (Zip Code)

Relationship to Resident: ☐ Resident ☐ Resident Representative

---

By signing below, I acknowledge that I have read and understand the above-listed fees. I hereby agree to the Schedule of Fees effective as of _____.

Resident's Signature	Print Name	Date
Resident's Representative's Signature (*if applicable*)	Print Name	Date
Operator/Operator's Representative Signature	Print Name	Date

COMMUNITY SCHEDULE OF FEES

Fees Due Prior To or At Admission

Community Fee (One-time charge)	$ One Month's Basic Rate
Deposit (Applied towards First Month's Fees)	$1,000.00

Monthly Basic Rates

Assisted Living (AH/EHP) (starting at)	$6,000.00
Spouse / 2nd Person	$1,500.00
Reflections (Memory Care) (starting at)	$8.000.00
Spouse / 2nd Person	$3,500.00
Respite Fee (Does NOT include Room/Board or Care)	$800.00 add'l

Customized Support Assessment Fees (Level of Care Fees)

Assisted Living (ALR/EALR) (EHP)		***Reflections* (Memory Care) ***	
Basic	$0	**Semi-private**	$8,000.00/month
Level 1	$1,300.00/month	**Private**	$9,500.00/month
Level 2	$1,900.00/month		
Level 3	$2,500.00/month		
Level 4	$3,100.00/month		
Level 5	$3,700.00/month		

*** Rates are All-inclusive**

Medication Administration Assistance Fees

Medication Administration Assistance is included in the monthly base rate for all AL levels and all *Reflections* residents.

Late Payment Fees

A late fee in the amount of 1.5 % will be assessed on any outstanding monthly balance not paid by the fifth (5th) calendar day of each month.

Resident (or Resident's Representative's) Initials _____

COMMUNITY SCHEDULE OF FEES (*continued*)

Additional Services Fees

1. Clinical Services	
Emergency Pendant Replacement Fee	$150.00
Medical supplies, toiletries, dietary supplements incontinence products	Billed directly by Pharmacy
2. Guest Meal Services	
Breakfast	$10.00
Lunch	$15.00
Dinner	$20.00
3. Pet Services	
Deposit (refundable if no damage)	$500.00
Monthly Pet Fee	$30.00
4. Salon Services	As posted
5. Telephone Services	$35/month
6. Transportation Services	
Medical Transportation	No charge if within 4–6-mile radius
Trips / Special functions (Arranged through Life Enrichment Director)	Cost determined prior to services

Resident (or Resident's Representative's) Initials _____

Exhibit VIII.

RESIDENCE PROVIDERS AND LICENSURE/CERTIFICATION STATUS

Internal Medicine:
Maria Cahill, NP
License # 305969
Saturdays
Phone: 718.309.3867

Dr. Joseph Halio
License # 156815
241 East Shore Rd.
Great Neck, NY 11023
Tuesdays
Phone: 516.482.7632

Dr. Ed Benmen
License #184465
260-21 Union Tpke.
Glen Oaks, NY 11004
Thursdays
Phone: 718.347.4288

Dr. Dinesh Sethi
20 Meadowbrook Ln.
Glen Head, NY 11545
Fridays

Dentist:
On Site Provider Dentist
Mobile Dentist
Tuesdays
Phone: 866.411.2126 or
646.533.3313

Laboratory
Xeron Clinical Labs
43-65 147th Street
Flushing, NY 11355
Phone: 718.762.3310

Medical Supplies
MedLine

Optometrist:
SiteMD-Savoy Medical Plaza-Lower Level
55-15 Little Neck Parkway
Little Neck, NY 11362
Phone: 718.352.6700

X-Ray/Sonogram
Specialty Portable
99 Jericho Turnpike Suite 204
Jericho, NY 11753
Phone: 888-972-8669 (888-xray-now)

Psychiatrist:
Silverline NP Care
58-36 254 Street
Little Neck, NY 11362
Phone: 718.225.2030

Providers (*continued*)

Physical Therapist:
Metro Physical & Aquatic Therapy
800 East Gate Blvd.
Garden City, NY 11530
Phone: 516.304.5668

Podiatrist:
Mark Gasparini, DPM
License # 006114
119 New York Ave.
Massapequa NY 11758
Phone: 516.804.9038

Pharmacies:
IPPC of New York
275 Grand Blvd.
Westbury NY 11590
Phone: 516.544.4311

Town Pharmacy
96 Horace Harding Blvd.
Great Neck, NY
Phone: 516-439-5380

Exhibit IX.

