OPEN ITEMS

DATE	DESCRIPTION

OPEN ITEMS

DATE	DESCRIPTION

MANAGER'S ADMISSION FINANCIAL CHECKLIST:
ON ADMISSION PLEASE CHECK OFF COMPLETION AND FAX TO DIANE:

_____ FOOTPRINT PAGE HAS BEEN FAXED.

_____ CALL DHHS AND CONFIRM MAINECARE APPLICATION HAS BEEN SUBMITTED.

_____ CONFIRM MAINECARE APP IS PENDING
_____ CONFIRM MAINECARE APP IS COMPLETE.
_____ REQUEST COC LETTER

PLEASE NOTE WE WANT THEM TO CONFIRM COMPLETE TO ENSURE APP IS ALL SET.

_____ IF SOMEHOW MAINECARE APP HAS NOT BEEN DONE IT MUST BE FILLED OUT IMMEDIATELY WITH RETRO CHECKED AND SUBMITTED TO DHHS THE DAY THEY MOVE IN. (PLEASE FAX, EMAIL, AND PUT COPY IN FILE. THIS WILL ENSURE PAYMENT FROM DAY THEY MOVED IN.

_____ EXPLAIN TO RESIDENT COC IS THEIR INCOME MINUS 70.00. (RARE INSTANCES MIGHT BE 50.00 OR A DIFFERENT AMOUNT)
_____ EXPLAIN THEIR RENT IS DUE ON THE FIRST OF THE MONTH STARTING WITH THE FIRST AFTER THEY MOVED IN. (SO NO RENT IS DUE UNTIL THE FIRST OF THE MONTH)
_____ IF SOMEONE ELSE IS RESPONSIBLE FOR MAKING RENT PAYMENT CONTACT MUST BE MADE AND A PLAN IN PLACE FOR RECEIPT OF RENT. MAIL TO 80 MAIN ST IS BEST.
_____ FIGURE OUT HOW THEIR RENT IS GOING TO BE PAID ON THE FIRST. (CHECK, CARD, ETC.) ADD IT TO YOUR LIST OF RENT TO GATHER ON THE FIRST.

ADMISSION SKIN CHECK:

ATTENTION MANAGERS/ADMISSIONS:
THOROUGH SKIN CHECK MUST BE COMPLETED ON ADMISSION AND THE FOLLOWING FILLED OUT. PLEASE BE THOROUGH.

ANY SKIN ISSUES WHAT SO EVER:
IMMEDIATE REFERRAL REQUEST TO PCP (ALWAYS PHONE AND FAX) FOR WOUND CARE. MUST FOLLOW THROUGH AND GET IT SET UP ASAP. SEND TO ER IF NECESSARY. ***ANY SIGNS/SYMPTOMS OF INFECTION SEND TO ER.

ULCERS:

AMPUTEES:

RASHES:

RED AREAS:

OPEN AREAS OF ANY KIND:

POTENTIAL SKIN ISSUES:

SIGNIFICANT EDEMA (SWELLING):

ANY SURGICAL CLOSURES NOT 100% HEALED:

Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which office(s) should help you? Please check**.**

❒Office of MaineCare Services	❒ Office of Behavioral Health
❒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:
❒ Division of Licensing and Certification	❒ Other:

Whose information will be disclosed? Please print clearly.

Individual's Name			Date of Birth
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		

Please check: ❒ Release/Send my information to: ❒ Obtain/Get my information from:

Name of Individual			Organization
Address	Town/City	State	Zip Code
Telephone	Email address (optional)		

What is the purpose of the disclosure?

❒Personal request	❒To coordinate or manage my care
❒For a legal matter, including testimony	❒To see whether I qualify for insurance coverage, services, or benefits
❒Other:	

To share the information with others by EMAIL, please initial and complete the following.

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email**. INITIAL HERE _____**
Please print the email address where you want your information sent:

What information should be released or obtained? Please check all that apply.

General permission:	**Special permission: Drug/Alcohol Treatment or Referral for Services**
❒ **All** health information from the office(s) checked above ❒ Claims or encounter data (information about visits to health care providers) ❒ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ❒ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims from 2018-2020") ❒ Other: _____	❒ Include **all** drug/alcohol information in the release ❒ Include only the **specific** drug/alcohol records checked: ❒ Diagnosis and treatment ❒ Clinical notes and discharge summaries ❒ Drug/Alcohol history or summary ❒ Payment or claims information ❒ Living situation and social supports ❒ Medication, dosages or supplies ❒ Lab results ❒ Other: _____
Special permission: Mental/Behavioral Health Services ❒ Include this information in the release ❒ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ❒ Include this information in the release **Please note**: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- "Information" may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: _____
- This form permits additional releases until it expires.

Date: _____ Signature: _____

Personal Representative's authority to sign: _____

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Office for Family Independence
19 Union Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-4168; Toll-Free: (800) 442-6003
TTY: Dial 711 (Maine Relay); Fax: (207) 287-3455

Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name: _____

Individual's Date of Birth: _____

Individual's Social Security Number: _____

Individual's Address: _____

I (individual named above) hereby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name: _____

Address: _____

Telephone number: _____

Email address: _____

Existing legal authority (if any) for individual/organization to act on my behalf (check all that apply and attach copy of documentation):

_____ *Guardianship*

_____ *Power of Attorney*

_____ *Advance Healthcare Directive*

_____ *Other:* _____

By making this appointment, I want my Authorized Representative to (check all that apply):

_____ Sign and submit an application on my behalf (including an electronic application)

_____ Sign and submit a recertification form on my behalf (including an electronic recertification)

_____ Receive copies of Notices of Decision and all other written communications from the Department; I'm aware I may also need to complete an Authorization to Release Information form

_____ Obtain Food Supplement benefits on behalf of my household

_____ Represent me at a fair hearing; I'm aware that I may also need to complete an Authorization to Release Information form

_____ Other (please describe) _____

_____ Act on my behalf in all other matters with the Department of Health and Human Services; I'm aware I may also need to complete an Authorization to Release Information form

- My authorized representative's authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
  - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
  - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decision and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.
- I understand that an appointment of a representative for the TANF or Food Supplement programs is a representative for both me and my household and that my household will be liable for any over issuance of Food Supplement or TANF benefits that results from erroneous information given by the authorized representative.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date: _____

For the Authorized Representative

I (Individual or Organization Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as his/her Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as his/her Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 CFR § 155.260(f) (relating to confidentiality of information), 42 C.F.R. § 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date: _____

NEW RESIDENT:

DEMOGRAPHIC PAGE TO INCLUDE:
MAINECARE MEDICARE SOCIAL SECURITY DOB AND ALL OTHER INFO FILLED IN.
COPY OF MAR
LIST OF DIAGNOSIS

HT

WT

WHAT THEY DID FOR WORK

HIGHEST GRADE OF SCHOOL COMPLETED

WHERE BORN

TEETH OWN OR DENTURES OR NO TEETH

CONDITION OF TEETH IF THEIR OWN SOME MISSING BROKE

HEARING AIDES

GLASSES

INCONTINENT OF BOWEL BLADDER

WEARS DEPENDS

DO THEY HAVE A WALKER WHEELCHAIR OR CANE

MDS Questionnaire

Full name including middle initial:
Highest grade completed:
Do you stay up late at night:
Do you take naps during the day:
Do you like to go out (shopping, walking, collecting cans, etc.):

What are your hobbies

cards/board games	arts & crafts	sports/exercise
dancing	music	reading/writing
religion/church	trips/outings	walking
television	gardening	conversing
chores	cooking	computers

other:
Do you smoke or drink alcohol:
Do you attend church, if so where:
Do you maintain contact with any friends or relatives:

Do you have any trouble sleeping
restlessness, trouble waking, trouble falling asleep
Do you have any conflicts with staff, your roommate, or another resident:

Have you recently lost a family member or close friend:

Have you been involved in any serious accidents:

Do you have health concerns for another person:

Do you have any legal problems:

Have you ever been robbed or attacked:

