Dear Friend:

Thank you for your interest in our organization. Enclosed please find the application packet for admission to Seven Acres Pauline Sterne Wolff Jewish Senior Care Services campus. Please know that we are very sensitive to the urgent need of admission to Seven Acres and the complete application will be processed as quickly as possible.

For your convenience, we have included an application checklist to assist you in completing the application packet in full prior to returning it to us. Due to the volume of applications received for admission to Seven Acres, and to expedite this process, **we ask that you do not submit your application until it has been completed, signed, and dated, and all requested documents have been obtained by you**. Incomplete or unsigned packets will significantly delay the admission process.

Our experience indicates that medical records are the most difficult to obtain. For these documents, we advise that you contact the physician's office and inform them of your intention to make application for residency to Seven Acres. Due to the busy schedule of physicians and hospital staffs, it is often necessary for you to actually visit the physician's office or the medical records department to obtain such records. **You must provide them with the release forms included in this application packet**.

We have 305 beds, all private pay, Medicaid, and skilled care licensed. This includes a large 79-bed Alzheimer's secure unit and a 26-bed behavioral unit. We do not take Residents who need dialysis or have a tracheotomy or ventilator. Information about rates and services is included in the application packet.

For additional information, please feel free to call our admission information line at 713-778-5749. This information line should answer many of your questions. If any additional information is required, please call 713-778-5707.

If you have any questions regarding the fee for service schedule, please feel free to contact Administration at 713-778-5701 or 713-778-5783.

Thank you again for choosing Seven Acres and we look forward to serving the needs of your family member.

Sincerely

Malcolm Slatko

Malcolm P. Slatko
Chief Executive Officer

Seven Acres Services

Visit our Web Site: www.sevenacres.org

- Intermediate Care
- Certified Alzheimer's Unit
- Highly Specialized Dementia Behavioral Care
- Total Care
- Hospice Services
- On-site physicians. Complete Medical Suite with facilities for the following:
  - Dentistry • Psychiatry • Podiatry • Ophthalmology

Other On-site Services:

- Activity and Volunteer Services
- Social Services
- Chaplaincy and Religious Services
- Occupational and Physical Therapy
- Large Print Library and Music Center
- Beauty Shop
- Gift Shop
- Transportation Services
- Alzheimer's Support Group

The Medallion Assisted Living Residence

Visit the Medallion Web Site: www.themedallion.org

- Services for frail aged who require supervision (Call 713-778-5790)

For More Information:

Chief Executive Officer:	Malcolm P. Slatko:	713-778-5701
Chief Administrative Officer:	Pat Chandler:	713-778-5703
Charitable Donations:	Seth Malin:	713-778-5781

SEVEN ACRES
JEWISH SENIOR CARE SERVICES, INC.

6200 North Braeswood
Houston, TX 77074-7599

APPLICATION FOR ADMISSION

COMPLETE, SIGN AND RETURN

to:

Seven Acres Jewish Senior Care Services
Attention: Admissions Department
6200 North Braeswood Boulevard
Houston, TX 77074

Phone: 713-778-5700
Fax: 713-778-0823

SEVEN ACRES JEWISH SENIOR CARE SERVICES

APPLICATION CHECK LIST

(Below information to accompany application)

_____ Four-page Application fully completed

_____ Financial information form, fully completed

_____ Copies of Social Security, Medicare, and any additional insurance cards

_____ Medical Information Form

_____ Processing fee of $500 attached to the completed forms. This processing fee is non-refundable after evaluation except in the case of a facility denial of admission. *The fee is not applicable to persons with Medicaid benefits (include Medicaid number).*

Medical Records to accompany the Application and include the following:

(Authorization for Release forms are included in this packet for your convenience in obtaining the following records. **The Applicant, or power of attorney, or legal representative, must complete and sign the form and furnish it to the doctor, hospital, or health facility**.)

_____ **Hospital Records**: For current or most recent admission.
If no hospitalizations during the last 6 months, please disregard.

_____ **If the Applicant is currently in a hospital or other health care facility**, please request medical records from the facility and attending physician.

