Resident Care Handbook

WELCOME TO HOMESTEAD REHABILITATION CENTER

Care is a basic part of our total program. Our emphasis is on Resident care and bringing each individual to his or her maximum potential. We know the importance of helping people help themselves.

A team of professionals, led by your physician, will be working to help you reach your highest level of independence. The team may include nurses, nurse assistants, rehabilitation specialists, social workers, recreational services staff and nutritionists who are skilled in meeting the special needs of the Residents. The services of physical, speech, occupational and respiratory therapists, discharge planners and other support staff are available to actively assist in your care.

This information has been prepared to assist you and your family members in adjusting to a new experience. We hope that you will find answers to many of your questions. We encourage you to keep a copy of this booklet for easy reference, however also feel free to approach facility staff with any questions you may have. Working together, we hope to make your stay here as comfortable as possible.

Dear Resident, Guardian, Family Member, Power of Attorney:

I want to take this opportunity to welcome you to our neighborhood and thank you for choosing Homestead Rehabilitation Center to serve you. The entire staff from our Certified Nursing Assistants to the Administrator realizes the amount of trust you have given us to take care of you or your loved one. We personally welcome any suggestions, concerns and recommendations that you may have on how we can improve our services to you. Our Center, on all levels, strives to fulfill the needs of all Residents each and every day.

If you do have suggestions, feel free to contact one or both of us.

Regards,

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HOMESTEAD MISSION

Homestead Rehabilitation Center is an integral part in the continuum of care. Our delivery of services is adaptable to the provision of present and future care needs of our customers.

Our goal is to provide a highly skilled and supportive environment through which we can foster dignity, independence and self-determination to the fullest extent of our customers.

To meet the needs of our customer, our employees represent many disciplines and work together as an integrated clinical team to exceed your expectations.

We are firmly committed to providing our services within available resources consistent with achievable goals.
| GETTING FAMILIAR WITH YOUR SURROUNDINGS |

Call System

A nurse-call system is located near or on your bed and in the bathroom. By activating the cord or button, you will signal the nursing staff.

Food Items & Resident

Families must first check with the nursing department regarding food brought in from home to assure physician’s orders for diets are followed. Any perishable food items can be stored in the refrigerator near the Nurse’s Station and must store be in clean, sealed containers and labeled with the Resident’s name and the date. Food items must be tossed after 48 hours.

Privacy Curtains

Each bed is equipped with privacy curtains to be used to maintain privacy. The curtain may be closed by facility staff when they are providing you with care and at other times when privacy is needed. You may close the curtain at any time you desire privacy.

Storage

Once the admission procedure is completed, a facility staff member may help you get settled in your room. You will be assigned storage and closet space. There is also a nightstand and an over-the-bed table that is available for your use. Please use only your assigned space as space is limited. Nothing may be stored in boxes on the floor, under the bed or stacked on the closet floor. Families are encouraged to take extra items home for storage.

Safety Precautions

While you are a Resident of the facility, we ask you to observe the following safety precautions for your benefit and the benefit of other Residents and staff members.

Please use caution when getting in and out of bed. If you feel weak, use the nurse-call system for assistance. The effects of some medications may make you unsteady on your feet. We would much rather help you than have you risk getting hurt.

Always ask for assistance when getting in and out of a wheelchair. Do not lean forward or to the side, as this can tip the chair. When passing through a doorway, keep your arms on the chair armrests. Place both of your feet on the floor first when getting out of the wheelchair and make sure that the wheel locks are engaged. Handrails are located in the hallways and bathrooms for your use. We encourage you to use them.
CLOTHING AND PERSONAL ITEMS

The purchase of your personal clothing is your responsibility. Each Resident of this facility should have at least six changes of clothing, including underwear, socks and outer garments. In addition, Residents need at least two pairs of washable shoes, preferably walking shoes or sneakers. Slippers and nightclothes are also suggested. All clothing and shoes must be in good condition.

All personal items, including jewelry, appliances and clothing must be registered on the personal inventory sheet maintained in your medical record. Please notify the nursing staff on your floor when personal items are brought into the facility.

All Resident personal clothing and items need to be recorded on the “Homestead Admission Inventory” forms. A sample is located in the Forms Section of this Handbook. There are two of these forms, one for clothing and one for non-clothing items. Extra forms are available from the Resident’s Social Worker or from our Administrative Assistant. Periodically, this facility will check each Resident’s clothing and shoes. Families will be notified as to what each Resident needs, if anything. Replacement clothing properly labeled is to be brought in by the family within two (2) weeks of notification. Be sure to have the items inventoried by the nursing staff.

The facility may purchase clothing and/or other necessary items for the Resident, utilizing funds from the Resident’s trust account. The Resident will be notified of the cost of each item prior to any purchase using trust fund monies. Purchases will not be made without proper authorization by the Resident/representative or notification by the facility.

Proper labeling of Resident clothing, before it is brought into the facility, is very important. Labeled clothing is much less likely to be lost or misplaced. In respecting and preserving the Resident’s dignity and appearance, clothing and coats should be labeled on the inside collar. Pants, skirts, and undergarments should be labeled on the inside waistband. Footwear and socks should be marked on the inside. Hats, ties, scarves, and other personal items should be marked. It is preferable to use labeling or laundry markers, which will not fade in the laundry process. We strongly suggest the use of laundry tape, which does not easily come off in our laundry machines.

Clothing Tips

Each day will be an active day for the Resident. Residents will be asked to do as many things as they are able. The Resident will be encouraged to wear their own street clothes, take part in activities and recreational programs and to be up and about to the best of their abilities.

The Resident’s clothing needs depend upon their condition. Below are suggestions that may make the Resident’s stay more comfortable.

1) Shirts, dresses, pajamas, and robe opening completely down the front are best. Large buttons, Velcro closures, drawstrings, and loops attached to zippers will make dressing easier. Full skirts, loose fitting sleeves, and fabrics with stretch are also helpful. Wheelchair-bound Residents may find unrestricted clothing more comfortable.
2) Trousers and slacks, especially with elastic waistbands and loose-fitting pullover shirts can be very comfortable. Many Residents enjoy sweat or jogging suits.

3) Avoid socks and stockings with tight elastic bands. Sheer stockings should also be avoided as they easily snag.

4) Shoes should have laces or Velcro closures, if possible, with a non-slip flat sole. Slippers should have a fair amount of support and hard, flat, non-slip soles. Washable athletic shoes are also recommended.

If you need any assistance in obtaining clothing, please contact the Social Services Department. They can make arrangements to purchase clothing for the Resident.

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<tr>
<th>LIFE ENRICHMENT ACTIVITIES</th>
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| It is our primary focus to provide meaningful, quality-of-life activities to Residents of all different levels. Our specialized program is a balance of social, cognitive, spiritual, sensory and physical activities. Pet therapy and intergenerational visits from the community are also scheduled, and family members are encouraged to join the activities as well. The Archives of Internal Medicine published a study in 2009 which stated that social activity for seniors is just as important as exercise. Speed, dexterity and muscle strength requires social interaction to be maintained during the senior years. Available seven days a week, days and evenings, some of Homestead’s more popular activities are listed below:

- Dining events on and off campus
- Musical entertainment shows
- Parties
- Games: Bingo, cards, ladder ball, bean bags
- Scenic drives and community outings

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<th>BEAUTY AND BARBER SHOP SERVICES</th>
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| Beautician and Barber Services are available at the facility. Information regarding beauty shop hours, prices, and appointments is available through the Administrative Office. Services will be billed separately by our beautician. (Salon can be used by Resident’s personal beauticians Friday, Saturday and Sunday only.)

- Haircuts (includes wetting) $18.00
- Shampoo Sets $18.00
- Haircut / Blowdry $22.00
- Haircut / Shampoo / Style $30.00
- Haircut / Beard Trim $22.00
- Perm / Haircut / Style $60.00
- Color / Haircut / Style $60.00
- Hilites / Haircut / Style $65.00 and up
- Shampoo $ 5.00
- Style $18.00
LAUNDRY SERVICES

Family members may opt to provide laundry services for the Resident. If so, a hamper with a plastic liner will be needed. Soiled clothing should be picked up at least every three days. If this is not possible, you may request laundry services through the facility. Please contact the Administrative Office. The security of your personal belongings is very important to us. Please assist us with tracking your belongings using the following procedure. Due to the high temperature of the washer and dryer, please wash delicates by hand.

**Upon Admission/Preplanned Admission:**

1) **An inventory sheet will be provided for you and/or your family to fill out to identify all of your belongings upon admission.** Please complete the inventory sheet in its entirety and sign/date. Include ALL items, clothing, dentures (upper/lower), glasses, watches, jewelry, pictures, etc. You may specify brand names, color, etc for additional identification. If you need assistance with filling out the inventory sheet, please contact a facility staff member and someone will be assigned to assist you. An inventory form is available on page 76 and for download from [www.HomesteadRehab.com](http://www.HomesteadRehab.com).

2) All clothing items are required to be labeled, even if family intends to launder. We recommend the Resident bring with them six days worth of clothing items. To identify clothing items a *sharpie laundry pen, no-iron clothing labels or printed iron on labels* are available upon request. Mark all clothing with **first initial, last name** (example: J Smith) near tag.

3) Items of clothing brought in unlabeled must be bagged with the resident’s first and last name taped to the outside of the bag, and a completed inventory form placed inside the bag. Present the bag(s) to a staff member at the station the resident resides. The staff member will then take the bag to the labeling area. Clothing items will be labeled and returned to the resident within 72 hours.

4) Complete Inventory forms sent with clothing to be labeled will be looked over to assure all items inventoried have been labeled. On the first weekday of the month, the Housekeeping Manager will make a copy of any inventory form filled out from previous month. The original form is placed into the Unit Manager’s mail box; a copy will be placed in the three-ring binder in the labeling room.

**This Facility shall not be liable for the loss of or damage to personal property, unless it has been placed in this facility’s aforementioned secured area for the safekeeping of money and valuables. Please be aware of this policy and take the precautions necessary to protect your valuables per Homestead Personal Property & Missing Property Handbook.**

**During the Course of Stay:**

1) **If additional items are brought into the facility, the family is required to inventory those items on a facility inventory sheet.** These sheets can be supplied to you by one of your social workers or by our Administrative Assistant whose desk is located...

If you or your family member brings in additional unlabeled clothing items the clothing items must be bagged with the Resident’s first and last name taped to the outside of the bag, and a completed inventory form placed inside the bag. Present the bag(s) to a staff member at the station the Resident resides. The staff member will then take the bag to the labeling area. Clothing items will be labeled and returned to the Resident within 72 hours. It is also recommended that Residents bring seasonal clothing items and family switch the clothing items fall and spring.

**Upon Discharge:**

Please make sure when you/or your family member is discharging from the facility that you and a facility staff member sign the inventory sheet before leaving the building to insure you/or your family member received all personal belongings.

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<th>MEAL AND SNACK SERVICES</th>
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<td>A representative from our Dietary Department meets with each Resident to discuss the diet that his/her physician has prescribed. Residents are be asked about their food likes and dislikes. Our Dietary Staff will make every effort to follow his/her personal preferences. Substitutions may be available upon request. We encourage Residents to take their meals in the dining room to enhance socialization. Please see the nurse for meal times. If the Resident is unable to go to the dining room, his/her meal will be served at bedside. Snacks are available, if desired. Guest meals are also available at a minimal charge which can be paid at the office. Meals for guests should be ordered through the Administrative Office.</td>
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<th>RELIGIOUS SERVICES</th>
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<td>The Resident’s Minister, Priest, Rabbi or Cleric is always welcome to visit. In addition, Chaplains from our area may be available to serve you. Worship services are held at this facility. Times and dates are posted on the Activity Calendar which is posted in each room and on the Website. Pastoral visits can be arranged through the Social Services or Recreational Services Department. We can also make arrangements for the Resident to attend religious services outside the facility. The Social or Recreational Services Director will assist you in obtaining transportation, at the Resident’s own cost, to the religious service of choice.</td>
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<th>TELEPHONE</th>
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<td><strong>Long-Term Care/Extended Care:</strong> A private phone line may be installed and operated at the Resident’s own cost, as available, within the facility. See the Administrative Offices for further information on obtaining a private line. A public phone will be made available for the Resident’s use. Staff will be happy to direct Residents to the nearest location. <strong>Short-Stay:</strong> A private phone line is available in each room for local calls only. Please see your Social Worker or Reception for your room telephone number.</td>
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MAIL

Mail, including packages, gifts and flowers, is distributed daily, Monday through Friday, except on Holidays. If Residents need assistance in opening or reading mail, please ask. Social Services and Enhancement Activities personnel can also assist Residents with writing letters. Outgoing mail may be given to your nurse or another staff member. Letters and packages that arrive after you have been discharged will be forwarded to your new address.

RESIDENT POSSESSIONS

Valuables

Residents are advised against bringing large amounts of money, valuable clothing or valuable jewelry into the facility. It is our policy that any cash, credit cards or checks can not be left with the Resident and should be given to a responsible party for safekeeping. We recommend that any loose fitting rings and other personal items of significant monetary or sentimental value be placed with a responsible party for safekeeping.

Personal Property and Missing Property

We make every attempt to assure that possessions are not lost, misplaced or stolen. The loss of valuable personal property is an unfortunate event and a very difficult task to manage in a long-term care facility where many diverse Residents reside and employees work. There are many variables to control, including the presence of confused and/or ambulatory Residents, multiple occupancy of rooms, visits by friends and relatives, Residents frequently leaving the facility, etc.

Please take the following steps to prevent the potential loss of personal items:

1. If a Resident receives a large sum of money, please take it to the Administrative offices and deposit the money into bank account. Residents should NOT keep more than $5.00 with them or leave it in their room.

2. Any time Residents receive new clothing or other items such as jewelry, perfume, knickknacks, radios, television, etc., please ask the nurse in charge to please record these items on the “Homestead Admission Inventory” sheet that can be stored with Resident records. The facility cannot update an inventory of personal items unless the Resident and family provide this information.

3. If you see someone go into a room where they do not belong, report this to the nurse in charge or administration. Please give a description of the person if you do not know their name, along with what you saw them doing. This will be kept confidential.

If an item is missing, please take the following steps:

1. Note the time, date, and last known place of the missing item.

2. Report the incident to the nurse in charge or Social Services with the exact description of the missing item, including the color, size, and the last time and place the item was seen.
3. Follow up on the reported loss by also contacting either Social Services or the Administrator or designee with the description of the item, time of loss, date, and color as stated above.

The facility shall not be liable for the loss or damage to personal property, unless it has been placed in this facility’s aforementioned secured area for the safekeeping of money and valuables. Please be aware of this policy and take the precautions necessary to protect your valuables.

Resident Belonging Tracking Procedure | Revised 5/4/12

The security of personal belongings is very important to us. Please assist us with tracking Resident belongings using the following procedure.

Upon Admission:

1) The “Homestead Admission Inventory” sheet will be provided for the Resident and/or your family to fill out to identify all belongings. Please complete the inventory sheet in its entirety and sign/date the sheet. This should include ALL items, dentures (upper/lower), glasses, watches, jewelry, pictures, etc. Please make sure to include brand names, color, etc for all items. If assistance is needed with filling out the inventory sheet, please contact a facility staff member and someone will be assigned to assist.

2) It is required that all items be labeled, even if family intends to launder them. Please place any clothing items into the Homestead bag with your name on it. A staff member will then take the bag(s) to our labeling area and have labels ironed onto them. The item will be returned to the Resident within 72 hours.

5) When the facility has a preplanned admission, when possible, the family will receive labels prior to admission and we request that the family apply labels to the clothes prior to the Resident’s admittance to the facility.

6) **On the first weekday of the month, the Housekeeping Manager will make a copy of any inventory sheet filled out from previous month. The original is placed into the Unit Manager’s Mailbox, the copies will be placed in the three-ring binder in the labeling room.**

**THE FACILITY SHALL NOT BE LIABLE FOR THE LOSS OF OR DAMAGE TO PERSONAL PROPERTY. Please be aware of this policy and take the precautions necessary to protect your valuables per Homestead Personal Property & Missing Property Handbook**

During the Course of Stay:
If the Resident or your family member brings in additional items or removes any belongings, please ensure the items needing to be labeled are taken to the labeling area. A staff member can assist with this.

**Upon Discharge:**

Please make sure when the Resident is discharging from the facility that a family member and a facility staff member sign the inventory sheet before leaving the building to insure all personal belongings are received.

**Homestead Rehabilitation Discharge and Deceased Resident Room/Personal Possessions Policy | Effective 10/1/2009**

In the event that Resident discharges or a death occurs at Homestead Rehabilitation Center, the personal possessions of the Resident must be removed from the Resident’s room within 72 hours. Families can choose to remove the belongings and sign the discharge inventory or they may sort through the personal possessions and the facility will dispose and/or donate any items the family requests as appropriate. The family will then sign the discharge inventory and indicate which items the families are removing from the building.

Homestead recognizes the death of a loved one is a difficult time for families, and families are overwhelmed with many tasks. Homestead does not ask families to follow this policy to create additional burdens, however due to cleaning schedules and sanitation purposes, we must ask all families to comply with this policy.

If you are absolutely unable to remove your loved one’s personal possessions within the 72 hours, please contact the Social Services Department at Homestead to make alternative arrangements. However, be advised the belongings will be removed from the Resident’s room after 72 hours and stored in an alternative location until the earliest time when families can retrieve them. Items, which are not retrieved, will be disposed of after 30 days.

| **ELECTRONIC EQUIPMENT** |

Upon admission or any time after, the Resident or responsible party will declare that an electronic device is in possession of the Resident.

In addition, any electronic device brought into the facility for the Resident, needs to be added to inventory by a staff member (including the serial number and brand) and then the device needs to be engraved with the Resident’s name.