Do you have any unsettling relationships:

Have you recently lost some or all of your income:

Have you ever been a victim of sexual abuse:

Do you have any child custody issues:

Do you have any marital problems:

Do you feel you are capable of taking care of yourself:
Do you need any new devices
dentures, glasses, cane, hearing aide, adaptive equipment

Are you continent:
Do you frequently experience diarrhea or constipation:
Do you suffer from the following symptoms
shortness of breath(lying flat), edema or swelling, dizziness, delusions, hallucinations, hostility, suspiciousness, headache, numbness, blurred vision, dry mouth, drooling, change in appetite
Do you have any pain, if so where:

Rate your pain on a scale of 1-10:
Have you fallen in the past six months:
Do you have any chewing or swallowing problems or any mouth pain while eating:
Do you feel hungry a lot of the time:
Do you have any food allergies:
Have any of your teeth been lost or removed:
Do you have difficulty brushing your teeth:
Do you have any cuts, bruises, burns, or rashes:

Do you prefer to spend your time in your room, in the TV or smoke room, outside, or away from the facility:
Do you prefer activities in small or large groups or do you prefer to be alone:

Do you have a daily routine:

Do you have family or friends outside the facility that you visit with or visit you or you talk to by phone:

Are you registered to vote:
Would you like to be:
What are your goals
health promotion, social involvement, hobbies, advanced rehab, maintaining function, community service, other:

Ht: Wt: Hospital preference: Medical allergies:

Social/Recreational Assessment

Name_____Religion_____

Birthplace_____ Where is home?_____

Education_____ Registered voter(where)?_____

Occupations_____

Activity Preferences:
Large group_____ Small group_____ One on One_____ Solitary_____

Special interests: Arts _____Crafts _____Handiwork_____
Movies _____TV _____Computer_____
Favorite pets and name_____
Animals disliked/feared_____

Music:Country_____Clasical_____Opera_____Jazz_____Folk_____Rock_____
Singing _____Instruments played_____

Reading: Newspaper_____Books_____
Poetry_____Puzzles_____

Community: Church_____Plays_____
Concerts_____Organizations/Groups_____
_____

Games/Sports: Cards: Bridge_____Cribbage_____Poker_____63/83_____Solitare_____
Uno_____Other_____Beano_____Golf_____Bowling_____Baseball_____
Basketball_____Football_____Tennis_____Pool/Billiards_____Dancing_____
Exercise_____Swimming_____Fishing_____
Hiking/camping _____Bird watching_____
Gardening: Vegetables _____Flowers _____Herbs _____House plants _____
Yard work_____

Areas of special knowledge/interest_____
Hobbies/Collections_____
Food likes/dislikes:_____
Describe your typical daily routine_____
_____
_____
_____

GOLDEN ACRES
NEW RESIDENT ADMISSION INFORMATION

DATE: _____ DATE OF ADMISSION: _____

RESIDENT NAME: _____ ADDRESS: _____
SEX: MALE FEMALE RACE: _____ MARITAL STATUS: _____
ADMITTED FROM: _____ PLACED BY: _____
ADDRESS: _____ PHONE: _____
PREVIOUS ADMIT: _____ DOB: _____ PLACE OF BIRTH: _____
SOCIAL SECURITY NO. _____ MEDICARE: _____
OTHER INS. _____
RELIGION: _____ PREFERRED MINISTER: _____
MILITARY SERVICE: _____ LANGUAGE: _____

FINANCIAL INFORMATION/RESPONSIBLE PARTIES
NAME: _____ ADDRESS: _____
PHONE: _____ LEGAL: _____

MEDICAL INFORMATION:
PHYSICIAN: _____ DENTIST: _____
ADDRESS: _____ _____
PHONE: _____ _____

PODIATRIST: _____ PHARMACIST: _____
ADDRESS: _____ _____
PHONE: _____ _____

OPTOMETRIST: _____ MORTICIAN: _____
ADDRESS: _____ ADDRESS: _____
PHONE: _____ PHONE: _____
PREPAID BURIAL: _____

ALLERGIES: _____
DIAGNOSES: _____
SPECIAL CARE NEEDED: _____
MENTAL STATUS: ALERT _____ FORGETFUL _____ CONFUSED _____ WANDERS _____
HISTORY: _____
_____
AMBULATORY: _____ CONTINENT _____ INCONTINENT _____
DIET/EATS INDEPENDENTLY: _____
DATE OF LAST PHYSICAL: _____
MEDICATIONS: _____
_____
ADL'S: _____

RELATIVE OR FRIEND TO BE NOTIFIED: _____
PHONE: _____

ABOVE INFO TAKEN BY: _____

NOTICE OF CLIENT ADMIT/DEPARTURE

CLIENT'S NAME: _____ BIRTHDATE: _____

SOCIAL SECURITY NUMBER: _____

Boarding Home Adult Foster Home Adult Family Care Home

(CIRCLE ONE)

FACILITY NAME AND ADDRESS: _____

_____

_____

PHONE: _____

ADMISSION DATE: _____

DEPARTURE DATE: _____

CLIENT'S NEW ADDRESS UPON DEPARTURE

(IF KNOWN): _____

_____

_____

REMARKS: _____

_____

_____

RETURN TO:

Long Term Care,
Department of Human Services office nearest you.

Thank you,

DEPARTMENT OF HEALTH AND HUMAN SERVI
OIAS
13 Prescott Drive
Machias, ME 04654

TRANSFER AND REFERRAL RECORD

PATIENT'S NAME

DATE 19

TH DATE | SEX | S. M. W. D. ☐ ☐ ☐ ☐ | RELIGION | SOCIAL SECURITY NO.

EST N_ .TIVE | RELATIONSHIP

ADDRESS | PHONE

ATTENDING PHYSICIAN | PHONE

DRUG ACCOUNT | CHARGED TO:

DIAGNOSIS

TRANSFERRED FROM | NAME OF FACILITY

ADDRESS | PHONE

TRANSFERRED TO | NAME OF FACILITY

ADDRESS | PHONE

MEDICATIONS	TREATMENTS

AMBULATORY ☐ YES ☐ NO | WITH ASSISTANCE ☐ | DIET | APPETITE

ELIMINATION: BOWEL CONTROL | BLADDER CONTROL

REASON FOR TRANSFER

PATIENT TO RETURN TO

REMARKS AND PERTINENT INFORMATION (DESCRIBE BRIEFLY PATIENT'S CONDITION)

ALLERGIES:

SIDENT NO. _____ SIGNED _____ TITLE

PROFESSIONAL FORMS by JIM HERNDON FORMS, INC. P. O. DRAWER 9250 SHREVEPORT, LA. 71109

FORM 2004

Discharge Planning

Discharge Date_____

Reason for discharge_____

Destination: Facility Name_____
Address_____
Phone #_____

Discharged to the Care of_____

Record of Death

Date of Death_____Time_____

Person to notify at time of Death_____
Address_____Phone#_____

Alternate Contact_____
Address_____Phone#_____

Funeral Director_____Phone#_____

Physician_____Phone#_____

Funeral and Burial Arrangements: Please express your wishes about: Burial, Cremation, Funeral or Memorial Service

_____
_____
_____
_____
_____
_____
_____

At time of death, does the person to notify want to be contacted: day only night only

Please specify special clothes or jewelry to be worn.

V

Resuscitation Orders

****

THE GRACE HOME MOUNTAIN VISTA

****

- **NO RESUSCITATIVE EFFORT (No Code)**

  Nursing and medical Care will be provided for treatable illness, but resuscitation will not be attempted in case of cardio/pulmonary arrest.

