REGENCY VILLAGE Care Center
409 West Greene
Webster, Texas 77598
281-332-4738
Fax: 281-332-5449

We would like to welcome you to Regency Village. If you have any questions or concerns regarding any aspects of the facility, please feel free to visit with us:

Administrator:	Gail Barcelo
Admission Director:	Stephanie Holweg
Director of Nurses:	Ramona McAninch, DON, CNO
Assistant Director of Nurses:	Judah Mwabili, RN
Dietitian:	Nancy Corson, RD, LD
Activity Director:	Amanda Sciba
Facility Controller:	Julie Heath
Therapy Department:	Julie Zaretsky, PT
Social Worker:	Tammy King, SW
Discharge Planner:	Tammy King, SW
Business Office Manager:	Amber Mayeux
Care Plan Coordinator:	Betty Barajas

We invite you to make your loved one's room as personal as possible. Personal touches make all the difference in helping our residents feel at home. Our Activity Director keeps a hammer, small nails, and tacks in her office if you need to hang family pictures. We would appreciate it if you would not use large nails or screws so that the wallpaper can continue to look nice. It is our policy that the bedside drawers must stay between the bed and the wall/window. Do not forget to mark all your loved one's clothes (including socks, shoes, and undergarments) regardless, if facility does your loved one's laundry or you do it.

Please let nurses know if you bring any belongings after admission so that we can add them to the resident's inventory list.

Due to health and safety regulation

- Microwaves are not allowed in resident rooms
- Fans must be on a stand (no table fans)
- Clothes hampers must be metal and/or flame resistant
- Multiple plugs must have their own breaker
- Smoking is prohibited (League City Ordinance)

We invite you to join your loved one for meals at any time. Our meals cost $5.00 and $6.00 for holiday meals. The Main Dining room serves meals at 7:00 a.m., 12:00 p.m. and 5:00 p.m.. There are weekly menus located at the end of 300 and 500 halls. We have a private dining room that can be reserved for special occasions and holidays. Please make reservations with our activities director. By the main dining room you will find a soda and snack machine.

Residents have a telephone which is designated for their use at the end of 400 hall . Our staff will assist residents with phone calls at anytime.

Moving into a long term care facility can be difficult for both the resident and the family members. To help make this transition as smooth as possible, many families get involved in our facility's group activities. We also encourage families and children to become part of our Activity Program.

How did you hear about us:

A friend _____

At the hospital _____

Saw us in the paper/other print media _____

Online _____

Direct phone number to Room Number _____ is _____

ADMISSION AGREEMENT

This agreement is a contract between **RESIDENTS NAME**(hereinafter referred to as "you" or "your") and Penbar, Inc. d/b/a Regency Village (hereinafter referred to as "Regency Village", "we," "our", "us" or the "Facility").

I. Services Provided: The Facility will furnish a basic room, board and routine nursing services as required by the Resident's medical condition. Routine nursing services include such care as routine hygiene assistance, medication administration, treatment administration, and dietary supervision. If you are in doubt about whether or not a service is covered by your daily rate, you should contact the Facility's Administrator.

Facility staff will work with you and your attending physician to develop and maintain a written patient care plan for you. We will provide you with restorative nursing care which enables you to achieve the best possible degree of function, self-care and independence consistent with your medical condition.

The Facility **does not** provide one on one nursing care. Should your condition become such that one on one nursing care is required, the Facility will no longer be able to meet your needs and will assist you in making arrangements for transfer to another facility. Should your condition become such that assistance is needed with feeding, your family members or friends will not be allowed to assist with that feeding due to requirements of the Texas Department of Human Services.

The Facility will not be responsible for theft, destruction or other loss of money, clothing, jewelry, dentures, eyeglasses, hearing aids or other personal property.

II. Other Providers:

A. You may choose any licensed physician to provide medical services to you, as long as your physician agrees to follow all medical staff policies and procedures required by the Facility or the Texas Department of Human Services, Texas Department of Health, United States Health Care Financing Administration or any other governmental entity. Should your physician fail to follow any of the above, you agree to retain a licensed physician who will comply with the policies and procedures referred to above.

B. You or your family may retain the services of a private sitter. If you decide to use a private sitter, you must tell the Administrator or Director of Nursing before you hire the private sitter and you and the private sitter must comply with all policies and procedures of the Facility. You and/or RESIDENTS NAME, as well as the person you retain as a Private Sitter must sign a Private Sitter Agreement which will be provided by the Facility. The Private Sitter may not provide services to you which would otherwise be the responsibility of the Facility's staff.

C. You have chosen the following persons or entities to provide the following services to you:

PHYSICIAN:	123456
PHARMACY:	ADVANCED PHARMACY OF HOUSTON

D. Your personal and medical records must be treated confidentially. You have the right to approve or refuse their release to anyone outside the Facility except in case of your transfer or as required by law or third-party payment contracts.

III. Charges and Fees:

A. Each resident admitted to Regency Village is admitted either as private pay, as a Medicaid recipient or as a Medicare Part A recipient. During a resident's stay, the resident may be admitted under one of the above payment arrangements and later change to one of the other payment arrangements. Following are the conditions for the residents admission under the payment arrangement applicable at the time of admission. Should the resident remain in the Facility under one of the other payment arrangements, the Resident and **RESPONSIBLE PARTY** agree that the conditions set forth for that payment arrangement will apply at that time along with the terms and conditions of the Financial Responsibility executed by **RESIDENTS NAME** in conjunction with this Admission Agreement.

1. Private Pay: In return for the services we will provide to you under this Agreement, you agree to pay us **$ N/A** dollars per day. This basic daily charge is based on the Facility's rates in effect at the time you sign this contract. If these rates or any other fees change during your stay at this Facility, you will receive thirty days written notice before that change. If the resident is the beneficiary of an insurance policy which will pay all or a portion of the expense for the residents stay at the Facility, it will be the responsibility of **RESIDENTS NAME** to make payment to the Facility and seek reimbursement from the insurance carrier. The Facility will not be responsible for billing the insurance carrier directly. Should you be hospitalized or leave the Facility on therapeutic leave, we will not hold a bed for you unless you request that we hold your bed by paying a bed hold fee equal to the daily rate specified above. You understand that the bed being held for you may not be the bed in the same resident room you had before leaving the Facility. This bed hold rate is based on the Facility's rate in effect at the time you sign this contract. Should the daily rate increase in the future as noted above, the bed hold rate will also increase. If you are originally admitted as private pay and spend all of your own funds during your stay in the Facility, you should apply for Medicaid benefits. The Facility will help you with your application, but the Facility cannot guarantee that you will be found eligible. The local Texas Department of Human Services decides whether you are eligible to receive Medicaid benefits. The Facility is certified to participate in the Medicaid program and will accept Medicaid payments.

2. Medicaid: As a Medicaid recipient, you agree to pay the Medicaid recipient portion (hereinafter "applied income") of the cost of services provided under this Agreement. The amount of the applied income payable to the Facility is established by the Texas Department of Human Services, the state agency which administers the Medicaid program. The applied income must be paid on or before the tenth day of each month. Should you be hospitalized or leave the Facility on therapeutic leave, we will not hold a bed for you unless you request that we hold your bed by paying a bed hold fee equal to the Medicaid daily vendor rate being paid at the time you leave the Facility. You understand that the bed being held for you may not be the bed in the same resident room you had before leaving the Facility.

3. Medicare Part A: If you are admitted to the Facility as a Medicare Part A recipient, you agree to pay all deductibles and co-payment amounts directly to the Facility. Our facility Medicare Intermediary is Mutual of Omaha. Should you have an insurance policy which pays all or a portion of your obligation to pay any deductible or co-payment, the Facility may, at its option, bill your insurance carrier directly for such payment. However, any such billing will not relieve you of your obligation for payment of any unpaid amounts your insurer fails for any reason to pay. Should your eligibility under Medicare Part A terminate while you are a resident of the facility, you may elect to leave the facility or continue your residency under the terms specified in this Agreement as either a Private

Pay resident or Medicaid resident, if applicable. If you are originally admitted as Medicare Part A and wish to continue as a resident after you no longer qualify under Medicare Part A but cannot pay for your care at the Facility, you should apply for Medicaid benefits. The Facility will help you with your application, but the Facility cannot guarantee that you will be found eligible. The local Texas Department of Human Services decides whether you are eligible to receive Medicaid benefits. The Facility is certified to participate in the Medicaid program and will accept Medicaid payments.

B. Should the resident, the resident's family or guests of the resident cause damage to the resident's room, other areas in the building, property or the equipment of the Facility beyond expected reasonable wear and tear from standard usage of such property, **RESIDENTS NAME**shall be responsible for costs of repair or replacement. By their signature below, **RESIDENTS NAME**accept such responsibility and agree that this charge may be made over and above any charges covered by Medicare, Medicaid or any other third party payor.

C. The Facility neither extends credit nor accepts payments in installments. All fees payable by the resident for the current month are due and payable in full not later than the tenth day of the current month.

IF YOU DO NOT PAY ALL FEES PAYABLE TO US BY THE TENTH DAY OF THE MONTH IN WHICH THEY ARE DUE, YOU WILL BE CHARGED A FIFTY DOLLAR LATE FEE.

WE WILL NOT TOLERATE REPEATED LATE PAYMENTS. IF YOU FAIL TO MAKE YOUR PAYMENTS, THE FACILITY NOT ONLY WILL CHARGE LATE FEES AND TAKE COLLECTION ACTION, THE FACILITY MAY DISCHARGE YOU AS WELL. SEE ITEM 4 BELOW FOR FURTHER INFORMATION ABOUT DISCHARGES.

IF YOU DO NOT PAY THE FACILITY'S FEES SPECIFIED ABOVE AND THE FACILITY MUST HIRE AN ATTORNEY, YOU MUST PAY ALL OF THE ATTORNEY'S FEES AND EXPENSES AND ANY COURT COSTS.

D. Should you be discharged permanently for any reason during the month and appropriate notice was provided to the Facility, we will refund to you the daily rate or your monthly applied income times the actual number of days in the month the room was not used. The refund will be mailed to you within thirty days of the date of discharge.

IV. Termination, Transfer or Discharge

A. You may terminate this agreement by giving us ten days written notice. You must pay all the money you owe us before the termination's effective date. Private payors pay their basic daily rate for the entire ten day notice period, even if you leave here before that time is up.

B. The Facility may terminate this contract without your consent for any one of the following reasons:

1) The resident's needs cannot be met in the Facility;
2) The safety or health of the Resident or other residents in the Facility are compromised by the Residents continued placement in the Facility;
3) The Facility ceases to operate; or
4) Non-payment of any amounts due to the Facility for the Resident's care.

C. The Facility will attempt to maintain transfer agreements with local hospitals. If your physician orders medical services that are not available at the Facility, you may be transferred to any hospital selected by you. In the event of an emergency, the Facility will attempt to transfer you to the hospital of your choice; however, in the event you are unable to specify your preference in hospital's, by your signature on this Agreement, you are consenting to transfer to a hospital as chosen by your physician or

the Facility.

V. Your Responsibilities: By signing this contract, you acknowledge that you have received a copy of our rules and regulations and that you agree to comply with those rules and regulations. Your agreement to this provision does not mean that you give up any of your rights as outlined in Section II or specified in the Resident Bill of Rights you acknowledge you have received.