_____ **If not in the hospital or other nursing facility, the following is needed:**

(1) History and Physical from your primary care physician.
Must be within the past 90 days.

(2) Records from Primary Physician
See Authorization for Release form

RECORDS MAY BE FAXED DIRECTLY TO SEVEN ACRES AT 713-778-0823

SEVEN ACRES JEWISH SENIOR CARE SERVICES

6200 North Braeswood, Houston, TX 77074-7599

TEL: 713-778-5700 FAX: 713-778-0823

APPLICATION FOR ADMISSION

NAME OF APPLICANT _____
(First) (Middle) (Maiden) (Last)

ADDRESS OF APPLICANT _____
(*Street*) *(City/State)* *(Zip)*

_____
Telephone #)

MARITAL STATUS _____

SOCIAL SECURITY # _____ MEDICARE # _____ MEDICAID # _____

BIRTHDATE _____ BIRTHPLACE _____ AGE _____ SEX _____

CITIZEN _____ ALIEN REGISTRATION # _____ YEARS IN HOUSTON _____

PAST OCCUPATION _____ VETERAN? _____ Which Branch? _____

EDUCATION _____ PREFERRED LANGUAGE: _____

REFERRED BY: _____ REASON FOR APPLYING TO SEVEN ACRES _____

_____

RESPONSIBLE PARTY
(Medical Power of Attorney) (Primary Contact)

NAME _____

ADDRESS _____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL ADD.: _____

RELATIONSHIP: _____

FINANCIAL RESPONSIBLE PARTY
(Financial Power of Attorney) (Person who handles bills)

NAME _____

ADDRESS _____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL ADD.: _____

RELATIONSHIP: _____

ADDITIONAL CONTACTS AND TELEPHONE NUMBERS: _____

_____

HAVE YOU EVER BEEN ADMITTED TO ANY OTHER FACILITIES? _____

IF YES, PLEASE LIST NAMES AND DATES OF RESIDENCY. _____

_____

_____

PRESENT LOCATION OF APPLICANT: _____

DO YOU BELONG TO A HEALTH CARE MAINTENANCE ORGANIZATION **(HMO)** THAT REPLACES YOUR MEDICARE BENEFITS? NO ☐ YES ☐

IF YES, NAME OF HMO _____

PRIMARY INSURANCE COMPANY _____
(*Name)*

_____
(Address)

SECONDARY INSURANCE COMPANY _____
(*Name*)

_____
(Address)

POLICY #/GROUP #/MEMBER #: _____

MEDICARE Part "D" PROVIDER & # _____

RELIGIOUS PREFERENCE: _____ CONGREGATION: _____

FUNERAL HOME PREFERENCE: _____

1. LIVING WILL/DIRECTIVE TO PHYSICIANS: ☐ NO ☐ YES
2. MEDICAL POWER OF ATTORNEY: ☐ NO ☐ YES

_____
(*NAME OF PERSON APPOINTED AS MEDICAL POWER OF ATTORNEY)*

3. FINANCIAL POWER OF ATTORNEY: ☐ NO ☐ YES

_____
(*NAME OF PERSON APPOINTED AS FINANCIAL POWER OF ATTORNEY)*

4. LEGAL GUARDIANSHIP/COURT ORDER: ☐ NO ☐ YES

_____
(*NAME OF PERSON APPOINTED AS LEGAL GUARDIAN)*

Please provide copies of above documents on admission. ALL APPLICATIONS MUST INCLUDE copies of Social Security and Medicare cards and any additional insurance cards.

THE INFORMATION GIVEN IN THIS APPLICATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PLEASE COMPLETE AND SIGN THE ATTACHED FINANCIAL INFORMATION SHEET ON THE APPLICANT.