CONSUMER INFORMATION GUIDE: ASSISTED LIVING RESIDENCE

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INTRODUCTION

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

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

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

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

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

WHAT IS AN ASSISTED LIVING RESIDENCE (ALR)?

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

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

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

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

WHO OPERATES ALRs?

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

PAYING FOR AN ALR

It is important to ask the ALR what kind of payment it accepts. Many ALRs accept private payment or long term care insurance, and some accept Supplemental Security Income (SSI) as the primary method of payment. Currently, Medicaid and Medicare will NOT pay for residing in an ALR, although they may pay for certain medical services received while in the ALR.

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

TYPES OF ALRs AND RESIDENT QUALIFICATIONS

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

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

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

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

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

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

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

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

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

a) The resident hires 24-hour appropriate nursing and medical care to meet their needs;

b) The resident's physician and home care services agency decide his/her care can be safely delivered in the Enhanced ALR;

c) The operator agrees to provide services or arrange for services and is willing to coordinate care; and

d) The resident agrees with the plan.

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

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

An example of a person who could be in a Special Needs ALR, is one who develops dementia with associated problems, needs 24-hour supervision, and needs additional help completing his or her activities of daily living. The Special Needs ALR is required to have a specialized plan to address the person's behavioral changes caused by dementia. Some of these changes

may present a danger to the person or others in the Special Needs ALR. Often such residents are provided medical, social or neuro-behavioral care. If the symptoms become unmanageable despite modifications to the care plan, a person may need to move to another level of care where his or her needs can be safely met. The ALR's case manager is responsible to assist residents to find the right residential setting to safely meet their needs.

Comparison of Types of ALRs

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

HOW TO CHOOSE AN ALR

VISITING ALRs: Be sure to visit several ALRs before making a decision to apply for residence. Look around, talk to residents and staff and ask lots of questions. Selecting a home needs to be comfortable.
Ask to examine an "open" or "model" unit and look for features that will support living safely and independently. If certain features are desirable or required, ask building management if they are available or can be installed. Remember charges may be added for any special modifications requested.

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

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

Location: Is the residence close to family and friends?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADMISSION CRITERIA AND INDIVIDUALIZED SERVICE PLANS (ISP)

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

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

APPLYING TO AN ALR

The following are part of entering an ALR:

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

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

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

An Assisted Living Model Residency Admission Agreement is available on the New York State Health Department's website at:
http://www.nyhealth.gov/facilities/assisted_living/docs/model_residency_agreement.pdf .

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

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

Financial Information: Ask what types of financial documents are needed (bank statements, long term care insurance policies, etc.). Decide how much financing is needed in order to qualify to live in the ALR. Does the residence require a deposit or fee before moving in? Is the fee refundable, and, if so, what are the conditions for the refund?

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

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

LICENSING AND OVERSIGHT

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

INFORMATION AND COMPLAINTS

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

Glossary of Terms Related to Guide

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



State of New York
Department of Health

1505 12/10

Exhibit X.

RULES OF THE RESIDENCE

1. The Resident will use the suite and the Community for residential dwelling purposes only and will comply, at all times, with the rules and policies of the community as in effect from time to time. The Resident acknowledges that the Resident has read the rules and policies of the community and agrees to comply therewith. The Resident further acknowledges that the community may amend these rules and policies and will notify Resident of any such amendments or modifications with an advanced 30 days' notice.

2. The Resident will be the sole occupant of the suite except that another individual ("Second Resident") may occupy the suite subject to the following two conditions: First, such person must meet all requirements for admission to the Community as determined by the Community. Second, the Community and the Second Resident must execute a separate Residency Agreement. The Resident and the Second Resident must execute a separate Residency Agreement. The Resident and the Second Resident will each pay the Community Fee listed on the Schedule of Fees.

3. If the Second Resident is a spouse, a special Spouse 2nd Person fee shall apply while both occupants reside in the same unit and the primary fees are being paid as well. In the event only one resident is occupying the unit, the Spouse 2nd Person fees shall no longer apply and the occupant will pay the primary fees.

4. The Resident will not destroy, deface, damage, impair or remove any part of the suite or building.

5. The Resident will not alter the suite in any manner without the prior written consent of the Operator.

6. The Resident acknowledges that he or she has had an opportunity to inspect the suite and the Resident accepts the suite in its "as is" condition.