Signature_____Date_____

****

- **LIMITED RESUSCITATIVE EFFORT (Limited Code)**

  Routine patient care to be maintained with the following additional procedures allowed in the event of cardiac or respiratory arrest, shock or other life-threatening occurrences:

  Temporary mask and bag support.....YES NO
  Endotracheal intubation with mechanical ventilation.....YES NO
  Cardiac Compressions.....YES NO
  Defibrillation.....YES NO
  IV Medications(to be given only if spontaneous or artificial circulation present).YES NO
  Temporary Pacemaker.....YES NO
  Other.....YES NO

Signature_____Date_____

****

- **FULL RESUSCITAVE EFFORT (FULL Code)**

  May include endotracheal intubation, mechanical ventilation, chest compressions, defibrillations, IV drugs, temporary pacemaker and other procedures as indicated.

- Do not/Do wish to be kept alive in a persistent vegetative state with a feeding tube or respirator .

- Signature_____Date_____

****

- **PALLATIVE CARE**

  Only measures to promote comfort will be undertaken, including nursing care and pain management. Hospitalization will ordinarily not be considered unless required to provide comfort.

Signature_____Date_____

X_____ _____

Health Care Provider Date

must fax to doctor for Signature
then put in file.

Admission Check List

Task	Completed
TGH/MV/DHHS Contracts signed	_____
Admitting Orders(with Meds)	_____
Standing Orders	_____
Self-Administration Meds	_____
Resuscitation Orders	_____
POA	_____
Advance Directives	_____
Vital Signs including HT/WT	_____
Inventory	_____
Discharge Planning	_____
Signed Medical Release	_____
Acknowledgement of Info signed	_____
Photo for Med Book	_____
Add to daily Census Log	_____
Admission/Progress Note	_____
Fax MDS- Muskie/BEAS/DHHS	_____
Service Plan	_____
Create Face Sheet in Hi-Tech	_____
Billing Info in Hi-Tech	_____

N/N - 24 hrs. to do!

RESIDENT ASSESMENT**SELF-ADMINISTRATION OF MEDICATIONS

RESIDENT NAME:
PHYSICIAN:
DATE:
DATE OF ARRIVAL:

GROUP DISCUSSION:

DECISION:

WILL RESIDENT SELF-ADMINISTER MEDICATIONS? YES NO

ATTENDANTS:

Inventory List

Serial # Serial #

Serial# Serial #

Circle Appropriate items

Glasses	Jewelry	Cane
Hearing aids	Rings	Transfer Board
Contacts	Watch	Artificial Limbs
Dentures-upper lower	Wheelchair	Prosthetics
Partial Plate	Walker	

The Grace Home and Mountain Vista do not encourage bringing items of great sentimental or financial value and are not responsible for replacement costs.

I acknowledge this inventory list and agree to he accuracy of its contents.

_____ Date_____
Resident or Responsible Party

_____ Date_____
Administrator/Resident Manager

WRITTEN CONSENT TO SHARE CONFIDENTIAL INFORMATION

Resident Name:_____
Date Entered Facility:_____

I, _____ give Golden Acres staff permission to discuss confidential information regarding myself to the following physician(s):_____
_____, to the following optometrist(s):_____,
to the following podiatrist(s):_____,to the following dentist(s):_____,to the following ministry(s):_____,to the following pharmacy(s):_____,to the following family member(s):_____
_____,
and with anyone else listed here:_____.

I understand that I can change this at anytime.

_____ _____
Resident Signature Facility Representative

_____ _____
Date Date

~~* DO NOT DATE *~~

APPENDIX A

LICENSED ASSISTED HOUSING PROGRAM
STANDARD CONTRACT

This contract is entered into between Golden Acres Boarding Home Inc. (hereinafter "the Provider") and you, _____. This contract describes your financial obligations, as well as other responsibilities and rights. It also describes the rights and obligations that apply to the Provider in the course of providing services to you.

This contract is a standard contract required for use in the State of Maine. Providers may add additional provisions to the standard contract in a customized addendum but these additional provisions may not conflict with or replace the use of the standard contract. The intent of having a standard contract in Maine is to permit you to compare costs and services among providers. Providers are required to disclose their contracts and rates.

In consideration of the payment and promises made in this contract, you and the Provider agree as follows:

I STANDARDS

The Provider will help to further your independence and respect your privacy and personal choices, including your choice to continue to reside here for as long as the Provider and program, as it is fundamentally designed, is able to meet your needs. The Provider's programs will be consumer oriented and meet professional standards of quality at all times.

This means that if your needs exceed the Provider's ability to provide services, the Provider will assist you in making other arrangements including moving somewhere else, if necessary.

II PROVIDER LICENSE

The Provider is licensed in conformity with the requirements of the State of Maine. The type of provider is stated on the license issued by the Maine Department of Human Services and posted for public inspection in the d. room or kitchen. This Provider is licensed as follows (check one):

- ☐ Level I Residential Care Facility
- ☐ Level II Residential Care Facility
- ☐ Level III Residential Care Facility
- ☑ Level IV Residential Care Facility
- ☐ Level I PNMI Residential Care Facility
- ☐ Level II PNMI Residential Care Facility
- ☐ Level III PNMI Residential Care Facility
- ☐ Level IV PNMI Residential Care Facility
- ☐ Type I Assisted Living Program
- ☐ Type II Assisted Living Program

☐ This box will be checked if you rent your unit from a separate entity (referred to in this contract as the "Landlord") that is not the Provider. The Landlord is responsible for enforcing the terms and conditions

of the lease. The Provider is responsible for assuring that the terms and conditions of your lease agreement with the Landlord do not conflict with this contract. The State of Maine has reviewed the separate lease agreement and has determined that it complies with all laws and regulations related to the provision of assisted living services. A copy of this lease is attached for reference as Appendix F to this contract. Even though you have a lease with separate landlord, you have the same rights as you would have if the landlord and provider were one and the same.

III APPENDICES

The following Appendices are attached and made a part of this contract:

- ☒ Appendix A: Admissions Policy
- ☒ Appendix B: Your Rights
- ☒ Appendix C: Grievance Policy
- ☒ Appendix D: Tenancy Obligations (check if this applies)
- ☐ Appendix E: Additional terms in Customized Addendum (check if this applies)
- ☐ Appendix F: Applies only if you rent your unit from an entity (the "Landlord") that is not the Provider

IV ADMISSION POLICY

There is an Admission Policy that meets the requirements of the State of Maine that describes who can be admitted and the types of services provided. A copy of this policy is attached as Appendix A.

V SERVICES PROVIDED DIRECTLY OR INDIRECTLY BY PROVIDER INCLUDED IN THE DAILY/MONTHLY RATE

A. You agree to purchase:

- ☒ Housing and Services.
- ☐ Housing Only.

B. You agree to pay the following current rate to the Provider:

- ☐ Daily rate of $_____
- ☐ Monthly rate of $_____
- ☒ The amount you pay will be determined by the MaineCare Program.

C. If you rent your unit from a landlord that is a different entity from the Provider, you understand that:

The landlord is_____.

The amount of your current monthly rent is _____.

D. Certain basic services must be provided in all licensed assisted housing programs. If you have decided to purchase assisted living services, these basic services are provided under the daily/monthly rate you pay for your care. This means the Provider must act in accordance with the regulations to:

1. Observe and assess how you function and/or your individual behaviors for the purpose of enhancing your health and safety or the health and safety of others;
2. Protect you from environmental hazards by mitigating risk in the physical environment to prevent unnecessary injury or accident; and
3. Identify your needs and strengths, develop a service plan and arrange for and monitor service delivery.

E. There is a wide range of services available. Those services and their costs are listed in Appendix E. What you actually receive for services will be based on whether you are purchasing assisted living services, and on your individual assessment and service plan.