Any electronic device brought into the facility is strongly encouraged to have a tracking application, if available, on it prior to bringing it into the facility. This will help locate the device by GPS, if it gets lost.

**Homestead Rehabilitation Center is NOT RESPONSIBLE FOR REPLACEMENT OF ELECTRONIC OR OTHER DEVICES.**
For safety of our Residents, **all electrical equipment must be checked in with our Maintenance Supervisor for compliance with facility policy.** These items include, but are not limited to, televisions, DVD/VCRs, radios, telephones, refrigerators, fans, holiday lights and extension cords.

**POWER STRIPS AND EXTENSION CORDS**

Power strips and extension cords are **NOT PERMITTED** in the facility due to safety regulations.

**VISITORS, VISITING HOURS AND SECURITY**

Visits by family members, children and friends are greatly encouraged. Normal visiting hours are from 9:00 a.m. to 8:00 p.m. You may have visitors at other times, provided that the rights of the Residents to privacy and a quiet environment are not violated.

We ask that visitors sign in when they arrive and out again when they leave. This information is critical to facility staff in assuring the safety of all Residents in their care. If approached by a staff member who may not recognize a visitor, please understand that they are attempting to maintain secured environment for you.

For the security of our Residents, facility doors are locked from 7:00 pm to 7:00 am. To gain entrance when facility doors are locked, you will need to use the **access code 1379** or **call (402) 488-0977**. Please inform the staff person at which entrance you are located.

- Lobby Doors or Main Entrance: east side of the building.
- Southeast Doors or Therapy Entrance.
- Northwest Doors or Memory Care Entrance.

We ask that all visitors enter through the Main Entrance and sign in. Visitors may be asked show picture identification. Visitors should be reminded that the privacy of all Residents is to be respected at all times. Visitors should not enter Resident rooms without first knocking and obtaining permission to enter. Visitors are asked to follow facility policies and to respect the property and space of Residents and of the facility.

**USE OF CAMERAS OR CAMERA PHONES ON THE FACILITY PREMISES IS STRICTLY PROHIBITED.** The facility has implemented this policy in effort to maintain Resident confidentiality.

If you would like to organize a special gathering with your loved ones, arrangements may be made to use the dining room or another area by contacting Administrative staff. Residents have the right to refuse visits by any person. Visitors violating the rights of any Resident will be asked to leave the facility.

Leashed or crated pets are welcome to visit with permission from the Administrator and with receipt of current vaccinations.

**LEAVING THE BUILDING FOR FIELD TRIPS OR FAMILY OUTINGS**
To create fun and exciting activities for our Residents, our Enhancement Activities Department plans visits to locations and events outside the facility. Before we can permit a Resident to participate in any of these activities, we are required to receive an authorization from the Resident’s physician.

Residents may go on daytime, overnight or longer outings with a family member or friend. Arrangements must be made in advance with the nursing staff and must be approved by the Resident’s physician. The family member or friend will be required to sign the Resident out at the nursing station prior to leaving and back in upon return. The family member also assumes all responsibility for the Resident while outside the facility. A family member or POA is encouraged to accompany the Resident to medical appointments. The family member or POA assumes responsibility for the Resident’s Advance Directive while the Resident is outside of the building. A copy of the Advance Directive is available in the Resident’s chart.

| EMERGENCY PREPAREDNESS DRILLS |
Emergency drills, such as fire and tornado, are held regularly to help ensure that our staff is prepared to assist in Resident safety and security.

| GRIEVANCES AND COMPLAINTS |
Throughout the Resident’s stay, grievances and complaints may be voiced without the fear of reprisal, discrimination or intimidation.

Residents have a right to present grievances or complaints to the following:

- Administration
- Director of Social Services
- Charge Nurse or Other Facility Staff
- Resident Council
- Office for Civil Rights
- State Department of Public Health

The address and phone numbers of the following offices will be prominently posted in the Facility:

- State Department of Public Health
- State Department of Human Services
- State Ombudsman Office
- Department on Aging
- Office for Civil Rights

The facility Administration shall be responsible for ensuring:

- All grievances/complaints received from Residents, Representatives and Families including those with respect to the behavior of other Residents are addressed.
- A public telephone is made available to all Residents.
- A Grievance/Complaint File is maintained in the Administrative office.
• A permanent record is maintained for inspection by the State Department of Public Health, of all complaints submitted to the Administrator or designee that are considered by this facility, to be resolved.

• Residents shall not be subject to retaliation by the Administrator or staff as a result of a complaint.

• Grievances involving differences of opinion due to a conflict of individual rights among Residents may be reviewed with the Resident or Family Councils.

• Procedures for the implementation of the Grievance Policy shall be developed and made known to all staff during staff orientation and in-service training.

• Grievances and concerns will also be investigated when received from Resident and/or Family Councils.

| NONDISCRIMINATION POLICY |

It is the policy of this facility to provide service to all persons without regard to race, color, national origin, creed, religion, sex, disability, age, marital status, veteran status or sexual orientation in compliance with the Congressional Federal Register. The same requirements are applied to all, and there is no distinction in eligibility for, or in the manner of providing services. All services are available without distinction to all program participants regardless of race, color, national origin, creed, religion, sex, disability, age, marital status, veteran status or sexual orientation. All persons and organizations, having occasion either to refer persons for services or to recommend our services, are advised to do so without regard to the person’s race, color, national origin, creed, religion, sex, disability, age, marital status, veteran status or sexual orientation.

The person designated to coordinate compliance with Section 504 of the Rehabilitation Act of 1973 (Nondiscrimination Against the Disabled) is the Administrator.

| RESIDENT RIGHTS FOR PEOPLE IN LONG TERM CARE FACILITIES |

Long-term care Residents residing in Nebraska are guaranteed certain rights, protections and privileges according to State and Federal law.

**Your Rights to Safety and Good Care**

• The facility must provide services to keep your physical and mental health, and sense of satisfaction with yourself at their highest practical levels.

• The facility must be clean and stay at a healthy temperature.

• You must not be abused by anyone; physically, verbally, mentally, financially or sexually.

• The facility must not physically restrain you unless there is no other way to keep you safe and you agree to the restraint.
You may be given medicine intended to change your mood or how you think only with your permission and only as part of an overall plan designed to change or remove the problems for which the medicines are given.

Your Rights to Participate in Your Own Care

- You have a right to participate in the planning of total care, or to refuse treatment. You may only participate in experimental research upon proper informed consent.
- The facility must develop a written care plan which states all the services the facility will provide to you and everything you are expected to do. The facility must make reasonable arrangements to meet your needs and choices.
- You may go to the care plan conference where your care plan is decided.
- You may choose to have family, friends or a representative participate in the care plan conference.
- You have the right to choose your own doctor. You have a right to be fully informed by your physician of your health and medical condition, unless medically contraindicated. You will have to pay the doctor yourself unless Medicare, your insurance plan or Medicaid will pay the doctor bill.
- The facility must tell you the name and specialty of each doctor responsible for your care, and how to contact that doctor.
- You have the right to be in charge of taking your own medicine if your care planning team and your doctor says that you are able to do so.
- You have the right to refuse any medical treatment. If you refuse treatment, the facility must tell you what may happen because of your refusal and tell you of other possible treatments. This is called a negotiated risk agreement and must be documented in your care plan.
- You have the right to complete information about your medical condition and treatment in a language that you can understand.
- You have the right to make a Living Will or Durable Power of Attorney for Health Care, so the facility will know your wishes if you can no longer speak for yourself.
- The facility must allow you to see your medical records within 24 hours of your request. You may obtain a copy of part or all of your records and may be charged a reasonable copy fee with two working days’ advance notice.
- The facility may not require you to work.
- You have the right to move out of the facility after you give the administrator, nurse or doctor written notice that you plan to move. You may leave the facility Against Medical Advice “AMA.” However, if you plan to leave with the consent of your physician, discharge planning and discharge orders from your physician are needed.

Your Rights to Privacy

- Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care.
• Facility staff must knock before entering your room.
• The facility may not give information about you or your care to unauthorized persons without your permission, unless you are being transferred to a hospital or to another health care facility.
• You have the right to have private visits at any reasonable hour. The only exception is if your doctor has ordered limited visits for medical reasons.
• You may ask any visitor to leave your personal living area at any time.
• You have the right to make and receive phone calls in private.
• The facility must deliver your mail to you promptly, and promptly send mail out for you. The facility may not open your personal mail without your permission.
• If you are married, you and your spouse have the right to share a room unless no room is available or your doctor has said you cannot share a room for medical/safety reasons.

Your Rights Regarding Your Money
• You have the right to manage your own money. Without your written permission, the facility may not become your money manager or your Social Security representative payee.
• If you ask the facility to manage your personal money for you, it must do so (State licensed and Medicare or Medicaid certified facilities only).
• If the facility manages your money
  o It may spend your money only with your permission.
  o It must give you an itemized written statement at least once every three months for all the money put into your account and all of the money taken out of your account.
• It must put your money in a bank account that earns interests for you if you live in a Medicaid facility and have over $50 or
• If the facility manages your money and you get Medicaid, the facility must tell you if your savings come within $200 of the amount Medicaid allows you to keep. Money saved over that amount may be used to pay for your care in the facility.
• If you die, within 30 days of your death the facility must give your family, or whoever is in charge of distributing your property, a final accounting of all money left in any account that the facility managed for you.
• You may see your financial record at any time.

Your Personal Property Rights
• You have the right to keep and wear your own appropriate clothing.
• You may keep and use your own property; including some furniture if there is enough space, unless this interferes with the health and safety of other Residents.
• You have the right to expect the facility to have a safe place where you can keep small valuables that you can get to daily.

• The facility must try to keep your property from being lost or stolen. If your property is missing, the facility must try to find it.

**Your Rights in Paying for Your Care and Getting Medicare and Medicaid**

• If you are paying for some or all of your care at the facility, you must be given a contract that states what services are provided by the facility and how much they cost. The contract must say what expenses are not part of the regular rate.

• The facility must not require anyone else to sign an agreement saying that they will pay your bill if you cannot pay it yourself. The only one who can be required to pay your bill for you is a court appointed guardian or someone else who is handling your money for you.

• The facility must give you information about how to apply for Medicaid and Medicare and rules about “spousal impoverishment.” Spousal impoverishment rules allow you to give money and property to your spouse and still be eligible for Medicaid.

• You have the right to apply for Medicaid or Medicare to help pay for your care.

• If you receive Medicaid, the facility may not make you pay for anything that Medicaid covers. The facility must give you a written list of what items and services Medicaid pays, and items and services for which you could be charged.

**Your Rights to Stay in the Facility**

• You have a right to be free from arbitrary transfer or discharge. You may only be discharged upon the following terms:
  o Upon your consent;
  o For medical reasons which must be based on your needs and be determined and documented by a physician;
  o For your safety or safety of other Residents or facility employees;
  o When rehabilitation is such that a movement to a less restrictive setting is possible;

• For nonpayment of the Resident’s stay, except as prohibited by the Title XVII of XIX of the Social Security Act as amended, or the Nebraska Nursing Home Act, Neb.Rev.Stat. Sections 71-6008 or 71-6037. Non-payment under the Nebraska Nursing Home Act must not include a change in Resident economic status so that the Resident receives Medicaid or becomes eligible for Medicaid if the Resident has resided in the facility for a period of one year after July 17, 1986, unless 10% of the facility’s Residents are receiving Medicaid or are eligible for Medicaid.

• A minimum of thirty (30) days written notice must be given to you or your designee prior to involuntary transfer or discharge, except:
Five days written notice must be given if the transfer is to a less restrictive setting due to rehabilitation;

Ten days written notice will be given if you are five or more days in arrears of payment of stay;

Written notice is not required in the event of emergency transfer or discharge if the transfer or discharge is mandated by your health care needs and is in accord with the written orders and medical justification of the attending physician, or if mandated for safety of other Residents or facility employees as documented by facility’s records.

Written notice must contain the following:

- The stated reason for transfer or discharge;
- The effective date of the transfer or discharge;
- If not less than 12-point, type the following text:

“A health care facility or health care service shall not discriminate or retaliate against a person residing in, served by, or employed at the facility or service who has initiated or participated in any proceeding authorized by the Health Care Facility Licensure Act or who has presented a complaint or provided information to the administrator of the facility or service, the Department of Health and Human Services, the Department of Health and Human Services Finance and Support, or the Department of Health and Human Services Regulation and Licensure. Such person may maintain an action for any type of relief, including injunctive and declaratory relief permitted by law.

- If you receive Medicaid and are hospitalized for 14 or fewer days,
  - The facility must let you return when you leave the hospital even if the facility has given you a Notice of Involuntary Transfer or Discharge.

- If you are hospitalized for more than 15 days, the facility must let you return if it has a bed available and you still need that kind of care.

- If the facility is full, you must be allowed to have the first available semi-private room, if you still need that kind of care.

- You have the right to be told in advance if your room or roommate is being changed (State licensed and Medicare and Medicaid certified facilities only).

**Your Rights as a Citizen and a Facility Resident**

- The facility must let you see reports of all inspections by the Nebraska Department of Health and Human Services, from the last five years and the most recent survey of the facility along with any corrective action plans from the facility.

- You have a right to be fully informed of your rights and responsibilities and of all rules and regulations governing Resident conduct and responsibilities. This information must be provided prior to or at the time of admission and its receipt
acknowledged by the Resident in writing, or in the case of Residents already in the facility, upon facility’s adoption of amendment of Resident right policies.

- You do not lose your rights as a citizen of Nebraska and the United States because you live in a long-term facility.
- If a court of law has appointed a legal guardian for you, your guardian may exercise your rights for you, according to the court order.
- If you named an agent under a Durable Power of Attorney for Health Care, your agent may exercise your rights for you.
- You have freedom of religion. At your request, the facility must make arrangements for you to attend religious services of your choice as long as you agree to pay any travel-related costs. The facility may not force you to follow any religious beliefs or practices and cannot require you to attend any religious services.
- You have the right to vote for the candidate of your choice in public elections.
- You have the right to participate in social and community activities that do not interfere with the rights of other Residents; you have a right to participate in an organized Resident group that functions to address facility issues. You have a right to review and receive a copy of their permanent record within two working days.
- You have a right to be fully informed in writing prior or at the time of admission and during your stay, of services available in the facility, and of related charges including any charges for services not covered by the facility’s basic per diem rate.
- You have a right to manage your personal financial affairs. Under specific written authorization by the Resident, the facility may assist in such management to the extent specified by the Resident.
- You have the right to participate with other Residents in the Resident Council. The facility must respond to concerns raised by the council.
- You have the right to be free from abuse, neglect, and misappropriation of your money and personal property.
- You have a right to retain personal possessions, including furnishings and clothing as space permits, unless to do so would infringe upon the rights and safety of other Residents.
- You have a right to access to the use of telephone with auxiliary aides where calls can be made private.
- You have a right to self-administer medications, if it is safe to do so.
- You have a right to refuse to perform services for the facility.
- You have a right to be treated with consideration, respect, and full recognition of your dignity and individuality, including privacy in treatment and care for or your personal needs.
• You have the right to receive visitors as long as this does not infringe on the rights and safety of other Residents in the facility. The administrator may refuse access to any person for any of the following reasons:
  o Resident refuses to see the visitor;
  o The presence of that person would be injurious to the health and safety of a Resident, especially as documented by the attending physician;
  o The visitor’s behavior is unreasonably disruptive to the facility and this behavior is documented by the facility;
  o The presence of that person would threaten the security of a Resident’s property or facility property; or
  o The visit is for commercial purposes only;
  o Any person refused access to a facility may, within 30 days of such refusal, request a hearing by the Department. The wrongful refusal of a nursing home to grant access to any person as required by Neb.Rev.Stat. Sections 71-6019 and 71-6020 constitutes a violation of the Nebraska Nursing Home Act. A nursing home may appeal any citation issued pursuant to this section as provided in 175 NAC 12-008.02.

• You have the right to meet with the Long Term Ombudsman, community organizations, social service groups, legal advocates, and members of the general public who come to the facility. Representatives of these groups may come to the facility to provide services, tell you about your rights or help you assert your rights.

• You have the right to present grievances

  • To the facility and to get a prompt response. The facility may not threaten or punish you in any way for asserting your rights or presenting grievances.

  • To outside organization(s) and advocate(s). The telephone numbers for these agencies will be provided to you by the facility at the time when you receive this handbook.

• If the rights presented in the booklet are not uniformly and consistently applied within the long-term facility, the following actions may be taken:
  o Define the problem. Writing it down may help make clear exactly what has happened and why it is wrong. When did it happen? (Give times and dates if possible). Who was involved or saw the incident? Ask questions of others who may be involved or know about the problem.
  o If it seems appropriate, talk the problem over with the staff responsible for taking care of you. Find out the facility procedures for resolving problems or concerns. If this does not seem like a good idea, or if you are not satisfied after you do, choose someone with more authority in the facility to talk to. Consider the Administrator, the Director of Nursing, your Physician, the Social Worker or Floor Nurse.
  o Participate in the Resident Council. The Council may present complaints on behalf of a Resident to any person it considers appropriate.
o Ask for assistance. If you or the Resident Council needs help solving the problem, you may ask the Long Term Care Ombudsman Program of assistance. The Long Term Care Ombudsman Program offers confidential help to older adults who have questions, concerns, and/or complaints regarding the care they are receiving in their long-term facility.

• If the problem relates to a person with a developmental disability or mental illness, you may ask for help from League of Human Dignity, a non-profit organization that provides protection and advocacy for people with disabilities in all aspects of community living regardless of age.