7. The Resident will vacate the suite immediately upon termination of this Agreement, remove all of the Resident's property and deliver possession of the suite and the community's furniture, equipment, appliances, and fixtures to the community in the same condition as of the date of this Agreement, reasonable wear and tear is accepted. The Resident will pay the cost of removing and storing any property of the Resident remaining in the suite after termination of this Agreement.

8. The Resident represents to the Operator that all oral and/or written statements made or furnished by, or on behalf of, the Resident in connection with the Resident's application for admission to the Community are true and correct in all respects.

9. The Resident agrees to allow a community representative to enter the Resident's suite for the following purposes:

    a) To conduct necessary inspections, repairs, alterations and improvements, and to carry out the Operator's obligation to provide assisted living services needed by the Resident.
    b) When there is· good reason to believe that a Resident requires assistance, such as a response or lack of response to an emergency signaling device.
    c) When there is good reason to believe that the Resident may have damaged the suite.
    d) The community will respect the Resident's privacy and will schedule entry in advance, when possible, and will make their presence known (except in emergency situations) when entering the Resident's suite.

10. The Resident will provide the Community with a completed physician's report on the form provided by the Community that conforms to regulations of the New York State Department of Health. This report must include a screening for tuberculosis, done through either a PPD or chest x-ray, or QuantiFERON, and state that the Resident is free of tuberculosis in a communicable form. This physical examination must be conducted within the thirty (30) day period prior to move-in and once every 12 months or more frequently if a change in condition warrants.

11. Informing the community promptly of change in health status, change in physician, or change in medications.

12. The Resident is responsible for payment of all medical expenses including transportation for medical purposes, except when payments are under Medicare, Medicaid or other third party coverage, or transportation provided as a courtesy by the community.

13. The community recommends review of this Agreement by an attorney or other representative chosen by the Resident.

14. The Resident will behave and require others on the premises with the Resident's consent to behave in a civil manner that will not cause unreasonable distress, discomfort, annoyance, disturbance or inconvenience to other residents, employees, and management.

15. The Resident will avoid making or permitting loud or disturbing noises; not cause odors or disturbances; not place foreign matter in toilets or sinks; not obstruct or permit to be obstructed sidewalks, driveways, hallways or parking areas; not store flammable or toxic materials; not leave rubbish or personal articles in hallways or common areas; shall not install exterior antennas without consent; not change locks without consent; not use the apartment in any manner that is offensive, improper or contrary to any law or ordinance.

16. If the Resident is taking psychotropic drugs or has a history of aggressive behavior, the Resident will provide to the Operator a report of a current psychiatric examination prior to move-in to determine if the Resident's needs can be met in the community. After move-in, the Operator may require a psychiatric consultation when the Operator, in consultation with the Resident's physician, determines that the Resident's condition warrants such.

17. The Operator will provide case management services to assist the Resident. The Resident agrees to maintain his/her own physician and to provide the case management services director any paperwork, physicians' orders, or new appointments.

18. All medications, including prescriptions and over-the-counter drugs and medical supplies must be ordered by a physician, be properly labeled, and be kept locked in the drug cart or the medicine room unless the resident has been assessed and approved for self-administration of medications. No medications or medical supplies of any type are permitted in the resident's room unless approved and ordered by your physician.

19. No smoking is permitted inside the premises of the community. Smoking is allowed only in the designated outside smoking area. Violation of this policy by a resident or his/her guest may result in the resident being asked to move out of the community.

20. All residents and guests are required to sign in and out of the community. The sign in/ sign out book is located in the main lobby at the concierge desk.

21. Residents are permitted to have a pet provided that all conditions of the Pet Addendum (if applicable) are met and authorized.

22. Firearms, weapons and ammunition are strictly prohibited.

Exhibit XI.

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 other 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 the 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 the 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 to respect the person 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;

(P) Every Resident shall have the right to written notice of any fee increase not less than forty- five days prior to the proposed effective date of the fee increase, however providing additional services to a resident shall not be considered a fee increase pursuant to this paragraph; and

(Q) Every Resident of an assisted living residence that is also certified to provide Enhanced Assisted living and/or Special Needs Assisted Living shall have a right to be informed by the Operator, by a conspicuous posting in the residence, on at least a monthly basis, of the then-current vacancies available, if any, under the Operator's Enhanced and/or Special Needs Assisted Living Programs.

WAIVER OF ANY OF THE 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 XII.

