Respite Application

Winter Growth

Name: _____ Telephone: _____

Address: _____

Date of Birth: _____ Primary Language(s): _____

If other than English, is applicant able to communicate in English? ❑ Yes ❑ No

Additional Information regarding communication: _____

Health Insurance Company: _____ Number: _____

Medicare: _____ Medicaid: _____ (if applicable)

Primary Caregiver (Relationship:_____)
Check if: ❑ Power of Attorney ❑ DPoA Healthcare ❑ Guardian

Name: _____ Address: _____

Phone: (H)_____ (W) _____ (C) _____

Email address:_____

Location during Respite Stay_____

Contact number during Respite Stay_____

Alternate Person to be Notified in Emergency (Relationship:_____)
Check if: ❑ Power of Attorney ❑ DPoA Healthcare ❑ Guardian

Name: _____ Address: _____

Phone: (H)_____ (W) _____ (C) _____

Email address:_____

If applicant has *Advanced Directives* for healthcare, please submit a copy.
A completed MOLST form is recommended for all clients staying for overnight respite.

Attending Physician: _____ Phone: _____ Fax: _____

Address_____

Specialist: _____ Phone: _____ Fax: _____

Address_____

Personal/Social History

The information in this section will help us to develop a truly individual person-centered activity program for your loved one. We appreciate your sharing his or her uniqueness with us.

Place of Birth: _____ Grew Up: _____

Considers Home State/Country to Be: _____

Ever Lived Abroad: ❑ No ❑ Yes (Where? _____)

Marital Status**:** ❑ Single ❑ Widowed ❑ Married ❑ Separated ❑ Divorced How long?_____

Education/Work History:

❑ Did Not Complete High School ❑ Completed High School / GED ❑ College ❑ Post Graduate

Occupation(s) most important listed first:_____

Military Service: Is applicant a veteran? ❑ Yes ❑ No Was spouse a veteran? ❑ Yes ❑ No
Branch? ❑ Army ❑ Navy ❑ Air Corp/Air Force ❑ Marines ❑ Coast Guard Rank: _____
Wars Served In: ❑ WWII ❑ Korean ❑ Vietnam ❑ Middle East

Interests/Hobbies: *(**CHECK** all that apply to the **Past**; **CIRCLE** all that apply to **Current**):*
❑Arts/Crafts ❑Babies/Children ❑Being Read To ❑Board/Card Games ❑Cooking ❑Dancing
❑Discussion Groups ❑Educational Programs ❑Field Trips ❑Lawn Games ❑Music/Sing-A-Long
❑Music/Listening ❑Needlework ❑Pet Cats ❑Pet Dogs ❑Philosophy ❑Physical Fitness
❑Reading ❑Religion ❑Reminiscing ❑Shopping ❑Travel Logs ❑Sports ❑Writing
❑Other (Please List) _____

Spiritual Tradition(s) ❑Buddhism ❑Christianity ❑Hinduism ❑Islam ❑Judaism ❑Non-Specified
❑Other _____ ❑Currently attends services ❑Previously attended services

Life Traumas/ Tragedies of Which We Should be Aware: ______

_____

Medical History

Experiences (*If applicable please explain):*

Anxiety: _____

Depression: _____

Challenging Behaviors? (*verbally inappropriate, disruptive, combative, etc.*)

_____

_____

If yes, what makes it better?_____

Briefly describe RECENT (within past 6 months) changes in health or behavioral status, hospitalizations, falls, and CURRENT medical diagnoses:

_____

_____

Briefly describe any PAST illnesses or chronic conditions (including hospitalizations):

_____

_____

Allergies (Include medication, food, and environment. Add reactions, such as rash, if applicable.):

_____

_____

****Diabetic**: ❑ No If Yes, ❑ Diet Controlled ☐ Medication Controlled ☐ Insulin Dependent

Nutritional Needs

Does applicant have medical or dental conditions affecting (check all that apply):