• File a grievance with the Central Complaint Registry. Nebraska has a formal Central Complaint Registry in the Nebraska Department of Health and Human Services. If you think the facility is violating your rights or those of your fellow Residents, you can make a complaint against it. The Department of Health and Human Services will investigate your grievance, and if a violation has been found, the long-term care facility will be cited and corrective action will be taken.

| RESIDENT RESPONSIBILITIES |

We understand that illness may limit some Residents in their ability to meet all of the following responsibilities, in which case a family member, friend or guardian may assume the responsibilities.

1. Residents are expected to be considerate to and of other Residents, staff members, and visitors. Verbal or physical abuse from Residents will not be tolerated and may be cause for discharge if a discharge criterion is met. Residents are responsible for being respectful of the property and space of others and of the facility.

2. Residents are asked not to pay employees or to give them gifts to perform routine or special services. However, small acts of kindness such as cookies, cakes or candy are permitted and may be accepted by staff members.

3. Private telephone lines may be installed in the Resident’s room, as available. The Resident or representative must pay all expenses for the installment and use of a private telephone.

4. Funds may be deposited into a Resident trust account. Questions concerning personal funds should be referred to the Administrator, Business Office or Social Services Department.

5. Residents are encouraged to leave valuables (i.e. rings, pins, jewelry, etc.) at home or with family members. All valuables retained by the Resident will be inventoried and documented in the Resident’s medical record. Please let the Admitting Nurse, Director of Nursing or Administrator know of any valuables brought into the facility for the Resident so they can be inventoried.

6. Residents are expected to maintain good relations with their roommate(s). Problems that arise should be discussed with Social Services. Residents
occupying semi-private rooms are expected to share their rooms equally with their roommate(s).

7. Religious, social, and recreational programs are conducted in the facility. Residents are encouraged to attend all programs. Bedside programs are provided for those Residents who are not able to attend. Family and friends are encouraged to participate in our scheduled activities. Residents are encouraged to eat their meals in the dining room.

8. Residents may not leave the premises without signing out at their respective nurse’s station. Employees will not be permitted to sign Residents out unless authorized in writing from the representative and the facility Administrator.

9. Smoking is permitted only in designated areas. Smoking regulations are posted throughout the facility and must be followed at all times.

10. Residents are expected to be observant of the rights of others.

11. Residents wishing to watch TV later than the established time may do so in the Resident lounge, unless otherwise agreed upon by the Resident’s roommate.

12. Overhead lights must be turned off at bedtime so as not to disturb other Residents. Residents may utilize overhead lighting for personal use.

13. Residents and/or visitors should not talk loudly or disturb other Residents. Complaints could result in limiting the number of visitors in a room.

14. Residents are prohibited from keeping any weapons in their possession, i.e. gun, knife, razorblade, scissors or stick (other than a cane) that may cause bodily harm.

15. Residents may not leave the facility for overnight visits unless approved by their doctor and meet the current Medicare/Medicaid regulations.

16. When fire or other drills are conducted, Residents and visitors are expected to follow the instructions issued by the person in charge.

17. Only authorized electrical appliances will be permitted in Resident rooms. Pictures, calendars, etc. may be hung on bulletin boards in rooms.

18. It is the responsibility of the Resident or the Resident’s Representative to notify the Administrative office if the Resident’s bed is to be held should the Resident be transferred to the hospital or for therapeutic leave. Failure to do so may result in the Resident’s loss of bed space.

19. Family and friends may visit during visiting hours. All facility rules must be followed as well as any instructions issued by the charge nurse or person in charge.

20. The facility reserves the right to clean any area and to discard any items not considered to be sanitary and in accordance with our established housekeeping policies and procedures.
21. Equipment, *i.e.* wheelchairs, walkers, canes, etc. belonging to the facility and for the general use of all Residents may not be removed from the facility when Residents go home for overnight visits unless authorized by Administration.

22. Our facility cannot keep a Resident against his/her will. Should a Resident wish to be discharged; every effort will be made to contact the legal guardian or representative before the Resident is discharged. Documentation of such discharge is recorded in the Resident’s medical record. NOTE: Please direct questions concerning this matter to the Administrator or Director of Nursing.

23. It is the facility’s desire to provide quality care and services. Residents and/or their legal guardians or representatives are encouraged to discuss problems concerning treatment, care, operations, etc. with the Administrator. We solicit all recommendations/suggestions that would be beneficial to all concerned.

24. It is each Resident’s/representative’s responsibility to provide, to the best of his/her knowledge accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.

25. The Resident, who is able to communicate, is responsible for reporting changes in his/her condition to the charge nurse, aide and/or therapist.

26. The Resident is responsible for following the treatment plan prescribed by his/her doctor, and for the following facility rules and regulations affecting Resident care and conduct.

27. The Resident is responsible for his/her actions if he/she refuses treatment or refuses to follow doctor’s orders.

28. The Resident/representative is responsible for clearly labeling all his/her personal property.

29. The Resident/legal representative is responsible for assuring that the financial obligations of his/her health care are fulfilled.

30. It is the Resident’s responsibility, if able; to make it understood whether he/she understands a planned course of action and what is expected of him/her.

31. The Resident is responsible to practice good personal hygiene and if necessary, accept assistance from facility employees in maintaining good hygiene. Residents are required to be fully dressed including shoes, when out of their room. If not in street clothes, they must be clothed in a gown, robe, and slippers.

32. Residents may not keep medication in their rooms unless ordered by the physician.

33. Each Resident and/or representative is encouraged to participate in developing an individualized plan of care to meet the needs of the Resident.
ADVANCE HEALTH CARE DIRECTIVES AND LIVING WILLS

Residents who are legally competent to make their own health care decisions are encouraged to execute a Health Care Power of Attorney and/or Living Will. The Health Care Power of Attorney and Living Will are legal documents. You and your family may want to contact your attorney for the completion and execution of such documents. If you and your family do not have an attorney, the Administrator or the Director of Social Services of the facility can assist you in locating one.

A **Health Care Power of Attorney** allows you to name another person to make all health care decisions on your behalf when you are not able to do so. The Health Care Power of Attorney also allows you to specifically indicate whether your wish to be kept alive on life-support systems under various circumstances.

The **Living Will** has a more limited purpose. It states your wishes, regarding certain medical and life-sustaining treatments, should you become terminally ill and death is imminent.

This facility will follow instructions contained in an appropriately executed living will. The facility will also follow the directions of a person named in a Health Care Power of Attorney as being authorized to make health care decisions for you.

This facility also has a **Do Not Resuscitate (DNR) Order** policy. Under this policy, a competent patient can direct that a DNR order be entered. This means that in the event of a heart attack or pulmonary arrest, CPR and other forms of resuscitation will not be administered.

If you have any further questions regarding these policies, please contact the Administrator, Director of Social Services or Director of Nursing.

DO NOT RESUSCITATE ORDERS (DNR)

**Normal Procedures for Cardiac or Pulmonary Arrest**

In the absence of a DNR order, Cardiopulmonary Resuscitation (CPR) and/or other emergency procedures will be initiated in all circumstances of a Resident’s cardiac or pulmonary arrest.

**Effect of a DNR Order**

With a valid DNR order from the Resident’s attending physician, CPR will not be initiated (or if initiated will be discontinued) in the event of a cardiac or pulmonary arrest. By itself, a DNR order does not mean that other life sustaining treatment, therapy, hospitalization or use of any other aspect of emergency or routine care is to be withheld. Unless otherwise indicated in the physician’s orders, a Resident with a DNR order should receive routine treatment and care consistent with federal and state law and acceptable standards of practice.

It is this facility’s policy to accept DNR orders from a Resident’s attending physician, when such orders are in confirmation of a competent Resident’s written instructions, or someone legally allowed to make such a decision on a Resident’s behalf. This facility
will not accept a DNR order without the written consent of a competent Resident/agent. Such orders must be written by the physician in the Resident’s chart.

**Documentation**

The physician will enter, sign, and date the DNR order in the following place:
- The DNR Request and/or Physician Order Sheet.
- The order must contain the words “Do Not Resuscitate” or “DNR.”

**Duration and Review of DNR Order**

A DNR order shall remain in effect unless revoked.

A DNR order in this facility will not be terminated or rendered ineffective in this facility by a temporary hospital transfer. Upon the Resident’s return from the hospital, the DNR order will remain in effect unless revoked. However, if a Resident voluntarily discharges himself or herself from the facility and is readmitted at a future date, then a new consent and a new DNR order must be written before a DNR order shall again be in effect. CPR will be performed on a Resident unless and until a DNR order is written at this facility by the Resident’s attending physician in accordance with these established procedures.

**Revocation**

The person who consented to the DNR order may revoke the order at any time. Revocation by the person who consented must be made to the physician orally or in writing. Upon revocation, the DNR order forms shall be removed from the Resident’s medical record. Thereafter, CPR will be provided for the Resident. The Physician shall amend the Physician’s Order Sheet to show revocation of the DNR order.

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**CLINICAL SERVICES**

The following clinical services are available at the facility. These services are not included in the daily room and board rate and will be billed separately.

- **DENTAL SERVICES** – Dental assessments, examinations of prosthetic appliances (i.e. dentures) and treatments as necessary
- **PODIATRY SERVICES** – Limited to procedures for nails and skin
- **THERAPY & REHABILITATION SERVICES** – Consist of Occupational, Physical, Respiratory and Speech/Language
- **OPTICAL CARE** – General eye care and glasses
- **PHARMACY SERVICES** – Drugs and other pharmacy items ordered by your physician under your plan of care are provided through a selected pharmacy
RESIDENT COUNCIL

Residents of this facility are encouraged to participate in monthly Resident Council meetings to discuss the diverse matters of long-term care. The purpose of the Resident Council is to protect and preserve Residents’ rights and to afford Residents a forum to voice and discuss grievances and other problems and to participate in the resolution of these concerns. The Council is encouraged to make recommendations regarding facility operations, quality of life, Resident care issues, and to assist in the planning of outings, parties and special events, and other activity programming.

The facility will provide Residents with an appropriate meeting place and privacy will be afforded during meetings. The Council is to be formed by all Residents who wish to participate. Meetings are open to all Residents and their invited guests, i.e. employees of the Facility, family, friends, and members of community organizations. The Administrator and all Department Directors shall be available to meet with Resident Council upon the Council’s request. The facility staff shall afford those Residents who need transportation assistance to and from meetings.

The Activities Staff Member is responsible for the coordination and establishment of the Resident Council and is available to render assistance as needed. The Council members may develop the format, procedures, and agenda with the assistance of the Activities Staff Member. The Council shall determine the leadership structure, if any and/or officers in accordance with the by-laws.

These persons shall preside at the meetings of the Council, assisted by the Activities Staff Member when requested. The Activities Staff Member shall be available to attend meetings. In the event the Residents desire to establish mini-Resident Councils for wings or units of the facility, each unit shall be represented on an overall facility Resident Council. The Activities Staff Member will inform new Residents of the Resident Council. The date, time, and location of the meetings shall be posted on the monthly activities calendar.

All suggestions, complaints or views of the Resident Council presented in writing to the Administrator, Social Service Director or other facility staff will be reviewed and acted upon. The Facility’s Concern/Suggestion form will be used to document all concerns and complaints. The Administrator will respond to all written recommendations and complaints of the Council in writing and in accordance with the Facility grievance policy. When the Resident Council is not the appropriate forum for resolving the complaint(s), the Administrator shall be notified and make available other resources for resolving the complaint(s). The Resident Council may present complaints on behalf of a Resident to the Nebraska Department of Health and Human Services or to any other person/agency it considers appropriate.

RESTRAINT POLICY

In accordance with Federal and State laws, we have a very stringent policy regarding the use of physical and chemical restraints on Residents. Our philosophy of providing each Resident with the highest possible quality of care and life is reflective of our belief that is essential for our Residents to maintain their dignity and independence by being permitted to take the normal risks of everyday life. Restraints used in an attempt to remove these
normal risks of life violate the rights of the Resident; greatly reduce his/her quality of life, and present significant physical and psychological risks.

For these reasons and in accordance with current Federal and State laws, restraint use in our facility will only be considered in order to treat a medical symptom or condition that endangers the physical safety of the Resident or other Residents.

If restraint use is deemed necessary, the goal will be to use the least restrictive type of restraint for the shortest period of time possible. Every Resident will be individually assessed regarding the need for appropriate safety measures and will be periodically reassessed as his/her needs change throughout his/her stay at the facility.

Contact information for all appropriate State Protection and Advocacy organizations are provided in the “State and Federal Notification Requirements” section of this Handbook.

<table>
<thead>
<tr>
<th>SMOKING POLICY</th>
<th>Revised 2/2015</th>
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<tbody>
<tr>
<td>Standards</td>
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<tr>
<td>1. Smoking is a Resident privilege, not a right. That privilege may be revoked by the physician and/or the facility if the health and/or safety of the individual, other Residents or staff are threatened.</td>
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<tr>
<td>2. All Residents who desire to smoke will have a smoking assessment performed by a Licensed Nurse (for safety purposes) before they are allowed to smoke. The assessments will be reviewed by an interdisciplinary team for determination of appropriate interventions, if needed, as well as care plan development. Assessments will be performed quarterly.</td>
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<tr>
<td>3. Smoking risk assessments are performed quarterly with recommended changes, which could affect the safety of the Resident. The assessments are reviewed by the interdisciplinary team for agreement and planning of interventions.</td>
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<td>4. All Residents able to smoke will be able to do so in the facility’s courtyard (supervised by a staff member) area at the designated time specified on Form located at the end of this document and/or included in the pocket. In addition, a Resident who passes the smoking evaluation may be required to wear a smoking apron as an additional safety precaution.</td>
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<td>5. Employees shall receive training in emergency procedures and evacuation techniques should an accident occur as a result of smoking (See Fire and Disaster procedures).</td>
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<td>6. Tobacco products and smoking materials will not be sold in the facility. Smoking materials will be kept in a smoking box at Station 3. No smoking materials are allowed in rooms. If a Resident fails to follow housekeeping rules when using smokeless tobacco, privileges will be revoked.</td>
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<td>7. A fire extinguisher is located within close proximity to the designated smoking area(s).</td>
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<td>8. Smoking by Residents is only allowed during the posted smoking time while on company property. No exception will be allowed. Smoking is not allowed during field trips or a doctor’s appointment.</td>
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9. If the temperature is below 15°F (wind-chill included) or 90°F (heat index included), smoking will not be allowed. The smoke breaks is fifteen (15) minutes long.

10. Any Residents using smokeless tobacco must use such products at the designated smoking time.

11. Effective October 1, 2014, E-Cigarettes are only allowed outside during the above smoking time.

12. Failure to abide by this policy will result in the Resident forfeiting his/her smoking privileges on either a temporary or permanent basis.

13. Families who want to take their loved one out to smoke while visiting are not allowed to smoke on the property. Smoking is only allowed at the designated time and the designated location.

____________________________________      ________ ____________________________
Resident                                DON/SSD/ED

**PLEASE SIGN ON FORM LOCATED AT THE END OF THIS DOCUMENT.**
**COVERED AND NON-COVERED SERVICES** | Effective 9/1/14

**Covered Charges per diem rate for All Pay Types:**
- 24-hour Nursing Services
- Housekeeping and laundry services
- Nutritional meals and snacks to meet the dietary needs under the direction of a Dietitian
- Individual and group activities
- Basic Cable Television
- Social Services
- Restorative programs
- Ancillary supplies
- Laundry service
- Use of Homestead equipment (such as wheelchairs)

**Non-Covered Charges Per Pay Type:**

**Private**
- Physician Visits
- Medications, Lab and X-rays (may be covered by Medicare Part B or private insurance)
- Physical, Occupational and Speech Therapy (Therapy may be covered under Medicare Part B at 80%)
- Podiatry, Dental and Optical Visits (may be covered by Medicare Part B or private insurance)
- Personal Shopping Needs/Clothing
- Beauty/Barber Shop Services
- Transportation for medical needs are $25 per round trip (Escort is additional $25)
- Incontinent products
- Oxygen

**Medicare Part A**
- Co-Payment after 20 days of Medicare time (may be covered by supplemental insurance)
- Personal Shopping Needs/Clothing
- Beauty/Barber Shop Services

**Medicaid**
- Personal Shopping Needs/Clothing
- Beauty/Barber Shop Services

*Transportation available for medical needs only.*
RESIDENT BED RESERVE AND READMISSION POLICY

It is the policy of this facility to allow Residents to reserve a bed while away for a hospital stay or therapeutic leave, providing the bed reserve charge is paid, as required.

All transfers and re-admissions are made in accordance with the physician’s orders and the ability of the facility to provide the services you require upon your return. If the Resident requires a level of care not usually provided in his/her former unit, the facility retains the right to place the Resident in a different unit in order to assure appropriate care.

The present daily rate for bed reserve is equal to the current daily room rate.

Private Pay

A bed may be held for an indefinite period of time provided that you pay the daily bed reserve charge. In the event you do not desire to pay for a bed to be held, you may put in a request to be placed on our reservation/waiting list. Once you are able to return to the facility, you will be notified of the next available semi-private room.

Medicaid Recipients

1. Hospital Leave:

A bed may be held for up to fifteen (15) days for a physician-approved hospital leave. Reimbursement for the approved bed reserve is made at a rate determined by the State Medicaid program. If a Resident’s hospital stay exceeds the allotted fifteen (15) day period, he/she may choose to:

- Be placed on a waiting list for the next available semi-private room. Or
- May elect to pay the daily rate to have a bed held.

2. Therapeutic Leave:

A bed may be held for up to eighteen (18) days in a calendar year. Under these circumstances, the Resident may choose to:

- Be placed on a waiting list for the next available semi-private room. Or
- May elect to pay the daily rate to have a bed held.

Therapeutic Leave must be prescribed by the attending physician and be consistent with the Resident’s care plan. Prior physician authorization is required for reimbursement of a Therapeutic Leave and is made at the approval Medicaid rate.