RESIDENT GRIEVANCE POLICY AND PROCEDURES

Policy: All residents have the right to present their concerns to the proper authorities.

Procedures: Residents and/or their Representative may present their concerns to the Residence Staff and/or the Executive Director.

Residents and/or their Representative may address any concerns or complaints directly with the appropriate Department Head and/or Executive Director, Associate Executive Director at any time.

Resident and/or their Representative will be informed of action and resolution by the Executive Director or Designee verbally (in writing if requested) within fourteen (14) days' time.

All Grievances and recommendations will be kept confidential if requested by Resident and/or their Representative. All anonymous grievances can be placed in the secured suggestion box located at the Community front desk. All anonymous grievances will be addressed at the next occurring Resident Council Meeting.

The Resident may address grievances to the following outside representatives when the Resident feels their grievances have not been properly resolved through the Community's grievance procedure:

New York State Office for the Aging
2 Empire State Plaza
Albany, NY 12223-1251
NYSOFA Senior Citizens' Help Line 1-800-342-9871

Long Term Care Ombudsman Program
Kathleen Bartley – (929) 719-4373
kathleen.bartley@fsl-li.org
www.ltcombudsman.ny.gov

This may be done without fear of reprisal in any form and they will receive a prompt and reasonable response. Our doors are always open and we will make every effort to promptly and equitably resolve problems that are brought to our attention.

Exhibit XIII.

PHOTOGRAPHY RELEASE

I,_____, hereby give Brandywine Assisted Living at The Savoy permission to use photographs or videos taken of me. I understand that these may be used for public relations, presentation and promotion purposes and to help others in the community better understand the concept of senior living. I understand that I will receive no compensation if any of the photographs or videos are to be used.

Resident's Signature	Print Name	Date
Resident's Representative Signature (*If applicable*)	Print Name	Date
Resident's Legal Representative Signature (*If applicable*)	Print Name	Date
Operator/Operator's Representative Signature	Print Name	Date

Exhibit XIV.

PET ADDENDUM
(*if applicable*)

Resident Name:_____Apartment#:_____

Please Complete if you are bringing a pet to the Residence:

The Operator/Operator's Representative consents to Resident keeping in their Apartment the household pet described below:

Type of animal: _____Breed: _____
(Dogs only breeds not permitted: Chows, German Shepherds, Pit bulls, and Rottweilers)

Pet Name: _____Color: _____Height: _____
(maximum height permitted is 18 inches)

Age: _____Weight: _____
(maximum weight permitted is 30 pounds)

AGREEMENT

1. Responsibilities of the Resident:

1.1. The Resident will keep the pet in Resident's Apartment, except when walking the pet, if applicable, or transporting it to and from their Apartment. In addition, the Resident agrees to pay the Pet Deposit set forth in the Schedule of Fees. The Resident will not allow the pet in building lobbies or in common areas of the Residence and will transport the pet to and from the Resident's Apartment only by designated entrances of the building. The Resident will walk and curb the pet only in designated areas and will be responsible for cleaning up after the pet.

1.2. When the pet is not in the Resident's Apartment, the Resident will keep the pet on a leash no longer than five (5) feet, in a cage/crate or other appropriate, closed, and ventilated container, and in control of the Resident. The Resident will ensure that their pet wears a collar with appropriate identification (including the Resident's name and telephone number) at all times.

1.3. The Resident will comply with all vaccination and licensing requirements applicable to the pet, will provide proof of such upon request, and will comply with appropriate standards of care, treatment, and grooming. The Resident will be responsible for the health, welfare, and proper care of the pet. The Resident will ensure that the pet does not disturb the rights of the other residents at the Residence or impede Residence operations. The Resident will not leave the pet unattended when the pet is not in the Resident's Apartment.

1.4. The Resident will be liable for any personal injury or property damage caused by the pet that is suffered by the Residence, its staff, residents, guests, or invitees. If the Resident fails to timely make good any personal injury or property damage reference in the preceding sentence, the Resident will be responsible for all costs and expenses, including reasonable attorneys' fees and court costs, incurred by the Residence in enforcing the liability of the Resident as outlined here.

2. Term and Termination:

2.1. This Addendum will continue until the Residency Agreement between the Resident and Residence is terminated, unless either party terminates this Addendum for any reason by giving seven (7) days prior written notice to the other party.