* _____ _____
(REQUIRED - Signature of Applicant)* *(Date of Application)*

OR

* _____ _____
(REQUIRED - Signature of Responsible Relative)* *(Relationship)* *(Date of Application)*

$500.000 Application Fee is Enclosed: ☐ NO ☐ YES ☐ N/A

FAMILY MEMBERS

Names of Spouse, Adult Children, Parents, and/or Nearest Living Relatives

_____

_____

_____

_____

PERSON(S) CHOSEN TO ACT FOR THE APPLICANT (select one from below)

Legal Guardian(s) under a Court Order or Person(s) Appointed in Medical Power of Attorney

_____

_____

OR

Adult Child with Consent of All Other Adult Children to Act for Applicant

_____

OR

Individual Clearly Identified to Act for Applicant, such as Nearest Living Relative or Member of Clergy

_____

Does the applicant have a will? _____ A trust? _____ A written family agreement? _____

Please provide the name, address, and telephone number of the named Executor/Administrator named in the will, or the Trustee:

_____

State where the will is to be probated: _____

County where the will is to be probated: _____

Please provide a copy of the applicant's will.

SEVEN ACRES JEWISH SENIOR CARE SERVICES

APPLICANT FINANCIAL RESOURCE INFORMATION

NAME:_____

ADDRESS:_____
(Street) (City/State) (ZIP) (telephone)

ASSETS		MONTHLY SOURCES OF INCOME	
Checking Account:	$	Monthly Base Salary:	$
Savings Account:	$	Monthly Overtime Wages:	$
Stocks/Bonds:	$	Monthly Bonus/Commissions:	$
Investment in Own Business	$	Monthly Interest/Dividends:	$
Accounts/Notes Receivable	$	Monthly Real Estate Income:	$
Owned Real Estate Value	$	Spouse's Monthly Income:	$
Automobiles (year/make):	$	Social Security Income:	$
Personal Property:	$	Social Security Insurance (SSI):	$
Life Insurance Cash Value:	$	Spouse's Social Security:	$
Other Assets:	$	Other Income—Itemize:	$
	$		$
	$		$
TOTAL ASSETS:	$ $ 0.00	TOTAL MONTHLY INCOME:	$ $ 0.00

PERSONAL INFORMATION

Past Occupation or Type of Business:_____

Employer:_____

Position Held & Number of Years _____

I understand that Seven Acres Jewish Senior Care Services relies on this information to determine financial responsibility. I state that this information is accurate as submitted. I understand and accept my financial responsibility for the maintenance of _____,
(Applicant's Name)
who will pay **full fee** while a resident of Seven Acres Jewish Senior Care Services.

*_____
* REQUIRED - Signature Date

I understand that no contribution or donation of any kind is required for admission or continued stay of any resident.

*_____
* REQUIRED - Signature Date

☐ I am currently a "*Friend of Seven Acres"* Member.
☐ I have contributed to the Seven Acres Capital Campaign and/or Building Fund.

MEDICAL INFORMATION

APPLICANT_____

Primary Physician

Name_____

Phone_____

Date of Last Visit_____

Other Attending Physicians

Name_____ Name_____

Phone_____ Phone_____

Date of Last Visit_____ Date of Last Visit_____

Hospital Information

Name_____ Name_____

Dates(s) of Hospitalization_____ Dates(s) of Hospitalization_____

_____ _____

Please return this form with your application.

Primary Care Physician

Seven Acres Jewish Senior Care Services

6200 North Braeswood Blvd.Houston, TX 77074-7599

Phone: 713.778.5700 Fax: 713.778.0823

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION*

Name of Applicant to Seven Acres	Date of Birth	Social Security Number
Applicant's Home Address	City, State and Zip Code	Telephone Number ( )

I authorize: _____

Name of Medical Provider

to release protected health information from the records of _____

Name of Applicant

To: SEVEN ACRES JEWISH SENIOR CARE SERVICES ATTN:: ADMISSIONS

Address: 6200 NORTH BRAESWOOD BOULEVARD

City, State, Zip Code: HOUSTON, TX 77074-7599

Phone Number: (713) 778-5707 OR (713) 778-5700 Fax Number: (713) 778-0823

Reason for Authorization: Release of Information

Date(s) of Service: Most current 3 to 6 months of records

*This line **must** be filled with specific dates*

Purpose of Authorization ☐ Continuity of Care ☐ Patient Transfer

Requested Protected Health Information for disclosure/the following records as available