By signing this contract, you agree to abide by all of the provisions contained in this contract. You acknowledge that you have read this contract and that you understand this contract, your questions have been answered and you have been given the opportunity to consult your own attorney or to have another person with you while this contract is discussed.

VI. Acknowledgment by **RESIDENTS NAME**or **RESPONSIBLE PARTY** If this Admission Agreement is signed by **RESIDENTS NAME**or **RESPONSIBLE PARTY** the terms "You" and "Your" as used in this contract shall be construed to mean **RESIDENTS NAME**shall be primarily and severally liable for the payment and performance of all liabilities and obligations of Resident hereunder and in connection with the Facility's nursing services rendered to Resident.

VII. Arbitration Agreement: **It is agreed that any and all disputes, claims (whether tort, contract, statutory or otherwise) and controversies which relate in any manner to the Resident's admission to and/or care in the Facility, including but not limited to claims alleging negligence on the part of the Facility, its employees, owners, agents, parents, subsidiaries, landlords or subcontractors, will be resolved through arbitration as provided under the Federal Arbitration Act. This arbitration agreement will apply to all disputes or claims between the Resident, the Resident's Estate, the Resident's agents or others claiming by or through the Resident, the RESPONSIBLE PARTY, The RESIDENTS NAMEEstate, the RESIDENTS NAMEagents or others claiming by or though the RESIDENTS NAMEand the Facility, its employees, owners, agents, parents, subsidiaries, landlords or subcontractors. Any final decision though arbitration will be final and binding on both parties. The procedure for any such arbitration and selection of an arbitrator will be established by the rules of arbitration as promulgated by the American Arbitration Association. The terms, provisions, and conditions contained in this agreement are binding on and inure to the benefit of the parties and their respective heirs, successors an assigns. The Resident and RESPONSIBLE PARTY may revoke this Arbitration Clause by providing to the Facility Administrator a written statement that they wish to so revoke this Arbitration Clause. The revocation must be received by the Facility Administrator no later than the thirtieth day following the date the Admission Agreement is executed. After this initial thirty day period, this Arbitration Agreement will be irrevocable, will survive that Resident's termination of residency at the Facility and may only be waived by the mutual written consent of all parties. Specifically excepted from the Arbitration Agreement are any claims having an amount in dispute of $10,000.00 or less. All other disputes and claims will be subject to this Arbitration Agreement unless rescinded within the time limits and as required herein.**

VIII. Conflict with Medicare, Medicaid or other Laws or Regulations: In the event any portion of this Agreement is in conflict with any regulation of Medicare, Medicaid or any other federal, state or local law or regulation, said law or regulation will control and the remainder of this Agreement will be construed as if that section in conflict were omitted.

IX. Non- Discrimination: The Facility strives to comply with Title VI of the Civil Rights Act of 1964 and sections 503-504 of the Rehabilitation Act of 1973 and all laws and regulations promulgated pursuant to those acts. This facility does not discriminate in regard to race, color, national origin, disability, age, or gender.

XI. Employee Drug Testing Policy: Though it is regrettable, it is a fact of life in today's society that drug abuse is an ever present danger in all walks of life. In an effort to better insure the safety of our residents and improve the care they receive, Regency Village has enacted a drug testing policy for our employees. Employees are required to participate in controlled substance testing: (l) After being involved in a work related accident resulting in medical treatment of the employee, (2) When any supervisor determines that there is Reasonable Suspicion to believe that an employee is using, is under the influence of, or is in possession of alcohol or controlled substances and (3) After returning to employment following removal due to a positive test result. If you are interested in a more detailed description of our drug testing policy, please ask us and we will be happy to supply you with a copy of our policy for employee drug tests.

XII. Readmission Agreement: Upon a resident's discharge from the hospital, Regency Village holds the right to reassess the resident to determine medical necessity and possible admission. Residents whose needs cannot be met by the facility will not be readmitted.

I CONFIRM THAT I, AS THE RESIDENTS NAMEAND/OR RESPONSIBLE PARTY AM SIGNING THE DOCUMENTS CONTAINED IN THIS ADMISSION PACKET IN ELECTRONIC FORM AND I AM AFFIXING MY SIGNATURE IN ELECTRONIC FORM. I AM AWARE THAT I MAY REQUEST HARD COPIES OF THIS ADMISSION PACKET AND MAY SIGN THOSE COPIES RATHER THAN SIGNING THESE ELECTRONIC DOCUMENTS.

RESIDENTS NAME

_____

RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipaegui

FACILITY REP

FINANCIAL AGREEMENT

The daily room rate for admission of the below named individual as a resident of Regency Village (the Facility) has been provided to the Resident and **RESPONSIBLE PARTY**. It is understood that this daily rate may change during the course of the Resident's stay at the Facility. In the event such a change should occur, RESPONSIBLE PARTY will be notified of that change at least 30 days prior to the change in the daily rate for the Resident's care. In addition to the above daily rate, there may be additional charges for other services.

If the Resident is admitted or becomes a qualified Medicaid recipient: **RESIDENTS NAME**agrees to make payment of any applied income amounts which are to be paid in addition to reimbursement received from Medicaid. If the Resident is making application to Medicaid, **RESIDENTS NAME**and the **RESPONSIBLE PARTY** will be responsible for payment of any charges which are not covered by Medicaid during the application process unless Medicaid retroactively covers those charges. Furthermore, if the Resident does not elect to have the applied income directly forwarded to the Facility, **RESIDENTS NAME**represents that **RESPONSIBLE PARTY** has control over that applied income and accepts responsibility for payment to the Facility. The Facility may assist **RESIDENTS NAME**in the application process for Medicaid, but the ultimate responsibility for application lies with the Resident and **RESPONSIBLE PARTY** This provision includes the Responsible Parties for Residents who are admitted under Medicare, private pay or some other payer program and later qualify as Medicaid recipients.

If the Resident is admitted or readmitted under a program reimbursed by Medicare:
RESPONSIBLE PARTY will be responsible for any co-payment or any items or services which are not covered by Medicare and which may be properly charged to the Resident.

If the Resident is admitted under any program of private insurance or as a private payer: The Facility may assist in submitting charges for such payment, but ultimate responsibility for payment will remain the responsibility of **RESIDENTS NAME**and **RESPONSIBLE PARTY**. If the Resident is otherwise admitted to the Facility, RESIDENT agrees to make payment of the daily room rate and charges for any other services requested by RESIDENT or ordered by the Resident's physician which are supplied by the Facility or the Facility's contract services. ****** **RESPONSIBLE PARTY** IS RESPONSIBLE ONLY TO THE DEGREE WHICH THE RP HAS LEGAL ACCESS TO THE RESIDENT'S INCOME OR RESOURCES*****

IF THE RESIDENT IS ADMITTED TO THE FACILITY UNDER AN HMO, PPO OR OTHER INSURANCE OR SUPPLEMENTAL INSURANCE, INCLUDING SUCH PAYORS THAT MAY PAY IN ADDITION TO OR IN PLACE OF MEDICARE OR MEDICAID, THE RESIDENT AND/OR RESPONSIBLE PARTY WILL BE RESPONSIBLE FOR MAKING PAYMENT TO THE EXTENT ALLOWED BY APPLICABLE LAWS AND REGULATIONS IF THAT ALTERNATIVE PAYOR DENIES COVERAGE OR PAYMENT

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagu

FACILITY REP

Assignment of Benefits Form

(Statement to Permit Payment of Supplemental Insurance, Medicare A & B Benefits to Provider)

To the Beneficiary: The purpose of this form is to permit Regency Village Care Center to bill Medicare and Supplemental Insurance for benefits you received from our facility. Without this form we will be unable to bill Medicare or Supplemental Insurance and will have to bill you directly for all services you may incur.

TODAY'S DATE: **ADMIT DATE**

BENEFICIARY'S NAME: **RESIDENTS NAME**

BENEFICIARY'S HIC #: **MC #**

ADMIT DATE

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its Intermediaries or carriers or to the professional standards review organization any information needed for this or any other related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I assign payable for covered services allowed under Part B of the Medicare Program to the physician or organization furnishing the service authorized by the said physician or organization and authorized them to submit claim(s) to Medicare for payment on my behalf.

I further authorize any Co-insurance charges related to covered services to be billed to any secondary insurance carrier that I may have.

BENEFICIARY'S NAME: **RESIDENTS NAME**

BENEFICIARY/RESIDENTS SIGNATURE: _____

Admission Policies

1. Residents are admitted only upon the recommendation of a licensed physician, and must remain under the continuous care of a physician. At admission the resident must bring from his physician the following documentation:
   A. A history and physical including current medical findings, diagnosis, orders for immediate care and the resident's discharge and rehabilitation potential or
   B. A copy of a recent hospital discharge summary, history and physical examination report which contains all of the required information listed in **A** above.
   If the admitting physician is not the attending physician the attending physician must see the resident within seven (7) days after admission and prepare a history and physical report to acknowledge the appropriate report from the hospital.
2. The attending physician must agree to visit the patient at admission and to conform to the following schedule:
   A. Visit resident in the Medicare facility at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter.
   B. For all other residents, visit every 30 days for the first 90 days and every 60 days thereafter.
3. The attending physician must provide or arrange for provision of physician services 24 hours a day in case of an emergency.
4. At the option of the physician required visits after the initial visit any alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.
5. If the attending physician selected by the resident uses the services of a physician assistant or nurse practitioner the Permission Slip for use of Nurse practitioner of Physicians Assistant must be signed or on file in the resident's record.
6. A written agreement must be signed at the time of admission by **RESPONSIBLE PARTY** and facility representative covering medical care, charges and refund policy. A copy will be furnished to the resident and /or **RESPONSIBLE PARTY** and/or legal representative.
7. The patient must bring adequate changes of clothing. All clothing and other personal items must be clearly marked with the patient's name and re-labeled as needed. The nursing home cannot assume responsibility for loss or damage to personal items.
8. The patient will have to the extent possible freedom of choice of rooms, pharmacy, and physician and all other health care services and providers. The facility reserves the right to re-assign residents to rooms according to the resident's medical needs.

Personal Laundry

1. If you prefer to do the laundry a fireproof closed container must be provided for soiled clothing. If the resident is incontinent, the clothes must be picked up and washed daily, otherwise the clothing must be collected and cleaned at least weekly.
2. Personal laundry services are available for those who desire the service.
   _____ Facility to do laundry.
   _____ Family to do laundry.

Medications

1. Medication cannot be accepted in the facility unless they are properly labeled according to state regulations.
2. All medications must be administered by the nurse on duty as ordered by the physician and with the consultation of a registered pharmacist unless the interdisciplinary team determines that the resident is capable of self administration of his/her medication and the resident makes a written request to do so.
3. If the interdisciplinary team has determined that the resident may self administer his/her medication must be kept in the secure area provided and the drugs administered and maintained in accordance with the facilities Self Administration of Medication Policy.
4. Except in the above situation all medications must be kept in the medication room. The resident is not permitted to keep medication in his/her possession except for emergency drugs on the physician's orders

Food

1. Meals are served three times a day; bedtime and between meal snacks are provided according to the resident's individual preference and diet order.
2. Adequate portions of food will be served. Larger portions and/or second servings will be provided on request and/ or as needed.
3. Resident's likes and dislikes and meal patterns are recorded in an interview with the Food Service Supervisor. All efforts are made to honor the resident's wishes
4. Therapeutic diets are provided as ordered by the physician.
5. For residents on therapeutic diets please check with the charge nurse and/or food service supervisor before bringing in food from the outside. All food and beverages brought from the outside to the resident should be reported to the charge nurse so the resident's dietary intake can be properly monitored.
6. Please do not bring perishable food into the rooms.