❑ Chewing ❑ Swallowing ❑ Eating ❑ Pocketing food ❑ Gastronomy Tube Fed

Note any special therapeutic diet (e.g. sodium restricted, renal, calorie, or sugar restricted):
❑ Regular ❑ No Added Salt ❑ No Concentrated Sweets ❑ Renal ❑ No Pork ❑ No Shellfish
❑ Vegetarian ❑ Mechanical Soft ❑ Thick Liquids ❑ Pureed

Eating patterns and food preferences *(check all that apply)*
□ Eats full meals ❑ Eats only two meals ❑ Eats small portions
□ Finger foods ❑ Eats only **what** he/she wants, but maintains weight
□ Supplements (type)_____
Favorite food: _____
Strong dislikes: _____

Functional Needs

Does the applicant experience incontinence?
Bowel: _____

Bladder: _____

Does the individual have any of the following: ❑Gait Problem ❑Impaired Balance ❑Foot Deformity
❑Assistive Devices for Walking (Please Explain)_____

Skin condition(s):
❑Jaundice ❑Rash ❑Scar ❑Abrasion ❑Laceration ❑Decubitus ❑Burn ❑Erythemous ❑Petechia

Hearing condition: ❑Adequate ❑Poor ❑Deaf ❑Uses corrective aid (__Left Ear +/or __Right Ear)

Vision: ❑ Adequate ❑ Poor

Uses corrective lenses: ❑ Glasses ❑ Contacts
Is blind (check all that apply): ❑ Right Eye ❑ Left Eye

Is there a history of seizures? ❑ No ❑ Yes Type/Cause (if known)_____
Date of Last Seizure _____

Daily Living (ADLs)

Eating: ❑ Independent Needs assistance (please explain):_____

Walking: ❑ Independent Needs assistance (please explain):_____

Adaptive Equipment: ❑ Cane ❑ 4 Pronged Cane ❑ Walker ❑ Wheelchair: __Manual __Motorized

Move In/Out of Bed, Chair or Toilet: ❑ Independent ❑ Unable
□ Needs assistance (please explain):_____
Adaptive Equipment: ❑ Lift ❑ Slide Board ❑ Trapeze ❑ Other ❑ Multiple

Use of Stairs: ❑ Independent ❑ Unable
□ Needs assistance (please explain):_____

Toileting: ❑ Independent ❑ Total Care
□ Needs assistance (please explain):_____

Bathing: ❑ Independent ❑ Total Care
□ Needs assistance (please explain):_____

Grooming (teeth, make-up, shaving, hair): ☐Independent ☐Total Care
□ Needs assistance (please explain):_____
If dentures: ❑ Partial ❑ Upper ❑ Lower

Getting Dressed/Changing Clothes: ❑ Independent ❑ Total Care
□ Needs assistance (please explain):_____

Wanders ***If applicable please explain frequency of behavior (occasional, weekly, daily)***

Persistent moving/walking about without purpose _____
Looks for non-existent place (former house /bus) _____
Actively tries to leave house _____
Wanders during day _____
Wanders in evening &/or night _____

Does this person hide personal items and then believe they are either lost or stolen? _____

Could this person become combative under stress? _____

_____

Current Daily Routine

Usual time up in the morning: _____
Is the applicant easy or difficult to wake? (circle one)
Usual bedtime: _____

Preferred time to shower/bathe: _____
Meal time preferences: _____
Preferred evening/after dinner activities (Eg. television, crossword, reading, etc.): _____
_____

Any other things we should know about your loved one?

_____
_____
_____
_____

Permission to leave building during visit

While _____ is staying in Respite Care I authorize the following people to take the client out of the building during the day:_____;
(respite client name)

_____; _____.

Take the client out of the building overnight:_____.

By signing this application, in addition to the above referenced people, I can verbally authorize other individuals to take the respite client out of the building by speaking to the Assisted Living Manager or designated representative and that such authorization will be documented.

_____

_____Representative Signature and Date

Winter Growth, Inc.
Short-Term Resident Rental & Service Agreement

The terms of this "Agreement" between Winter Growth Assisted Housing (hereinafter called "Provider", "we", "our") and _____ (thereafter called "Resident", "you", "your") shall become effective as of _____**, 202___** and will remain effective until either party indicates (in writing) to the other of the desire for a change.