If checked below, the service is offered by the Provider as part of your current daily/monthly rate and there is no additional charge to you if it becomes part of your service plan:

1. Personal Supervision.
   - [X] Even though you may travel independently in the community, the Provider will keep track of your general whereabouts
   - [X] Staff will accompany you to medical appointments
   - [ ] The Provider provides an escort for regular travel
   - [X] The Provider has qualified staff in the building 24-hours/day
   - [ ] Other_____
   - [ ] Additional provisions: See Appendix E

2. Assistance with activities of daily living. (These are tasks that you may routinely need assistance with in order to maintain your best level of physical function.)
   - [X] Walking
   - [X] Changing position in bed
   - [X] Transferring from place to place
   - [X] Dressing
   - [X] Eating
   - [X] Using the bathroom
   - [X] Bathing
   - [X] Personal hygiene, such as help washing your hair
   - [ ] Other _____
   - [ ] Additional Provisions: See Appendix E

3. Incidental activities of daily living.
   - [X] Using the telephone
   - [ ] Handling your finances
   - [ ] Banking
   - [X] Shopping
   - [X] Light housekeeping
   - [X] Heavy housekeeping
   - [X] Getting to appointments
   - [X] Barber/beautician services at cost to you
   - [ ] Other _____
   - [ ] Additional Provisions: See Appendix E

4. Medication assistance.
   - [X] Obtaining medications from the Pharmacy of your choice:_____.
     - [X] Ordered by Provider

- [x] Delivered by the Pharmacy
- [x] Ordered by you/family member
- [x] Picked up by Provider
- [x] Picked up by you/family member

- [x] Provide qualified staff to help you take your medications (such as reading the container labels, watching while you take a medication, checking the correct dosage, removing the dosage from the container, administering prescribed dosage, filling a syringe, administering any medication as allowed by applicable licensing regulations)

- [x] Maintaining an individual medication administration record for you that will include all the medications and treatments that your physician orders for you, and a record that includes, for example, information that they have been administered at the right time and in the right dose

- [ ] Other _____
- [ ] Additional Provisions: See Appendix E

5. Food Service.

- [x] Meal preparation (including the cost of food) 3 times each day
- [ ] Meal preparation (food purchased separately by you) _____ times each day
- [x] Nutritious between-meal snacks 3 times each day
- [ ] Special diets ordered by your physician as follows:

_____

- [ ] Shopping for groceries you purchase
- [ ] Meal planning
- [ ] Other _____
- [ ] Additional Provisions: See Appendix E

6. Transportation services.

- [x] Arranging transportation (cost of transportation included) 30 miles roundtrip
- [ ] Arranging transportation (cost of transportation not included)
- [ ] Transportation without escort to medical appointments within _____ miles roundtrip
- [x] Transportation with escort to medical appointments within 30 miles roundtrip
- [x] Other logistic care + other transportation 30 miles round trip

7. Nursing services. Some providers provide the services of a registered professional nurse. Others use registered professional nurses to coordinate the services and oversee staff who are not nurses. The following nursing services are part of your daily/monthly rate:

- [ ] None
- [ ] Skilled nursing services provided by a registered professional nurse.
- [x] Registered professional nurse who oversees staff and coordinates your health care needs.
  RN Consultant

8. Housing Costs. These costs include those associated with your housing instead of your services, and may include things such as heat, lights, cable TV, telephone, your unit and other costs. Check all that apply:

- [ ] All housing costs (there will be no extra charges)
- [x] All housing costs except:
  private phone

☒ Semi-private room
☒ Shared bathroom
☐ Private room
☐ Private bathroom
☐ Efficiency apartment
☐ One Bedroom Apartment
☐ Two Bedroom Apartment
☐ Other
☐ Additional Provisions: See Appendix E
☐ You have a lease agreement with a landlord other than the Provider: See Appendix F

9. Equipment and supplies. The Provider will supply the following equipment and supplies, as needed, as part of the daily cost that you pay:

☐ None
☐ Non-prescription analgesics and antacids
☒ Bedroom furnishings: bed, bureau, chair lamp, nightstand
☒ Pillows, sheets, linens, towels
☒ Laundry supplies and equipment
☐ Laxatives
☒ Thermometers
☒ Non-prescription skin creams/lubricants
☒ Mouthwash
☒ Toothpaste
☐ Other non-prescription ointments:_____
☒ Shampoo
☒ Soap
☒ Facial tissue
☒ Toilet tissue
☒ Paper towels
☐ Incontinence supplies
☐ Other:_____

10. Additional Services

☐ See Appendix E

VI. SERVICES NOT INCLUDED IN THE DAILY RATE.

In some instances you may wish to purchase services beyond those included in your daily rate at an additional charge.

☐ See Appendix E for listing of items that are available at an additional charge.

VII. BILLING AND PAYMENT

A. Payment for services covered by the daily/monthly rate. The Provider requires you to pay for your care under the terms of this contract within the following time frame: 1st of the month. If there is a separate lease agreement, payment must also be made in accordance with that agreement. You should be aware that failure to pay for your

services in accordance with this contract may result in your discharge from the Provider's facility or program. The Provider may not hold you responsible for the payment of attorneys' fees or any other cost of collecting payment.

B. Source of payment for services covered by the daily/monthly rate:
☒ Self-pay
☒ Self-pay and billing to a third party: +/or MaineCare if applicable

C. Payment for services not covered by the daily/monthly rate. You agree to be responsible for payment for any services or convenience items not specifically included by this contract in the daily/monthly rate. Those that are provided by the Provider will be billed directly to you at the end of each month in addition to the daily/monthly rate.

D. Source of payment for services not covered by the daily/monthly rate:
☒ Self-pay
☐ Other_____

E. Holding your unit. If you are away temporarily, you are still responsible for paying for your unit and you may return as long as you continue to pay and this contract is in force.

F. Security deposit. A security deposit may be charged only for apartment units in an assisted living program.
☐ There is a security deposit. This security deposit will not exceed one month's rent (currently $_____), and will be refunded to you within thirty (30) days from date of discharge/death.

☐ The following costs may be deducted from the security deposit:
_____
_____

☐ Security deposits are part of your separate lease with the Landlord.

G. Calculation of refund. You are entitled to a refund for any advance payments you make on a prorated basis when you are discharged. This will include a refund for the day in which you are discharged.

☒ In residential care facilities, the refund is calculated by multiplying the amount you paid per day times the remaining number of days in the month, including the date of discharge.

☐ In assisted living programs, your refund is calculated from the date your apartment unit is vacated or from the last day of any required notice period, whichever is later. The refund is calculated by multiplying the amount you paid per day times the remaining number of days in the month, including the date your unit is vacated or the last day of any required notice period, whichever is later.

VIII. RIGHTS REGARDING TRANSFER AND DISCHARGE

You have certain rights under law and regulations regarding transfer and discharge. A copy of a document explaining your rights is attached as Appendix B.

IX. MODIFICATION OF CONTRACT TERMS

At least thirty (30) days written notice is required for any modifications of contract terms including, but not limited to, rate and charge changes, responsibilities, services to be provided or any other items included in this contract. The thirty (30) days notice will not be required if you are the one requesting additional services not already included in the rate you pay pursuant to this contract.

X. NOTICE PROVISION

Any notice required by this contract shall be in writing. The notice shall be considered delivered on the date of its receipt, if hand delivered. If the notice is deposited with the U.S. Postal Service, it shall be considered delivered three (3) days from the date of deposit in the mail. Notice to the Agent shall be by delivering it to him/her at the address provided at the end of this contract.

XI. ACKNOWLEDGEMENT

A. You acknowledge that your rights, attached as Appendix B and included as part of this contract, have been explained to you and you have signed that attachment.

B. You acknowledge that you have been given a copy of the Provider's admission policy, grievance policy and any tenancy obligations (See Appendix A, C and D).

C. You have made arrangement for the management of your affairs, either personal and/or financial, as follows:

- ☐ Manage own affairs
- ☐ Durable Financial Power of Attorney
- ☐ Health Care Power of Attorney
- ☐ Representative Payee
- ☐ Guardian
- ☐ Conservator
- ☐ Trustee
- ☐ Advance Directive/Living will
- ☐ Other

You agree to supply copies of all relevant information about those individuals who are responsible for your affairs as they relate to your care under this contract.

XII. CHANGES IN LAW

Any provision of this contract that is found to be invalid or unenforceable as a result of a change in Federal or State law or regulation will not invalidate the remaining provisions of this contract and it is agreed that, to the extent possible, you and the Provider will continue to fulfill your respective obligations under this contract consistent with law.