2.2. The Residence may terminate this Addendum upon twenty-four (24) hours' notice in the event the Resident breaches any of the Resident's obligations hereunder. If the pet is left unattended for more than twenty-four (24) hours, or if the Residence determines that the Resident, for any reason, is unable to care for the pet, the Residence reserves the right to arrange for the pet to be delivered to:_____, ("Sponsor") or to such other individual or agency as the Residence deems advisable. The Resident agrees to pay all costs of delivery, feeding, care, treatment, and housing of the pet in such an instance. The Resident acknowledges that the Resident has no right to keep a pet unless permitted by this Addendum and that the Residence reserves the right to withdraw its consent to the Resident keeping the pet at any time by terminating this Addendum as permitted above.

The Resident agrees to provide the Residence with a current photograph of the above pet at the time this Addendum is executed.

Resident's Signature	Print Name	Date
Operator/Operator's Representative Signature	Print Name	Date

Exhibit XV.

ENHANCED ASSISTED LIVING RESIDENCE ADDENDUM
(*if applicable*)

This Enhanced Assisted Living Residence ("EALR") Addendum ("Addendum") to the Residency Agreement ("Agreement") is made by and between:

GWC-Savoy Inc., (the "Operator") and _____,
(the "Resident" or "You"), and/or _____,("Resident's Representative," *if applicable*), and/or _____,("Resident's Legal Representative, *if applicable*).
Such Residency Agreement is dated_____, 20___.
This Addendum is entered into as of _____, 20___.

This Addendum adds new sections and amends, if any, only the sections specified in this Addendum. All other provisions of the Agreement shall remain in effect, unless otherwise amended in accordance with the Agreement. This Addendum must be attached to the 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 Brandywine Assisted Living at The Savoy located at 55-15 Little Neck Parkway, Little Neck, NY 11362.

II. Physician Report

You have submitted to 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 twenty-four (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 to ELAR

You have requested to become a resident at the Residence 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 ELAR Appendix I and made part of this Addendum is a written description of:

- **A.** Services to be provided in the Enhanced Assisted Living Residence;
- **B.** Staffing Levels;
- **C.** Staff Education and training work requirements, and any professional affiliations or special characteristics relevant to serving persons in the Enhanced Assisted Living Residence; and
- **D.** 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 a point where You are in need of twenty-four (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 New York State Mental Hygiene Law, the Operator will initiate proceedings for the termination of Your Residency Agreement and to discharge You from residency, UNLESS each of the following conditions are met:

- **A.** Any environmental modifications that have been made to protect the health, safety, and welfare of persons in the Residence; 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 Article 28 of New York State Public Health Law or Articles 19, 31, or 32 of Mental Hygiene Law; AND
- **C.** The Operator agrees to retain You as a Resident and to coordinate the care provided by the Operator and the additional nursing, medical, or hospice staff you hire; AND
- **D.** You are otherwise eligible to reside at the Residence.

VII. Addendum Authorization

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

Resident Signature	Print Name	Date
Resident's Representative's Signature *(if applicable)*	Print Name	Date
Resident's Legal Representative's Signature (*if applicable*)	Print Name	Date
Operator/Operator's Representative's Signature	Print Name	Date

Appendix I.

ADDITIONAL DISCLOSURES FOR ALL ENHANCED ASSISTED LIVING RESIDENTS

I. Services to be Provided

a) Physical Assist with Transfers and Ambulation
b) Change of bag only for: Indwelling Catheter or Suprapubic or Condom type
c) Change of bag only for: Ostomy-colostomy, ileostomy, urostomy
d) Superficial wound treatment
e) Physical Assist with Feeding (non-swallowing issues only)
f) Diabetic Care (including Insulin injections and Blood Glucose Testing)
g) Injectable medications (such as Epogen and Levenox)
h) IV Therapy: Service must be provided by a Registered Nurse from a Licensed Agency
i) Medications with Parameters (such as Digoxin- take pulse and hold if below 50)
j) Administration of eye and ear drops
k) Brace assist: (Leg, Back, Wrist)
l) Vital Signs, Bowel Sounds, Lung Sounds
m) Hospice: Bed bound, physical assist turning and positioning
n) Behavioral Services
o) Maximum physical assist with Activities of Daily Living (ADLs)
p) Incontinence Management

The following are some examples of services that will not be available or allowable in the Residence:

a) Naso Gastric (NG) Tube
b) Tracheotomy Care
c) Geri Chair
d) Chest Tubes
e) Pressure Ulcer Treatment
f) PICC Line
g) Chemical or any type of Physical Restraint
h) Bed side rail

II. Staffing Levels

Staffing levels will be maintained according to all applicable laws and regulations. At full capacity, there will be no fewer than three (3) personal care aides or nurses to provide supervision and meet the needs of EALR residents at all times. During the first shift there are generally more Wellness Staff, in addition to administrative and managerial staff to serve our EALR residents. The staffing plan will be adjusted to meet the needs and census of Residents enrolled in the EALR program. There is a comprehensive activities program with an activities staff that plans and conducts activities designed to promote EALR Residents' activity in the Residence.