Winter Growth, Inc. possesses a valid license to operate an Assisted Living Facility issued by the Office of Health Care Quality pursuant to Code of Maryland Regulations 10.07.14 (COMAR 10.07.14). The Agreement incorporates the provisions required by the State of Maryland pursuant to COMAR 10.07.14. The Provider and the State of Maryland strongly encourage you to have your attorney or other authorized representative review this agreement before you sign it.

Whereas the parties hereto (the "Parties") desire to set forth the terms and conditions for Resident's use of Provider's facilities (the "Facilities") located at (initial selected site):

_____ Montgomery 18110 Prince Philip Drive, Olney, MD 20832

_____ Maryland Memories 5460 Ruth Keeton Way, Columbia, MD 21044

_____ Ruth Keeton House 5466 Ruth Keeton Way, Columbia, MD 21044

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual promises of the Parties set forth herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

Resident's Representative

1. The authority of the Resident's Representative (the "Representative") to make decisions on behalf of the Resident shall be recognized by Winter Growth if appropriate documentation is received designating:

a. A guardian of the person under Estates and Trusts Article, §13-705, Annotated Code of Maryland;

b. A guardian of the property under Estates and Trusts Article, §13-201, Annotated Code of Maryland;

c. An advance directive that meets the requirements of Health-General Article, §5-602, Annotated Code of Maryland;

d. A surrogate decision maker with authority under Health-General Article, §5-605, Annotated Code of Maryland;.

e. A power of attorney that meets the requirements of Estates and Trusts Article, §13-601, Annotated Code of Maryland;

f. A representative payee or other similar fiduciary; or

g. Any other person, if that person was designated by a resident who was competent at the time of designation, and the resident or representative has provided the assisted living program with documentation of the designation.

2. Winter Growth shall document in the Resident's record the name of the person, if any, with the authority identified above or include the documentation in the record.

3. Winter Growth may not recognize the authority of a Resident's Representative if the Representative attempts to exceed the authority:

a. Stated in the instrument that grants the representative authority; or

b. Established by State law.

4. List the Individual(s) to be contacted in the event of an emergency (use a separate piece of paper for additional contacts):

1st Person to be contacted Relationship Phone #s(indicate C-cell/H-home/W-work)

2nd Person to be contacted Relationship Phone #s(indicate C-cell/H-home/W-work)

Services and Accommodations

Winter Growth will provide the following services/amenities:

1. **Accommodations(All private rooms)**-We will provide a private room furnished with a bed and two pillows; lamp, comfortable chair, at least a two drawer chest of drawers, night stand with a drawer, a mirror and bed and bath linens. You are entitled to use your own furniture and/or linens, however, all upholstered furniture MUST be certified clear of dirt and pests by an authorized cleaner and is subject to inspection. In addition, you agree that you are responsible for the maintenance and repair of any personal belongings you bring to the Center. All mattresses MUST be new in the original packaging or you shall provide proof of purchases within the past thirty (30) days. For safety and sanitation reasons, the number and size of furniture pieces and personal items will be limited. Furniture must be

in good repair for the above reasons as well. You will be assigned an open bedroom at the time of your visit. You are also entitled to use and enjoy with all other residents the common areas of the Center.

2. **Staffing**-We will provide 24 hour supervision, seven days a week.

3. **Medication Management**-Our staff will supervise and/or administer the taking of medications per doctor's orders.

4. **Personal Care Assistance**- We will provide grooming, bathing, dressing, transferring, eating, and toileting as needed. **Please note:** Winter Growth's housing program is not a medical service. Nursing care is not available during hours that the Medical Day Care program is not in operation. Therefore, we are not able to serve those requiring this care on a twenty-four hour basis.

5. **Personal Toiletries**-Unless mandated by Maryland State regulations you are responsible to provide all necessary toiletries to include shampoo, deodorant, soap, and body wash.

6. **Meals**-We will serve three nutritionally balanced meals daily. Snacks are available 24 hours a day upon request. A five-week menu plan will be submitted to a Maryland approved nutritionist or dietitian for review and approval as deemed necessary.