History of Physical (or Physician's Report/form attached)	Consultations
Progress Notes	Medication/Treatment Orders
Immunization Records	Nurses Notes
Lab Reports	Psychosocial Notes
Radiology Reports	Therapy Evaluation(s)
Diagnostic Studies	Discharge Summary

_____ I understand the information in the health record may include information pertaining to treatment for alcohol or drug abuse, information about behavior or mental health services, sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

Initials

I have read and understand the information presented to me. I understand I have the right to revoke this authorization at any time. Should I revoke this authorization, I must do so in writing, I understand protected health information may, previously, have been disclosed in pursuant to this authorization and will not apply to the revocation. I understand any disclosure of information has the potential to have unauthorized re-disclosure and may not be protected by federal confidentiality rules.

I understand this authorization is voluntary. I, therefore, authorize the provider named above to disclose the protected health information requested above.

_____ _____ _____

Applicant's or Personal Representative's Signature | Date of Authorization | Authorization's Expiration Date

_____

Relationship to Applicant if signed by a Personal Representative

****Note**: *This authorization will expire in 90 days from the date of its initial signed authorization and will only cover the area(s) requested.*

Revised July 5, 2006

Hospital, Health Care Facility, other Physician

Seven Acres Jewish Senior Care Services
6200 North Braeswood Blvd.Houston, TX 77074-7599
Phone: 713.778.5700 Fax: 713.778.0823

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION*

Name of Applicant to Seven Acres	Date of Birth	Social Security Number
Applicant's Home Address	City, State and Zip Code	Telephone Number ( )

I authorize: _____
Name of Medical Provider

to release protected health information from the records of_____
Name of Applicant

To: SEVEN ACRES JEWISH SENIOR CARE SERVICES ATTN:: ADMISSIONS

Address: 6200 NORTH BRAESWOOD BOULEVARD

City, State, Zip Code: HOUSTON, TX 77074-7599

Phone Number: (713) 778-5707 OR (713) 778-5700 Fax Number: (713) 778-0823

Reason for Authorization: Release of Information

Date(s) of Service: Most current 3 to 6 months of records
*This line **must** be filled with specific dates*

Purpose of Authorization ☐ Continuity of Care ☐ Patient Transfer

Requested Protected Health Information for disclosure/the following records as available

History of Physical (or Physician's Report/form attached)	Consultations
Progress Notes	Medication/Treatment Orders
Immunization Records	Nurses Notes
Lab Reports	Psychosocial Notes
Radiology Reports	Therapy Evaluation(s)
Diagnostic Studies	Discharge Summary

_____ I understand the information in the health record may include information pertaining to treatment for alcohol or drug abuse, information about behavior or mental health services, sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
Initials

I have read and understand the information presented to me. I understand I have the right to revoke this authorization at any time. Should I revoke this authorization, I must do so in writing, I understand protected health information may, previously, have been disclosed in pursuant to this authorization and will not apply to the revocation. I understand any disclosure of information has the potential to have unauthorized re-disclosure and may not be protected by federal confidentiality rules.

I understand this authorization is voluntary. I, therefore, authorize the provider named above to disclose the protected health information requested above.

_____ _____ _____
Applicant's or Personal Representative's Signature Date of Authorization Authorization's Expiration Date

_____
Relationship to Applicant if signed by a Personal Representative

**Note: This authorization will expire in 90 days from the date of its initial signed authorization and will only cover the area(s) requested.*
Revised July 5, 2006

SEVEN ACRES JEWISH SENIOR CARE SERVICES
PHYSICIAN'S REPORT

NAME OF APPLICANT_____ DATE OF EXAM_____

DIAGNOSES AND SIGNIFICANT PAST MEDICAL HISTORY

_____
_____
_____
_____
_____

ALLERGIES_____ HT._____ WT. _____

DATES OF THE FOLLOWING (AS AVAILABLE):

FLU_____ PNEUMOVAX_____ TETANUS_____ TB SKIN TEST _____

MENTAL STATUS _____

BLOOD PRESSURE_____ PULSE_____ RESPIRATION_____ TEMP _____

EYES_____ EARS_____ THROAT _____TEETH_____

HEART_____ BREAST _____ LUNGS_____

ABDOMEN _____ GENITO-URINARY _____

RECTAL _____ HERNIA_____ EXTREMITIES_____

ARTERIAL PULSES _____ SKIN_____ NODES _____

NEUROLOGICAL_____

MEDICATIONS_____
_____
_____
_____
_____
_____

DIET_____ CODE STATUS _____

PHYSICIAN'S SIGNATURE AND DATE_____

See Authorization for Release form for requested medical records.