Transportation

The facility will provide or assist in arranging for transportation with respect to outside rehabilitation therapy, laboratory, radiological, dental services, and transfers to hospital and other needed medical services.

Religion

This facility is non-denominational offering a wide range of religious services and complete freedom of religion worship.

Visitors

1. Visitors hours are 7 a.m. to 9 p.m.
2. Visitors are welcome. Residents are permitted to receive visitors and to associate freely inside or outside the facility with persons and groups of their choice unless medically contraindicated and documented in the resident's medical record by the attending physician.

Social Care – Activities

Medically oriented social care is deemed necessary to give the resident the most satisfying life possible. Professional staff, facilities, and equipment are provided for residents, games, programs, singing, reading, movies, and arts and crafts. The activities plan for each resident is approved by his her personal physician.

Employees

1. Employees may not receive tips. Please do not offer them.
2. Requests for information about a resident should be addressed to the charge nurse, the assistant director of nursing, the director of nursing or the administrator.
3. Residents and/or responsible parties and/or legal representatives are invited to participate in the care-planning of each resident so the facility can stay informed on how to best meet the resident's needs. Each resident is scheduled for a full care plan review each 90 days. You will be informed in advance of the time and place of this conference. If you cannot attend please feel free to make an appointment with the Social Services Worker at your convenience. Your input into the care of the resident is vital to provide the best efforts to maintain his/her quality of life. You may also request a conference at any time you feel this is needed.
4. Employees are not to do private duty with residents except when they have permission from the director of nurses.
5. All private nurses or sitters are to be approved by the nursing director and they will be under his/her supervision.

Notification of Change

1. Except in a medical emergency or when the resident is incompetent, the facility must consult with the resident immediately and notify the resident's legal representative and/or **RESPONSIBLE PARTY** within 24 hours when any of the following occurs:
   a. An incident involving the resident which results in injury.
   b. A significant change in the resident's physical, mental, or psychosocial status.
   c. A need to alter treatment significantly or;
   d. A decision to transfer or discharge the resident.

e. A change in roommate.

2. The resident's physician is notified if there is a medical problem or any change in the resident's condition or in an emergency. If the attending physician or his designated alternate is not available the facility reserves the right to call the medical director to handle the emergency. The resident and/or **RESPONSIBLE PARTY** and/or legal representative will be consulted when possible before contacting the medical director.

Valuables

The Nursing Facility cannot assume responsibility for valuable personal property kept in the resident's room. Residents should never have more than $5.00 in cash. Jewelry and other items of value should not be brought to the facility.

Health, Safety, and Personal Rights

1. The health and safety of each resident is of major concern to this facility. All work procedures stress both sanitation and safety.
2. Regency Village is a non smoking facility and therefore will not admit any smokers into the facility. **NO SMOKING IN ANY AREA OF THE NURSING HOME.**
3. The resident is not allowed to keep matches, cigarette lighters or other smoking paraphernalia in the room.

Rates and Billing Procedures

1. Rates are quoted on a daily basis and must be paid in advance upon billing.
2. Charges are made for the day of admission regardless of the time of admission.
3. For private pay clients, charges are also made for the day of discharge regardless of the time of admission.
4. Accounts are due and payable on the first day of the month. A service charge of $50.00 will be assessed if payment is not made by the10th of the month.
5. Medicaid residents are responsible only for the budgeted amount according to State and Federal guidelines.

Refund Procedure

Refunds will be pro-rated on the unused days of advance payments. All refunds will be made in accordance with the Refund Policy listed in the Admission Agreement.

Discharge – Transfers

1. Residents may be discharged only on physician's orders.
2. Accounts must be paid in full at the time of discharge.
3. A pre-discharge conference will be held with the administrator and/or bookkeeper and family or RESIDENTS NAME.
4. All personal effects must be picked up from the facility immediately after discharge. Those effects not removed within 10 days will be discarded.
5. Married residents will be allowed to share rooms except where the physician documents medical reasons why this should not be done.
6. Transfers within the facility may be made at the request of the resident and/or **RESPONSIBLE PARTY** and/or legal representative. The facility will transfer or discharge a resident from the **facility**, or within the facility only under the following conditions:

   a. When the resident's needs cannot be met by the facility or in the section of the facility where she/he is located.

   b. The resident's health has improved and she/he no longer needs the services of the facility, or the section of the facility in which she/he is located.

   c. The safety and/or health of individuals in the facility are endangered.

   d. Failure to pay the bill after reasonable notice.

   e. The facility ceases to operate.

   f. The resident and/or **RESPONSIBLE PARTY** and/or his legal representative request the transfer or discharge.

All discharges or transfers to other facilities are made under the orders and direction of the attending physician or medical director. The resident and **RESPONSIBLE PARTY** and/or legal representative are given 30 days advance notice except:

A. In a medical emergency when the health and/or safety of the resident or other individuals are threatened.
b. The resident has not resided in the facility for 30 days.

7. A resident is relocated to another room in the facility only when absolutely necessary in accordance with the reasons in #6. Except in an emergency or when the resident and/or RE and/or legal representative requests the move. The relocation is made in accordance with the facility's relocation Resident Policy.

Wandering Residents

RESIDENTS NAMEfully understands that Regency Village does not admit and does not retain residents who may wander off the grounds of the facility. This policy is for the ultimate protection of the resident. Consequently, if a resident is admitted and at any time after the admission develops a behavioral problem where he/she is a threat to wander away from the facility the following action will be taken.

1. The resident will be discharged to the care of **RESPONSIBLE PARTY**, or
2. The resident will be discharged to another facility.

Holding Rooms

If a resident wishes to hold his/her room during a temporary absence or period of hospitalization the room will be held in accordance with the Facility Bed Hold Policy. This policy and format is addressed in the Admission Contract.

Room Decoration

1. You may hang two items on the painted wall on your side of the room.
2. Please do not hang anything on the walls with wallpaper.
3. Refrigerators are not allowed in the rooms.
4. We are attempting to keep the rooms clutter free. Please do not bring too many items into the room.
5. The night stands are to remain between the bed and the wall.
6. No appliances are to be placed on the night stands. The night stands are used for placement of decorations only.

Survey Results

The facility will post a copy of the most recent survey conducted by the Texas Department of Human Services. The report can be found posted in the cabinet outside of the café. A second copy in a black binder clearly marked "Survey Book" is located in a drawer in the front lobby. These reports have been placed in these areas for your review. If you have questions concerning a survey, please contact the Administrator.

Grievance and Complaint Procedure

There is an established procedure for receiving grievances and/or complaints. This procedure is provided upon admission.

Discrimination Policy

This facility provides services and programs to all persons without regard to race, color, national origin, disability, gender, or age.

I HAVE BEEN PROVIDED A COPY OF THE ADMISSION POLICIES. I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THESE POLICIES.

RESIDENTS NAME

_____

RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagua

_____

FACILITY REP

CARE PLAN MEETING

Dear Resident/Family Member:

Thank you for choosing Regency Village for you rehabilitation. In order to make sure we are meeting all your expectations our Care Plan Team would like to meet with you and your family 1 week after your admission. It will be a **short meeting** lasting up to 15 minutes to discuss the plan of care, discharge expectations, and make sure our goals are the same. We look forward to meeting with you on _____ at _____.

We schedule these minutes 15 minutes apart so it is very important to arrive on time. If you are unable to attend a meeting we could also set up a conference call at your convenience. If you have problems with care this should be directed to the Director of Nurses.

If you have any questions please contact KIMBERLY LOVELL at 281-332-4738.

Sincerely,

Betty Barajas, RN
Care Plan Coordinator
Regency Village

BED HOLD AND READMISSION POLICY

After placement in the nursing home, it may be necessary for the resident to go out of the facility for brief periods of hospitalization or therapeutic home visits. It is the policy of this facility to hold beds and readmit residents as follows:

A. PRIVATE PAY: Private pay residents may come and go from the facility as often and for as many days as desired at any time. However, during these leaves of absences from the facility, the resident continues to pay the same daily rate as if he was in the facility.

B. MEDICAID RECIPIENTS: 1. on therapeutic visits, the Medicaid program allows each resident to leave the facility for up to 72 consecutive hours at any one time. The days are counted in 24 hour periods from midnight to midnight.

2. When the Medicaid resident is admitted to a hospital for a period in excess of 24 hours the Medicaid portion of the resident's bill must be paid by the resident in order for a bed to be held. A bed will be reserved for a resident for as long as the bed hold charges are paid when he/she is out of the facility. Bed hold charges may be discontinued at any time if the resident and/or **RESPONSIBLE PARTY** notifies the Administrator's office and all the residents personal belongings are removed from the room.

For a Medicaid recipient who does not hold a bed during his/hospitalization, the resident may be admitted to the facility immediately upon the first available bed in a semi-private room in the long term care section of the facility.

I have read and acknowledge this bed hold policy and hereby request the facility to (place signing parties' initials on the appropriate line):

_____ Hold the bed for **RESIDENTS NAME**during any stay away from the facility. I agree to pay the same private rate or the Medicaid portion of the Medicaid rate for each day the above resident remains out of the facility.

__X____ I do not wish to pay bed hold charges while **RESIDENTS NAME**is away from the facility. I will remove all personal belongings and release any claim to his/her bed. I realize on readmission that it will be necessary to wait for the next available bed in the section for which the above resident requires placement.

IF YOU DO NOT HOLD THE BED ALL PERSONAL BELONGINGS MUST BE PICKED UP WITHIN 48 HOURS SO WE CAN UTILIZE THE ROOM.

RESIDENTS NAME

_____

RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagin

_____

FACILITY REP

Medicaid Qualifications & Instructions
Texas Department of Human Services

1. To Qualify For Medicaid benefits in the facility the individual must meet the following criteria:
   a. Receive determination of medical need from Texas Health Department Long Term Care Unit.
   b. Have current income from all sources below
      ** $ 4,398.00 – couple
      ** $ 2,199.00 – individual
   c. Have no disposable assets other than their own home
   d. Have a bank balance below :
      ** $ 2,000.00 - individual
      ** $ 3,000.00 – couple
2. If the individual meets the above criteria he/she must be admitted to a facility before the Medicaid application can be presented to the Medicaid Case worker.
3. After admission to the facility the RESPONSIBLE PARTY or legal representative must contact the local Medicaid Case Worker for the financial packet needed to make the Medicaid application. The facility Case worker with the Texas Department of Human services is :

   Name : Yolanda Robertson

   Address : 220 Meadowfern Ste 158 Houston, Tx 77067

   Phone Number : 281-775-7988

4. **RESIDENTS NAME**and / or legal representative must complete the application and case worker as soon as possible. Failure to follow through on the application process will delay Medicaid payment to the facility. Regency Village does require the client, **RESPONSIBLE PARTY** and / or legal representative To pay the private daily rate until the Medicaid application has been approved.