During a Hospital or Therapeutic Leave, you are responsible to pay the facility your monthly available income as determined by the Medicaid Office.

Medicare Recipients

Medicare does not offer bed reservation coverage. You may elect to be put on a waiting list or pay privately for a bed to be reserved.

In the event you do not desire to pay for a bed to be held, you may put in a request to be placed on our reservation/waiting list. Once you are able to return to the facility, you will be notified of the next available semi-private room.
**Other Third Party Payer Recipients**

If a Third Party Payer covers your room and board, you may be entitled to bed reserve according to that plan. Our administrative office will be happy to assist you in determining the extent to which the Third Party Payer will cover a bed reserve and explain our Bed Reservation Request Plan. If your Third Party Payer does not cover bed reserve, you have the option of paying to reserve a bed from your own funds.

In the event you do not desire to pay for a bed to be held, you may put in a request to be placed on our reservation/waiting list. Once you are able to return to the facility, you will be notified of the next available semi-private room.

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**SINGLE ROOM ACCOMMODATIONS FOR MEDICAID RESIDENTS POLICY**

Private Room Allowed Pursuant to Resident Choice

**WHEREAS,** on October 27, 2005, the State of Nebraska approved a change to the state Medicaid plan that allows private supplementation of the Medicaid rate paid to nursing facilities so that a Medicaid recipient residing in a nursing facility may remain in, or utilize, a single-room in the nursing facility. The supplementation will not be income to the Medicaid Resident so as to disqualify the Resident for Medicaid.

**WHEREAS,** 471 NAC Chapter 12-009.05(5) provides that each nursing facility may make a decision on whether to provide single-room accommodations for Medicaid Residents and each facility is to have a written policy on single-room accommodations for all payers.

**THEREFORE,** the single-room accommodation policy of Homestead Rehabilitation Center is:

1. Single-room accommodation by all Residents regardless of payer source is authorized if the room is available and if the Resident chooses single-room accommodation. Single-room accommodation will be made, if available in the situation where the Resident therapeutically requires a single-room accommodation pursuant to a physician order.

2. No adjustment will be made on the cost report to remove the additional cost of the single-room accommodations only available to certain Residents as all Residents are eligible for single-room accommodation at the Resident’s choice.

3. If a Medicaid Resident wishes to remain in a private room, they must pay the difference between their Medicaid rate and the Private rate. This rate may fluctuate, as a Resident’s care level deems necessary.
| SINGLE ROOM ACCOMMODATIONS FOR VA RESIDENTS POLICY |

Private Room Allowed Pursuant to Resident Choice

WHEREAS, on October 27, 2005 NE-IA VA Affairs approved a change to the state VA plan that allows private supplementation of the VA rate paid to nursing facilities so that a VA recipient residing in a nursing facility may remain in, or utilize, a single-room in the nursing facility. The supplementation will not be income to the VA Resident so as to disqualify the Resident for VA.

WHEREAS, 471 NAC Chapter 12-009.05(5) provides that each nursing facility may make a decision on whether to provide single-room accommodations for VA Residents and each facility is to have a written policy on single-room accommodations for all payers.

THEREFORE, the single-room accommodation policy of Homestead Rehabilitation Center is:

1. Single-room accommodation by all Residents regardless of payer source is authorized if the room is available and if the Resident chooses single-room accommodation. Single-room accommodation will be made, if available in the situation where the Resident therapeutically requires a single-room accommodation pursuant to a physician order.

2. No adjustment will be made on the cost report to remove the additional cost of the single-room accommodations only available to certain Residents as all Residents are eligible for single-room accommodation at the Resident’s choice.

3. If a VA Resident wishes to remain in a private room, they must pay the difference between their VA rate and the Private rate. This rate may fluctuate, as a Resident’s care level deems necessary.

| DELINQUENT ACCOUNT POLICY |

When a Resident or Legal Representative of such Resident neglects to pay in full, the monthly amount due for cost of care and services rendered, the Facility may proceed with the following:

- File to become Representative Payee
- Enroll in Direct Deposit for Social Security
- File a request with any pension companies, annuities, and/or other income sources to enroll in Direct Deposit
- Initiate Discharge Proceedings for nonpayment
- Forward to a Collections Agency
- Begin Court Proceedings
ABUSE AND NEGLECT PREVENTION AND REPORTING POLICY

In accordance with State and Federal laws, we have a very stringent policy regarding abuse and neglect prevention and reporting abuse. We try to protect Residents and staff from abusive acts and to adequately train facility personnel in methods of detection and prevention of abuse and neglect. This facility complies with State and Federal regulations for reporting suspected and/or actual acts of abuse and/or neglect.

This policy is made known to all Residents and families during the admission process and to all employees during ongoing staff training. Procedures are posted in prominent locations regarding the manner of reporting allegations, incidents, and/or complaints for reference by Residents, families, visitors, and staff. Procedures to validate licensure, references, and certifications are completed prior to employment. Personnel policies specifically address provisions for termination of any employee who intentionally abuses a Resident or has direct knowledge of abuse and fails to report it. Any person or employee who, in good faith, reports abuse will not be subject to retaliation by Administrative personnel.

ABUSE means any physical or mental injury or sexual assault inflicted on a Resident other than by accidental means in a facility. This also includes the deprivation of goods and services necessary to attain or maintain physical, mental, and psychosocial well-being.

NEGLECT means the failure of a facility to provide adequate medical or personal care or maintenance to a Resident which results in physical or mental injury or in the deterioration of a Resident’s physical or mental condition.

Following are various classification of abuse.

- **MENTAL**—Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

- **PHYSICAL**—Includes hitting, slapping, pinching, kicking, biting, etc. Also includes controlling behavior through corporal punishment or restraining in an unauthorized manner against the Restraint Policy and related regulations.

- **SEXUAL**—Includes, but is not limited to, sexual harassment, sexual coercion, sexual assault or Resident-to-Resident/staff-to-Resident/Resident-to-staff non-consensual acts. Some consensual situations may meet definition depending on the cognitive status.

- **VERBAL**—Refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to Residents or their families to describe Residents in a negative manner, regardless of their age, ability to comprehend or disability.

Department directors will incorporate into departmental operating procedures provisions for monitoring care/services, staff/Resident interactions, and department deployment of staff to meet Resident needs.

Any staff member who has knowledge of or reasonable cause to believe a Resident has been or is being abused, or has knowledge that a Resident has sustained a physical injury
which is not reasonably explained by the history of injuries provided in the Resident’s medical record, is required to make an immediate oral report to the Administrator, Director of Nursing, the supervisor or Social Service Director, if appropriate.

The nurse on duty and other disciplines as appropriate and available shall promptly address complaints of abuse by a Resident or another individual. A Concern/Suggestion form shall be completed on behalf of the Resident, including details of the complaint, results of the investigation and notification to family, physician, and Administration. Assessment findings will be documented in the nurses’ notes and the incident will be further documented on an Accident/Incident Report, if there is alleged physical abuse.

If the abusive act is of a physical nature requiring nursing and/or medical intervention, a licensed nurse is responsible for assessing the Resident, promptly developing interventions and notifying the attending physician, Administrator, Director of Nursing, and Medical Director.

The Social Service Director or designee is responsible for visiting the Residents who have experienced an abusive incident to assess their psychosocial needs and to develop interventions to address identified needs.

The Administrator or designee shall notify the Resident’s representative promptly of any known abuse or neglect. The Administrator will supervise the investigative process and assure that interventions are promptly implemented, monitored for effectiveness and will ensure that appropriate follow up methods are utilized. Facility management staff will conduct investigations in a matter that is not designed to find fault or blame, but as an analysis to determine causative factors that can be controlled or eliminated to prevent future occurrences. The Administrator is responsible to notify the C.N.A. Registry or appropriate licensing authorities in the event the facility becomes aware of any actions by a court of law against an employee that indicates he/she is unfit for duty. The facility Administrator or designee will contact the Nebraska Department of Health and Human Services by telephone or fax immediately within 24 hours upon determining a situation exits (or existed) that is reportable under the Department’s guidelines. In addition to reporting occurrences to the Nebraska Department of Health and Human Services, reports will be made to Adult Protective Services and the local Ombudsman. If the incident appears to be a criminal act, the Administrator will notify the appropriate local law enforcement agencies.
STATE AND FEDERAL NOTIFICATION REQUIREMENTS

State Agency Information

In compliance with Federal and State regulations, these addresses and phone numbers are hereby provided for the protection of our Residents:

a) Nebraska Department of Health & Human Services
   301 Centennial Mall South
   Lincoln, NE 68509
   (402) 471-3121
   Complaint Intake Line: (402) 471-0316
   Complaint Intake Fax: (402) 471-1679

b) League of Humanity
   Lincoln Center for Independent Living
   1701 P Street
   Lincoln, NE 68508
   (402) 441-7871
   Fax: (402) 441-7650
   info@leagueofhuman dignity.com

c) Office of the Long-Term Care Ombudsman
   HHS – Division of Aging Services
   P.O. Box 95026
   Lincoln, NE 68509-5044
   (402) 471-2307
   1-800-942-7830 (Nebraska only)

d) Nebraska Adult Protective Services
   24-hour toll-free hotline at 1-800-652-1999

HEALTH CARE RECORDS – PRIVACY ACT STATEMENT

Authority for Collection of Information Including Social Security Number (SSN)

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Principal Purposes for Which Information is Intended to be Used

This statement provides you the advice required by The Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purposes of evaluation and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.

Routine Uses

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory,
reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

Whether Disclosure is Mandatory or Voluntary and Effect on Individual of Not Providing Information

For Nursing Home Residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished, the determination of beneficiary services and resultant reimbursement may not be possible.

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<th>PRIVACY PRACTICES</th>
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<td>Health Information Rights</td>
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Although your health record is the physical property of the nursing facility, the information in your health record belongs to you. You have the following rights. Your personal representative has the right to exercise your rights on your behalf.

1. You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the facility’s general health care operations and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing on a form provided by the
facility and submitted to the facility Administrator. Although the facility will consider your request, please be aware that the facility is under no obligation to agree to your request.

2. If you are dissatisfied with the manner in which, or the location where, or the location where, you are receiving communications from the facility that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the facility Administrator. We will accommodate all reasonable requests.

3. You may request to inspect and/or obtain copies of your health information, which will be provided to you in the time frames established by law. If you request copies, the facility may charge a reasonable fee for copying maintained by the facility or its business associates in a designated record set except for (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and (c) health information that is subject to the Clinical Laboratory Improvements Amendments of 1988 (“CLIA”) and which the law prohibits provisions to you; or exempt from CLIA. In addition, the facility may deny your request if (i) the information was provided to you by someone other than health care provider under a promise of confidentiality and access would be reasonable likely to reveal the source of the information; (ii) if disclosure is reasonably likely to endanger your life or physical safety or that of another persons; (iii) any other reason where the disclosure is prohibited by state or federal law.

4. If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that the facility correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment. We ask that you use the form provided by our facility to make such requests. For a request form, please contact the facility Administrator.

5. You may request that the facility provide you with a written accounting of all disclosures made by the facility during the time period for which you request (not to exceed 6 years) or the time prior to April 14, 2003, whichever is less. Such requests should be made in writing on a form provided by our facility. Please note that an accounting will not apply to any of the following types of disclosures; disclosures made for reasons of treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures to law enforcement officials; and disclosures for national security purposes. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

6. You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.
7. You have the right to have us disclose some or all of your health information to someone of your choice, except for disclosures not permitted or required.

**Use or Disclosure of Your Health Information**

**BUSINESS ASSOCIATES:** There are some services provided to the facility through contracts with others called “business associates.” Examples include our accountants, consultants, and attorneys. When these services are contracted, we disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, unless the business associate is a health care provider, we only disclose the information that is minimally necessary for the business associate to perform its services. We also require the business associates to appropriately safeguard your information.

**COMMUNICABLE DISEASE:** We may disclose your health information to a person who may have been exposed to a communicable disease that you may have, or who may be at risk for contracting or spreading a disease or condition that you have.

**COMMUNICATION WITH FAMILY:** Health professionals, using their best judgment, may disclose health or payment information related to your care to a family member, other relative, close personal friend or any other person you identify.

**DIRECTORY:** Unless you notify us that you object, we may use your name, location in the Facility, general condition and religious affiliation for directory purposes. This information may be provided to members of the clergy and except for religious affiliation, to other people who ask for you by name. We may also display your name on a nameplate next to or on your door in order to identify your room, unless you notify us that you object.

**FOOD AND DRUG ADMINISTRATION (FDA):** We may disclose health information to the FDA or to an individual or entity that is subject to regulation by the FDA about a product that is regulated by the FDA. The disclosure would be used for activities related to the quality, safety or effectiveness of the FDA.

**FUNERAL DIRECTORS/CORONERS:** We may disclose health information to funeral directors and coroners to carry out their duties with applicable law.

**HEALTH CARE OPERATIONS:** We will use your health information for the Facility’s regular health operations. For example, members of the nursing staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

**HEALTH CARE OVERSIGHT:** We may disclose health information to a health oversight agency for oversight activities authorized by law for purposes of licensure, audits, investigations, inspections, disciplinary activities, civil, criminal or administrative proceeding or actions and other activities.

**LAW ENFORCEMENT:** We may disclose health information for law enforcement purposes as required or permitted by law or in response to a valid subpoena, or the order of a court of administrative tribunal, if requirements have been met under law.
MARKETING: A facility representative may contact you to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services and events, celebrations and activities that may be of interest to you.

NOTIFICATION: We may use or disclose information to notify or to assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided.

ORGAN PROCUREMENT ORGANIZATIONS: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

PAYMENT: We will use your health information for payment. For example, a bill may be sent to you or a third-party payer, including Medicare or Medicaid. The information on or accompanying the bill may include information that identifies you as well as your diagnoses, procedures and supplies used.

PUBLIC HEALTH: As required by law, we may disclose your health information to Public Health or legal authorities charged with preventing or controlling disease, injury, disability or investigating physical abuse.

REPORTS: Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

RESEARCH: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

TREATMENT: We will use your health information for treatment. For example, information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from our nursing facility.

WORKERS COMPENSATION: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
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<th>ELECTRONIC DATA TRANSFER</th>
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The United States Federal Government requires that certain information form your health care record be electronically submitted to them by this facility. The government has assured this facility that this information will remain completely confidential. The information collected will be used to improve the health care delivery system in the United States. We are required by the government to notify you of this data submission.

The information being supplied to the government is known as the Minimum Data Set (MDS) assessment of health information for the Resident. This standardized MDS is collected for every Resident in a long-term care facility throughout the United States.

Even though the MDS includes identification and background information, security measures have been put in place by this facility to ensure the privacy and confidentiality of each Resident’s medical record.

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<th>YOUR BENEFIT RIGHTS UNDER MEDICARE</th>
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Medicare is a health insurance program funded by the Federal government. With certain exceptions, an individual must be 65 years of age or older to be eligible for Medicare. The program is administered by the Federal Centers for Medicare and Medicaid Services through private intermediaries.

**PART A** of the Medicare program helps pay for certain services provided by a hospital, skilled nursing facility, hospice or home health agency.

**PART B** of the Medicare program helps pay for physicians, therapists, and other services not covered by Part A.

**PART D** helps pay for some of your medications.

Unless you have been automatically enrolled in Medicare, you may be required to file an application at your local Social Security office. Once enrolled in Medicare, you should receive a Medicare card that will state your recipient claim number, and whether you are enrolled in Part A, Part B or both. Health care providers may require you to produce this card in order for you to use your Medicare benefits to help pay for services or products. You must enroll for the Part D medication benefit separately.

Medicare Part A presently will pay, under certain conditions, a portion of inpatient skilled nursing or rehabilitation services provided in a participating nursing facility for up to one hundred days after at a three-day (midnight) qualifying hospital stay. Medicare will pay all of the covered services for the first twenty days. During the last eighty days, the recipient is required to pay a daily co-insurance charge, and Medicare will pay the balance over and above the co-insurance amount. While the maximum Part A benefit for a nursing home stay is one hundred days, each Resident’s coverage will vary based on individual medical conditions.

The daily Medicare co-insurance amount for the 21st to 100th day of skilled nursing home care is indicated in Attachment #2, of the Admission Packet. This amount is adjusted annually for inflation. The provider of the services covered under Medicare Part B bills Medicare Part B services. The Part B service provider is additionally responsible for
providing you with the appropriate co-insurance amount to pay. Medicare Part B insurance requires a twenty percent co-payment after an annual deductible.

When you enroll in the Part D medication assistance program, you will be asked to choose a Prescription Drug Plan (PDP). You should ensure that the PDP you choose covers the medications you need. Based on the PDP you choose, you may have different monthly premiums, deductibles and co-insurance. Your income level may also influence the amount of your premiums, deductibles and co-insurance. You may apply for Low Income Subsidy Assistance for your Part D expenses by calling your local Social Security Office or 1-800-772-12133.

If you have any questions about your Medicare benefits, call your local Social Security office, 800-MEDICARE or visit the web site www.Medicare.gov.

YOUR BENEFIT RIGHTS AND ELIGIBILITY UNDER MEDICAID

If you have any questions about eligibility or the application process under Medicaid or need information about how to receive funds for previous payments covered by such benefits, please see our Admissions Department. They will provide you with information to assist you in the application or reimbursement process. You may also call the Nebraska Department of Health and Human Services at (402) 471-3121 or visit their Website at http://www.hhs.state.ne.us.

It is the responsibility of each Resident/representative to apply for Medicaid when assets are not expected to cover charges for more than a three month period. This will allow an appropriate amount of time for the Medicaid application process. Medicaid defines “Assets” or Resources” as cash-on-hand, cash deposits in banks or other financial institutions, stocks, bonds, cash value of life insurance policies, real estate, etc. Please note that Residents who have a spouse in the community may qualify for additional benefits that will permit a greater asset allowance.