SEVEN ACRES JEWISH SENIOR CARE SERVICES

Fee for Care Charges Effective September 1, 2017 through August 31, 2018

****

I. Room Accommodations: Intermediate Nursing Care

A.	**Deluxe room rate**	**$306.00/day**
B.	**Small Private room rate**	**$295.00/day**
C.	**Deluxe semi-private room rate**	**$258.00/day**
D.	**Semi-private room rate**	**$237.00/day**

For intermediate nursing care residents, this is an inclusive fee with the exception of the following:

- **A. Prescriptions**
- **B. Prosthetic Appliances, walkers, and wheelchair rental fees**
- **C. Gift Shop and Beauty Shop Charges**
- **D. Co-Insurance Deductibles and Ancillary Services Not Covered by Insurance**
- **E. Special Incontinent Garments**
- **F. Transportation Charges**
- **G. Dental Services**

II. Seven Acres is a licensed and certified Medicaid facility. Those Residents who meet the State level of care and financial criteria to qualify for Medicaid are expected to apply for Medicaid. The full fee for service will be expected until the Medicaid approval is received. The Medicaid Help Line is 800-252-8263. You may contact Medicaid for information concerning receiving funds for previous payments covered by such benefits.

III. Seven Acres is also a licensed and certified Medicare facility. Residents who meet the Federal level of care qualifications for Medicare Part A and who are covered by Medicare Part A will qualify for these services. Residents will be responsible for any applicable co-pays and co-insurances. The Medicare information phone number is 800-Medicare; the website is www.medicare.gov. You may contact Medicare for information concerning receiving funds for previous payments covered by such benefits.

IV. Private room accommodations are reserved for those applicants who are able to pay Seven Acres' full charge for care. Residents who are, or become, unable to pay the full private room rate are candidates to be moved to a semi-private room as the needs of the facility arise. Private rooms may be available to Medicaid applicants and/or residents if the family and/or responsible party wish to pay the difference between the Medicaid reimbursement for the particular resident and the Seven Acres fee for a private or deluxe private room. Private rooms are available upon request for Medicare applicants and/or residents who wish to pay the difference between the semi-private and private room rates.

V. If you have any questions regarding the fee for service schedule, please feel free to contact Administration at (713) 778-5701 or 713-778-5703. Thank you.

SEVEN ACRES JEWISH SENIOR CARE SERVICES

PHYSICIAN AND PHARMACY SERVICES

Primary Care Physician
Trumen Physicians and Associates PLLC
OR
Physician of Your Choice

Trumen Physicians and Associates PLLC - physicians and nurse practitioners are on site on a regular basis to provide medical services. You may choose Trumen Physicians and Associates PLLC, . as your primary physician, or you may choose another physician. The decision must be made prior to admission. If you choose another primary care physician, the physician must agree prior to admission to provide the services and must agree to obtain credentialing to practice at Seven Acres.

Other Physician Consultants

The following supporting medical services are on site on a regular basis to provide services as needed if the Resident chooses to use them: Psychiatry, Podiatry, Physiatry, Ophthalmology and Dental

Pharmacy Services
PharMerica

The above pharmacy service delivers to Seven Acres. You may also choose an outside pharmacy with the following conditions:

- All prescriptions must conform to Seven Acres policies and must be blister-packed.
- The family or pharmacy is required to deliver medications when required.
- If the family/pharmacy cannot deliver an emergency medication, Seven Acres will order from one of the above pharmacies and the resident/family will be billed.
- Seven Acres will call the family to reorder when new prescriptions are needed.
- Personal preference over-the-counter medications (those not on the formulary) are the responsibility of the resident/family and must be labeled.
- Drugs not FDA approved from outside the USA cannot be used.