III. Staff Education and Training

Each one of the Residence's personal care aides, home health aides, and nurses receive comprehensive training effectively and respectfully meeting the needs of persons retained in the Enhanced Assisted Living Residence. The training includes methods on assisting with mobility impairments, cuing residents to independently perform personal care tasks, coordinating care with the resident's family and for our licensed staff, delivering the available nursing services which are listed in Section I of this Appendix.

IV. Environmental Modifications

Enhanced Assisted Living Residents will reside throughout the Residence. The Residence is equipped with a sprinkler system throughout, emergency call bell system in resident rooms and bathrooms, personal emergency pendant, smoke corridors, and supervised smoke detection systems for resident safety.

Exhibit XV.

ENHANCED ASSISTED LIVING RESIDENCE ADDENDUM
(*if applicable*)

This Enhanced Assisted Living Residence ("EALR") Addendum ("Addendum") to the Residency Agreement ("Agreement") is made by and between:

GWC-Savoy Inc., (the "Operator") and _____,
(the "Resident" or "You"), and/or _____,("Resident's Representative," *if applicable*), and/or _____,("Resident's Legal Representative, *if applicable*).
Such Residency Agreement is dated_____, 20___.
This Addendum is entered into as of _____, 20___.

This Addendum adds new sections and amends, if any, only the sections specified in this Addendum. All other provisions of the Agreement shall remain in effect, unless otherwise amended in accordance with the Agreement. This Addendum must be attached to the 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 Brandywine Assisted Living at The Savoy located at 55-15 Little Neck Parkway, Little Neck, NY 11362.

II. Physician Report

You have submitted to 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 twenty-four (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 to ELAR

You have requested to become a resident at the Residence 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 ELAR Appendix I and made part of this Addendum is a written description of:

- **A.** Services to be provided in the Enhanced Assisted Living Residence;
- **B.** Staffing Levels;
- **C.** Staff Education and training work requirements, and any professional affiliations or special characteristics relevant to serving persons in the Enhanced Assisted Living Residence; and
- **D.** 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 a point where You are in need of twenty-four (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 New York State Mental Hygiene Law, the Operator will initiate proceedings for the termination of Your Residency Agreement and to discharge You from residency, UNLESS each of the following conditions are met:

- **A.** Any environmental modifications that have been made to protect the health, safety, and welfare of persons in the Residence; 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 Article 28 of New York State Public Health Law or Articles 19, 31, or 32 of Mental Hygiene Law; AND
- **C.** The Operator agrees to retain You as a Resident and to coordinate the care provided by the Operator and the additional nursing, medical, or hospice staff you hire; AND
- **D.** You are otherwise eligible to reside at the Residence.

VII. Addendum Authorization

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

Resident Signature	Print Name	Date
Resident's Representative's Signature *(if applicable)*	Print Name	Date
Resident's Legal Representative's Signature (*if applicable*)	Print Name	Date
Operator/Operator's Representative's Signature	Print Name	Date

Appendix I.

ADDITIONAL DISCLOSURES FOR ALL ENHANCED ASSISTED LIVING RESIDENTS

I. Services to be Provided

a) Physical Assist with Transfers and Ambulation
b) Change of bag only for: Indwelling Catheter or Suprapubic or Condom type
c) Change of bag only for: Ostomy-colostomy, ileostomy, urostomy
d) Superficial wound treatment
e) Physical Assist with Feeding (non-swallowing issues only)
f) Diabetic Care (including Insulin injections and Blood Glucose Testing)
g) Injectable medications (such as Epogen and Levenox)
h) IV Therapy: Service must be provided by a Registered Nurse from a Licensed Agency
i) Medications with Parameters (such as Digoxin- take pulse and hold if below 50)
j) Administration of eye and ear drops
k) Brace assist: (Leg, Back, Wrist)
l) Vital Signs, Bowel Sounds, Lung Sounds
m) Hospice: Bed bound, physical assist turning and positioning
n) Behavioral Services
o) Maximum physical assist with Activities of Daily Living (ADLs)
p) Incontinence Management