XIII. SIGNATURES

This contract may not require or encourage any person other than yourself to obligate himself/herself for the payment of your expenses. If any person informs the Provider that he/she wishes to guarantee payment of your expenses, he/she can do so only in a separate written agreement. The separate written agreement allows for the guarantor of payment to change his/her mind within forty-eight (48) hours of signing this separate written agreement.

If someone else who you authorize (hereinafter "your Agent") signs this contract in his/her capacity as Agent, the individual may or may not be able to make health care or other decisions on your behalf. The extent of the Agent's authority depends on the nature of that legal relationship.

Seen and agreed by:

Date: _____

_____
Signature of Provider Representative

_____
Name of Provider

_____
Address

_____
Your Name

_____
Your Signature or Signature of Your Agent

_____
Address

_____
Telephone Number

APPENDIX F

This Appendix applies only if you rent your unit from an entity (the "Landlord") that is not the Provider.

A. Your Landlord is: _____

B. Your current monthly rent is: _____

C. Among other things, your lease provides that you will receive the following (check all that applies):

☐ All housing costs (there will be no extra charges)
☐ All housing costs except:

_____
_____
_____

☐ Semi-private room
☐ Shared bathroom
☐ Private room
☐ Private bathroom
☐ Efficiency apartment
☐ One Bedroom Apartment
☐ Two Bedroom Apartment
☐ Other

D. Your lease is attached here for reference.

Section 5

Resident Rights

5.1 Resident rights. The assisted housing program shall promote and encourage residents to exercise their rights, to age in place and make informed choices. *[Class IV]*

5.2 Freedom of choice of provider. For services and supplies not provided by the licensee, each resident has the right to select the provider of his/her choice. *[Class IV]*

5.3 Rights regarding transfer and discharge. Each resident has the right to continued residence whenever a valid contract for services is in force. The facility must show documented evidence of strategies used to prevent involuntary transfers or discharges. A resident shall not be transferred or discharged involuntarily, except for the following reasons:

5.3.1 When there is documented evidence that a resident has violated the admission contract obligations, despite reasonable attempts at problem resolution; *[Class IV]*

5.3.2 A resident's continued tenancy constitutes a direct threat to the health or safety of others; *[Class IV]*

5.3.3 A resident's intentional behavior has resulted in substantial physical damage to the property of the assisted housing program or others residing in or working there; *[Class IV]*

5.3.4 A resident has not paid for his/her residential services in accordance with the contract between the assisted housing program and the resident; *[Class IV]*

5.3.5 When there is documented evidence that the facility cannot meet the needs of the resident as the program is fundamentally designed; *[Class IV]* or

5.3.6 The license has been revoked, not renewed, or voluntarily surrendered. *[Class IV]*

5.4 Transfer or discharge. When a resident is transferred or discharged in a non-emergency situation, the resident or his/her guardian shall be provided with at least fifteen (15) days advance written notice to ensure adequate time to find an alternative placement that is safe and appropriate. The provider has an affirmative responsibility to assist in the transfer or discharge process and to produce a safe and orderly discharge plan. If no discharge plan is possible, then no involuntary non-emergency discharge shall occur until a safe discharge plan is in place. Appropriate information, including copies of pertinent records, shall be transferred with a resident to a new placement. *[Class IV]* Each notice must be written and include the following:

5.4.1 The reason for the transfer or discharge, including events which are the basis for such action; *[Class IV]*

5.4.2 The effective date of the transfer or discharge; *[Class IV]*

5.4.3 Notice of the resident's right to appeal the transfer or discharge as set forth in Section 5.28; *[Class IV]*

5.4.4 The mailing address and toll-free telephone number of the Long Term Care Ombudsman Program; *[Class IV]*

5.4.5 In the case of residents with developmental disabilities or mental illness, the mailing address and telephone number of the Office of Advocacy, Department of Health and Human Services (formerly known as the Department of Behavioral and Developmental Services (BDS)); *[Class IV]*

5.4.6 The resident's right to be represented by himself/herself or by legal counsel, a relative, friend or other spokesperson. *[Class IV]*

5.5 Emergency transfer or discharge. When an emergency situation exists, no written notice is required, but such notice as is practical under the circumstance shall be given to the resident and/or resident's representative. The facility shall assist the resident and authorized representatives in locating an appropriate placement. Transfer to an acute hospital is not considered a placement and the obligation in regard to such assistance does not necessarily terminate. *[Class IV]*

5.6 Leaves of absence. When a resident is away, and continues to pay for services in accordance with the contract, the resident shall be permitted to return unless any of the reasons set forth in Section 5.3 are present and the resident or resident's legal representative has been given notice as may be required in these regulations. *[Class IV]*

5.7 Assistance in finding alternative placement. Residents who choose to relocate shall be offered assistance in doing so.

5.7.1 Residents of residential care facilities shall not be required to give advance notice. *[Class IV]*

5.8 Right to communicate grievances and recommend changes. The facility/program shall assist and encourage residents to exercise their rights as residents and citizens. Residents may freely communicate grievances and recommend changes in policies and services to the assisted housing program and to outside representatives of their choice, without restraint, interference, coercion, discrimination or reprisal. All grievances shall be documented. The resident has the right to be assisted throughout the grievance by a representative of his/her choice. Section 5.25 of these regulations lists advocacy services which may be available to the resident.
Assisted housing programs shall establish and implement a procedure for the timely review and disposition of grievances, and shall notify residents upon admission of their right to file a grievance and information about how to do so. The procedure shall include a written response to the grievant describing disposition of the complaint. These documents shall be maintained and available for review upon request by the Department. *[Class IV]*

5.8.1 Residents who are class members under the AMHI consent decree may also file grievances alleging a violation of the terms of the AMHI settlement agreement. The grievances may be brought by or on behalf of individuals or groups of class members. If the grievances include allegations of employee misconduct, no disciplinary action may be taken nor facts found with regard to the alleged misconduct except in accordance with the provider's personnel policies and with any employment contract provisions.

A class member who files a grievance is entitled to a hearing conducted by an impartial hearing officer, who may be employed by the provider but who must not have been directly involved in the incident. The hearing officer must hold a hearing, either in person or by telephone; must accept evidence from both parties, including testimony of witnesses; and must make a decision in writing promptly after the hearing. The hearing must be recorded verbatim. The hearing must be expedited if the resident can establish that an emergency will exist if the grievance is not resolved very soon.

5.9 **Right to manage financial affairs.** Residents shall manage their own financial affairs, unless there is a representative payee, other legal representative appointed or other person designated by the resident. *[Class IV]*

5.10 **Right to freedom from abuse, neglect or exploitation.** Residents shall be free from mental, verbal, physical and/or sexual abuse, neglect and exploitation. *[Class I, II, III, IV]*

5.11 **Rights regarding restraints and aversive conditioning.** There shall be no use of physical, chemical, psychological or mechanical restraints or aversive conditioning, except in accordance with this section. *[Class I, II, III, IV]*

5.11.1 Full-length bedrails on both sides of the bed are considered restraints and shall not be attached to the bed. Half-length bedrails attached to the top half of the bed are permissible. One full-length bed rail and one half-length bed rail may be used if the full-length rail is on the side against the wall. *[Class I, II, III, IV]*

5.11.2 In the case of a person with mental retardation, the provider must comply with the requirements of the *Regulations Governing the Use of Behavioral Procedures in Maine Programs Serving Persons with Mental Retardation* and the *Regulations Governing the Use of Restraints in Community Settings*. These regulations are promulgated and enforced by the Department of Health and Human Services (formerly known as the Department of Behavioral and Developmental Services BDS)). *[Class I, II, III, IV]*

5.11.3 For any resident who is a client of the Department of Health and Human Services Adult Mental Health Program (formerly known as the Department of Behavioral and Development Services (BDS)) due to his/her mental illness, the facility/program shall comply with the *Rights of Recipients of Mental Health*