Texas Department of Aging and Disability Services

Form 3641-A
November 2004

Alzheimer's Disclosure Statement for Nursing Facilities

Instructions to the Facility

1. Complete the Disclosure Statement according to the care and services that your facility provides.
2. Post the Disclosure Statement with your facility's license.
3. Provide copies of this Disclosure Statement to anyone who requests information on Alzheimer's or related dementia care in your facility.

Facility Name Seven Acres Senior Care Services, Inc.		Telephone No. 713-778-5700
Address 6200 North Braeswood Boulevard, Houston, TX 77074		
Administrator Malcolm P. Slatko		Date Disclosure Statement Completed 2/17/14
Completed By: Patricia M. Chandler	Title Chief Administrative Officer	
Completed By: Marsha Cayton	Title Administrator of Campus Services	
Completed By:	Title	

The items checked apply to this facility:

- ☐ Free-standing Alzheimer's/ dementia facility
- ☒ Provides specialized care for residents with dementia
- ☒ Has a specialized unit for residents with dementia
- ☒ Has a specialized secured unit for residents with dementia
- ☒ Has a voluntary state certified Alzheimer's unit/facility

Number of MEDICARE beds available for specialized dementia care:	Number of MEDICAID beds available for specialized dementia care: 79	Number of specialized dementia care beds: 79

What is the purpose of this Disclosure Statement?

The purpose of this Disclosure Statement is two-fold. First, it empowers **consumers**. The Disclosure Statement lets the facility describe the services it provides and how these services target the special needs of residents with dementia. Although the information categories are standardized, the information reported is facility-specific. This format gives families and other interested persons consistent categories of information from which they can compare facilities and services. This Disclosure Statement is not intended to take the place of visiting the facility, talking with other residents' family members, or meeting one-on-one with facility staff. Rather, this statement is additional information with which families can make more informed decisions about care.

Second, the process of completing the Disclosure Statement helps facilities develop and define their philosophy, care, and services that specifically target residents with dementia. By requiring the Disclosure Statement, the State of Texas is not mandating what services should be provided, but provides a format to describe them. This promotes autonomy, innovation, and competition at the facility level.

Do all nursing facilities provide a Disclosure Statement?

The law requires that the Disclosure Statement is provided by all nursing facilities that advertise, market, or otherwise promote that they provide specialized services to residents with Alzheimer's disease or related disorders. This means that a Disclosure Statement must be provided by all nursing facilities, with or without designated units, if the criteria apply.

Recommended resource materials:

1. Guidelines for Dignity, published by the Alzheimer's Association.
2. Family Perceptions of Alzheimer Care in Residential Settings, published by the Alzheimer's Association.
3. Residential Care: A Guide to Choosing a New Home, published by the Alzheimer's Association.
4. The 36-Hour Day, by Nancy Mace and Peter Rabins.

In this document:

1. All questions relate to the specialized dementia care that the individual facility provides.
2. "Family member" includes guardian, power of attorney for health care, and/or surrogate decision maker.

To obtain information on nursing facilities in Texas or to register complaints, contact:
Texas Department of Aging and Disability Services at 1-800-458-9858

Facility Name: **Seven Acres Jewish Senior Care Services, Inc.**

I. Philosophy (Statement of overall philosophy and mission which reflects how special needs of residents with dementia are addressed.)

This facility strives to provide Residents with a safe and structured environment that supports the functioning of cognitively impaired adult Residents, accompanied behaviors and aims to maintain functional abilities, promotes safety, and encourages independence of Residents within their cognitive abilities. The facility strives to meet the physical, emotional, social, and spiritual needs of the Residents throughout the disease progression.

II. Pre-admission Process

1. What is the cost to the resident for the Alzheimer's program? You may attach the facility's fee schedule.
   ☐ The Alzheimer's program cost is $ _____ per _____ ☒ Facility's fee schedule is attached.