Once the application process has been completed the Medicaid office will notify you whether assistance has been granted or denied. You will also be provided with information on how to file an appeal if you don’t agree with the decision. The Department of Human Services will determine the date they will begin assistance and notify you of the amount you are responsible to pay the facility.

Married Couples With a Spouse in the Community

If you are married, a portion of your non-exempt resources, as determined by the Nebraska Department of Health and Human Services, are protected in order to prevent the impoverishment of your community spouse. You may transfer some of your assets to your spouse, depending on the total assets your spouse already has. In addition, when you go into a nursing home, your spouse may keep your home, your car, and your household furnishings. They are not counted toward assets. Under the Spousal Impoverishment Protection Law, Medicaid may allow part or all of your monthly income to go to your spouse in the community.
Protecting Income for Your Spouse and Dependents

Deductions, from the amount of income you have to apply to the cost of care at this Facility, may be permitted for your spouse and any other dependent family members. These may include dependent children under age 21, dependent adult children, dependent partners or dependent brothers or sisters of either you or your spouse.

Applying for Medical Financial Assistance Under Medicaid

You, or the person helping you, will be required to fill out an application that requires a record of your assets and income. You will need to provide verification of your assets and supporting documentation. Copies of the following items will be required:

- Driver’s License and/or Photo Identification card
- Birth Certificate or Baptismal Certificate
- Proof of US Citizenship and/or Immigration Papers (if applicable)
- Social Security Card
- Medicare Card
- Marriage Certificate, Divorce Decree, Death Certificate of spouse (if applicable)
- Legal Guardian and/or Power of Attorney papers
- Health insurance cards (copy of both sides) and verification of premium payments for Resident and spouse (if applicable)
- Last five (5) years of Federal and State income tax returns
- Last five (5) years of savings and checking account statements
- Last five (5) years of credit union, money markets, IRA, mutual funds, etc.
- An explanation of deposits and withdrawals and copies of checks over $500, excluding Social Security and Pension income, over the last five (5) years
- Stocks, Bonds, and trusts owned or sold in the last five (5) years
- Social Security, Pension, Railroad Retirement, Disability, Rental Property, and all income checks for Resident and spouse (if applicable)
- Deeds, property tax statement, mortgage contract, contract for deed, sales contract (if applicable) on any real estate owned currently or sold in the last 5 years
- Title and registration on any/all motor vehicles. Payment book if applicable
- Complete life insurance policies. Obtain letter from insurance company (on company stationary) showing cash and face value
- Unpaid medical bills for three (3) month period prior to date of application
- Burial plot deed and burial plan contract, proof of ownership and value

| SURVEY RESULTS |

The results of the most recent long-term care inspection survey(s) conducted by Federal and State surveyors and any approved plan(s) or correction in effect with respect to this facility are accessible to Residents. Please check with the Nurse in Charge or the Facility’s Administrator about the location of this information.
RESIDENT ADMISSION AGREEMENT

HOMESTEAD REHABILITATION CENTER, LLC

Resident Admission Agreement

This Agreement is made and entered into between Homestead Rehabilitation Center, LLC, (hereinafter referred to as “Facility”) and ________________________ (hereinafter referred to as “Resident”) for admission to Facility on ____________________________ (date of admission) and ____________________________, Resident’s legal representative and/or the individual who has lawful access to Resident’s income and financial resources available to pay for Facility care (hereinafter referred to as “Responsible Person” and used interchangeably with “Resident”).

Resident and Responsible Person agree that the information provided in any pre-admission conversations is true and accurate and acknowledge that the submission of any false information may constitute grounds to terminate this Agreement.

Facility, Resident and Responsible Person, agree to the following terms and conditions:

I. DEFINITIONS

A. Nursing Facility

“Facility” or “Nursing Facility” means the health care facility to which Resident is being or has been admitted and shall include all agents, employees, consultants, experts, attorneys and other person acting or purporting to act on behalf of Facility.

B. Resident

“Resident” means the individual being admitted for care, room and board in Facility.

C. Responsible Person

“Responsible Person” means the individual with access to Resident’s income and assets, who shall be responsible for ensuring Resident’s income and assets are used to pay for Resident’s financial obligations to Facility. This term may include a court-appointed Guardian, Conservator, Power of Attorney, or Resident. It further means, the individual, along with Resident, who is personally liable to satisfy from Resident’s income and assets any and all charges for services provided by Facility to Resident, beginning on the date of admission and ending on the date of discharge. This includes, but is not limited to, Facility’s charges incurred due to: (1) any denial and/or delay of Resident’s application to participate in the Medicaid program; (2) Medicare co-insurance and Medicare non-covered services; (3) third-party payer source denial of coverage; and (4) Resident/Responsible Person failure to apply for Medicaid eligibility or to cooperate in establishing Resident’s eligibility. By signing this Agreement, Responsible Person agrees to be personally liable for the entire balance of the account if he/she does not use Resident’s income and assets to pay Facility for the care provided to Resident. If
Responsible Person, Power of Attorney, or Guardian does not pay the Resident’s Share of Cost each month, then the Facility will submit the Responsible Person’s/Party to Adult Protective Services. An investigation will then take place on behalf of Adult Protective Services and the Lincoln Police Department to investigate misappropriation of funds on behalf of a vulnerable adult. If Resident begins receiving Medicaid, Responsible Person is thereafter only personally liable to the extent he/she fails to pay Facility Resident’s income and assets identified as Resident’s share of cost by Nebraska Medicaid. Responsible Party is also obligated as set forth in Section IV of this Agreement. By signing this Agreement, the Responsible Person, under this subsection, acknowledges that Facility is not requiring the third-party guarantee of payment by the Responsible Person as a condition of admission.

D. Physician

“Physician” means Resident’s primary care physician or his/her designee, Facility’s Medical Director or any other physician approved by the primary care physician, Medical Director or Resident/Responsible Person.

E. Medicaid

“Medicaid” means any applicable state Title XIX financial assistance program.

F. Medicaid Pending

“Medicaid Pending” means that a completed, signed application for Nebraska Medical Assistance Program (i.e. Medicaid) has been received in the NHHS office, but a final decision about financial eligibility has not yet been made by the NHHS staff.

G. Daily/Basic Rate

“Daily Rate” means the daily charge for routine services rendered to Resident by Facility under the terms of this Agreement. The Daily Rate is subject to change from time to time.

H. Agreement

“Agreement” or “Admission Agreement” means this Resident Admission Agreement and any attachments thereto.

I. Facility Standards

“Facility Standards” means the Rules and Regulations of the applicable state and federal laws.

J. Plan of Care

“Plan of Care” means a care plan for nursing care, activities, restorative and rehabilitative services and psychosocial care, offered by Facility, as identified in Resident’s Plan of Care established by Facility.
K. Resident Paying Privately

“Resident Paying Privately” is a Resident for whom Facility does not receive payment from Medicaid or from the Veteran’s Administration. A Resident Paying Privately may be covered by Medicare and/or another third-party payor.

II. SERVICES TO BE PROVIDED

A. Nursing Service: Beginning on the date of admission, Facility will provide Resident with routine nursing services as required by Resident’s Plan of Care and as identified in the rate schedule; room and board; three meals a day except as otherwise medically indicated; bedding and linens; laundry housekeeping and activity and social programs developed by Facility. The Plan of Care is based on an assessment of Resident and will change as Resident’s needs change.

B. Physician Services: Resident must be under the care of a licensed physician in Nebraska, to be admitted. Resident may choose the licensed physician to provide medical services to Resident and the licensed physician must follow Facility’s policies and procedures. Facility is not obligated to provide Resident with any medications, treatments, special diets or equipment without specific orders from Resident’s attending physician. In the event Resident’s attending physician is unavailable, Facility’s Medical Director may issue appropriate orders. Resident is responsible for paying for all services or equipment ordered by Resident’s attending physician or Facility’s Medical Director for Resident’s care unless the service may be covered by Medicare, Medicaid, or another third-party payor.

C. Services of Other Providers: Facility may make available, from time-to-time, the services of outside providers which Resident may choose such as a dentist, therapist, and rehabilitation therapies. Resident may also choose his or her own dentist, therapist or other health practitioner to provide the service so long as the practitioner is properly licensed and agrees to comply with the policies and procedures of Facility. Unless the services are covered by another payment source, Resident is responsible for the charges.

If Resident chooses to use the services of a private duty nurse or attendant, Resident must inform the Director of Nursing and such private duty nurse or attendant must be properly licensed or trained, and although the private duty nurse or attendant is not an employee of Facility, he or she will comply with Facility’s standards of care and practice. Facility does not assume any liability for the actions of the private duty nurse or attendant and reserves the right to request that Resident terminate the relationship.

D. Pharmacy Services: Facility utilizes the Blister Pack system for dispensing medications. agrees to accept the pharmaceutical arrangement or to use a pharmacy which will administer medications through Facility’s pharmacy so Facility may regulate the medication and reduce medication errors. Facility will assist Resident to establish a relationship with a pharmacy that will comply with the rules and regulations for Medicare Part D. Pharmacy charges will be billed to Resident and Resident is responsible for the charges unless the charges are covered by Medicaid, Medicare or private insurance. Facility reserves the right to change pharmacy providers or medication dispensing systems following notice to Resident.
E. Ancillary Services and Supplies: Facility will provide ancillary services and supplies as identified on the Ancillary Price List, attached as Exhibit A, and such other ancillary services and supplies at the option and upon the request of or at the direction of treating physician or Facility’s Medical Director. The ancillary services and supplies as identified on the Ancillary Price List are subject to change from time-to-time at the discretion of Facility.

III. CHARGES AND PAYMENT

A. Monthly Payment for Basic Rate: Resident will pay the basic rate as specified on the rate schedule in effect at the time the service is rendered for routine nursing services provided to Resident and as outlined in the attached Exhibit B. The basic rate may be changed from time-to-time as provided in this Agreement. Charges for a Resident whose payor source is Medicare Part A or Medicaid will begin no earlier than the date of the admission.

B. Additional Charges: If Resident utilizes ancillary services and supplies not a part of the daily rate such as treatment not considered part of routine nursing care and supplies, equipment, additional personal care items, transportation, and physician ordered food supplements, as outlined in Resident Policies, the charges will be added to the daily rate. The charges for ancillary services and supplies are subject to change from time-to-time.

C. Outside Providers: In addition to Facility’s charges, Resident will pay for all fees and costs for goods and services furnished to or for Resident by anyone other than Facility unless otherwise covered in full by another third-party payor such as Medicare or Medicaid. These costs and fees are not included in the basic rate or the additional charges for ancillary services. Fees for services rendered by a physician are not included in the basic rate and will be charged directly by the physician to Resident.

D. Delivery of Statements: Facility will deliver by mail, or other method as requested by Resident/Responsible Person, to Resident or Responsible Person on or near the 15th of each month, a billing statement reflecting changes for nursing services for the following month and charges for ancillary services and supplies which were incurred in the prior month. Statements are due and payable on receipt of the monthly statement, however, no later than the twenty-fifth (25th) day of the month in which the statement is received. Interest will be charged at the rate of 14% for every account thirty (30) days past due.

E. Insurance: If Resident has private insurance, Facility will process the claim for Resident. Preapproval by the insurance company does not guarantee payment by the insurance company and Resident or Responsible Person is responsible for any charges not covered by the insurance company. Any co-payments are to be paid in advance of the service provided. If Resident has Medicare or Medicaid insurance benefits, Facility will bill Medicare or Medicaid for services that are covered. Resident or Responsible Person is responsible for paying any charges that Medicare or Medicaid does not cover as allowed by applicable laws. Resident agrees to use products in Facility’s formulary unless contraindicated in writing by the physician.

F. Modification of Charges: Facility reserves the right to change from time-to-time the amount of its charges or how or when the charges are computed, billed or become due. Resident’s care
needs may change while residing at Facility. Resident’s level of care will be reviewed at least quarterly and whenever there is a significant change in condition. Changes in the daily rate as a result of a change in the level of care will be provided to Resident/Responsible Person in writing and the new rate will be effective immediately.

G. Cost of Collection: If Facility initiates any legal action or proceedings to collect payment due from Resident, Resident or Responsible Person will be responsible for paying all attorneys’ fees and costs incurred by Facility in pursuing the enforcement of Resident’s financial obligations under this Agreement.

H. Obligations Resident’s Estate and Assignment of Property: Resident and Responsible Person understand that the charges for services provided by Facility remain due and payable until paid in full. This Agreement will operate as an assignment, transfer and conveyance to Facility of so much of Resident’s property as is equal in value to the amount of any unpaid obligations under this Agreement, and this assignment will be an obligation of Resident’s estate and may be enforced against Resident’s estate. Resident’s estate will be liable to and will pay to Facility an amount equal to any unpaid obligations of Resident under this Agreement. This assignment will apply whether or not Resident is occupying Facility at the time of Resident’s death.

I. Assignment of Payments: Resident may or may not be eligible for payments from a third-party. Resident authorizes Facility to make claims and to take other actions to secure for Facility receipt of the third-party payments to reimburse Facility for its charges for the stay and care of Resident. To the extent allowed by law as security for payment of Facility’s charges, Resident hereby assigns to Facility all of Resident’s rights to any third-party payments now or subsequently payable to the extent of all charges due under this Agreement. Resident or Responsible Person agrees to sign any necessary documents to forward third-party payments to Facility.

J. Payment. Regardless of payment source, Resident is responsible for paying all sums due and owing which are not covered by the payment source. If any payment is missed, Resident authorizes Facility to be appointed as Representative Payee for Social Security, Pension, Annuity, or other payment source. Said payment will be paid by direct deposit to Facility.

We request that you allow the facility to become Rep Payee for your loved one. Please contact the Business Office and they can assist you with submitting the necessary paperwork. Allowing Homestead Rehabilitation Center to become Rep Payee will eliminate unnecessary delays in payment to the facility as well as free you, the POA, of having to remember writing a check to us each month.

K. Medicaid Payment Source.

☐ Medicaid  ☐ Medicaid-Pending  ☐ Will Apply for Medicaid

1. If an application for Medical Assistance (“Medicaid”) is going to be made, Resident/Responsible Person agree that Resident is considered self-pay until Facility receives an official approval notice. Resident/Responsible Person agree that while the Medicaid application is being reviewed at a minimum, an estimated Private Portion
will be paid to Facility at the time of admission and each month. The estimated Private Portion is considered to be Resident’s current monthly income, minus the personal spending allowance and any allowable monthly deductions as designated in the State Medicaid Plan.

2. Resident/Responsible Person agree to make application for Medicaid in a timely manner and in no case later than ninety (90) days prior to the time Resident’s income, assets and resources are equal to the State’s Medical Assistance income and asset guidelines. Resident/Responsible Person agree to provide the Medicaid Caseworker with all of the requested information in a timely manner but in no case longer than ten (10) calendar days from the date the Medicaid Case Worker makes a request for the information. If Resident/Responsible Person fails to provide the Medicaid Case Worker with a proper, completed, signed application or fails to provide the requested information to the Case Worker and the application is denied, Resident/Responsible Person shall be liable for the self-pay charges owed to the extent Medicaid would have covered those self-pay charges to the extent permitted by Federal and State law.

3. Resident/Responsible Person agrees to inform Facility when a Medical Assistance application has been filed.

4. If the Medical Assistance application or subsequent review for eligibility is denied for any reason, the entire self-pay balance is due immediately upon receipt of the final Medical Assistance denial.

5. If Resident is a recipient of Medical Assistance, Resident and all persons financially responsible for Resident, if any, signing this Agreement shall pay to Facility any insurance, Social Security or other benefits to which Resident is entitled.

6. If Facility is certified for participation in a federal medical assistance payment program, neither the prospective Resident, nor anyone on Resident’s behalf, is required to, with the exception of share of costs as determined by Nebraska Medicaid or co-pays or deductibles; i) pay privately any amount for which Resident’s care at Facility has been approved for payment by medical assistance; or ii) make any kind of donation, voluntary or otherwise.

7. There is no condition of admission that Resident remains self-pay for any period of time.

L. Medicare Payment Source

1. If Facility is certified for participation in the Medicare program, Resident may be eligible for Medicare benefits depending upon certain Medicare Part A SNF coverage and eligibility criteria. If Resident is eligible and meets coverage guidelines for Medicare Part A SNF, Resident consents to engage in treatments, which have been prescribed by the physician.
2. If Resident meets the Medicare coverage and eligibility criteria for Medicare Part A SNF benefit, the first 20 coverable days of a benefit period, will be paid by Medicare. From the 21st day to the 100th day of benefit period, Resident will be responsible for the current year daily coinsurance amount set by Medicare.

3. If Resident utilizes Medicare Part A SNF benefits, Facility will bill Medicare for covered services. When eligibility has been determined retroactively, Facility will return any and all payments made by Resident, or by any person on Resident’s behalf, for services covered by Medicare.

4. If Facility does not believe that Medicare will pay because Resident does not require a Medicare Part A SNF level of care, Facility will provide a non-coverage notice indicating the reasons why Facility believes Resident’s stay will not be paid by Medicare and that Resident will be responsible for any financial costs incurred during the continued stay.

5. When Medicare Part A SNF benefit days have been exhausted, Resident will be responsible for any further financial costs incurred during the continued stay.

M. Changes in Charges. Any changes in charges due to cost of living increases will be communicated in writing to Resident/Responsible Person at least thirty (30) days prior to the effective date of such change.