Services, promulgated and enforced by the Department of Health and Human Services (formerly known as the Department of Behavioral and Developmental Services (BDS)). *[Class I, II, III, IV]*

5.12 Right to confidentiality. Residents' records and information pertaining to their personal, medical and mental health status is confidential. Residents and their legal representatives shall have access to all records pertaining to the resident at reasonable times, in the presence of the provider or his/her representative, within one (1) business day of the request. Residents and their legal representatives are entitled to have copies made of their record within one (1) business day of the request. The licensee and employees shall have access to confidential information about each resident only to the extent needed to carry out the requirements of the licensing regulations or as authorized by any other applicable state of federal law. The written consent of the resident or his/her legal representative shall be required for release of information to any other person except authorized representatives of the Department or the Long Term Care Ombudsman Program. The Department shall have access to these records for determining compliance with these regulations. Records shall not be removed from the facility, except as may be necessary to carry out these regulations. Upon admission, each resident shall sign and date a written consent which lists individuals, groups, or categories with whom the program may share information (e.g., sons, daughters, family members or duly authorized licensed practitioners, etc.). A written consent to release of information shall be renewed and time dated every thirty (30) months, pursuant to 22 M.R.S.A. §1711-C (4). Consent may be withdrawn at any time. *[Class IV]*

5.13 Right to refuse to perform services for the facility. Residents may refuse to perform services for the facility. *[Class IV]*

5.14 Right to privacy and consideration. Residents shall be treated with respect. Residents shall also be treated with respect and consideration with regard to their individual need for privacy when receiving personal care or treatment, preferred mode of language and communication. *[Class IV]*

5.15 Right to communicate privately with persons of choice. Residents may associate and communicate privately with persons of their choice at any time, unless to do so would infringe on the rights of others. They may receive personal mail, unopened, and shall be assisted when necessary with writing and mailing letters and making phone calls. Residents shall have privacy when having telephone conversations. *[Class IV]*

5.16 Right to participate in activities of choice. Residents may participate in social, political, religious and community activities, unless to do so would infringe on the rights of others. *[Class IV]*

5.17 Right to personal clothing and possessions. Residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or impair the provider's ability to meet the purpose of these rules. *[Class IV]*

Section 5 LEVEL IV RESIDENTIAL CARE FACILITIES

5.18 **Couples.** A couple residing in an assisted housing program has the right to share a room. *[Class IV]*

5.19 **Right to be informed of services provided by the facility/program.** Residents shall be fully informed of items or services which are included in the rate they pay. This rate shall include the cost of repair or replacement of items damaged by normal wear and tear. *[Class IV]*

5.20 **Right to refuse treatment or services.** Residents may choose to refuse medications, treatments or services. If the resident refuses necessary care or treatment, the provider shall make reasonable efforts to consult the resident's duly authorized licensed practitioner, caseworker or other appropriate individuals in order to encourage residents to receive necessary services. No person without legal authority to do so shall order treatment, which has not been consented to by a competent resident. *[Class IV]*

5.21 **Right to be free from discrimination.** A resident shall be provided services without regard to race, age, national origin, religion, disability, gender or sexual orientation. *[Class IV]*

5.22 **Right to information regarding deficiencies.** Residents have the right to be fully informed of findings of the most recent survey conducted by the Department. The provider shall inform residents or their legal representatives that the survey results are public information and are available in a common area of the facility. Residents and their legal representatives shall be notified by the provider, in writing, of any actions proposed or taken against the license of the facility/program by the Department, including but not limited to, decisions to issue a Directed Plan of Correction, decisions to issue a Conditional license, refusal to renew a license, appointment of a receiver or decisions to impose fines or other sanctions. This notification shall take place within fifteen (15) working days from receipt of notice of action. *[Class IV]*

5.23 **Notification of Residents Rights.** The provider shall inform each resident and legal representative of these rights prior to or at admission and shall provide them with a copy of these rights. In addition, the provider shall inform each resident and legal representative, within thirty (30) calendar days of any changes to Section 5 and shall provide them with a copy of the change. The provider must accommodate for any communication barriers that may exist, to ensure that each resident is fully informed of his/her rights. *[Class IV]*

5.24 **Bill of rights for persons with mental retardation.** Facilities/programs serving persons with mental retardation shall post and comply with the *Bill of Rights for Persons with Mental Retardation*, Title 34-B M.R.S.A. § 5601 et seq. *[Class IV]*

5.25 **Mandatory report of rights violations.** Any person or professional who provides health care, social services or mental health services or who administers a long term care facility or program who has reasonable cause to suspect that the regulations pertaining to residents' rights or the conduct of resident care have been violated, shall immediately report the alleged violation to the Department of Health and Human Services (800 383-2441) and to one or more of the following:

Disability Rights Center (DRC), pursuant to Title 5 M.R.S.A. § 19501 through § 19508 for incidents involving persons with mental illness; the Long Term Care Ombudsman Program, pursuant to Title 22 M.R.S.A. § 5107-A for incidents involving elderly persons; the Office of Advocacy, pursuant to Title 34-B M.R.S.A. § 1205 for incidents involving persons with mental retardation; or Adult Protective Services, pursuant to Title 22 M.R.S.A. § 3470 through § 3487.

Reporting suspected abuse, neglect and exploitation is mandatory in all cases. Documentation shall be maintained in the facility that a report has been made.

Mandated reporters shall contact the Department of Health and Human Services (800 383-2441) immediately after receiving and/or obtaining information about any rights violations. *[Class IV]*

5.26 **Reasonable modifications and accommodations.** To afford individuals with disabilities the opportunity to reside in an assisted living program, the provider shall:

5.26.1 Permit directly, or through an agreement with the property owner, if the property owner is a separate entity, reasonable modification of the existing premises, at the expense of the disabled individual or other willing payer. Where it is reasonable to do so, the provider may require the disabled individual to return the premises to the condition that existed before the modification, upon discharge of that individual. The provider is not required to make the modification at his/her own expense, if it imposes a financial burden. *[Class IV]*

5.26.2 Make reasonable accommodation in regulations, policies, practices or services, including permitting reasonable supplementary services to be brought into the facility/program. The provider is not required to make the accommodation, if it imposes an undue financial burden or results in a fundamental change in the program. *[Class IV]*

5.27 Right of action. In addition to any remedies contained herein, any resident whose rights have been violated may commence a civil action in Superior Court for injunctive and declaratory relief pursuant to Title 22 M.R.S.A. § 7948 et seq. *[Class IV]*

5.28 **Right to appeal an involuntary transfer or discharge.** The resident has the right to an expedited administrative hearing to appeal an involuntary transfer or discharge. A resident may not appeal a discharge due to the impending closure of the program unless he/she believes the transfer or discharge is not safe or appropriate. To file an appeal regarding an involuntary transfer or discharge, the resident must submit the appeal within five (5) calendar days of receipt of a written notice. If the resident has already been discharged on an emergency basis, the provider shall hold a space available for the resident pending receipt of an administrative decision. Requests for appeals shall be submitted to the Assistant Director of the Division of Licensing and Certification, Community Services Programs for submission to the Office of Administrative Hearings, 11 State House Station, Augusta, Maine 04333-0011. The provider is

responsible for defending its decision to transfer or discharge the resident at the administrative hearing. *[Class IV]*

5.29 **Resident adjudicated incompetent.** In the case of a resident adjudicated incompetent, the rights of the resident are exercised by the resident's legal representative, as defined in Section 2.29 of these Regulations. *[Class IV]*

5.30 Resident councils

5.30.1 Residents of assisted living programs and residential care facilities have the right to establish a resident council, pursuant to Title 22 M.R.S.A. § 7923. Residents and their families shall be notified of this right, orally and in writing, within the first month after admission, in a manner understood by each resident and by a notice of the right to form a council being posted prominently in a public area.

5.30.2 If a majority of the residents choose not to establish a council, they shall be given the opportunity to choose otherwise at least once each year thereafter.