2. What are acceptable diagnoses for admission to specialized units?
   ☒ Alzheimer's disease ☒ Organic brain syndrome ☒ Other dementia

3. Are the diagnoses verified by:
   ☒ Family physician ☒ Neurologist ☒ Psychiatrist ☒ Other

4. What is the role of the physician in the pre-admission process?
   ☒ Diagnosis ☒ Care planning ☒ Counseling ☒ Assessment

5. How do you decide who is appropriate for admission?
   ☒ Need ☐ Financial Resources ☒ Referral by physician ☐ Payment source

6. Does the payment source affect the access to care?
   ☐ Yes ☒ No If Yes, explain how: _____

7. What happens when the resident's financial status changes?
   ☒ No Change ☐ Moved to another part of the facility ☐ Discharge

8. Is there a waiting list for specialized care?
   ☒ Yes ☐ No

9. How are families involved in the pre-admission process?
   ☒ Visit to facility ☒ Application ☒ Home assessment ☒ Family interview

10. Is information available to families on:
    ☒ Area support groups ☒ Community resources ☒ Dementia literature

III. Admission Process

1. What is the admission process for new residents?
   ☒ Physician's orders ☒ Residency Agreement ☒ History and Physical ☒ Deposit/payment
   ☐ Other (describe): _____

2. Is there a trial period for residents?
   ☐ Yes ☒ No If Yes, how long? _____

3. Do you have an orientation program for families?
   ☒ Yes ☐ No

4. What is your refund policy if the resident does not stay the entire period?
A daily rate is charged one month in advance. Refunds are sent for any unused portion.

IV. Discharge/Transfer

1. What would cause temporary transfer from specialized care?

☒ Medical condition requiring hospitalization ☒ Unacceptable physical or verbal abuse

2. What would cause permanent transfer from specialized care?

☒ Behavior management with verbal aggression ☒ Behavior management with physical aggression
☐ Intravenous (IV) therapy ☒ Other

3. Who would make the discharge decision?

☒ Facility Administrator ☒ Physician ☒ Family ☒ Other

4. Do family members have input into discharge/transfer decisions?

☒ Yes ☐ No

5. How are families informed of the right to appeal the transfer/discharge decision?

☒ On admission ☒ At time of transfer/discharge

6. Do you assist families in making discharge plans?

☒ Yes ☐ No

V. Planning and Implementing Care

1. Who is involved in the care planning process?

☒ Family Members ☒ Nurse Aides ☒ Dietary Staff ☐ Administrator
☒ Licensed Nurses ☒ Social Worker ☒ Physician

2. How often is the resident care plan reviewed/revised/updated?

☐ Monthly ☒ Quarterly ☐ Annually ☒ As Needed

3. How are individual resident needs communicated to the direct care staff?

☒ Verbal instruction from charge nurse ☒ Written instruction from charge nurse
☒ Verbal communication from peers ☐ Written communication from peers

4. How many hours of structured activities are scheduled per day?

☐ 1 – 2 hours ☐ 2 – 4 hours ☒ 4 – 6 hours ☐ 6 – 8 hours ☐ more than 8 hours

5. What specific techniques do you use to address physical and verbal aggressiveness?

☒ PRN medications (as needed) ☒ Physician-ordered restraints ☒ Redirection ☒ Isolation
☒ Other (describe): Contact attend.phys, revw med. profile for recent chnges, req. lab wk orders, discuss need for psych intervention

6. What techniques do you use to address wandering?

☒ Outdoor access ☒ Electro-magnetic locking system ☒ Wander Guard (or similar system)
☒ Other (describe): Elevator lock pad, staff intervention, and redirection

7. What restraint alternatives do you use?

See Policies and Procedures—Use of Physical Restraints (attached)

8. Are residents taken off the premises?

☒ Yes ☐ No

9. Check the services that are available in this facility:

☒ Dental ☒ Optical ☒ Podiatry ☒ Audiology ☒ Mental Health Services
☒ Occupational Therapy ☒ Physical Therapy ☒ Speech Therapy ☐ Other (describe) _____

VI. Change in Condition Issues

1. What do you do when the resident develops:

Changes in behavior?