5. If the application is completed timely and all appointments and requirements of the case worker are met, the Medicaid payments will become effective back to the date of admissions to the facility, the date on which the resident first met all the above criteria. The resident must be in the facility for thirty (30) consecutive days before the case worker can process the application. The stay may be interrupted by a hospitalization or a move to another facility. However, the resident must be continuously in the facility or another health care facility for Medicaid to be retroactive back to the first day of admission. If the resident is discharged home before the 30th day, Medicaid will not pay and he/she must pay the private rate.
6. If the individual is married a spouse resource assessment is available upon request from the Department of Human services. The purpose of this assessment is to determine a protected amount for the spouse who remains in the community.

STATEMENT OF SERVICES AND CHARGES FOR RESIDENTS RECEIVING MEDICAID ASSISTANCE

A. The following services and items are included in the vendor payment or daily rate:

1. Semi-private room accommodations with furnishings.
2. Regular laundry and linen services (except dry cleaning)
3. Housekeeping services
4. Maintenance service to provide a safe comfortable environment (exclusive of personal Furnishings and appliances).
5. Three nutritious meals per day prepared under the direction of a Registered Dietitian.
6. Snacks and nourishments.
7. Twenty-four (24) hour licensed nursing care with a Registered Nurse directing nursing services.
8. An M.D. Medical Advisor directing medical care to the resident
9. Confidential medical records service.
10. Medical accessories
11. Medical supplies needed to provide care to the residents.
12. Non-legend drugs.
13. Personal health and hygiene-items, i.e., toothbrush, toothpaste, shampoo, shaving cream, razor blades, sanitary napkins, comb or hairbrush soap, body lotion, denture adhesive and cleansers, and facial tissue. If the resident prefers to use a specific brand of personal need item, then the resident will be responsible for the cost.
14. Assistant devices that are used to assist individuals in accomplishing a task.
15. Equipment which can be used by more than one person, i.e., Geri-chair, wheelchair, walkers, crutches, canes, etc. If the resident desires equipment for full-time use as a convenience rather than a documented need, its purchase will be the responsibility of the resident. Upon discharge from the facility, the resident must retain the equipment which was purchased, and in the event of death the purchased equipment will be transferred to the estate.
16. Prescription medications covered by Medicaid will be paid by Medicaid.
17. Transportation will be provided for normal non-emergency and routine medical service visits outside the facility. Charges for medically necessary ambulance services are not the responsibility of the facility but are payable through the health insuring agent as a Medicaid benefit. The facility will encourage volunteers to assist with transportation.
18. Individual and group social/recreational activities.
19. Social Services through staff social worker.
20. Religious and Pastoral guidance.
21. Library and News Media including large print books and materials for the visually Handicapped.
22. Volunteer and auxiliary services.
23. Resident Representative – advocacy program.
24. Resident's Council.
25. Activities Council.
26. Family Support Groups.
27. Mail Delivery and pick-up.
28. Regularly scheduled safety and maintenance inspections.
29. Social/Psychological referral services.
30. Responsible administrative services.
31. Facility security services.
32. Physician services by those with attending physician privileges will be billed by the physician directly to Medicare/Medicaid for eligible recipients.

33. Oxygen

The following are services available by contract through this facility and can be billed directly to Medicare/Medicaid for recipients utilizing these services. RESIDENT and/or his legal representative has complete freedom of choice to choose any medical services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services unless the provider causes the facility to be out of compliance with the state requirements.

Podiatrist	Respiratory Therapist
Physical Therapist	Laboratory, X-Ray, EKG
Speech Pathologist	Dermatologist
Psychologist	Ophthalmologist

C. The following services and items are not covered/in the daily rate:
1. Parental Fluids
2. Guest meals, accommodations and delivery charges.
3. Beauty Shop/Barber
4. Special laundry services (dry cleaning)
5. Non-medical transportation
6. Private telephone
7. Cable Television

D. Protection of Funds:
1. The resident is under no obligation to deposit funds with the facility.
2. The resident has the right to determine how personal funds will be handled.
3. The resident may receive, retain and manage personal funds or have this done by a legal guardian.
4. The resident has the right to apply to the Social Security Administration to have a Representative payee designated for Federal or State benefits to which she/he may be entitled.
5. The resident has the right to designate in writing another person to manage personal funds except when **Number 4** is applicable.
6. It is the facility's obligation, upon written authorization by the resident, to hold, safeguard, and account for the resident's personal funds.
7. Any charges for the handling of personal funds by the facility are included in the basic rates.
8. The facility must have written permission from **RESIDENTS NAME/ RESPONSIBLE PARTY** to handle personal funds.
9. If the resident becomes incapable of managing personal funds and does not have a Representative payee or RP, the facility is required to notify the Department of Human Services Regional Medicaid Eligibility Worker.
10. Reasonable access to financial records will be provided to each recipient.
11. Recipient funds held in the facility will be returned immediately upon request, transfer, or discharge whichever comes first.

ADMIT DATE

_____

RP SIGNED NAME

Pharmacy Services Acknowledgement

Regency Village is contracted with ADVANCED PHARMACY OF HOUSTON to provide pharmacy services for all Skilled and Medicaid residents residing in the facility. Regency's decision to contract with ADVANCED PHARMACY OF HOUSTON is based on their ability to provide medications at competitively priced rates, deliver medications timely, and honor all prescription drug plan discounts.

PATIENTS RESIDING IN THE SKILLED UNIT:

As mentioned above, medications for all skilled level patients will be provided by ADVANCED PHARMACY OF HOUSTON. In the event you discharge into the long term care unit at the end of your skilled stay, you are not required to continue using ADVANCED PHARMACY OF HOUSTON as your primary pharmacy. However, it is your responsibility to inform Admission Manager of the pharmacy you wish to use. In the event you do not instruct the Admission's Manager as to a pharmacy of your choice, we will advise ADVANCED PHARMACY OF HOUSTON to bill you for pharmacy services.

Name of Preferred Pharmacy should patient convert to long term care unit:

_____

Phone # of Pharmacy: _____

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagin
_____
FACILITY REP

STATEMENT OF RESIDENT RIGHTS

You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. It is against the law for any nursing facility employee to threaten, coerce, intimidate or retaliate against you for exercising your rights.

If anyone hurts you, threatens to hurt you, neglects your care, takes your property, or violates your dignity, you have the right to file a complaint with the Texas Department of Human Services by calling 1-800-458-9858.

You have a right:

1. to all care necessary for you to have the highest possible level of health;

2. to safe, decent and clean conditions;

3. to be free from abuse and exploitation;

4. to be treated with courtesy, consideration, and respect;

5. to be free from discrimination based on age, race, religion, sex, nationality, or disability and to practice your own religious beliefs;

6. to privacy, including privacy during visits and telephone calls;

7. to complain about the facility and to organize or participate in any program that presents residents' concerns to the administrator of the facility;

8. to have facility information about you maintained as confidential;

9. to retain the services of a physician of your choice, at your own expense or through a health care plan, and to have a physician explain to you, in language you understand, your complete medical condition, the recommended treatment, and the expected results of the treatment;

10. to participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research;

11. to a written statement or admission agreement describing the services provided by the facility and the related charges;

12. to manage your own finance or to delegate that responsibility to another person;

13. to access money and property you have deposited with the facility and to an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on behalf of you;

14. to keep and use personal property, secure from theft or loss;

15. to not be relocated within the facility, except in accordance with nursing facility regulations;

16. to receive visitors;

17. to receive unopened mail and to receive assistance in reading or writing correspondence;

18. to participate in activities inside and outside the facility;

19. to wear your own clothes;

20. to discharge yourself from the facility unless you have been adjudicated mentally incompetent;

21. to not be discharged from the facility, except as provided in the nursing facility regulations;

22. To be free from any physical or chemical restraints for the purposes of discipline or convenience and not required to treat your medical symptoms.

23. receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee, to have any psychoactive medications prescribed and administered in a responsible manner, as mandated by the Health and Safety Code, 242.505, and to refuse to consent to the prescription of psychoactive medications; and

24. Place an electronic monitoring device in your room that is owned and operated by you or provided by your guardian or legal representative.

Your rights may be restricted only to the extent necessary to protect you or another person from danger or harm or to protect a right of another resident, particularly those relating to privacy and confidentiality.
I have received a copy of the above list of Resident's Rights.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

FACILITY REP

RESIDENT ABUSE/NEGLECT REPORTING

It is the policy of this facility that all personnel promptly report any incidents or any suspected incidents of resident abuse/neglect, including injuries of an unknown source. Upon a report of an allegation of resident abuse/neglect, the facility will investigate each instance as to determine if the allegation did occur. The facility will report and notify the Texas Department of Human Services as outlined in the State Operations Manual.

The facility has assigned the ADMINISTRATOR as the Abuse Prevention Coordinator. They will coordinate all functions of abuse/neglect prevention. To include staff training, policy implementation and revision, investigation/reporting, and disciplinary actions.

Any facility staff member who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person must report the abuse, neglect, or exploitation, which includes conduct or conditions resulting in serious accidental injury or hospitalization of residents. Conduct or conditions means a facility practice, actions/inaction by staff or circumstances within a facility resulting in:

1. Serious accidental injury to residents: or
2. Hospitalization of residents.

The person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Director of Nursing or Administrator.

If both the Director of Nursing and Administrator are unavailable the report should be made to the charge nurse: the charge nurse will be responsible for contacting the Director of Nursing or Administrator. The administrator is the abuse coordinator.
As applied in this policy, the following words have the following meaning:

Abuse – Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes verbal, sexual, mental, psychological, physical abuse (including corporal punishment), involuntary seclusion or any other mistreatment within this definition.
Verbal Abuse – The use of any oral, written, or gestured language that includes disparaging or derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.
Sexual Abuse – Any touching or exposure of the anus, breast, or any part of the genitals of a resident without the voluntary, informed consent of the resident, and with the intent to arouse or gratify the sexual desire of any person, and includes but is not limited to sexual harassment, sexual coercion, or sexual assault.
Physical Abuse – Physical action within the definition of abuse in this paragraph which includes, but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.
Involuntary Seclusion – The separation of a resident from others or from his or her room against his or her will or the will of his or her legal representative. Temporary monitored separation from other residents will be considered involuntary seclusion and may be permitted if used as a therapeutic intervention as determined by professional staff and consistent with the resident's plan of care.
Mental/Psychological Abuse – The mistreatment within the definition of abuse in this paragraph which does not result in physical harm and includes, but not limited to, humiliation, harassment, threats of punishment, deprivation, or intimidation.
Exploitation – The illegal or improper act or process of a caretaker using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain.

Neglect – A deprivation of life's necessities of food, water or shelter, or failure of an individual to provide services, treatment or care to a resident which causes mental physical injury or ham or death to the resident.

An employee who fails to report an incident of abuse, neglect or exploitation will be subject to disciplinary action up to and including termination. Failure to report such an incident of abuse, neglect or exploitation may subject the individual to criminal prosecution.
Per the State's Operation Manual, the facility will report the allegation to the Intake Coordinator, Investigations Section, Long Term Care – Regulatory at 1-800-458-9858. Allegations occurring after 5:00 p.m., or on weekends or holidays, are reported by calling 1-800-458-9858 and leaving a message.

Employee accused of resident abuse/neglect may be reassigned to another unit within the facility or suspended.

The facility will conduct an investigation as to identify if abuse/neglect has occurred. If the investigation finds that abuse/neglect has occurred, the employee will be discharged. If the investigation finds abuse/neglect has not occurred, the employee will be reinstated.