5.30.3 The council has the following rights:

5.30.3.1 To be provided with a copy of the facility's policies and procedures relating to resident rights and to make recommendations to the administrator on how they may be improved; *[Class IV]*

5.30.3.2 To establish procedures that will ensure that all residents are informed about and understand their rights; *[Class IV]*

5.30.3.3 To elicit and disseminate information regarding programming in the facility and to make recommendations for improvement; *[Class IV]*

5.30.3.4 To help identify residents' problems and recommend ways to ensure early resolution; *[Class IV]*

5.30.3.5 To inform the administrator of the opinions and concerns of the residents; *[Class IV]*

5.30.3.6 To find ways of involving the families and residents of the facility; *[Class IV]*

5.30.3.7 To notify the Department and Long Term Care Ombudsman Program when the council is constituted; and *[Class IV]*

5.30.3.8 To disseminate records of council meetings and decisions to the residents and the administrator and to make these records available to family members or their designated representatives and the Department, upon request. *[Class IV]*

Section 5 LEVEL IV RESIDENTIAL CARE FACILITIES

5.31 **Right to a service plan.** The provider shall assist residents to implement any reasonable plan of service developed with community or state agencies. *[Class IV]*

STAFF TRAINING:

GOLDEN ACRES STAFF MEETS THE STATE REGULATIONS IN REGARDS TO STAFF TRAINING. OUR DIRECT CARE STAFF WILL COMPLETE THE PERSONAL SUPPORT SPECIALIST TRAINING. OUR MEDICATION GIVERS ARE CERTIFIED BY THE DEPARTMENT OF HUMAN SERVICES. UPON HIRING A NEW STAFF MEMBER UNDERGOES A MINIMUM OF 2 DAYS OF TRAINING WITH A QUALIFIED STAFF MEMBER. FURTHER TRAINING IS GIVEN TO INDIVIDUALS WHO REQUIRE IT. CONTINUING EDUCATION HAPPENS FREQUENTLY THROUGHOUT EMPLOYMENT IN VARIOUS FORMS. ON THE JOB EXPERIENCE, IN-HOUSE INSERVICES, SEMINARS, UPDATING CERTIFICATIONS AND SPECIFIC CLASSES ON THE PUBLIC THAT WE SERVE SUCH AS ALZHEIMERS, DEMENTIA, DIABETICS, ETC. ARE UTILIZED THROUGHOUT EMPLOYMENT. GOLDEN ACRES HAS AN R.N. CONSULTANT AND PHARMACIST CONSULTANT THAT PROVIDES TRAINING TO STAFF IN APPLICABLE AREAS WHEN NECESSARY.

LICENSING STATUS: Golden Acres of Hancock currently undergoing inspection as of ~~1/1/13~~ ~~1/2010~~ ~~3/2011~~ 3/2012 GOLDEN ACRES LICENSE WAS RENEWED WITH NO RESTRICTIONS FOR A CAPACITY OF ~~45 BEDS~~. WE ARE A LEVEL IV RESIDENTIAL CARE FACILITY. OUR LICENSE IS RENEWED ANNUALLY AND THE RESULTS OF EACH INSPECTION ARE AVAILABLE AT GOLDEN ACRES FOR YOUR VIEWING. ~~3/2011~~ 2013

Franklin Graces - last inspection ~~1/2010~~ license good for 2 years. 2013

Surry-Patten Pond House provisional license 3/24

Mountain Vista 7/2/12

Grace Home Lic 7/2/12

update 2/1/2017

All licensed are updated every 2 years by the state. All currently are in good standing.

EMERGENCY PHONE NUMBERS:

OMBUDSMAN PROGRAM 1/800/499/0229
ADULT PROTECTION SERVICES 1/800/624/8404
ASSISTED LIVING LICENSING SERVICES 1/800/432/7825
& DIVISION OF LICENSING & CERTIFICATIONS

ENCLOSED PLEASE FIND AN OMBUDSMAN PAMPHLET.

grievance policy

X _____
Signature

GRIEVANCE POLICY

STEP ONE: A STAFF MEMBER, RESIDENT, FAMILY MEMBER OR OTHER VISITING GUEST MAY HAVE A GRIEVANCE OR AN ISSUE THAT THEY WOULD LIKE TO BRING TO MY ATTENTION AS THE ADMINISTRATOR. THIS MAY ENTAIL ANY AREA OF LIFE HERE AT GOLDEN ACRES. IT MAY CONSIST OF SOMETHING YOU PERCEIVE AS A SERIOUS ELEMENT OR JUST AN ISSUE THAT YOU FELT CONCERN ABOUT IN REGARDS TO AN INDIVIDUAL RESIDENT OR GOLDEN ACRES AS A WHOLE.

STEP TWO: A GRIEVANCE REPORT SHOULD THEN BE FILED. YOU SHOULD ASK ME FOR A GRIEVANCE FORM AND I CAN HELP YOU FILL IT OUT OR YOU MAY FILL IT OUT INDEPENDENTLY AND THEN RETURN IT TO ME.

STEP THREE: WE WILL DISCUSS THE ISSUES AND DETERMINE IF THERE IS AN AREA GOLDEN AREAS NEEDS TO IMPROVE ON. SOME ISSUES MAY NOT WARRANT ANY ACTION AS THEY MAY BE MANDATED BY STATE LAW, PHYSICIAN'S ORDER, GOLDEN ACRES POLICIES FOR THE SAFETY AND WELL-BEING OF EVERYONE IN THE FACILITY OR A MISUNDERSTANDING REGARDING THE ACTUAL ELEMENTS OF THE SITUATION.

STEP FOUR: YOU WILL HAVE A CHANCE TO RESPOND IN WRITING TO THE OUTCOME OF THE GRIEVANCE ON THE GRIEVANCE FORM. I, AS THE ADMINISTRATOR WILL VALIDATE ANY ACTIONS TAKEN OR LACK THEREOF IN WRITING ALSO ON THE FORM.

STEP FIVE: YOU HAVE THE OPTION TO TAKE ANY SITUATIONS YOU ARE DISSATISFIED WITH AND REPORT THEM TO A HIGHER AGENCY FOR THEIR DISCRETION. OMBUDSMAN NUMBERS ARE POSTED BESIDE THE MENU BOARD FOR YOUR CONVENIENCE.

STEP SIX: I, AS THE ADMINISTRATOR, WILL MONITOR THE SITUATION TO MAKE SURE ANY ACTIONS TAKEN ARE CARRIED THROUGH AND IMPLEMENTED IN THE FUTURE.

NOTE: CONFIDENTIALITY WILL BE UPHELD AND THERE NEED NOT BE ANY FEAR OF REPRISAL OR BACKLASH FROM ANY OF THE ABOVE ACTIONS OR STEPS.