N. Deposit. Resident shall deposit with Facility, at or prior to the execution of this Agreement, a sum equal to the Basic Fee set forth on Attachment B (herein “Deposit”) as security for Resident’s full, timely and faithful performance of all of Resident’s obligations under this Agreement, including, but not limited to the payment of the one month’s Basic Fees. If Resident fails to pay any fees or any other charges required to be paid to Facility under this Agreement, or otherwise defaults with respect to any provisions of this Agreement, Facility may, but shall not be required to, use, apply or retain all or any portion of the Deposit for the payment of any of such fees or other charges in default or for payment of any other sums for which Resident may become obligated to Facility by reason of Resident’s default, or to compensate Facility for any loss or damage which Facility may suffer by reason of such Resident’s default. If Facility so uses or applies all or any portion of such Deposit, Resident shall, within ten (10) days after written demand therefore, deposit cash with Facility in an amount sufficient to restore said Deposit to the full amount hereinabove stated and Resident’s failure to do so shall be a breach of this Agreement. Resident shall not be entitled to any interest upon such Deposit nor shall Facility be required to segregate or hold such Deposit separate from Facility’s general accounts, carrying such sum as a bookkeeping entry only. In the event that Resident shall fully perform all of the terms and provisions of this Agreement, Facility shall refund such Deposit or the unused balance thereof, if any, to Resident within thirty (30) days after Resident has vacated.

O. Credit Card Authorization: At the time of admission, Resident/Responsible Person will provide to Facility a credit card number and authorization for use by Facility if Resident fails to pay his/her bill as outlined herein. Attached as Exhibit C is the authorization for automatic payment.
IV. OBLIGATIONS OF RESPONSIBLE PERSON

A. Resident has a right to identify a Responsible Person who will have the ability to receive notices due Resident and is responsible for Resident’s financial resources. If a Responsible Person is identified at the beginning of this Agreement, Responsible Person will sign this Agreement. Responsible Person is obligated to pay for services and supplies that are billed by or through Facility or billed directly to Resident or Responsible Person by any other provider from Resident’s resources. Responsible Person will be personally responsible for compliance with all other terms of this Agreement. Responsible Person will assist in the preparation, completion and submission, if applicable, of Resident’s application for Medicare or Medicaid benefits. The failure to timely assist in the application process may result in the discharge of Resident for nonpayment. In the event Resident applies for Medicaid benefits, Responsible Person will arrange for the designation of Facility a representative payee for any Social Security related benefits or other income sources of Resident in the amount to be determined as Resident’s portion of the monthly benefit.

B. By signing this Agreement, Responsible Person agrees to be personally liable for the entire balance of the account if he/she does not use Resident’s income and assets to pay Facility for the care provided to Resident. If Resident begins receiving Medicaid, Responsible Person is thereafter only personally liable to the extent he/she fails to pay Facility Resident’s income and assets identified as Resident’s share of cost by Nebraska Medicaid. Responsible Person will also be obligated to pay Facility from Responsible Person’s personal resources as liquidated damages an amount equivalent to revenue lost by Facility due to Responsible Person’s failure to cooperate in the Medicaid eligibility or redetermination process.

V. MEDICARE OR MEDICAID PROGRAMS

A. Participation in Programs: Facility currently participates in the Nebraska Medical Assistance Program and the federal Medicare program. Facility reserves the right to withdraw from the programs at any time in accordance with law. The Nebraska Department of Health and Human Services is responsible for administering the Medicaid program and the Centers for Medicare and Medicaid Services is responsible for administering the Medicare program. Facility is not responsible for and makes no representations regarding the decisions in the administration of these programs.

B. Medicaid Benefits:

1. Notice of Medicaid Application Process: Resident/Responsible Person is required to continue to pay in advance for services until Resident receives notice that Resident is eligible for benefits. Facility cannot guarantee that a Medicaid certified bed will be available when Resident becomes eligible for benefits.

2. Medicaid Application: Resident/Responsible Person is responsible for applying for benefits, however, Facility will assist with documentation as needed to complete the application. The Nebraska Department of Health and Human Services determines Resident’s eligibility. Resident or Responsible Person is obligated to make full and
complete disclosure regarding financial resources during the application process. Failure to identify all resource or income, or the submission of false information, may result in the termination of this Agreement.

3. **Resident Pay Amount**: If Resident is approved for Medicaid benefits, Facility will accept payment from the Nebraska Medical Assistance Program, and Resident’s pay amount as determined by the Nebraska Department of Health and Human Services as payment in full for only those amounts covered by the Medicaid program. Services not covered by Medicaid remain the responsibility of Resident. In the event Resident applies for Medicaid benefits, Resident/Responsible Person, to the extent permitted by law, irrevocably designates Facility as representative payee for any Social Security related benefits or other income sources of Resident in the amount to be determined as Resident’s portion of the monthly benefit and will take action to assure Facility receipt of third-party payments to reimburse Facility.

4. **Authorization to Apply**: In the event of Resident’s incapacity and in situations where it appears that Resident’s resources appear to be depleted to the extent that Resident can no longer pay privately for nursing facility care, and if it appears that Resident has or will become eligible for Medicaid benefits to cover the cost of Resident’s continued stay in Facility, and if there is no Responsible Person authorized or willing to act on Resident’s behalf, then Resident hereby authorizes Facility to apply for Medicaid benefits on behalf of assisting Resident to secure payment through the Medical Assistance Program for Resident’s continued stay in Facility. In the event such benefits are denied or subsequently discontinued, Resident authorizes Facility to file on Resident’s behalf an appeal of the denial of benefits on discontinuance of Medicaid benefits and to take other action to secure Medicaid benefits as Facility deems appropriate. This clause does not guarantee that Facility will not initiate the process to discharge Resident for nonpayment.

5. **Communication with Nebraska Medicaid**: Resident gives full authority to communicate with, and receive all documentation from, Nebraska Medicaid. Facility is authorized to release medical information and other pertinent information to health care professional, insurance companies, survey agencies, or other official or medical entities. Resident and Responsible Person authorize Facility to provide Resident emergency medical treatment its staff has been trained to provide. Resident and Responsible Person authorize Facility to transfer Resident to a hospital or other Facility for emergency purposes. Facility may share Resident’s health information with other health care providers.

C. **Medicare**: To the extent that Resident is a beneficiary under either Medicare Part A or Medicare Part B insurance and the nursing services or ancillary services or supplies ordered by a physician are covered by such insurance, Facility or other provider will bill the Medicare program for the services or charges. Resident remains responsible for the co-insurance or deductible amounts. Facility will accept payment from the Medicare program as payment in full only for those services deemed to be covered in full under the Medicare program. Costs for services not covered by the Medicare program are the responsibility of Resident.
D. Medicare Part D Prescription Drug Benefits

1. **Enrollment in Medicare Part D Plan.** If Resident is an eligible beneficiary under the Medicare Part D insurance program and has enrolled or has been mandatorily enrolled in a Medicare Part D Prescription Drug or Medicare Advantage Plan (“PDP”), Resident shall advise Facility in writing of Resident’s chosen PDP upon admission. In the event that Resident becomes an eligible beneficiary under Medicare Part D after admission, or subsequently chooses to enroll in a PDP following admission, Resident shall notify Facility in writing of Resident’s chosen PDP prior to enrollment in the PDP. Resident shall advise Facility if Resident elects to change PDPs, and shall provide written notice of such election, including the name/identity of the newly-selected PDP prior to the effective date of the change in the PDP.

2. **Resident’s Responsibility to Pay for Pharmaceuticals.** Resident is responsible to pay the charges for all prescription and other drugs or medications while a Resident in Facility, except to the extent that such drugs and medications are covered in whole or in part by any applicable government reimbursement program. Some or all of the charges for prescription drugs and other drugs and medications may be covered by certain benefits available through Medicare Part D or other private insurance or governmental insurance/benefit programs, including Medicare Part A or B. In the event that coverage for any prescription drug, supply, medication or pharmaceutical provided to Resident is denied by any applicable governmental reimbursement program or other potentially available third-party payor or insurance program, then Resident or Responsible Person shall remain responsible to pay for all such prescription drugs, supplies, other medications or pharmaceuticals.

3. **Actions of Medicare Part D Plan.** Facility is not responsible for and has made no representations regarding the actions or decisions of any PDP, including, but not limited to, decisions relating to the establishment of the PDP formulary, denial of coverage issues, or contractual arrangements between the PDP and Resident, and with respect to any decisions made by the PDP relating to any long term care pharmacy provider that may be under contract with Facility.

4. **Dually Eligible Residents.** If Resident becomes eligible for Medicaid at any time during Resident’s stay at Facility, and also qualifies for benefits under the Medicare Program, then Resident shall be required to enroll in a PDP to ensure coverage of Resident’s prescription drug needs. Resident and/or Responsible Person shall take all necessary action to enroll Resident in a PDP, and shall advise Facility of such enrollment upon Resident’s acceptance into the PDP. Resident acknowledges that should Resident and/or Responsible Person fail to select a PDP, then the federal Centers for Medicare and Medicaid Services (“CMS”) will assign Resident to a PDP. Resident shall provide written notice to Facility of the name of Resident’s PDP and the effective date of enrollment.

5. **Billing and Resident Cost Sharing Obligations.** To the extent that Resident is a beneficiary under Medicare Part D, and the pharmacy prescriptions and/or services ordered by a physician are covered by Medicare Part D, then the Pharmaceutical Provider (as required by law) shall bill the charges for the covered services to
Resident’s PDP. Resident is responsible for and shall pay any and all cost-sharing amounts applicable under Medicare Part D insurance. Facility shall not be responsible to pay for any fees or cost-sharing amounts, including co-insurance and deductibles, relating to the provision of covered Medicare Part D pharmaceuticals to Resident. To the extent that Resident may qualify as a “subsidy eligible individual” who would be entitled to a reduction or elimination of some or all of the cost-sharing or premium amounts under the Medicare Part D benefit, Resident and/or Responsible Person has the sole responsibility to apply for such benefits.

6. Authorization to Request and/or Appeal Coverage Determinations. In the event that Resident is denied coverage under Resident’s PDP for pharmaceutical services or supplies prescribed by Resident’s attending physician, then the following shall apply:

a. Resident and/or Responsible Person may independently (i) request an exception from Resident’s PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a redetermination of any coverage denial issued by Resident’s PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for redetermination.

b. In the event of Resident’s incapacity, and if there is no other legal representative of Resident known to Facility or any other friend or relative known to Facility who is authorized and/or is promptly available or willing to act timely on behalf of Resident, or if Resident’s physician is unable or unwilling to act on behalf of Resident, then Resident authorizes Facility to (i) request an exception from Resident’s PDP to cover non-formulary or non-covered Medicare Part D drugs that are otherwise needed or required by Resident; (ii) file a request for a redetermination of any coverage denial issued by Resident’s PDP; (iii) file an appeal with the appropriate agency and judicial tribunals to challenge any denial of a request for redetermination.

c. In the event of an initial denial of coverage by Resident’s PDP, then pending the outcome of an exception request, a request for redetermination, or an appeal, and in the event that Resident’s attending physician fails to prescribe a clinically and reasonably acceptable substitute prescription medication, Resident authorizes Facility’s Medical Director to prescribe a clinically and reasonably acceptable substitute prescription medication which is covered by Resident’s PDP, if such clinically and reasonably acceptable substitute is available.

d. If a request for exception (filed by Resident, Facility or any other authorized representative) is ultimately denied following either reconsideration by the PDP or appeal to an appropriate tribunal, and if the requested pharmaceuticals are deemed medically necessary by Resident’s physician, and no reasonably acceptable substitute, as determined by Facility’s Medical Director, from the formulary of Resident’s PDP exists, then Facility shall make arrangements to provide the requested pharmaceuticals to Resident through an arrangement with an outside pharmacy. In any such situation, Resident shall be responsible to pay
all fees and costs for the non-covered pharmaceuticals, consistent with the requirements of this Section.

7. **No Effect on Medicare Part A Covered Nursing Services.** Resident’s Medicare Part D prescription drug benefits do not apply while Resident’s stay in Facility is covered under Medicare Part A. While Resident is in Facility on a Medicare Part A stay, Resident’s pharmaceutical needs generally are covered Medicare Part A.

E. **Non-Covered Services.** Resident is and remains obligated to pay Facility for services and supplies not covered by the Medicaid or the Medicare programs.

**VI. DURABLE POWER OF ATTORNEY**

Resident is encouraged to furnish to Facility, no later than the date of admission, a Durable Power of Attorney executed by Resident designating someone other than Facility as a person to make financial decisions, pay for services and, if appropriate, give medical consents. In the event that Resident fails to designate a Power of Attorney, Resident will be responsible to pay for a guardianship/conservatorship proceeding related to the appointment of someone to make decision on behalf of Resident if Resident lacks the capacity to make such decisions as determined by Facility. The Power of Attorney will be maintained in the files of Facility.

**VII. CHANGES IN ROOM ASSIGNMENT**

Facility reserves the right and discretion to transfer Resident to another room or bed within Facility, and the right and discretion to transfer Resident’s roommate to another room or bed, consistent with the safety, care and welfare of Resident. Resident may be requested to move to another room if there is a roommate conflict or to accommodate a new admission.

**VIII. TERMINATION, TRANSFER OR DISCHARGE**

A. **Resident Initiated:** Resident may terminate this Agreement at any time. Facility recommends that Resident provide three (3) days notice to Facility prior to termination. Any amounts owed should be paid prior to leaving Facility. The daily rate and charges will be adjusted accordingly if Resident receives Medicaid or Medicare benefits.

B. **Facility Initiated:** Unless Resident voluntarily consents, Facility will not terminate this Agreement or transfer or discharge Resident without at least thirty (30) days written notice as required by law except, Facility may terminate this Agreement and Resident’s stay within another legal time frame if:

1. The transfer or discharge is necessary to meet Resident’s welfare and Resident’s needs cannot be met in Facility;

2. If Resident’s health has improved sufficiently so that Resident no longer needs the services provided by Facility;

3. The safety or health of individuals in Facility is or otherwise would be endangered;

4. Resident has failed, after notice, to pay for charges for Resident’s care and stay at Facility; or

5. Facility ceases to operate.
IX. READMISSION – BED HOLD POLICY

A. Private Pay Residents. If Resident leaves Facility for a period of hospitalization, therapeutic leave, or any other reason (other than Resident’s death), and if Resident is not eligible for, or receiving Medical Assistance benefits, Resident’s bed will be reserved and Resident shall be obligated to pay the Basic Rate for any days that Resident’s bed is reserved. Facility will continue to hold the bed until notified in writing by Resident or Responsible Person that the bed is no longer desired. If Resident elects in writing not to reserve a bed, then Resident will be discharged from Facility and readmission to Facility shall be subject to bed availability.

B. Medical Assistance Residents. If Resident is eligible for, or is receiving Medical Assistance Benefits, and Resident leaves Facility for a period of hospitalization or therapeutic leave, Resident’s bed will be reserved for the applicable maximum number of days paid for a reserved bed under the Nebraska Medical Assistance program which is fifteen (15) days, and eighteen (18) days for therapeutic leave. The bed reservation period may be subject to change in accordance with any changes in the Nebraska Medical Assistance program. If the period of hospitalization or therapeutic leave exceeds the maximum time for reservation of a bed under the Nebraska Medical Assistance Program, Resident will be entitled to the first available accommodation suitable for Resident’s level of care if, at the time of readmission, Resident requires the services provided by Facility. Alternatively, following the lapse of the bed reservation period covered by the Medical Assistance Program, Resident may reserve a bed by electing to pay the Medical Assistance per diem rate charged immediately prior to the leave, and by providing written notice and advance payment for the days included in the reservation period.

C. Medicare Residents. In the event that a Resident eligible for Medicare Part A benefits is transferred to or readmitted to a hospital, Medicare Part A eligibility will be terminated on the day Resident is admitted to the hospital. Resident’s bed will be reserved at the Basic Rate unless Resident or Responsible Person elects, in writing, not to reserve a bed.

X. RULES AND REGULATIONS

A. Resident agrees to follow the rules, regulations and guidelines for Residents which are included in Resident and Family Handbook.

B. Resident acknowledges receipt of Resident Bill of Rights and acknowledges he/she should read, or have read to him or her, Resident Bill of Rights.

C. Facility reserves the right to amend or change its rules, regulations, policies and procedures. Facility’s rules, regulations, policies or procedures will not be construed as imposing contractual obligations on Facility or granting any contractual rights to Resident.

XI. PERSONAL PROPERTY OR FUNDS

A. Resident may manage his or her personal funds. If requested, Facility will manage personal funds and keep personal funds separate from Facility funds. Facility will provide a regular accounting of personal funds. Attachment D is the Trust Fund Policy and Authorization.
B. Facility accepts responsibility for personal property delivered to the administrator, or the administrator’s designee, for safekeeping and for which the administrator, or the designee, gives Resident a signed receipt. Facility is not otherwise responsible, as outlined by applicable law, for the loss, theft, or destruction of personal property, including money. At the time of admission, Resident is responsible for providing Facility with a list of personal property Resident brought to Facility.

C. Facility reserves the right to limit the items of personal property if the item violates fire safety regulations, create a hazard to the health or safety of others in Facility, or there is insufficient space for the item.

D. In the event of Resident’s death, Facility is authorized to transfer Resident’s personal property to a duly authorized representative of Resident’s estate. The duly authorized representative of Resident’s estate will acknowledge in writing the receipt of the personal property transferred to his or her custody by Facility.

E. If Resident’s personal property is not claimed or removed within 72 hours of Resident’s permanent transfer, discharge or death, Facility may move and place Resident’s personal property in storage until claimed. If Resident’s personal property remains unclaimed for 30 days after permanent transfer, discharge or death, Facility may dispose of Resident’s property. Facility is not responsible for any damages incurred to Resident's property if storage becomes necessary. Resident or Resident’s estate is obligated to pay all costs of storage or disposition and will bear the risk of loss or damage to the property.

F. Resident or Resident’s estate is responsible for any damage caused to Facility property beyond normal wear and tear, and will pay for the replacement or repair of damaged property, based on the actual charge or cost to Facility for such repair or replacement.