The facility will document findings on a Facility Investigation Report form. The form will be completed and forwarded (see address instructions below) within 5 working days.

Texas Department of Human Services, Long Term Care- Regulatory, Customer Service Section E-349, P.O. Box 149030, Austin, Texas 78714-9030

All reports of alleged abuse shall be kept confidential.

For injuries from an unknown source (i.e. bruising or skin tears), the facility will internally investigate as to rule out abuse and or neglect. If the facility determines abuse and or neglect has occurred, the facility will implement all reporting requirements as outlined in the Stat's Operational Manual and all in-house policy and procedure as to resolve the incident.

The facility may not terminate, or in any other manner discriminate or take retaliatory actions against an employee for:

A. Reporting any action described in subsection B and C of this section to DHS or a law enforcement agency
B. Reporting the abuse or neglect or other complaint to the person's supervisor; or
C. For initiating or cooperating in any investigation or proceeding of a governmental entity relating to care, services, or conditions at the nursing facility.

As part of the admissions process I have received and reviewed a copy of the facility policy and procedure regarding abuse prevention, reporting, and documentation.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagui
_____
FACILITY REP

ACKNOWLEDGEMENT-ADVANCED DIRECTIVES-

RESIDENTS NAME: **SS #**

MR # **DOB**

PLEASE READ THE FOLLOWING STATEMENTS.

1. I have been given written materials about my rights to refuse or accept medical treatment.

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK AND INITIAL ONE OF THE FOLLOWING STATEMENTS:

_____ I **HAVE** executed an Advance Directive.

____ I **HAVE NOT** executed an Advance Directive.

PLEASE CHECK AND INITIAL ONE OF THE FOLLOWING STATEMENTS:

_____ **DO NOT RESUSCITATE**

____ **RESUSCITATE**

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagui

FACILITY REP

NOTICE REGARDING THE OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

RESIDENTS NAME

I confirm that on DATE the information concerning the Out of hospital Do Not Resuscitate Order was provided to me by the administration of Regency Village Health Care Center. I have elected to not execute the Out of hospital Do Not Resuscitate Order and I understand that the effect of my not executing the document is that I will be considered "full code". This means that, in the event of cardiac arrest, cardiopulmonary resuscitation and any other resuscitative measures deemed appropriate will be undertaken in an effort to restore cardiac function. I also understand that I may choose to execute the Out of hospital Do Not Resuscitate Order in the future.

_____

Resident's Signature

(If the resident has not executed an Out of hospital Do Not Resuscitate Order or provided a copy of previously executed order to the facility and cannot complete the above section RESPONSIBLE PARTY should sign below.)

As the RP, I confirm that the resident is not able to execute the above document and I confirm that I have read the above and understand the effect of there being no Out of hospital Do Not Resuscitate Order in place.

_____ **ADMIT DATE**

RP SIGNED NAME

CONCERN RESOLUTION

POLICY:
Grievance Reporting

PROCEDURE:

Each resident and/or representative has the right to voice grievances without discrimination or reprisal including those grievances lodged with respect to treatment which has been delivered as well as that which has not been delivered.

(1) Any resident or representative of a resident who wishes to voice a grievance regarding facility services is encouraged to immediately contact the facility. Concerns may be made verbally or in writing and should be directed to the appropriate Department Manager. The Administrator, Director of Nursing, and Social Worker is also available to address any concerns or grievance.

(2) The facility Department Manager will promptly undertake efforts to resolve grievances the resident or representative may have, including those with respect to the behavior of other residents.

(3) In the event a Department Manager or the Administrator is unavailable, grievances can be filed with a charge nurse or written on a grievance form. The grievance forms can be found in a red binder across the hall from the Director of Nursing's office. The completed form can be given to the charge nurse or placed in the locked wooden box next to the red binder.

(4) If the grievance is not handled in a timely manner or in a manner satisfactory to the resident or the representative, the resident or representative may contact the Ombudsman responsible for this facility. The Ombudsman is a specially trained volunteer who can provide information to residents and their representatives about the rights of the resident and procedures regarding the resident's care. The Ombudsman can work with residents and facility staff to resolve complaints or difficulties. The Ombudsman may be contacted through the State Ombudsman Program at 800.252.2412

(5) The facility will not retaliate or discriminate against a resident if the resident, the resident's representative or any other person makes a complaint or files a grievance concerning the facility.

_____

RP SIGNED NAME **ADMIT DATE**

LOST & FOUND PERSONAL BELONGINGS

POLICY:
It is the policy of this facility to make every effort possible to prevent loss or damage to resident's personal belongings. All items brought into the facility must be clearly marked with RESIDENTS NAME. All personal property, i.e., jewelry, furniture, appliances, medical equipment, etc. must be recorded on the Resident's Inventory Sheet form which is kept on the resident's clinical record.

DO NOT BRING LARGE AMOUNTS OF CASH TO FACILITY. WE RECOMMEND $5 OR LESS.

PROCEDURE:
The following steps will be taken when an item is reported missing:

- **A Missing Item Report form must be completed as soon as the item(s) is known to be missing. Forms are available at the nurses' station.**
- **once the Activities Director is in receipt of a "Missing Item(s) Report she will assume responsibility for the search of the missing item(s).**
- **The Activities Director will maintain a record of all lost item(s).**
- **The Activities Director will contact the resident, where applicable, and RESIDENT within 14 days from the date of the Missing Item Report with a status report.**
- **If the item has not been located within 30 days from the date of the "Missing Item(s) Report", the search will be discontinued. The resident where applicable, and RESPONSIBLE PARTY will be notified.**

Dentures ____ upper _____ lower ____ partial

Hearing aids _____left _____ right

Glasses _____

***THE FACILITY IS NOT RESPONSIBLE FOR LOST OR DAMAGED EYE GLASSES, HEARING AIDS, CELL PHONES, CHARGERS, OR DENTURES.**

By your signature, you agree to fully release the facility from any responsibility for lost or stolen personal property.

_____ ADMIT DATE
RP SIGNED NAME

Restraint Proper Environment

We at Regency Village have a strong belief that the residents in our facility have the right to be treated in a dignified and hospitable way.

As you are probably aware, Congress has requested long term care facilities to use restraints, both chemical and physical, only when absolutely necessary. All restraints utilized at this facility are at the direction and on order of the attending physician of the resident.

Our goal is to use restraints only as a last resort if needed to protect the well-being of the resident or other residents on the facility.

Restraint Proper Environment
Statement of Understanding

I, RESPONSIBLE PARTY on behalf of facility resident, RESIDENTS NAME, have been informed of Regency Village's restraint proper environment program and am aware that through the implementation of the program, that the above-named resident will be evaluated fully for restraint elimination and/or reduction in the restraint usage. I understand that this process would allow the resident more freedom of movement and will hopefully benefit the resident's well-being.

PERMISSION FOR USE OF RESTRAINTS

It is the policy of this facility to not restrain residents except for their own safety or to prevent harm to others. Upon admission to the facility the resident is carefully observed for his/her ability to walk and support his/her weight without falling. Also he/she is observed for his/her ability to control his/her body movements. If at any time the resident loses mental or physical control of his/her body, the physician will be notified and restraints applied in accordance with his/her orders.

_X_ The facility has my permission to use restraints as needed in accordance with the resident's comprehensive care plan and physician's orders.

____ The facility is not to use restraints at anytime. I realize that this may lead to increased incidents of falls/or possible injury to the resident.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagin
_____
FACILITY REP

REGENCY VILLAGE
409 West Green
Webster, Texas 77598
(281) 332 4738

CONSENT TO PHOTOGRAPH

I, **RESIDENTS NAME**, a current resident at REGENCY VILLAGE hereby authorize the attending physician or other designated person(s) to take:

1. Photographs of me for identification purposes
2. Photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition. (I understand that any photographs taken will be placed in and remain part of my medical record.)
3. Photographs of me may be placed in the facility for activity purposes.
4. Photographs of me may be used for community newspapers or newsletters.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipaguu

FACILITY REP

Social Media Consent

Family Members and Residents:

By signing this agreement, you consent to allow Penbar, Inc. d/b/a REGENCY VILLAGE to share/post both previous and current communications regarding your and your family member's experiences on our facility communications boards, websites, social media sites and other marketing communications and materials. Communications will include, but not limited to, thank you letters, comments shared with staff, holiday cards, etc.

Personal Information - We will strive to remove any personally identifiable information such as addresses, phone numbers, social security numbers, e-mail addresses, last names and any other information beyond your first name and the names of family members that might identify you. However, your comments alone may identify you to others who have heard your comments or who are aware of your comments.

Release and Indemnity – By providing consent to the use of your communications as outlined above you agree to release and indemnify REGENCY VILLAGE against any claims of lawsuits that may arise as a result of the use of your communications.

Thank You – REGENCY VILLAGE wants to thank you for allowing our use of your communications and, more importantly, we want to thank you for trusting us for your care of for the care of your loved one.

RESIDENTS NAME

_____

RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

FACILITY REP

Regency Village
409 West Green
Webster, Texas 77598
(281) 332 4738

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

I AUTHORIZE THE FOLLOWING T O DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:
Person/Organization Name _____ _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____ _____
WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Organization Name _____ _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____ _____
SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative DATE
Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____
A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain
types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).
SIGNATURE X_____ _____
Signature of Minor Individual DATE

NAME OF PATIENT OR INDIVIDUAL
_____
Last First Middle
OTHER NAME(S) USED _____
DATE OF BIRTH Month _____Day _____ Year_____
ADDRESS _____
_____
CITY _____**STATE**_____ **ZIP**_____
PHONE (_____)_____ **ALT. PHONE** (_____)_____
EMAIL ADDRESS (Optional): _____
EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided

by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

REASON FOR DISCLOSURE

(Choose only one option below)

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information** ☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results
☐ Physician's Orders ☐ Patient Allergies ☐ Operation Reports ☐ Consultation Reports
☐ Progress Notes ☐ Discharge Summary ☐ Diagnostic Test Reports ☐ EKG/Cardiology Reports
☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

Important Information About the Authorization to Disclose Protected Health Information

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health informa - tion" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and a lso educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

• Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
• Drug, alcohol, or substance abuse records.
• Records or tests relating to HIV/AIDS.
• Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual' s health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individu - al's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in t he "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified per son or organization, and staff members or agents (such as busi - ness associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified overed entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information r elated to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy

notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).
Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.
The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirement s of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**
Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law . (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).
The authorization provided by use of the form means that the organization, entity or person authorized can disclose, commu - nicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cynthia Pagan

FACILITY REP

Regency Village
409 West Green
Webster, Texas 77598
(281) 332 4738

"Inspection of Records Policy"

1. The resident or his/her legal representative has the following rights:
   a. Upon an oral or written request, to access all records pertaining to himself/herself, including clinical records, within 24 hours; and
   b. After receipt of his records for inspection, to purchase photocopies of all or any portion of the records, at a cost not to exceed the community standard, upon request and two work days advance notice to the facility.

2. For persons other than the resident or his/her legal representative to see the record, they must have written permission from the resident.

3. All requests to see medical records must be referred to the Administrator and/or Director of Nursing and the appropriate forms completed before giving the resident the clinical record.

4. The attending physician is to be notified that the resident and/or legal representative have requested to see the clinical record.