A change in behavior and minor illnesses may trigger a full assessment and possible new MDS by the interdisciplinary team. The care plan is modified to fit the changing needs of he Resident, and families are informed. The resident is assessed to determine causal factor. Physician is notified for appropriate intervention.

Minor illnesses?

See above.

Medical emergencies?

Handled on an individual basis, with physician being contacted and transfer to hospital if necessary. If behaviors become extremely bizarre or uncontrollable, Residents are reviewed for possible placement on another unit to meet needs.

2. What options are available for advanced and/or terminal stage care?

1. Residents can be transferred to another unit that is able to give care for advanced or terminal stage care.
2: Hospice Care and Palliative Care are offered.

3. Under what circumstances are sitters recommended?

Recommendations for sitters are based on a joint decision by the attending physician, the interdisciplinary team, and the family, when one-on-one care is deemed necessary.

VII. Staff Training on Dementia Care

1. What topics does the training cover?

☒ Etiology of dementia ☒ Treatment of dementia ☒ Stages of Alzheimer's ☒ Behavior management
☒ Special needs of cognitively impaired residents ☒ Guidelines for assisting with memory loss and confusion

2. Who receives training?

☒ Administrator ☒ Licensed nurses ☒ Direct care staff ☒ Activity director
☒ Dietary Staff ☒ Housekeeping staff ☒ Other

3. What training do new employees receive before working in dementia care?

☒ Orientation of 8 hours ☒ Review of resident care plan ☒ On the job training with another employee for 24 hours
☒ Other (describe): See staff training and dementia care.

4. What type of training do volunteers receive?

☐ Orientation of _____ hours ☐ On the job training for _____ hours
☒ Other (describe): Meet w/dementia wing soc.wkr for orientation of wing's milieu, res. behavior, interventions, staff intro, job desc. w/supervision

5. How do you reinforce training?

☐ Monthly inservice ☐ Quarterly inservice ☒ Annual update

Please indicate length of training (example, 30 minutes monthly): 4-hour Alzheimer's training annually

6. Who gives the training and what are their qualifications?

Dementia Wing Licensed Social Workers and ADON of Dementia Wing (RN) & Inservice Coordinator

VIII. Staffing

1. Who is in charge of dementia care in the facility and what are their qualifications?
   Meron Melles, RN
   Gabrielle Langley, LCSW.

2. What characteristics do you look for when hiring staff for dementia care?
   Exp'd, caring staff choosing to wk w/ cognitively impaired Residents. Patient, non-judgmental, willing & able to learn new approaches to care. Provide support and guidance to team, assist in address'g & solving problems and issues re social work, maintain ongoing reg contact with Residents' families both individually and on a monthly basis via support group sessions, and to plan special social and spiritual programs.

3. What do you do to attract and keep capable staff?
   Staff paid above min. wage; eligible for merit increases based on performance. Benefits incl. health & dental insurance, retirement plan, paid vacation, sick days and holidays, continued inservices, and annual reorientation. Staff treated with dignity and respect and there are growth opportunities.

4. Minimum staffing provided by the facility for a 24-hour period:

TIME PERIOD	NURSE AIDE	LVN	RN	ACTIVITIES PERSONNEL	OTHER
7–3	8	4	1	2.5	3cma,1sw,1ra, 1 ward clerk
3–11	8	2	1.5	.5	3 cma
11–7	6	3	.5		

IX. Physical Environment

1. What safety features are provided in your building?
   ☒ Emergency pull cords ☒ Window opening restriction ☒ Magnetic locks ☒ Sprinkler system
   ☒ Fire alarm system ☒ Wander Guard (or similar system) ☒ Locked doors on emergency exits

2. Information about your outside area(s):
   Size: Two large protected gardens.
   Access: All times.

3. What is your policy on the use of outdoor area(s)?
   ☒ Supervised access ☒ Free daytime access (weather permitting)
   ☐ Other (describe): _____

X. Program Evaluation

Describe how you evaluate whether or not your program is working?
Outcomes on care plans, satisfaction level of Residents and/or their responsible parties, family feedback, ongoing social service evaluations, CQI performance monitoring and CQI Dementia teams. Annual administrative review.

Signature – Facility Administrator

4/26/16
Date