XII. RELEASE OF INFORMATION

Resident authorizes Facility to release Resident’s personal and medical records maintained by Facility for treatment, payments and operations as determined reasonable necessary by Facility. Resident also authorizes the release of the records prepared and/or maintained by Facility to Facility’s employees, agents, other health care providers from whom Resident receives treatment, to third-party payers of health services or others deemed reasonable necessary by Facility for purposes of treatment, payments and operations. Resident also authorizes the release to Facility of records prepared or maintained by other health care providers from whom Resident receives services or treatment. Resident also authorizes the release to Facility of records prepared or maintained by any third-party payer of health services pertaining to health services rendered Resident by Facility. Resident records otherwise will be confidential and will not be available to anyone other than Resident, authorized agents of the state or federal government without the written consent of Resident or without a subpoena or other legal order.
XIII. WAIVER

Facility reserves the right to waive any obligation of Resident under the provisions of this Agreement in its sole and absolute discretion. No term, provision or obligation of this Agreement will be deemed to have been waived by Facility unless there is a waiver in writing by Facility. Any waiver by Facility will not be deemed a waiver of any other term or provision of this Agreement, and the other obligations of Resident or Responsible Person will remain in full force and effect.

XIV. FACILITY’S GRIEVANCE PROCEDURE

A. If Resident/Responsible Person believe Resident is being mistreated in any way or Resident’s rights have been or are being violated by staff or another Resident, Resident/Responsible Person shall make a complaint to Facility’s Director of Nursing, Administrator or Director of Social Services. Resident/Responsible Person must notify Facility before pursuing any other legal avenues. This agreement is not intended to preclude Resident’s or Responsible Person’s right to file a complaint with any governmental regulatory agency at any time.

B. Facility will review and investigate the complaint and provide a response to Resident/Responsible Person.

XV. INDEMNIFICATION

Resident will indemnify and hold Facility harmless from, and is responsible to pay for any damages or injuries to other persons and Resident, or to the property or other persons or Residents, caused by the acts or omissions of Resident, to the extent permitted by law.

XVI. ACKNOWLEDGMENTS

A. Rates: Resident and Responsible Person acknowledge the receipt of a copy of the daily rate schedule and the ancillary services not included in the daily rate.

B. Resident Rights: Resident and Responsible Person acknowledge being informed, orally and in writing, of Resident’s Rights as specified in state and federal law, and acknowledge having an opportunity to ask questions about those rights. The notice given to Resident regarding Resident’s Rights is subject to change by law and will not be construed as imposing any contractual obligation on Facility or granting any contractual rights to Resident.

C. Governing Law: This Agreement is governed by the laws of the state of Nebraska.

D. Advanced Directives: Resident and Responsible Person acknowledge being informed, orally and in writing, of Facility’s policy on advance directives and medical treatment decisions.

E. Resident Policies: Resident and Responsible Person acknowledge the receipt of a copy of Resident and Family Handbook and the opportunity to ask questions about Facility’s policies and procedures contained in Resident and Family Handbook. Resident and Family Handbook are
subject to change and will not be construed as imposing any contractual obligations on Facility or granting any contractual rights to Resident.

F. Statutes and Regulations: Resident and Responsible Person acknowledge they have been informed by a representative of Facility that Facility is to comply with various state and federal statutes and regulations. Resident and Responsible Person agree that these statutes and regulations do not impose any contractual obligations on Facility or grant any contractual rights to Resident.

G. Agreement: Resident and Responsible Person acknowledge they have read and understand the terms of this Agreement, that the terms have been explained to them by a representative of Facility, and that they have had an opportunity to ask questions about the Agreement or to consult their own attorney regarding the terms of the Agreement.

H. Captions: All captions and headings are for convenience purposes only and have no independent meaning.

I. Smoking: Resident agrees to follow the smoking procedure outlined in Resident Handbook and/or addendum.

J. Photographs: Resident agrees that appropriate photographs of Resident may be used by Facility in marketing, public relations, or other promotional materials. Resident also agrees photos of Resident may be used for identification and treatment purposes.

K. Mail: Facility staff will assist in opening mail if requested by Resident.

L. Miscellaneous: Resident shall provide personal clothing as needed and desired, and agrees to follow the procedure for reporting clothing and other personal items to the nurse’s station. All medicines, liquids and food brought to Resident must be checked by the nurses; electronic devices such as heating pads, electric blankets and extension cords are not allowed; throw or scatter rugs are not permitted.
**DATED** this _____ day of _______________________, 20____

_____________________________________________________
Resident

_____________________________________________________
Responsible Person

_____________________________________________________
Responsible Person - Print Name

Responsible Person’s Address, City, State and Zip

H: ________________  W: ________________  C: ________________

Responsible Person’s Telephone Numbers

_____________________________________________________
Responsible Person’s Email Address

_____________________________________________________
Homestead Rehabilitation Center Representative
RESIDENT ADMISSION AGREEMENT
GUARANTEE

Resident Name: ________________________________________________________________
(Please Print)

The undersigned Guarantor, whether one or more, to induce Facility to enter into the foregoing Admission Agreement with Resident/Responsible Person, hereby guarantees the prompt and complete performance of all financial obligations of Resident/Responsible Person arising under the terms of the Admission Agreement. The Guarantor, from his/her personal estate, shall pay to Facility any and all sums that Resident/Responsible Person fails to pay when due. Each Guarantor shall be liable to pay the amounts owing immediately, without the necessity of demand on either Resident/Responsible Person or Guarantor, and without regard to the liability or availability of assets of any other person. In the event Resident becomes eligible for services from Facility under the Nebraska Medicaid Program, this Guaranty shall immediately become unenforceable as to any financial obligations for the waiver program, without impairing the enforcement of the Guaranty as to any financial obligations previously accrued.

Dated this __________ day of _____________________________, 20__________.

Signed: ___________________________________________ __________________________
(Guarantor)

Guarantor’s Printed Name: ______________________________________________________

Guarantor’s Telephone Number: _______________________________________________
ATTACHMENT A TO ADMISSION AGREEMENT

ANCILLARY SERVICES AND SUPPLIES FOR PRIVATE PAY RESIDENTS

1. **Wheelchairs.** Facility will provide a standard 18” wheelchair. If a smaller, larger, or specialized adaptive wheelchair is required, the responsibility lies with the family or financial provider. A $5.00 per day charge will be assessed to Residents using Facility wheelchairs.

2. **Telephone.** Resident will be charged the connection fee billed to Facility from the telephone service provider as well as the monthly service charges.

3. **Transportation Charges.** Resident or his/her Responsible Person shall provide transportation for medical appointments outside Facility. If Responsible Person is not available, Resident may use Facility van at a flat rate charge plus mileage. If a professional must accompany Resident, an hourly wage will be assessed.

Transportation charges are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round Trip</td>
<td>$25</td>
</tr>
<tr>
<td>Escort</td>
<td>$25</td>
</tr>
</tbody>
</table>

4. **Incontinent Products.** Briefs are $15-20 per package.

5. **Secure Care Bracelet.** A secure care bracelet is $175.

6. **Beauty/Barber Shop:** See “Beauty and Barber Shop Services” on page 6.

7. **Personal Needs/Clothing:** Costs vary.

8. **Medications:** Resident is responsible for all medication costs.

9. **Oxygen:** Resident is responsible for all medication costs.
ATTACHMENT B TO ADMISSION AGREEMENT

BASIC ROOM RATE INFORMATION

<table>
<thead>
<tr>
<th>Long-Term (Extended) Care</th>
<th>Private</th>
<th>$ 240 per day or $_______ per month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Semi-private</td>
<td>$ 220 per day or $_______ per month</td>
</tr>
<tr>
<td>Short-Stay Rehabilitation</td>
<td>Station 5 Private</td>
<td>$ 295 per day or $_______ per month</td>
</tr>
<tr>
<td></td>
<td>Semi-private</td>
<td>$ 250 per day or $_______ per month</td>
</tr>
<tr>
<td></td>
<td>Station 6 Private</td>
<td>$ 295 per day or $_______ per month</td>
</tr>
<tr>
<td>Memory Care/Alzheimer’s Care</td>
<td>Private</td>
<td>$ 240 per day or $_______ per month</td>
</tr>
<tr>
<td></td>
<td>Semi-private</td>
<td>$ 220 per day or $_______ per month</td>
</tr>
</tbody>
</table>

- Rates include meals and care provided to Residents, with the exception of Residents who require one-on-one care. In the event that Nursing Staff provide one-on-one care, the daily private rate is $15 per hour.

- Therapy, supplies and medications are not included in the daily room rate.

- Facility accepts Medicare, Medicaid, Veteran’s Administration (VA) benefits, Managed Care, Private Pay, Commercial Insurance and is a preferred provider for most insurance companies.

- Room rates apply to our bed hold policy. If a Resident chooses not to pay, the bed will be held for three (3) days (day of transfer and two consecutive days following). Once three days have passed and “No Paid Bed Hold” was selected, Facility has the right to offer that bed to another prospective Resident. See Bed Hold Policy below.

Bed Hold Policy

It is the policy of Homestead Rehabilitation, LLC Center to offer Short Stay Rehabilitation Residents (Medicare A, Insurance, Private Pay, Managed Care) the option to pay if they are transported to the hospital during their stay and wish to be readmitted to the same bed at the rates listed above. Facility will contact the patient 24 hours after admitted to the hospital. If it is determined that the patient cannot return to Facility due to clinical needs, Resident will be refunded the bed hold charges from the date it was determined readmission was not possible. The belongings/personal items of the discharged patient will then be stored at Facility until they are picked up by the former Resident, POA, family member, etc., for removal within 72 hours.

Medicare Co-Insurance Rate

- Effective January 1, 2015, the daily Medicare Co-Insurance rate is $__________ per day.
- The Medicare Co-Insurance rate is subject to change on a yearly basis and is effective January first of each year.

Paid Bed Hold (check one)  □ YES  □ NO
ATTACHMENT C TO ADMISSION AGREEMENT

AUTOMATIC PAYMENT FORM

I authorize Facility to charge the credit/debit card listed below on the 5th/20th (circle one) day of the month in the amount of $_______ per month until my account is paid in full. Please put the name that appears on the credit/debit card and the address in which the bill for credit/debit card is mailed.

Name: ______________________________________________________________________

Address: ____________________________________________________________________

Card Type:  ___ VISA  ___MASTERCARD  ___OTHER ________________________________

Account number: ____________________________________________________________________

3 digit security code (on back of card): __________________

Expiration Date: _________________________________

Signature: ______________________________________________________________________

Date: ________________________________________________________________________

PLEASE NOTE: Due to our billing cycle, payment may not appear on your bill until the following month.
ATTACHMENT D TO ADMISSION AGREEMENT

RESIDENT TRUST FUND POLICY NOTIFICATION & AUTHORIZATION

Resident Name: _________________________________________________________________________

Residents of Facility have the right to manage their own financial affairs and handle their own spending money. A resident has the right to have Facility keep his/her money in a trust account to safeguard and manage personal spending money. Facility has a resident trust available, upon written authorization of Resident/Responsible Person, to any resident that wishes to deposit funds for safekeeping. Facility will maintain a separate accounting of funds available to Resident/Responsible Person. Upon discharge, all funds and a final accounting will be provided to Resident, administrator of Resident's estate or agent legally entitled to such funds.

Accessible Cash Accounts: Resident funds under $50.00 are kept in a non-interest bearing, accessible cash account for use by Resident. Any funds in excess of $50.00 are deposited in an interest bearing account. Any interest on the account is accrued to Resident. According to Medicaid regulations, residents receiving Medicaid may not have more than $4,000.00. Any resident funds in excess of $4000.00 may be taken by Medicaid and applied toward the cost of care. Facility will inform Resident/Responsible Person whenever the trust funds balance approaches $4,000.00. A quarterly statement will be sent to Resident/Responsible Person displaying account activity and balances.

Purchases and Withdrawals: Purchases and withdrawals may be paid from the cash account, as long as the funds are available seven days a week. Any withdrawal over $5.00 requires two witnesses from someone other than nursing. No funds will be disbursed or purchases made without the appropriate written authorization of Resident.

In accordance with Facility's trust fund policy, any purchase made on Resident's behalf must be presented with a receipt for those items and signed for by either Resident/Responsible Person. Facility will pay out of Resident’s trust account, permitting funds are available, any charges presented to it by contract services such as the barber/beauty shop or clothing supplier, with Resident/Responsible Person’s written permission.

Please select the services you would like to participate in by placing a check mark and initialing:

☐ I DO authorize Facility to hold my personal funds for safekeeping in accordance with its written policy and disburse them as authorized below.

☐ I DO NOT wish to participate in Resident Trust Fund.

Regarding your quarterly statement, please select from the following:

☐ I DO want both Resident and Responsible Person to receive a quarterly trust fund statement.

☐ I DO NOT want Responsible Person to receive quarterly trust fund statement.

☐ I request only the Responsible Person receive a quarterly trust fund statement.

Regarding contract services, select from the following:

☐ I DO authorize Facility to pay for contract services on my behalf.

☐ I DO NOT authorize Facility to pay for contract services on my behalf.

__________________________________________  ______________________________________
Print Name of Resident  Signature of Resident or Legal Representative

__________________________________________  ______________________________________
Date  Facility Representative Name and Title
RESIDENT ADMISSION AGREEMENT ACKNOWLEDGEMENT
(Signature Page)

This signature page is part of a binding, legal contract. Please read the contents of the Agreement and attachments carefully before signing to make sure that you fully understand its terms and the obligations you are assuming. This Agreement becomes effective on the day the Resident is admitted to the Facility and stays in effect until it is terminated pursuant to the terms listed under Section 6 of the Agreement.

Please note that in additional signing this signature page, you will be asked to sign several attachments to this Agreement that require separate signatures.

Please maintain a copy of this Signature Page for your records, as it will be the proof of your binding contract with the Facility.

For the Facility: HOMESTEAD REHABILITATION CENTER

____________________________________________________________________________
Signature of Authorized Signatory for the Facility

Title of Authorized Signatory for the Facility ___________ Date of Signature

For the Resident: ____________________________ (Resident Name)

____________________________________________________________________________
Signature of the Resident/Legal Representative

____________________________________________________________________________
Print Name of the Resident/Legal Representative ___________ Date of Signature

*Legal Representative’s Address ____________________________ City ___________ State ___________ Zip ___________

(H) ___________________________ (W) ___________________________ (C) ___________________________

*Legal Representative’s Home, Work, & Cellular Telephone Numbers

*Legal Representative’s E-mail Address: ____________________________

*Required Information
MEDICARE SECONDARY PAYOR (MSP) SCREENING

Resident Name_________________________________ Medicare Number:_____________________________

Admission Date:_______________, 20______ Provider Number:  100256272

A center may be held liable for billed services if a Medicare overpayment occurs and Medicare determines that the center furnished erroneous information or failed to disclose facts it knew were relevant to payment. Therefore, the Resident must be asked to the applicable questions below. If the Resident responds “yes” to any question, ask the remaining questions in that section.

Illness/Injury Caused by Accident

1. Is the current illness or injury due to any kind of accident?
   □ NO If no, proceed to Question #2 below.
   □ YES If yes, Medicare may be a secondary payor source.

   Check the appropriate box below, and fill in the requested information.

   □ Motor Vehicle Accident
     Name of Resident’s automobile insurer: ________________________________
     Policy Number: ________________________________
     • Obtain a copy of insurance card.
     • Call to verify coverage
     If auto insurance is the primary payor source, bill the insurance company.

   □ Motor Vehicle Accident--Third Party Liability
     Name of third party’s liability insurer: ________________________________
     Policy Number: ________________________________
     The liability of the insurer may be a primary payor source. Bill Medicare unless the Resident’s automobile insurer is the primary payor source.
     • Attach copies of all pertinent documentation to this document.

   □ Work-Related Accident or Injury
     Name of Worker’s Compensation Insurer: ________________________________
     Group Number: ________________________________
     Resident’s Account Number: ________________________________
     Worker’s compensation insurer is the primary payor source. Bill the worker’s compensation insurer.
Slip and Fall Accident or Injury

Where did the fall occur? ___________________ ________________________________
Name of third party insurer: ______________________________ __________________________
Policy Number: ______________________________ ____________________________

- Obtain copy of third party insurer’s insurance card if available
- Call to verify coverage.

If fall occurred at a place other than the Resident’s home, determine whether a liability claim or suit will be filed or if any kind of compensation will be received or is due. Bill third party insurer as primary. If claim denied or received partial payment, bill Medicare.

Other Accident; No Third-Party Compensation

Give description of accident and location: ______________________________________

- Bill Medicare and attach copies of all pertinent documentation.

Coverage Through Other Government Entity

2. Does the Resident have coverage through the VA, the department of Labor’s Black Lung Program or some other federal or state agency program other than Medicaid?

☐ NO If no, proceed to Question #3 below.
☐ YES If yes, enter name of program: ______________________________ ______________________________
Policy/Claim Number: _____________________________________________________

- Obtain copy of insurance card
- Call to verify the coverage

The entity with which the Resident has coverage must be billed as primary and Medicare secondary. Medicare may reject the claim unless the entity pays as primary or submits a denial of the services.

Employer Group Coverage for Those 65 and Older

3. Is the Resident 65 or older and employed at the time of this service?

☐ NO If no, proceed to Question #4 below.
☐ YES If yes, enter the Resident’s date of birth (MM/DD/YY):___________________________
Name of Resident’s employer: ______________________________ ______________________________
☐ Full-time ☐ Part-time

Does the applicable employer employ 20 or more employees?

☐ Yes ☐ No

Does the Resident have an employer group health plan (“EGHP”) through his/her current employer?