5. Copies of the resident's records are to be kept confidential at all times.

6. Copies of the resident's records are available during business hours of 9:00a.m. - 5:00 p.m. or by special arrangement with the administration.

_____ **ADMIT DATE**
RP SIGNED NAME

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Regency Village is permitted by law to make for each of the following purposes:

a. Treatment, such as provision of information to your doctor.
b. Payment such as submitting your information to Medicare, Medicaid or an Insurer.
c. Health care operations, such as discussion of your information in quality assurance meetings.

Regency Village is permitted or required by the Privacy Regulations in certain instances to use or disclose protected health information without the individual's written authorization including:

a. Uses and disclosures required by law;
b. Uses and disclosures for public health activities;
c. Disclosures about victims of abuse, neglect or domestic violence;
d. Uses and disclosures for health oversight activities;
e. Disclosures for judicial and administrative proceedings;
f. Disclosures for law enforcement purposes;
g. Uses and disclosures about decedents;
h. Uses and disclosures required for cadaveric organ, eye or tissue donation purposes;
i. Uses and disclosures for research purposes;
j. Uses and disclosures to advert a serious threat to health or safety;
k. Uses and disclosures for specialized government functions; and
l. Disclosures for workers compensation.

If a use or disclosure described above is prohibited or materially limited by other laws, the description of the disclosure must reflect the more stringent law.

Other uses and disclosures will be made only with the individual's written authorization and that the individual may revoke such authorization as permitted by the individual's rights under HIPAA;

The individual's may exercise his/her rights to protected health information by:

a. Requesting restrictions on certain uses and disclosures of protected health information;
b. Regency Village is not required to agree to a requested restriction;
c. The individual's right to receive confidential communications of protected health information, as applicable;
d. The individual may exercise his/her right to inspect, copy, amend, and receive an accounting of disclosure of protected health information as provided in the Facility's policies;
e. The individual may exercise his/her right to obtain a paper copy of the notice from the covered entity, even if the individual has agreed to receive the notice electronically, as provided by the Facility's policies;
f. Regency Village is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
g. Regency Village is required to abide by the terms of the notice that is currently in effect;
h. For protected health information that is created or received prior to issuing a revised notice, Regency Village reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains;

i. Regency Village will promptly revise and distribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or other privacy practices stated in the notice, and how it will provide individuals with the revised notice;
j. Individuals may complain to Regency Village and to the Department of Health and Human Services if they believe their privacy rights have been violated.
k. An individual may file a complaint with Regency Village by contacting the Administrator, his/her designee or the Director of Nurses;
l. Regency Village will not retaliate against the individual for filing a complaint;
m. An individual may contact the Facility's Administrator or Director of Nursing for further information concerning the notice of privacy practices.

Regency Village may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Regency Village will promptly revise and redistribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, Regency Village legal duties, or other privacy practices stated in the notice.

Knowledge of a violation or potential violation of this policy must be reported directly to the Facility Administrator, his/her designee or the Director of Nursing.

I confirm that I have received Regency Village's *Notice of Privacy Practices*.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cynthia Pagan

FACILITY REP

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I consent to Regency Village using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a *Notice of Privacy Practice*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that Regency Village reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting that revised notice from the Facility Administrator.

I understand that I have the right to restrict how Regency Village uses or discloses my protected health information to carry out treatment, payment or healthcare operations; that Regency Village is not required to agree to the restrictions and; that Regency Village is bound by restrictions to which it agrees.

I understand I may request specific restrictions. Any restrictions made at this time have been submitted in writing, with this consent. Should I desire to make restrictions in the future, I realize that I may request those restrictions in writing by submitting them to the Facility's Administrator.

I have the right to revoke this consent by notifying Regency Village in writing, except to the extent that Regency Village has taken action in reliance on my consent.

I further specifically consent to the disclosure of the following information by my initials:

__X__ Placement of **RESIDENTS NAME**on or near the resident's door designating the resident's room.
__X__ Disclosure of the fact that the resident resides at the Facility.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagu

FACILITY REP

Authorization for the Use and Disclosure of Individually Identifiable Health Information
Upon Request

I hereby authorize the use or disclosure of my individual identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed:
MEDICAL INFORMATION AND UPDATES
2. The information will be used/disclosed for the following purpose(s):
ON A AS NEEDED BASIS
3. Persons/organizations authorized to use or disclose the information:
REGENCY VILLAGE STAFF, PHYSICIAN AND PHYSICIAN'S STAFF
4. Persons/organizations authorized to receive the information:

_____

_____

5. The person/organization authorized to use/disclose the information will receive compensation for doing so. ____ yes _x_ no
6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.
7. If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Regency Village reserves the right to deny treatment associated with such research.
8. If the purpose of this authorization is to disclose health information to another party base on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Regency Village reserves the right to deny that health care.
9. I understand that I may inspect or copy the information used or disclosed
10. I understand that I may revoke this authorization at any time by notifying Regency Village in writing, except to the extent that:
    a. Action has been taken in reliance on this authorization; or
    b. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
11. I understand that I have a right to request and receive a Notice of Privacy Practices from Regency Village.
12. This authorization expires on discharge

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipaqui

FACILITY REP

Authorized Electronic Monitoring

All residents residing at Regency Village are entitled to conduct Authorized Electronic Monitoring (AEM) under Subchapter R, Chapter 242, Health and Safety Code. Should a resident and/or representative elect to conduct AEM, the Administrator will assume the responsibility of providing you with copies of our policies which detail management of AEM.

If you choose to use AEM please contact the Admissions Director, *as proper forms and consents will need to be signed.*

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagu

FACILITY REP

Items Allowed in Resident's Personal Possession or Room While in Facility

Certain articles are not specifically controlled, nor restricted by codes, standards or regulations and may be permitted at the discretion of governing body and/or Administrator on an individual basis. Other articles are controlled by codes, standards and regulations or because the presence or use of such articles has been interpreted to have an adverse effect on the health and safety of the residents.

I. The following articles **<u>may be permitted</u>** at the discretion of the governing body and/or Administrator of the facility unless the presence or use of such articles could aversely affect the health and safety of residents.

A. Miscellaneous

1. Sewing machines and related equipment
2. Sewing scissors and materials. *Scissors must be blunt nosed*.
3. Hobby tools and equipment.
   a) Personal articles – like furniture, books, photos, electric razors, TV's, radios, stereos and telephones.

B. Food and non-alcoholic beverages may be used if the following conditions are met:

1. Foods and beverages are to be kept in insect/rodent proof containers.
2. Foods and beverages are not allowed to spoil.

C. Fans

Fans may be allowed if the following conditions are met:

1. The fan must be securely mounted to prevent the fan from toppling.
2. The fan must have the Underwriter's Laboratories, Inc. Seal of Approval. The manufacturer's precautionary instructions are to be following.

II. The following articles **<u>are not permitted</u>** because they are controlled by codes, regulations, standards, or because the presence and/or use of such articles have been interpreted by TDH to have an adverse effect on the health and safety of the residents.

A. Fuel burning space heaters
B. Portable electric heaters
C. Cooking and ironing equipment
D. Coffee and cup heating elements
E. Throw rugs
F. Razor blades and straight razors
G. Extension cords
H. Chemical products
   1. Flammable liquids
   2. Laundry and house cleaning products
I. Smoking tobacco, matches, lighters, or other smoking paraphernalia.

III. The following is a list of the Regency Village allowable and non-allowable items.

A. <u>Allowable</u>

1. Tooth brush, tooth paste, mouth wash – non-alcohol
2. Perfume, aftershave smaller sized containers.
3. Liquid Soap
4. Hair brush, comb and pump hair spray
5. Deodorant-Stick
6.

B. **<u>Non-allowable</u>**

1. Prescription Medication, Over the Counter Drugs, Supplements/Vitamins and topical.
2. Body Powder
3. Aerosol Hair spray, and Air Freshener
4. Nail Polish and Remover
5. Mineral Oil
6. Laundry Detergent
7. Refrigerators
8. Electronic cigarettes
9. Electric wheelchairs/scooters
10. Products labeled "KEEP OUT OF THE REACH OF CHILDREN" will be assessed utilizing the patient and facility centered approach.

When non-allowable items are removed from resident rooms, facility staff will notify the resident or RESPONSIBLE PARTY and give the items to RESIDENT for disposal, if possible or feasible.

RESIDENTS NAME

_____

RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

FACILITY REP

Generic Drug Policy

The generic substitution law of 1980 allows the pharmacist to substitute a less expensive generic drug for the drug name prescribed unless your physician instructs him/her otherwise. However, in the event your personal preference is for a brand name drug, you may choose this drug. Because neither Medicare nor Medicaid will pay for a brand name item, you will be charged for the prescription based on applicable cost.

Substitution of a generic for a brand name prescription is intended to reduce cost to the Medicaid and Medicare program.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

FACILITY REP

ANCILLARY CHARGES-PRIVATE PAY ROOM RATES

Base room rates and charges apply to private pay residents. Rates are subject to adjustment based on review of patient acuity and apply to all new admissions. Once a rate is set, the rate may be adjusted once annually for inflationary factors.

☐	Semi-Private Room	$162.00	per day	

		Rental		Purchase
___	Wheelchair	$40.00	monthly	$350.00
___	Concentrator	$50.00	monthly	$890.00
___	E-Tank	$80.00	monthly	N/A
___	Nebulizer	$20.00	monthly	N/A
☐	Incontinent Care	$150.00	monthly	N/A
☐	Satellite Television	$25.00	monthly	N/A
☐	Private Telephone	$21.00	monthly	N/A
___	Wander Guard*	$35.00	monthly	N/A
	*There will be a $100.00 replacement fee for lost Wander Guards.			
☐	Electric Bed	$100.00	monthly	$1,700.00
___	Low-Air-Loss Mattress	$9.00	per day	N/A

___	Isolation Supplies	N/A	$25.00	per day

- Transportation Fees: Costs will be quoted before transport.
- Family will be notified of cost in advance for any equipment order for rental or purchase.
- Medications are the responsibility of the resident and/or insurance, if applicable.

Preferred Pharmacy: _____

_____
RP SIGNED NAME

REGENCY VILLAGE

Kelsey Care Advantage/Texan Plus/Texas Health Springs/Medicare Part A Co-Insurance

I understand that I must provide proof of insurance to Regency Village upon admission.

____ **Kelsey Care** will only pay 100% for the first **20** days. Beginning on day **21**, the amount of **$125.00** per day is due to the facility. I understand that beginning day 21 I will be responsible for the co-pay.

____ **UNITED** will only pay _____% for the first _____ days. Beginning on day _____, the amount of **$_____.00** per day is due to the facility. I understand that beginning day 21 I will be responsible for the co-pay.

____ **CIGNA Health Springs** will only pay 100% for the first **10** days. Beginning on day **11**, the amount of **$20.00** per day is due to the facility up to 20th day, then on day 21 there is a **$100.00** co-pay per day. I understand that beginning day **11** I will be responsible for the co-pay, unless my plan is Cigna-HealthSpring Total Care (HMO SNP) Plan that pays 100% for days 1-100.

____ **Medicare** will only pay 100% for the first **20** days. Beginning on day **21**, the amount of **$164.50** per day is due to the facility. I understand that beginning day 21 I will be responsible for the co-pay.