ADMISSIONS POLICY

PROSPECTIVE NEW RESIDENTS ARE SCREENED BY THE ADMINISTRATOR TO DECIDE IF THEY ARE SUITABLE FOR ADMITTANCE INTO GOLDEN ACRES. THE PRE ADMISSIONS SCREENING IS FILLED OUT WHEN THE PROSPECTIVE RESIDENT AND/OR RESPONSIBLE FAMILY MEMBERS VISIT OUR FACILITY. IF APPLICABLE, THE PROSPECTIVE RESIDENTS CURRENT HOUSING WILL BE CONTACTED TO VERIFY AND PROVIDE A MORE IN-DEPTH, TRAINED OVERALL SUMMARY OF THE RESIDENT (I.E. NURSING HOME, BOARDING HOME). BASED ON THE ABOVE INFORMATION COMPILED WITH ANY OTHER AVAILABLE FEEDBACK FROM PERTINENT SOURCES (I.E. STAFF OF G.A., PHYSICIAN, ETC.) THE ADMINISTRATOR FORMS AN OPINION AS TO WHETHER GOLDEN ACRES CAN PROVIDE FOR THE INDIVIDUAL NEEDS OF THE RESIDENT. IF THERE ARE ANY CONCERNS REGARDING AN ELEMENT OF THE RESIDENTS CARE GOLDEN ACRES MAY LOOK TO OTHER OUTSIDE SERVICES TO SEE IF THEY CAN BE UTILIZED TO ASSIST IN THE AREA OF CONCERN. AT THIS POINT IT IS ALSO IMPORTANT TO CONSIDER THE SUITABILITY OF THE PROSPECTIVE RESIDENT TO THE CURRENT RESIDENTS AND ENVIRONMENT UPHELD AT GOLDEN ACRES. THIS WOULD ENCOMPASS A DETERMINATION AS TO WHETHER THE PROSPECTIVE RESIDENT WAS COMPATIBLE WITH SUCH FACTORS AS THE ACTIVITIES PROGRAM OF GOLDEN ACRES, THE LOCAL PROGRAMS THAT THE TOWN GOLDEN ACRES RESIDES IN MAY PROVIDE UPON RESIDENTS INTEREST, THE LARGE FAMILY ATMOSPHERE OF LOVE AND FRIENDSHIP INSTILLED AT GOLDEN ACRES AND THE APPROPRIATENESS OF THE PROSPECTIVE RESIDENT INTEGRATED WITH THE NEEDS AND STYLE OF GOLDEN ACRES AND CURRENT RESIDENTS. ONCE THE ABOVE HAS BEEN DETERMINED A DECISION IS MADE BY THE ADMINISTRATOR ON THE ADMITTANCE OF THE PROSPECTIVE RESIDENT.

NUR[redacted]

Resident Name: P[redacted]

Date and Time *24 HOUR NURSES NOTE ADMISSION DAY.*

[redacted]

[redacted]

[redacted]

[redacted]

GOLDEN ACRES
RESIDENT PNEUMONIA, FLU, AND TETANUS SHOT AND PHYSICAL RECORD

Resident Name: _____

Date of Admission: _____

Pneumonia Shot		Flu Shot		Physical		Tetanus	
Date	Comments	Date	Comments	Date	Comments	Date	Comments

The Grace Home
95 Willey District Road
Harrington, Maine
04643
207-483-2247

Mountain Vista
44 South Bay Road
Franklin, Maine
04634
207-565-3804

Release of Information

I, _____, authorize the release of pertinent medical or other information regarding (resident)_____

To The Grace Home / Mountain Vista. This release also authorizes The Grace Home and Mountain Vista to release information to facilities or individuals checked below.

_____ MDI Hospital
_____ Harrington Family Health Center
_____ Milbridge Medical Center
_____ Gouldsboro Medical Center
_____ Eastern Maine Medical Center
_____ Coastal Med Tech
_____ Ellsworth Family Practice
_____ RMCL
_____ CHCS
_____ Sunrise Home Health
_____ Maine Coast Memorial Hospital
_____ DownEast Community Hospital
_____ RN Consultant/Dietician
_____ OxyCare
_____ Ellsworth Internal Medicine
_____ Other_____

This release will remain in effect during my stay at this home. I may withdraw this release at anytime either verbally or in writing.

_____ Date_____
Resident or Responsible Party

Witness_____ Date_____

* DO NOT DATE *

GOLDEN ACRES BOARDING HOME MEDICATION ORDERS

PHONE/FAX: 207/565/2352

PLEASE FAX BACK TO GOLDEN ACRES ASAP. THANK YOU. DIANE DOW, ADMINISTRATOR

PATIENT:_____ PHYSICIAN:_____
DOB:_____ PHONE:_____
ALLERGIES:_____ FAX:_____

ORDERS ARE GOOD FOR ONE YEAR INCLUDING PSYCHOTROPICS
NO NEED TO PHONE DOCTOR EVERY TIME A PRN IS GIVEN

	AS A NEW RESIDENT AT GOLDEN ACRES WE NEED THE FOLLOWING
	INFORMATION.PLEASE FILL IN BELOW INFORMATION SIGN DATE
	AND FAX BACK AS SOON AS POSSIBLE.THANK YOU
	CODE STATUS-
	order does not expire
	ALLERGIES-
	LAST PNEUMONIA VACCINE-
	LAST FLU SHOT-
	LAST TETANUS-
	LAST PHYSICAL-
	NEXT APPOINTMENT WITH YOU-
	DIAGNOSIS-
	ALSO PHYSICIAN AGREES GOLDEN ACRES WILL MANAGE ALL MEDS.
	administer
	PLEASE MAKE ANY NECESSARY CHANGES

SIGNATURE:_____ DATE:_____

PLEASE SIGN AND DATE. THANK YOU. DIANE DOW, ADMINISTRATOR

Standing Medication Order Sheet

Resident:_____
Provider:_____
Provider phone #:_____

Please review Standing Orders. Cross out any orders you do not want for your patient.
Additional orders may be written in at the bottom of the form.

1. Fever-Temperature up to 101(oral)-Tylenol 500 mg-2 tabs by mouth every four hours as needed. Notify Provider if fever lasts more than 48 hours. Temperature >102 Give Tylenol and report to Provider.

2. Minor muscle aches, pains, headaches, dental pain, back aches or menstrual pain-Tylenol 500 mg -2 tabs by mouth every 4 hours as needed. If pain persists more than 3 cays-Call Provider.

3. Cough-Robitussin-2 teaspoons every 4 hours as needed, not to exceed 12 teaspoons in 24 hours. Call Provider if cough is productive (green or yellow), lasts more than 3 days, is accompanied by a fever, or weight gain of 3 or more pounds in a week.

4. Diarrhea-Clear liquids for 24 hours. If diarrhea continues after clear liquids, Imodium 2 mg-2 caplets by mouth after first loose stool. Give 1 caplet after each subsequent loose stool but do not exceed 4 caplets in 24 hours. If diarrhea lasts more than 48 hours, call Provider.

5. Constipation-If no BM-Day 3 , Milk of Magnesia-4 tablespoons by mouth at bedtime...Day 4, Dulcolax suppository. If no results in 4 hours administer Fleet Enema per rectum. Call Provider if no results.

6. Indigestion, heartburn, sour stomach-Maalox 2-4 teaspoons between meals and at bedtime. Do not exceed 12 teaspoons per 24 hours. Do not use longer than 2 weeks unless directed by Provider

7. Nausea-Emetrol 1 teaspoon every 15 minutes until nausea subsides. Do not take for more than 1 hour(5 doses). Notify provider if nausea persists more than 3 days.

8. Minor lacerations/abrasions-Clean with Normal saline. Apply Bacitracin and gauze pad if necessary. Call Provider or ER if sutures are needed. Suturing must be don within 24 hours.

10. Shortness of Breath, Wheezing or Congestion-Albuterol inhalation solution 0.083%(2.5 mg/3 ml) SDV via nebulizer every 4 hours as needed during an acute illness. Notify Provider if SOB/ Congestion is accompanied by a fever or treatments are administered more than 48 hours.

11. Medications may be held during an acute illness without contacting Provider. (Max 48 hours)
Standing Orders must be signed and dated every (12) twelve months.

12. UA and culture if indicated (urinalysis) for unexplained incontinence or fever.

Provider Signature_____ Date_____

Revised 02/13/2010

GOLDEN ACRES BOARDING HOME MEDICATION ORDERS

PHONE/FAX: 207/565/2352

PLEASE FAX BACK TO GOLDEN ACRES ASAP. THANK YOU. DIANE DOW, ADMINISTRATOR

TIENT:______________________ PHYSICIAN:______________________
OB:____________ PHONE:____________
ALLERGIES:______________________ FAX:____________

ORDERS ARE GOOD FOR ONE YEAR INCLUDING PSYCHOTROPICS

DATE:	MEDICATION ORDERS:
	PLEASE MAKE ANY NECESSARY CHANGES

ATURE:______________________ DATE:______________

ASE SIGN AND DATE. THANK YOU. DIANE DOW, ADMINISTRATOR