The following are some examples of services that will not be available or allowable in the Residence:

a) Naso Gastric (NG) Tube
b) Tracheotomy Care
c) Geri Chair
d) Chest Tubes
e) Pressure Ulcer Treatment
f) PICC Line
g) Chemical or any type of Physical Restraint
h) Bed side rail

II. Staffing Levels

Staffing levels will be maintained according to all applicable laws and regulations. At full capacity, there will be no fewer than three (3) personal care aides or nurses to provide supervision and meet the needs of EALR residents at all times. During the first shift there are generally more Wellness Staff, in addition to administrative and managerial staff to serve our EALR residents. The staffing plan will be adjusted to meet the needs and census of Residents enrolled in the EALR program. There is a comprehensive activities program with an activities staff that plans and conducts activities designed to promote EALR Residents' activity in the Residence.

III. Staff Education and Training

Each one of the Residence's personal care aides, home health aides, and nurses receive comprehensive training effectively and respectfully meeting the needs of persons retained in the Enhanced Assisted Living Residence. The training includes methods on assisting with mobility impairments, cuing residents to independently perform personal care tasks, coordinating care with the resident's family and for our licensed staff, delivering the available nursing services which are listed in Section I of this Appendix.

IV. Environmental Modifications

Enhanced Assisted Living Residents will reside throughout the Residence. The Residence is equipped with a sprinkler system throughout, emergency call bell system in resident rooms and bathrooms, personal emergency pendant, smoke corridors, and supervised smoke detection systems for resident safety.

Exhibit XVI.

SPECIAL NEEDS ASSISTED LIVING RESIDENCE ADDENDUM
(*if applicable*)

This Special Needs Assisted Living Residence ("SNALR") Addendum ("Addendum") to the Residency Agreement ("Agreement") is made by and between:

GWC-Savoy Inc., (the "Operator") and _____,
(the "Resident" or "You"), and/or _____,("Resident's Representative," *if applicable*), and/or _____,("Resident's Legal Representative, *if applicable*).
Such Residency Agreement is dated_____, 20___.
This Addendum is entered into as of _____, 20___.

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

I. Special Needs Assisted Living Certificates

The Operator is currently certified by the New York State Department of Health to provide Special Needs Assisted Living at Brandywine Assisted Living at The Savoy located at 55-15 Little Neck Parkway, Little Neck, NY 11362.

II. Request for and Acceptance of Admission

You have requested to become a resident at the Residence at this Special Needs Assisted Living Residence (the "Residence"), and the Operator has accepted Your request.

III. Specialized Programs, Staff Qualifications, and Environmental Modifications

A. Specialized services to be provided in the Residence include daily activities tailored to challenge Residents with dementia. The activities program is supervised by a Registered Professional Nurse.

B. Staffing levels will be maintained in compliance with all applicable laws and regulations appropriate for the level of care needed to perform and carry out the tasks that Residents require. The Residence will be staffed with direct care personnel, a program director, a qualified activities director and case manager. Other staff not specifically assigned to the Residence are available to attend to needs of Residents that arise. The staffing plan will

be adjusted to meet the needs of the Residents.

C. Each of our personal care aides, home health aides, and nurses receive comprehensive training on effectively and respectfully meeting the needs of persons with dementia. The training includes methods on successfully cuing such individuals to independently perform personal care tasks, coordinating care with the Resident and their family, and wandering prevention.

D. The Residence is organized as a secured unit that is equipped with delayed egress doors to prevent wandering. Window openings are limited to prevent accidents and elopement. The entire facility is equipped with a sprinkler system throughout, emergency call bells in all resident rooms and bathrooms, smoke corridors, and supervised smoke detection systems for Resident safety. Secured outdoor recreational areas are also available for Residents to safely enjoy the outdoors. The Residence has its own dining room to allow for staff to accommodate Resident's needs and dining schedule preferences and variations.

IV. Addendum Authorization

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

Resident Signature	Print Name	Date
Resident's Representative's Signature *(if applicable)*	Print Name	Date
Resident's Legal Representative's Signature (*if applicable*)	Print Name	Date
Operator/Operator's Representative's Signature	Print Name	Date