____ **USFHP** may have a co-pay of **$11** for the first day through their stay; unless their stay is less than 3 days, then their co-pay will be $22 per day. Or you have USFHP plan that covers your stay 100%.

____ **Other Insurance _____** will pay _____ for the first _____ days. Beginning on day _____ the amount of **$_____** per day is due to the facility. I understand that beginning day _____ I will be responsible for the co-pay.

*** If there is no secondary insurance coverage, or the secondary insurance does not have Skilled Nursing Home coverage, the co-pay amount is to be paid by the resident / **RESPONSIBLE PARTY**

***If the resident has active traditional Medicaid, this co-pay may be covered.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagan
_____
FACILITY REP

NURSING FACILITIES
PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), and 1864 of the Social Security Act.
Medicare and Medicaid participating long-term care facilities are requires to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA. Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are produces under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED
The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. 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 and 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. 09-70-0528, published in the Federal Register at Vol. 72, no. 52/Monday, March 19, 2007. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1)To support agency contractors, consultants or grantees, who have been engaged by the agency to assist in accomplishment of a CMS function; (2) assist another Federal or state agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds; (3) assist Quality Improvement Organizations to perform Title XI or Title XVIII functions; (4) assist insurance companies, underwriters, third party administrators, employers, group health plans for purposes of coordination of benefits with the Medicare Program; (6) the Federal Department of Justice, court, or adjudicatory body in litigation; (7)

to support a national accrediting organization to enable them to target potential or identified problems with accredited facilites; (8) assist a CMS contractor in the administration of a CMS-administered health benefits program; (9) to assist another Federal agency that administers or that has the authority to investigate potential fraud, waste or abuse in a health benefits program funded in whole or part by Federal funds.

4. Effect on individual of not providing information
The information contained in the Long-Term-Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagin

FACILITY REP

Regency Village
409 West Greene
Webster, TX 77598

CONSENT FOR HALF SIDE RAILS

I, **RESIDENTS NAME**, a current resident at REGENCY VILLAGE hereby authorize use of *half side rails on my bed for:

1. Enhancement attempt of independent mobility
2. Transfer and positioning aid

*Device is not utilized as a restraint.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyantpaguu

FACILITY REP

Evacuation Requirement Notification

RESIDENTS NAME:

___X_____ Resident will be discharged to the care of RESIDENT in the event Regency Village requests this action based on facility procedure to evacuate.

_____Resident has been identified as clinically complex. Regency Village has made arrangement to shelter resident in place, or evacuate resident as outlined in facility procedure should action be necessary.

_____

RP SIGNED NAME

Regency Village Skilled Nursing Center
Home Health Information Form

THIS LIST OF PROVIDERS IS MADE AVAILABLE AS A COURTESY TO YOU, OUR PATIENT, AND IS NOT INTENDED TO BE AN INCLUSIVE LIST OF PROVIDERS YOU MAY SELECT FROM. IT IS YOUR DECISION AND YOUR RIGHT TO CHOOSE A PROVIDER NOT LISTED ON THIS FORM.

Date of Discharge Consult: _____ Date of Expected Discharge: _____

RESIDENTS NAME SS #

I UNDERSTAND THAT UPON DISCHARGE I HAVE A RIGHT TO CHOOSE A MEDICAL EQUIPMENT SUPPLIER/HOME HEALTH PROVIDER OF MY CHOICE.

Home Health Providers

____ *Village Home Health

____ Signature Home Health

____ Memorial Hermann

____ Texas Home Health

____ Other: _____

Some individuals in the ownership or management of these companies may also be owners or managers of Baywind, Regency, and Tuscany Villages.

My signature indicates that I have made a choice of providers and grant permission for the nursing facility to contact the provider on my behalf.

_____ _____

RESIDENTS NAME **FACILITY REPRESENTATIVE**

My signature indicates that I have chosen not to make a choice at this time and will contact a provider on my own.

_____ _____

RESIDENTS NAME **FACILITY REPRESENTATIVE**

RESIDENTS NAME
ADMIT DATE

Prior Level of Function:

Living Situation: INDEPENDENT W/SPOUSE W/FAMILY FACILITY: _____

Mobility: INDEPENDENT ASSISTANCE EQUIPMENT: _____

Dressing: INDEPENDENT ASSISTANCE

Bathing/Grooming: INDEPENDENT ASSISTANCE

Toileting: INDEPENDENT ASSISTANCE INCONTINENT

Cooking/Meal Prep: INDEPENDENT SPOUSE FAMILY FACILITY: _____

Diet (history of swallowing problems?): YES NO RECENT

Medication Management: INDEPENDENT SPOUSE FAMILY FACILITY: _____

Financial Management: INDEPENDENT SPOUSE FAMILY FACILITY: _____

Hobbies:

Discharge Plan: HOME W/FAMILY FACILITY: _____ LONG TERM CARE

DME Owned: CANE WALKER WHEELCHAIR ROLLATOR POTTY CHAIR SHOWER CHAIR TRANSFER BOARD BPAP OXYGEN OTHER: _____

Military Affiliation: YES/NO ARMY MARINES NAVY AIRFORCE COAST GUARD

Comments:

Pharmacy:

Primary Care MD:

Specialists:

Regency Village Rehabilitation and Long-Term Care

Risk of falls Education Form

RESIDENTS NAME

Resident and/or RP Education:

Potential Risks:

Medications such as tranquilizers, sleeping aids, pain relievers, blood pressure pills or diuretics may cause dizziness and disorientation.
Diseases, conditions or treatments can cause weakness and unsteady gait or balance.
Awaking to an unfamiliar environment, especially at night
Inappropriate footwear (soft -- cushion or ill-fitting shoes)
Residents attempting to rise or walk without assistance when assistance is indicated
Residents not following caregivers instructions
Poor lighting or footing
Cluttered rooms and/or excessive amounts of furniture

Although some falls may be unavoidable, the following safety guidelines may minimize the risk.

Resident's Safety Guidelines to Decrease Risk of Fall:

When you need assistance, use your call light by the bed and/or restroom and wait for assistance.
It is recommended that you wear rubber soled or crepe soled slippers or shoes.
You are more likely to feel dizzy after sitting or lying for a long time. Before you get up, sit in the bed for a while before standing then rise carefully and slowly. Ask the staff for assistance if you feel dizzy or weak.
Walk carefully and slowly. Do not support yourself on rolling objects (live IV/feeding poles or over-bed tables)
Follow your physician's orders
Follow your caregivers' instructions (such as requesting and/or waiting for assistance to get up)
Do not bring excessive amount of furnishings from home, ask administration prior to bringing outside furnishings/furniture.
Observe wet floor signs in the hallways and other areas.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

FACILITY REP

Informed Consent – Fall Risk

RESIDENTS NAME

I have been informed that the above resident is at a greater than normal risk for falls. This may be because of the resident's inability to follow instructions, difficulty with mobility, underlying medical issues, dementia or Alzheimer's, mental aberration or a deteriorating medical condition. It has been explained to me and I understand that Regency Village cannot restrain residents to prevent falls and that such restraints may create a risk of more serious injury from falls. Regency Village is taking precautions to lessen the risk of a fall, but it has been explained to me and I understand that Regency Village cannot provide continuous attendance for a resident sufficient to ensure that the resident will not suffer a fall and the injuries which may result from a fall.

I UNDERSTAND THAT REGENCY VILLAGE ENDEAVORS TO PREVENT FALLS BUT THE FACILITY CANNOT GUARANTEE THAT THE RESIDENT WILL NOT SUFFER A FALL. I AM HEREBY INFORMED THAT IF I OR THE RESIDENT'S FAMLY OR RESIDENT DO NOT FIND THAT ACCEPTABLE THEN IN THE BEST INTEREST OF THE RESIDENT A SITTER, SUCH AS A FRIEND, FAMILY MEMBER OR A PAID SITTER, SHOULD BE PROVIDED ON A 24 HOUR BASIS DURING THE ENTIRE STAY OF THE RESIDENT.

RESIDENTS NAME

_____

RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

FACILITY REP

TUBERCULOSIS

All employees and residents of RegencyVillage will be required to provide records of a TB skin test or CXR within the last 12 months. If no documentation is provided, the facility will be required to perform a mantoux skin test within the first 10 days after hiring or admission.

WHAT IS TB? Tuberculosis (often called TB) is an infectious disease that usually attacks the lungs, but it can attack almost any part of the body. TB is spread from person to person through the air.

WHAT ARE THE SYMPTOMS? A person with TB infection will have no symptoms. A person with TB disease may have any, all, or none of the following symptoms:

- A cough that will not go away
- Feeling tired all of the time
- Weight loss
- Coughing up blood
- Night sweats

These symptoms may occur with other diseases so it is important to see a physician to determine if you have TB.

WHO GETS TB? Anyone can get TB. However, some groups are at higher risk to get active TB. The groups that are at high risk:

- Persons with signs, symptoms, and/or lab abnormalities suggestive of active TB
- People who interact with person with active TB
- Poor and medically under-served people
- Homeless people
- Those who come from countries with high TB incident rates
- Nursing home residents
- Alcoholics and intravenous drug users
- People with HIV or AIDS, or who are otherwise immune-suppressed
- People in Jail or Prison
- The elderly
- Health Care workers, Prison Guards, and others who work with high risk populations

WHAT IS THE TB SKIN TEST? The TB skin test is a way to find out if a person has TB infection. Although there is more than 1 TB skin test, the preferred method is the Mantoux skin test. This test requires a small amount of the testing material to be placed just beneath the skin. A nurse will inspect the injection site for the presence of induration and will measure it. The size of the induration will determine if the test is positive or negative. A CXR will be done on a person with a positive skin test to determine if the person has TB. All Healthcare workers and residents of long term care facilities are advised to get a skin test yearly.

For more information on TB infection and disease, visit the American Lung Association web site at http://www.lungusa.org

I acknowledge that I have received and reviewed information about TB and the skin test. I consent to the TB skin test to be given upon admission.

RESIDENTS NAME

RP SIGNED NAME _____ **ADMIT DATE**

Resident Pneumonia Vaccine Informed Consent Form

Regency Village
409 West Greene
Webster, TX 77598
Phone: 281-332-4738 Fax: 281-332-5449

Pneumococcal Disease can lead to serious infections of the lungs (pneumonia), the blood (bactermia), and the covering of the brain (meningitis). 1 of 20 people who get pneumococcal pneumonia dies from it. Transmission occurs via contact with droplets of respiratory secretions from the nose or mouth. It is particularly hard on the very old, very young, and chronically ill.

The Vaccine. PPV is relatively safe. The vaccine contains purified proteins from 23 serotypes of inactivated or destroyed pneumococcal bacteria. Getting vaccinated is particularly important since penicillin and other antibiotics that once eradicated these infections are no longer as effective as they once were. Usually one dose is all that is needed. Another dose can be given to those over 65 if five or more years have passed since the last dose. PPV may be less effective in some people, especially those with lower resistance to infection. These people should still be vaccinated, because they are more likely to get seriously ill from pneumococcal disease.

Risks and Possible Side Effects. The most common reactions include soreness, warmth, erythema, swelling and induration (localized hardening) at the injection site. A fever of less than 102 degrees has also been reported in less than 1% receiving this vaccine. Severe allergic reactions are rare; which are hives and difficulty breathing. Residents will be monitored for side effects for 24 hours. If a resident has a reaction, his or her personal physician will be immediately notified. If you have any questions, please ask.