7. **Utilities**-The cost of all utilities (gas, electric, water) is included. You are responsible for paying any other utility charges including, but not limited to, telephone, internet, and cable service. Access to a non-private phone for personal calls will be provided.

8. **Laundry and Linen Service**-We will launder your personal belongings and bed linens at least once a week.

9. **Housekeeping**-We will clean all areas used by residents at least weekly.

10. **Fire Protection**-We will establish a fire escape plan. The Center is provided with a sprinkler system, smoke detectors and fire extinguishers. Every effort is made to keep the center free of hazards. Fire extinguishers are checked monthly and fire drills are held quarterly. Exterior doors have an electronic locking system that allows them to be locked and released automatically with the fire alarm or a power outage.

ALL RESIDENTS MUST ABIDE BY THE PROVIDER'S SAFETY GUIDELINES. THE PROVIDER WILL NOT BE LIABLE FOR ACCIDENTS CAUSED BY A RESIDENT'S REFUSAL TO ACCEPT THE SAFETY GUIDELINES GIVEN BY THE PROVIDER. For the safety of all, smoking is not permitted inside the building including private rooms.

11. **Incident Reports**-We will keep a written account and record of each accident, illness, or any incident related to resident's health and well-being. We will also report any infectious disease, food poisoning, and dysentery to the appropriate government agency.

12. **Confidentiality**-We will provide for confidentiality of Resident files.

13. **Emergency**-In the event of an emergency situation, which could make it unsafe or unhealthy to continue to provide services at the facility, Winter Growth will make arrangements to temporarily relocate you to another one of its three facilities: 5460 Ruth Keeton Way, Columbia, Maryland 21044 / 5466 Ruth Keeton Way, Columbia, Maryland 21044 / 18110 Prince Philip Drive, Olney, MD 20832 or to a facility in which Winter Growth has a current Transfer Agreement.

Services Available But Not Included In Your Fees

1. **Therapeutic Services**-Physical Therapy, Speech Therapy and Occupational Therapy are available to you at your request. You are responsible for any fees associated with these services.

2. **Health Care Services**-You will be billed directly by the service provider.

Resident's Responsibilities

The Resident and/or Representative will:

1. **Personal Items**-***Winter Growth is not liable for any missing or damaged personal items.*** You must purchase clothing, toiletries, and necessary special personal items, such as incontinent pads, nutritional supplements, etc.

2. **Fees**-You and/or your Representative are responsible to pay a deposit PRIOR to your arrival and service fees when billed.

3. **Finances**-You or your Representative will handle the finances of the resident including the payments of monthly fees; co-payments for physician visits, hospitalizations, and rehabilitative therapies; and for the purchase or rental of essential or desired equipment and supplies. In addition, you or your Representative will arrange for, contract and pay for services not covered by the Resident agreement and purchase durable medical equipment as prescribed by the resident's physician. Winter Growth will provide assistance if requested in locating vendors.

4. **Transportation**-The Resident's Representative and/or family member **is responsible to provide transportation** to medical appointments and after discharge from a hospital or rehabilitation center. Winter Growth's community transportation may be available to assist with transportation. The family and/or Representative must contact the transportation department to make all arrangements. Transportation services are always **subject to availability and current rates will apply**.

5. **Emergency Room Visits**-If the Resident is transported to the hospital due to a medical emergency, a family member or the Representative will need to meet the Resident at the hospital. Winter Growth staff cannot leave the premises to be with the Resident in the hospital.

6. **Health Assessment**- The Representative shall assist Winter Growth staff in obtaining all required paperwork from the Resident's physician and other health care practitioners both upon admission and ongoing as requested by Winter Growth staff. You will accept regular medical supervision and take medication as prescribed by the Resident's physician or inform the physician of the intent to refuse so that staff may receive instructions from the physician.

7. **Medications**-You or your Representative will ensure all prescription medications are received in a timely manner to the facility.

8. **Right of Entry**-To ensure your safety and well-being, the staff has the right to enter your room; however, the staff will make every effort to be respectful of your privacy and will always knock before entering. **Please note:** if locks are deemed appropriate for the resident's room based on cognitive ability the Winter Growth staff SHALL have access to a key to the resident's room.