If YES, enter name of EGHP: ______________________________ ______________________________
Policy/Group Number: _____________________________________________________

- Obtain copy of insurance card
- Call to verify coverage

If the Resident is age 65 or older and has answered YES to the questions above, the EGHP shown is the primary payor source and should be billed accordingly. Medicare is the secondary payor source.
Medicare Secondary Payor (MSP) Screening (Continued)

4. Does the Resident have a spouse who is employed at the time of the applicable date of service?
   □ NO If no, proceed to Question #5 below.
   □ YES If yes, enter the Resident’s date of birth (MM/DD/YY):_________________________

   Name of spouse’s company/employer: _______________________________________________

   □ Full-time □ Part-time

   Does the employer employ 20 or more employees?
   □ Yes □ No

   Does the Resident have an EGHP through his/her current employment?
   □ Yes □ No

   If YES, enter name of EGHP: ______________________ ___________________________
   Policy/Group Number: _____________________________ ________________________

   • Obtain a copy of insurance card
   • Call to verify coverage

   If the Resident is age 65 or older and has answered YES to both questions above, the EGHP shown
   is the primary payor source and should be billed accordingly. Medicare is secondary payor source.

Employer Group Coverage for Those Entitled to Medicare Solely Due to End Stage Renal Disease

5. Is the Resident under the age of 65 and entitled to Medicare solely because of end state renal disease
   (“ESRD”) and in the first 18 months of Medicare entitlement?
   □ NO If no, proceed to Question #6 below.
   □ YES If yes, enter Resident’s date of entitlement as shown on the Resident’s Medicare card
   (MM/DD/YY):_________________________________________________________________

   Does the Resident have employer group health plan (“EGHP”) coverage through self,
   spouse, parent or guardian? □ Yes □ No

   Name of EGHP: ________________________________________________________________
   Policy/Group Number: ___________________________________________________________

   • Obtain copy of insurance card
   • Call to verify coverage

   If the Resident answered YES to both questions above, the EGHP is the primary payor source
   and should be billed accordingly. Medicare is the secondary payor source.

Employer Group Coverage for Those Entitled to Medicare Solely Because of Disability

6. Is the Resident under the age of 65 and entitled to Medicare solely because of a disability (does not
   have/has not has ESRD)?
   □ NO If no, proceed to Question #7 below
   □ YES If yes, enter Resident’s date of birth (MM/DD/YY):_________________________

   Does the Resident have coverage through his/her, a spouse’s, parent’s or guardian’s
   EGHP? □ Yes □ No
**Medicare Secondary Payor (MSP) Screening (Continued)**

If yes, enter name of each insured whose policy covers the Resident (e.g., Resident and Resident’s spouse).

<table>
<thead>
<tr>
<th>Name of corresponding employer(s).</th>
<th>Policy/Group Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of corresponding EGHP(s).</td>
<td>Policy/Group Number</td>
</tr>
</tbody>
</table>

• Obtain a copy of insurance card.
• Call to verify coverage

If the Resident answered **YES** to both questions above, the EGHP is/are primary and should be billed accordingly. Medicare is secondary or third payor source.

7. Is the Resident enrolled in a HMO that has Medicare benefits assigned?
   - **☐ NO** If no, proceed to question number 8 below.
   - **☐ YES** If yes, enter name of HMO: ____________________ _______________________
     Policy/Group Number: _____________________________ _______________

     If yes, IMPORTANT: obtain authorization by contacting HMO and copy of
     Resident’s HMO card.

     HMO is primary payor source; Medicare is NOT to be billed

8. Has the Resident elected hospice benefit instead of Medicare Part A and Part B benefits?
   - **☐ NO** If no, Medicare is the primary payor source and should be billed accordingly.
   - **☐ YES** If yes, Hospice is primary payor source and should be billed accordingly, unless
diagnosis is not hospice related.
     • Obtain copy of insurance card
     • Call to verify coverage

By signing below, the Resident certifies that the information provided above is true, accurate and complete. If signing on behalf of the Resident, write and date your signature, print your name and indicate the title that represents your affiliation of the Resident (Legal representative for finances and/or Healthcare or responsible party).

**Resident:** ____________________________________________ Date: ________________

Print Name Clearly: ____________________________________________

Print Title Clearly: ____________________________________________

**Homestead Rehabilitation Center Representative**

Print name and title clearly: ____________________________________________

Signature: ____________________________________________ Date: ________________
ADDITIONAL AUTHORIZATION FORM

Resident Name: _____________________________            Date: _______________________

Consent to Photograph

I hereby authorize the designated staff member at the Facility to take:
1. Photographs of Resident for identification purposes.  Yes_______     No_______
2. Photographs of Resident to be used for treatment purposes. Yes_______     No_______
3. Photographs of Resident for marketing purposes.          Yes_______     No_______

Permission for Therapeutic Recreation

The Recreational Therapy Program is geared toward helping to keep our Residents as alert and in as good of physical and emotional condition as possible. **Subject to Physician approval
I grant permission for the Resident to attend activities inside the Facility. ** Yes_______   No_______
I grant permission for the Resident to attend activities outside the Facility. ** Yes_______   No_______

Consent for Additional Services

I give permission to receive medical care from the following physician/services in contract with this nursing facility on an “as needed” basis. I understand that all bills shall be directed towards Medicare, Public Aid, and insurance Carriers. I further understand that charges for care & supplies not covered by Public Aid, Medicare, or insurance will be billed to the Resident.

_______Podiatrist    _______Optometrist     _______ Audiologist
_______Dentist    _______Psychological Services  _ ______Therapy Services

If the Resident/Legal Representative does not choose to use the in-house services, Resident/Legal Representative assumes the responsibility to make arrangements for the appointments for these services, including transportation.

Ambulance Transport Waiver

I authorize the Facility to contact and make arrangements for an ambulance company to transport the Resident to the hospital should an emergency arise.
In case of non-emergency situation, the Resident/Legal Representative chooses:

_____To have an ambulance service contacted for transportation.
_____Contact me personally to arrange for transportation arrangements.

Mortuary

Who is your choice mortuary?  ________________________________________________

Laundry

The Facility will launder bedding, linens, towels, and personal clothing of each Resident a minimum of 2 Xs per week at no additional charge. All clothing should be labeled with Resident’s name.

I request the Facility to do Resident’s personal laundry.        Yes_______   No_______

Barber/Beauty Salon Services

The services of a licensed beautician are available on a regular basis at this facility. Payment is expected for these services. If elected, the Resident/Legal Representative will be responsible for payment.

Barber/Beauty Salon service requested.        Yes_______   No_______
By signing below, I acknowledge that I agree to the above statements as indicated.

Resident/Legal Representative                          Date
CONSENT FOR DO NOT RESUSCITATE

I understand that until I inform the facility of my advance directives relating to my health care needs, CPR (Cardiopulmonary Resuscitation) and emergency transfer to the hospital will be implemented should I suffer cardiac arrest. CPR consists of two basic actions: rescue breathing and chest compressions. The objective is to let blood with oxygen into the heart and brain. Air exhaled from a rescuer’s lungs during rescue breathing contains enough oxygen to sustain life in a person who has stopped breathing. Chest compressions mean the rescuer applies external pressure to the victim’s chest so blood is pushed from the heart through the body’s blood vessels.

NO  I do not wish Cardiopulmonary Resuscitation efforts in the event of cardiac arrest.

YES  I do wish Cardiopulmonary Resuscitation efforts. I understand that the Emergency Medical System will automatically be activated (ambulance transfer to the hospital).

____________________________________________   ______________________
Resident Signature      Date

Or

____________________________________________   ______________________
Legal Representative                     Title   Date

____________________________________________   ______________________
Witness       Date

____________________________________________
Resident Name

____________________________________________
Doctor’s Name
I also wish the following medical interventions be provided in an emergency or critical situation:

1. Maximum efforts will be made including emergency transportation and if necessary, full life support measures in the hospital including, when appropriate, ventilator support (breathing machine) and intensive care unit.

2. Transportation to the hospital and provision of emergency life support measure but not using “artificial” life support such as a ventilator.

3. Transportation for emergency room evaluation should it if felt necessary, but no resuscitation efforts should be made if breathing or heart related complications should develop.

4. Evaluation would be limited to physician and nursing assessment at facility with treatment instituted there without transfer to the hospital or emergency room evaluation or hospitalization.

5. Intervention would be limited to providing ongoing supportive care per physician’s orders. Supportive care is that care needed to relieve a Resident’s suffering, but which does not prolong life beyond its natural cessation. I.E. good hygiene, medication as necessary and tolerated and positioning, suctioning, oxygen and pastoral services. It is anticipated that this category would apply primarily to patients who have a terminal illness and whose death is anticipated to be imminent.

6. The above forms of intervention are examples and if you feel there is an alternative form of intervention that would best meet your needs, please indicate so here:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Resident Name                                  Date
____________________________________                     ________________________

Guardian, devolved des, DPOA                      Date
____________________________________                      ________________________

Physician Signature                              Date
____________________________________                      ________________________
**PHYSICIAN’S DO NOT RESUSCITATE (DNR) ORDER FOR THE MEDICALLY ILL**

I, ____________________________, have been diagnosed as having a medical illness. I have discussed both the prognosis of this illness and the treatment options with my physician and request that in the event of my cardiopulmonary arrest, cardiopulmonary resuscitation and/or mechanical ventilations not be initiated.

I give permission for this information to be given to Emergency Medical Service and Mobile Health Care personnel, physicians, nurses, or other health care personnel as necessary to carry out these wishes. I understand that this order is valid from this point forward until rescinded by either myself or my designated Durable Power of Attorney for Health Care, and further agree that a copy of this form is as valid as the original. Incomplete forms may be returned as being invalid.

☐ **DO NOT INTUBATE**  I understand that **DO NOT INTUBATE** means that in the event that my breathing is inadequate I do not wish a tube placed in my airway to maintain my respirations artificially.

☐ **DO NOT RESUSCITATE (DNR)**  I understand that DNR means that if my heart stops beating, or is inadequate, or that if I stop breathing or my breathing is inadequate, that no artificial resuscitation will be initiated or continued. I understand that I will continue to receive supportive medical care as deemed appropriate by health care personnel, though cardiopulmonary resuscitation will not take place.

Patient, or Next of Kin Signature or Guardian of Person or Durable Power of Attorney for Health Care (Attach Appointment form).  

________________________________________  

Date  

Patient Address (Including facility name if applicable)  

________________________________________  

Witness  

I certify that I have discussed his or her medical illness, treatment and prognosis with the patient and that the entry of this DNR order is appropriate for:

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Date: <em><strong>/</strong></em>/___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Physician Name</td>
<td>Physician Signature</td>
<td>Date: <em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

Agency Completing Form and Signature of Agency Representative (required if *By Telephone Order box below is checked)

☐ By telephone order, the patient’s attending physician referenced above was consulted regarding the DNR status, however, was unavailable to personally appear to provide an original signature. The agency representative above verifies the consultation and authorization of the physician as indicated.

**Copy Distribution:**

☐ *Patient File  

☐ Attending Physician  

☐ Home Health/Hospice Agency  

☐ Patient’s Home (if applicable)

*Original DNR form must be kept in patient’s primary medical file.  

*KEEP IN PROMINENT PLACE

**DNR ORDER**
CONSENT TO BEGIN SERVICE AND DISCONNECT PHONE  
(STATIONS #1, #2 & #3) 

☐ YES. I do want a phone hookup and phone number assigned to my room. I know I am responsible for any charges or fees associated with this hookup and or phone usage. A bill will be sent to your home address and you will be responsible for paying. 

☐ NO. I do not want a phone hookup or phone number at this time. 

_______________________________________________________________________ 
Resident Name 

_______________________________________________________________________ 
Resident Billing Address 

___________________________  _______________________ 
Resident’s Social Security Number  Resident’s DOB 

____________________________________________ 
Family Member/Contact Phone Number 

___________________________ 
Homestead Rehabilitation Center Representative 

______________________________________ 
Date 

• New installation fee is $29.00. Deposits will not be required unless there is an outstanding balance on existing services 90+ days old. 
• Basic Residential Line is $17.50; long distance is $4.99/month and $.07/minute based on usage. Those rates are before taxes and fees. 
• Resident or their family will provide a phone for private- paid phone service. 
• You may qualify for telephone assistance. Please speak with your Social Worker.
SMOKING POLICY

Revised 2/2015

Standards

1. Smoking is a Resident privilege, not a right. That privilege may be revoked by the physician and/or the facility if the health and/or safety of the individual, other Residents or staff are threatened.

2. All Residents who desire to smoke will have a smoking assessment performed by a Licensed Nurse (for safety purposes) before they are allowed to smoke. The assessments will be reviewed by an interdisciplinary team for determination of appropriate interventions, if needed, as well as care plan development. Assessments will be performed quarterly.

3. Smoking risk assessments are performed quarterly with recommended changes, which could affect the safety of the Resident. The assessments are reviewed by the interdisciplinary team for agreement and planning of interventions.

4. All Residents able to smoke will be able to do so in the facility’s courtyard (supervised by a staff member) area at the designated time in the afternoon. In addition, a Resident who passes the smoking evaluation may be required to wear a smoking apron as an additional safety precaution.

5. Employees shall receive training in emergency procedures and evacuation techniques should an accident occur as a result of smoking (See Fire and Disaster procedures).

6. Tobacco products and smoking materials will not be sold in the facility. Smoking materials will be kept in a smoking box at Station 3. No smoking materials are allowed in rooms. If a Resident fails to follow housekeeping rules when using smokeless tobacco, privileges will be revoked.

7. A fire extinguisher is located within close proximity to the designated smoking area(s).

8. Smoking by Residents is only allowed during posted smoking times while on company property. No exception will be allowed. Smoking is not allowed during field trips or doctor’s appointment.

9. If the temperature is below 15°F (wind-chill included) or 90°F (heat index included), smoking will not be allowed. Smoke breaks are fifteen (15) minutes long.

10. Any Residents using smokeless tobacco must use such products at designated smoking times.

11. Effective October 1, 2014, E-Cigarettes are only allowed outside during above smoking times.

12. Failure to abide by this policy will result in the Resident forfeiting his/her smoking privileges on either a temporary or permanent basis.

13. Families who want to take their loved one out to smoke while visiting are not allowed to smoke on the property. Smoking is only allowed at the designated times and the designated courtyard.

______________________________________      _______ ______________________________
Resident             DON/SSD/ED
<table>
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<tr>
<th>Resident's Name:</th>
<th>Station:</th>
<th>Room #:</th>
<th>Date:</th>
<th>Inventory Items</th>
<th>Amount</th>
<th>BRAND</th>
<th>Description</th>
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INVENTORY COMPLETED BY: ____________________________ DATE: ___________ HRC STAFF
INITIALS: ___________ DATE: ___________
## RESIDENT BELONGING INVENTORY

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<tr>
<th>Inventory Items</th>
<th>Amount</th>
<th>BRAND</th>
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<tbody>
<tr>
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<td>EYEWEAR: GLASSES ______ CONTACT LENSES _______</td>
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</table>

INVENTORY COMPLETED BY: _______________ DATE: ____________ HRC STAFF
INITIALS: _____________ DATE: ____________
INFORMED CONSENT FOR VACCINATIONS

NAME OF RESIDENT: _______________________________  MEDICAL RECORD NO: _______________

Influenza Virus Vaccine

I hereby give the facility permission to administer the Influenza Vaccination annually. I have been provided a copy of the Centers for Disease Control (CDC) Information Statement which describes the risks and benefits of the vaccine. I have been instructed that as a result of the vaccination, I may experience some side effects such as: soreness at the injection site, flu-like symptoms, fever, muscle weakness and allergic reactions such as hives, rashes and allergic asthma. Guillain-Barre Syndrome (GBS) is an infrequent, but possible risk of the vaccine. Please note: the influenza vaccine may cause an adverse reaction if you are allergic to eggs, egg products, merthiolate (thimersal) or substances containing mercury.

I understand that I am in a group at high risk for illness or death from influenza and that the most effective means to prevent this disease is the influenza vaccine. Unless my physician feels that it is medically contraindicated, I give my consent to receive the influenza vaccine. I understand that the vaccine is administered annually prior to the influenza season and that I will receive yearly vaccinations if I provide my consent in writing. Further, I understand the risks associated with this vaccine, and will not hold the attending physician, this facility, or its agents responsible for any reactions as a result of the influenza vaccine.

☐ I request the Influenza Virus Vaccine.
☐ I decline Influenza Virus Vaccine.  Reason: ________________________________

____________________________  ______________________________
Signature of Resident/Authorized Representative    Date

Pneumococcal Immunization

I hereby give the facility permission to administer the Pneumococcal Immunization annually. I have been provided a copy of the Centers for Disease Control (CDC) Information Statement which describes the risks and benefits of the vaccine. I have been instructed that as a result of the vaccination, I may experience some side effects such as: soreness at the injection site, flu-like symptoms, fever, muscle weakness and allergic reactions such as hives, rashes and allergic asthma. Guillain-Barre Syndrome (GBS) is an infrequent, but possible risk of the vaccine.

I understand that I am in a group at high risk for illness or death from pneumonia and that the most effective means to prevent this disease is the pneumococcal vaccine. Unless my physician feels that it is medically contraindicated, I give my consent to receive the pneumococcal vaccine. I understand that the vaccine is administered only one time, but that there is a possibility that a booster vaccination may be required in about six (6) years. I understand the risks associated with this vaccine, and will not hold the attending physician, this facility, or its agents responsible for any reactions as a result of the pneumococcal vaccine.

☐ I request the Pneumococcal Immunization.
☐ I decline Pneumococcal Immunization.  Reason: ________________________________

____________________________  ______________________________
Signature of Resident/Authorized Representative    Date

Revised 07/2012

***TO BE UPLOADED IN MATRIX***