CONSENT/DECLINATION

I have received a copy of pneumonia vaccine information statement edition date 04/24/2015. I have read and have had opportunity to ask questions. I understand the benefits and the risks of the pneumonia vaccine as described.

I request the Pneumonia vaccine be given. _____

I request the Pneumonia vaccine **NOT** be given. _____

Resident has already had the Pneumonia Vaccine. _____ When _____

RESIDENTS NAME

RP Signature _____ **ADMIT DATE**

Verbal Consent: Yes ____
RESIDENTS NAMEinstructed to sign consent as soon as possible. Yes ____

Nurse's Signature:_____ **DATE:**_____
Time: _____

Resident Influenza Vaccine Informed Consent Form

Regency Village
409 West Greene
Webster, TX 77598
Phone: 281-332-4738 Fax: 281-332-5449

Influenza (flu) is a respiratory infection caused by several different viruses. When people get the flu, they may have a fever, chills, headaches, dry cough or muscle aches. Illnesses may last several days to a week or more and complete recovery is usual. However, complications may lead to pneumonia or death in some people.

It is not possible to estimate the risk of an individual getting the flu, but for the elderly and for the people with diabetes, heart, lung or kidney disease, the flu may be especially serious. For health care workers, immunization may help prevent transmission to patients.

The Flu Vaccine: An injection of the flu vaccine will not give you the flu because the vaccine is made from killed viruses. The vaccine is made from viruses selected by the office of Biologist, Food and Drug Administration and the Public Health Service.

Risks and Possible Side Effects: Side effects of influenza vaccine are generally mild in adults and occur at low frequency. These reactions consist of tenderness at the injection site, fever, chills, muscle aches. These symptoms can last up to 48 hours.

Special Precautions: Persons who are allergic to eggs, chicken feathers or chicken dander should not receive this vaccine until they have consulted their personal physician. Person with fever should not receive this vaccine. Persons who have received another type of vaccine within the last 14 days should see their personal physician before receiving this vaccine.

CONSENT/DECLINATION

I have received a copy of the influenza vaccine information statement edition date 04/24/2015. I have read and have had opportunity to ask questions. I understand the benefits and the risks of the influenza vaccine as described.

I request the Influenza vaccine be given. _____

I request the Influenza vaccine **NOT** be given. _____

Resident has already had the Influenza Vaccine. _____ When _____

RESIDENTS NAME

RP Signature _____ **ADMIT DATE**

Verbal Consent: Yes ____

RESIDENTS NAMEinstructed to sign consent as soon as possible. Yes ____

Nurse's Signature: _____ **DATE:**_____

ADVANCE CARE PLANNING EDUCATIONAL MATERIAL

RESIDENTS NAME
SS #
DOB

PLEASE READ THE FOLLOWING STATEMENT:

I have received a copy of the DADS handout on "Frequently Asked Questions about Advanced Care Planning." The handout was discussed and all questions were answered.

RESIDENTS NAME

_____
RP SIGNED NAME

FACILITY REPRESENTATIVE: **ADMIT DATE**

Cyamipagan

FACILITY REP

What Is Advance Care Planning?

Advance care planning means planning ahead for how you want to be treated if you are very ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die, they are not able to talk or to let others know how they feel. Texas law allows you to tell your doctor how you want to be treated by using an advance directive. Chapter 166 of the Texas Health and Safety code is the state law on advance care planning through advance directives. Chapter 166 explains advance directives, includes forms to use for advance directives and states how medical decisions can be made when a person does not have an advance directive.

Advance care planning is a 5-step process:

- Thinking about what you would want to happen if you could not talk or communicate with anyone
- Finding out about what kind of choices you will need to make if you become very ill at home, in a nursing home or in a hospital
- Talking with you family and doctor about how you want to be treated
- Filling out papers that spell out what you want if you are in an accident or become sick
- Telling people what you have decided

Questions and Answers about Advance Care Planning

If I get too sick to say what kind of help I want from doctors or nurses, what can I do?
Putting your wishes in writing makes sure that everyone knows what you want. You can do this using a form called the *Directive to Physicians, Family and Surrogates*. This form is also sometimes called a *Living Will*. The form tells doctors, family members or other people who are close to you the type of help you want when you are sick and how you want to be treated. The document includes written instructions on things that you do want and DO NOT want done to you.

Do I have to fill out this form?
No. No one can make you fill out the form. But with it the people helping you will know what you want if you can't tell them.

Can I change my mind about what I say on the form?
Yes. You can do that at any time you want. If you change your mind, you must make out a new form and throw away the old one rather than make changes to the old form. That way no one will make a mistake when they are trying to help you.
It is also a good idea to tell you family and doctor that you have changed your wishes.

Remember, this form can only be used when you can't tell people what you want. If you are awake and able to say what you want, then that is the only thing that matters.

Can someone speak for me if I am not able to say what I want?
Yes. You can fill out a form called a *Medical Power of Attorney*. This form lets you name someone to speak for you. The person you name is called an *agent* on the form. You can choose anyone you want to be your agent. It does not have to be a member of your family. But remember, it is always important for your family and agent to know what you want before something happens to you.

If you don't name someone to be your agent, then state law has a set of rules for how decisions will be made for

you.

What are the rules?

Do I need a lawyer to fill out any of these forms?
No. You can fill them out yourself. You can ask a lawyer to help you, but you do not have to. Once you have filled out the forms, all you have to do to make them legal is sign them in front of the proper witnesses. You do not need a notary public.

Do doctors, nurses and hospitals have to follow my instructions?
Yes, unless they inform you in advance that they cannot. If they do no intend to honor your wishes, they are required to give you a reasonable opportunity to or assist you to transfer to a physician or health care provider who will comply with your wishes. Health care professionals cannot simply ignore your wishes.

Other Questions about Hospitals and Nursing Facilities and Treatment at the End of Life

Sometimes people have questions about when it makes sense for them to move from a nursing facility to a hospital. The following information tries to answer some of those questions.

If I'm in a nursing facility and get very sick, should I stay where I am or go to the hospital?
This is a choice you will have to make after you talk to your doctor or family members. If you can get the care you need where you are, it is often safer and more comfortable to stay in the nursing facility. Moving to the hospital can cause problems because the people working there do not know everything about you. Sometimes this leads to problems with medications, pressure sores and infections. Ask your doctor if there are things you need that the nursing facility can't do for you. Make sure you understand all the risks in moving or staying where you are.

What is an Out-of-Hospital Do Not Resuscitate Order (OOHDNR)?
This form is for use when you are not in the hospital. It lets you tell health care workers, including Emergency Medical Services (EMS) workers, NOT to do some things if you stop breathing or your heart stops. If you don't have one of these forms filled out, EMS workers will ALWAYS give you CPR or advanced life support even if your advance care planning forms say not to. You should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power or Attorney form if you don't want CPR.

What is Cardiopulmonary Resuscitation (CPR)?
You have probably seen this on TV. CPR is pressing on your chest to keep blood flowing and also assistance with breathing, such as mouth to mouth assistance. Sometimes electrical shocks are used to help start the heart. CPR is only used for short periods until a person can get to the hospital.

Does CPR always work?
No. It depends on other things, including your overall health and your age. Everyone is different. It does not work very well for most people who have a life-threatening illness or are over 80. You should talk about CPR with your doctor and discuss what is best for you and what best fits with your personal values and goals.

What is Artificial Respiration or Ventilation?
This means getting assistance with breathing when you can't breathe on your own. A tube is put into your nose or mouth or into your windpipe. If this tube is needed for more than a few weeks, a surgeon will probably need to put the tube directly into your throat. Doing this causes problems with talking, eating and drinking. The tube is also attached to a machine, which makes it harder Advance Care Planning FAQ

Eating, Drinking and Pain During a Terminal Illness

What is Artificial Nutrition and Hydration?

These are medical treatments that allow a person to get food and water when they cannot eat or drink. Fluids can be given through a needle placed in a vein (IV). This is usually done for only a few days because of the risk of infection and because it is hard to keep the needle in place. Sometimes food and water are given through a tube that goes down the nose and throat into the stomach. If the tube needs to be in place for a long time, it is places directly into the stomach by a surgeon.

These different kinds of tube feeding are different from ordinary eating and drinking because they don't let the person taste or feel food and liquids like they are used to doing. Also, the person is not in control of their food or liquid intake. Doctors and nurses decide how much food and water they should have in this way.

Do Artificial Nutrition and Hydration Make People Live Longer?

Sometimes, but not always. How effective these kinds of treatment are depends on other medical problems. When a person with a terminal illness can't eat or drink it usually means that the body has stopped working like it should and it will not improve. If this is the case, tube feeding alone will not make the person healthy again. It may even make the person uncomfortable during their final days.

What about Pain and Comfort?

If a person has a medical problem that will cause them to die and they don't want artificial treatment, they can still be comfortable. Making people comfortable during the final part of their life is called *palliative care*. Even if there is no cure for a condition, doctors can treat pain, nausea and discomfort. Comfort should always be part of the treatment plan that doctor discusses with a patient or family.

The Importance of Advance Care Planning

Everyone is going to die sometime, but not everyone gets to choose how they are treated at the end of their lives. Taking the time to do advance care planning can help family members and medical staff act for you. They will be faced with hard decisions near the time of your death. Having an advance care plan lets you make sure that you are treated according to your values and wishes regardless of whether you can speak for yourself.

Level 1 Pasrr

Does resident have a history of having a serious mental illness and/or mental retardation or a related condition?

_____Yes

_____ No

Streets DME, LLC

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact: our Privacy Contact who is [Nancy Barcelo]

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by [if applicable, accessing our website pssi-midsouth.com], calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Understanding Your Health Record/Information

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record
- amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative
- locations revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Our organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to
- information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodated reasonable requests you may have to communicate health information by alternative means or at alternative locations

We will not use or disclose your health information without your authorization, except as described in this notice.
If you believe your privacy rights have been violated, you can file a complaint with our Privacy Contact or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. You may contact our Privacy Contact, Nancy Barcelo at (281) 338-0870 or streetsdme@aol.com for further information about the complaint process.

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.

For example: Information obtained by a therapist 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. We may provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

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

We will use your health information for regular health operations.
For example: Members of our 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 healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include our billing service and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

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.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

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, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision 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.

This notice was published and becomes effective on April 14, 2003.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Regency Village's health care operations. The Notice of Privacy Practices also describes my rights and Regency Village's duties with respect to my protected health information. Streets DME LLC reserves the right to change the privacy practices that are described in the Notice or Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the facility office and requesting a revised copy be sent in the mail.

_____ **ADMIT DATE**

RESIDENTS NAME

_____

Description of Personal Representative's Authority

Continuation of therapy

Your Insurance Company will follow your stay while here at Regency. Every week all clinical information and therapy documentation will be reviewed and it will be determined if the care you are receiving needs to continue here of if you are ready to continue your care in the community. Upon discharge, arrangements will be made for Home Health Services that will include both nursing and therapy interventions when needed. We will be notified 48 hours prior to discharge giving us time to set up these arrangements. Our USFHP patients are sometimes only given notice the previous day. If during your stay here you have any questions about this process, please contact the Discharge Planning Office.

RESIDENTS NAME

_____ **ADMIT DATE**

Cynthia Gaddis

FACILITY REP