9. **Representatives/Advance Directives**-You or your Representative will provide us with accurate, complete and current information about yourself, authorized representatives, and health care providers, including but not limited to addresses, phone numbers, and other means of contact. You will also provide us with copies of any power of attorney, guardianship, living will, or conservator documents, or other legal documents relating to the making of health or financial decisions or decision-makers. You further agree to immediately notify us of changes relating to the information stated above.

10. **Records**-You acknowledge that we are licensed by the State of Maryland and will provide records for inspection by any regulatory officials.

11. **Visitors**-You have a right to have guests, however, all guests must visit during hours that will not disturb other residents. In addition, overnight guests are not permitted unless approved by Administration.

Complaint and Grievance Procedures

A copy of the resident's rights is attached and incorporated by reference into the agreement. This facility will honor and respect the Resident's rights.

All residents and Representatives have the right to make suggestions, register complaints or present grievances about the care or services provided including concerns about services being unfairly denied, not provided equally, or provided in a sub-standard manner. Please address these concerns to Cyndi Rogers, Executive Director at (410) 964-9616. If you are not satisfied with the response from either individuals, you may contact the Chairman of the Board at (301) 774-7501. You will receive a response to your concern(s) within 5 business days.

Should you be dissatisfied with the response or you do not receive a response, for those in Montgomery County you may contact the DHHS at (240) 777-3000 or send a written

complaint to: DHHS, Licensure and Regulatory Services, 255 Rockville Pike, Suite 100, 1st Flr, Rockville, MD, 20850. In Howard County contact the Ombudsmen at (410) 313-6410 or send a written complaint to: 9830 Patuxent Woods Drive, Columbia, MD 21046. You can also contact the State Assisted Living Complaint Unit at 410-402-8217 or 1-877-402-8221 or send a written complaint to: MDH, OHCQ, 7120 Samuel Morse Drive 2nd Floor, Columbia, MD 20146-3422.

Fees

The fee for Short-Term residential care at Winter Growth's Ruth Keeton House and Maryland Memories is $250.00/night. ***Fees are subject to change***. You will receive notice of any fee increase. A signed Addendum acknowledging any increase is preferred. However, if you fail to return the addendum and continue to use our services and pay the increased amount then Winter Growth will understand that you have agreed to the increase.

Winter Growth is entirely financially dependent on fees paid for our services. As a non-profit, our fees are set as low as possible while maintaining high quality of care. There is no accommodation in our fees to carry accounts past their due dates. **For Winter Growth to maintain financial viability, it is critical that any fees billed are submitted no later than the 15th day of the month following the month in which services were provided.**

A late fee of $25 will be assessed for payments not received by the due date. Should collection expenses be incurred by Winter Growth for unpaid accounts, this expense will be due from the resident as well as the past due fees and penalties.

Payment of Rental Fees

I _____ as the Representative of the Resident agree to have all charges incurred by the Resident that have not been paid in advance submitted within twenty-five days after the end of each calendar month.

This agreement constitutes the entire agreement between the Resident and Winter Growth, Inc.

_____ _____

Representative Signature **Date**

_____ _____

Winter Growth Representative & Title **Date**

Attachments: Housing Rules and Level of Care Fee Schedule, Residents Rights, Staffing Disclosure

Resident's Rights

A resident of an assisted living program has the right to:

1. Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Privacy, including the right to have a staff member knock on the resident's door before entering unless the staff member knows that the resident is asleep;
4. Be free from mental, verbal, sexual, and physical abuse, neglect, involuntary seclusion, and exploitation;
5. Be free from physical and chemical restraints;
6. Confidentiality;
7. Manage personal financial affairs;
8. Maintain legal counsel;
9. Attend or not attend religious services as the resident chooses, and receive visits from members of the clergy;
10. Possess and use personal clothing and other personal effects to a reasonable extent, and to have reasonable security for those effects in accordance with the assisted living program's security policy;
11. Determine dress, hair style, or other personal effects according to individual preference, unless the personal hygiene of a resident is compromised;
12. Meet or visit privately with any individual the resident chooses, subject to reasonable restrictions on visiting hours and places, which shall be posted by the assisted living manager;
13. Make suggestions, complaints, or present grievances on behalf of the resident, or others, to the assisted living manager, government agencies, or other persons without threat or fear of retaliation;
14. Receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions, or grievances the resident may have;
15. Have access to the procedures for making complaints to:
    (a) The Long-Term Care Ombudsman Program of the Department of Aging as set forth in COMAR 32.03.02,
    (b) The adult protective services of the local department of social services,
    (c) The Office of Health Care Quality of the Department, and
    (d) The protection and advocacy agencies;
16. Have access to writing instruments, stationery, and postage;
17. Receive a prompt reasonable response from an assisted living manager or staff to a personal request of the resident;
18. Receive and send correspondence without delay, and without the correspondence being opened, censored, controlled, or restricted, except on request of the resident, or written request of the resident's representative;
19. Receive notice before the resident's roommate is changed and, to the extent possible, have input into the choice of roommate;
20. Have reasonable access to the private use of a common use telephone within the facility;
21. Participate in planning the resident's service plan and medical treatment;
22. Refuse treatment after the possible consequences of refusing treatment are fully explained; and
23. Retain personal clothing and possessions as space permits with the understanding that the assisted living program may limit the number of personal possessions retained at the facility for the health and safety of other residents.
24. Share a room with a spouse if it “is feasible to do so and not medically contraindicated” and both spouses agree to this arrangement.
25. Not be assigned to do any work for the assisted living program.

If you feel that these Rights are not being honored, please contact the Howard County Long-Term Care Ombudsman Program at 410-313-6423, the Maryland Department of Aging at 1-800-AGE-DIAL, or the Office of Health Care Quality at 410-402-8217.

Attachment #1

Winter Growth, Inc.

Rules Governing Winter Growth's Assisted Living Programs.

No resident shall be physically or verbally abusive of other residents or staff.

Staff shall never be physically or verbally abusive of residents or other staff.

Further, staff shall treat all residents and other staff as individuals who are worthy of respect and value.

Residents and/or their families will inform staff when the resident is leaving the building and an approximate time of return.

Smoking is NOT allowed on the property.

You have a right to have guests, however, all guests must not disturb other residents who have retired for the evening. In addition, overnight guests are not permitted unless approved by Administration.

Level of Care and Fee Ranges for Winter Growth's Assisted Living Programs

Care Level 1 & 2 = $4,424 - $5,208

Care Level 3 = $5,180 - $6,100

Level of care is determined through the use of an assessment tool provided by the Maryland Department of Health

Attachment #2

Winter Growth, Inc.

Rules Governing Winter Growth's Memory Care Programs.

No resident shall be physically or verbally abusive of other residents or staff.

Staff shall never be physically or verbally abusive of residents or other staff.

Further, staff shall treat all residents and other staff as individuals who are worthy of respect and value.

Residents and/or their families will inform staff when the resident is leaving the building and an approximate time of return.

Smoking is NOT allowed on the property.

You have a right to have guests, however, all guests must not disturb other residents who have retired for the evening. In addition, overnight guests are not permitted unless approved by Administration.

Level of Care and Fee Ranges for Winter Growth's Memory Care Programs

Care Level 1 = $4500 - $5500

Care Level 2 = $4500 - $5500

Care Level 3 = $5500 - $7000

Level of care is determined through the use of an assessment tool provided by the Department of Health and Mental Hygiene

Attachment #2

Winter Growth, Inc.

Staffing Pattern Disclosure

As stated in your housing contract, Winter Growth's assisted living program is not a medical service. The staff caring for our residents are trained caregivers and certified nursing assistants. Those giving medications are certified medication technicians under the Nurse Practice Act of the State of Maryland.

There will be a minimum of one awake staff on duty at all times. The awake night staff is responsible to assist all residents with toileting and any other needs they may have during the overnight hours.

Every reasonable precaution has been taken to ensure our residents safety and comfort both in the design and maintenance of the building and the staffing pattern. Absolute accident prevention is not possible. *Please be aware that we are unable to provide one-on-one supervision. If you feel your family member needs this service, it can be arranged through Winter Growth at an additional fee or through an agency.*

Furniture

If residents use their own furniture it must be kept in good repair and leave space for safe movement about the room and for emergency equipment should it be needed. Furniture in an environment with walkers, wheelchairs, and cleaning equipment is at risk for harder wear than may occur in a home therefore Winter Growth cannot guarantee the degree of any wear and tear that may occur as a result of its use in our building.

Care of Valuables

It is strongly encouraged not to keep valuables, especially keepsakes at the center. The individuals that we serve in our day and residential programs are given to wandering and rummaging through drawers, etc. It is impossible to keep track of small items, such as rings and other jewelry, watches, etc.

Lockable boxes are available for resident use in the resident's room. Winter Growth staff WILL NOT have access to these boxes. IF locks need to be forced open then the family shall be responsible to pay for the replacement of said lock.

Please mark below your interest in having a lockable box.

- ☐ **YES,** I would like a lockable box installed in the room.
- ☐ **NO,** I do not want a lockable box installed in the room.

Resident or Family Representative Signature

Attachment #3

RESIDENT ASSESSMENT TOOL

To be completed by a physician, certified nurse practitioner, registered nurse, or physician assistant within 30 days prior to admission, at least annually, & within 48 hours after a significant change of condition & each nonroutine hospitalization.

If this form is completed in its entirety by the Delegating Nurse/Case Manager (DN/CM), there is no need to complete an additional nursing assessment. If anyone other than the DN/CM completes this form, the DN/CM must document their assessment on a separate form.

An assisted living program may not provide services to an individual who at the time of initial admission requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or (6) Treatment for a disease or condition which requires more than contact isolation.
An exception is provided for residents who are under the care of a licensed general hospice program.

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy
Primary Spoken Language:	☐ Male ☐ Female	

Allergies (drug, food, & environmental):

Current Medical & Mental Health Diagnoses:

Past Medical & Mental Health History:

Airborne Communicable Disease.
Test to verify the resident is free from active TB *(completed no more than 1 year prior to admission)*:
PPD Date: mm-dd-yy Result: mm OR Chest X-Ray Date: mm-dd-yy Result:
Does the resident have any active reportable airborne communicable diseases? ☐ No ☐ Yes
(specify)

Vital Signs.
BP: / Pulse: Resp: T: °F Height: ft in Weight: lbs
Pain: ☐ No ☐ Yes (specify site, cause, & treatment)

Neuro. Alert & oriented to: ☐ Person ☐ Place ☐ Time
Answers questions: ☐ Readily ☐ Slowly ☐ Inappropriately ☐ No response
Memory: ☐ Adequate ☐ Forgetful – needs reminders ☐ Significant loss – must be directed
Is there evidence of dementia? ☐ No ☐ Yes (cause)
Cognitive status exam completed? ☐ No ☐ Yes (results)
Sensation: ☐ Intact ☐ Diminished/absent (describe below)
Sleep aids: ☐ No ☐ Yes (describe below) Seizures: ☐ No ☐ Yes (describe below)
Comments:

Eyes, Ears, & Throat. ☐ Own teeth ☐ Dentures Dental hygiene: ☐ Good ☐ Fair ☐ Poor
Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind - ☐ R ☐ L
Hearing: ☐ Adequate ☐ Poor ☐ Uses corrective aid ☐ Deaf - ☐ R ☐ L
Comments:

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy

Musculoskeletal. ROM: ☐ Full ☐ Limited
Mobility: ☐ Normal ☐ Impaired → Assistive devices: ☐ No ☐ Yes (describe below)
Motor development: ☐ Head control ☐ Sits ☐ Walks ☐ Hemiparesis ☐ Tremors
ADLs: (S=self; A=assist; T=total) Eating: Bathing: Dressing:
Is the resident at an increased risk of falling or injury? ☐ No ☐ Yes (explain below)
Comments:

Skin. Intact: ☐ Yes ☐ No (if no, a wound assessment must be completed)
☐ Normal ☐ Red ☐ Rash ☐ Irritation ☐ Abrasion ☐ Other
Any skin conditions requiring treatment or monitoring? ☐ No ☐ Yes (describe condition & treatment)

Respiratory. Respirations: ☐ Regular ☐ Unlabored ☐ Irregular ☐ Labored
Breath sounds: Right (☐ Clear ☐ Rales) Left (☐ Clear ☐ Rales)
Shortness of breath: ☐ No ☐ Yes (indicate triggers below)
Respiratory treatments: ☐ None ☐ Oxygen ☐ Aerosol/nebulizer ☐ CPAP/BIPAP
Comments:

Circulatory. History: ☐ N/A ☐ Arrhythmia ☐ Hypertension ☐ Hypotension
Pulse: ☐ Regular ☐ Irregular Edema: ☐ No ☐ Yes → Pitting: ☐ No ☐ Yes
Skin: ☐ Pink ☐ Cyanotic ☐ Pale ☐ Mottled ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic
Comments:

Diet/Nutrition. ☐ Regular ☐ No added salt ☐ Diabetic/no concentrated sweets
☐ Mechanical soft ☐ Pureed ☐ Other (explain below) ☐ Supplements (explain below)
Is there any condition which may impair chewing, eating, or swallowing? ☐ No ☐ Yes (explain below)
Is there evidence of or a risk for malnutrition or dehydration? ☐ No ☐ Yes (explain below)
Is any nutritional/fluid monitoring necessary? ☐ No ☐ Yes (describe type/frequency below)
Are assistive devices needed? ☐ No ☐ Yes (explain below)
Mucous membranes: ☐ Moist ☐ Dry Skin turgor: ☐ Good ☐ Fair ☐ Poor
Comments:

Elimination.
Bowel sounds present: ☐ Yes ☐ No Constipation: ☐ No ☐ Yes Ostomies: ☐ No ☐ Yes
Bladder: ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Daily incontinence
Bowel: ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Daily incontinence
(If any incontinence, describe management techniques)
Comments:

Additional Services Required. ☐ No ☐ Yes (indicate type, frequency, & reason)
☐ Physical therapy ☐ Home health ☐ Private duty ☐ Hospice ☐ Nursing home care ☐ Other
Comments:

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy

Substance Abuse. Does the resident have a history of or current problem with the abuse of medications, drugs, alcohol, or other substances? ☐ No ☐ Yes (explain)
Comments:

Psychosocial. KEY: *N = Never O = Occasional R = Regular C = Continuous*					
	N	O	R	C	Comments
Receptive/Expressive Aphasia	☐	☐	☐	☐	
Wanders	☐	☐	☐	☐	
Depressed	☐	☐	☐	☐	
Anxious	☐	☐	☐	☐	
Agitated	☐	☐	☐	☐	
Disturbed Sleep	☐	☐	☐	☐	
Resists Care	☐	☐	☐	☐	
Disruptive Behavior	☐	☐	☐	☐	
Impaired Judgment	☐	☐	☐	☐	
Unsafe Behaviors	☐	☐	☐	☐	
Hallucinations	☐	☐	☐	☐	
Delusions	☐	☐	☐	☐	
Aggression	☐	☐	☐	☐	
Dangerous to Self or Others	☐	☐	☐	☐	*(if response is anything other than never, explain)*

Awake Overnight Staff. Based on the results of this assessment & your clinical judgment, indicate if the resident requires monitoring by awake overnight staff: ☐ Yes ☐ No (explain your reason)

Health Care Decision-Making Capacity. Indicate the resident's highest level of ability to make health care decisions:

☐ Probably can make higher level decisions *(such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, & risks of proposed treatment)*

☐ Probably can make limited decisions that require simple understanding

☐ Probably can express agreement with decisions proposed by someone else

☐ Cannot effectively participate in any kind of health care decision-making

Ability to Self-Administer Medications. Indicate the resident's ability to take his/her own medications safely & appropriately:

☐ Independently without assistance

☐ Can do so with physical assistance, reminders, or supervision only

☐ Needs to have medications administered by someone else

General Comments.

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy

Health Care Practitioner's Signature: _____ Date: mm-dd-yy

Print Name & Title:

Skip this box if you are not the Delegating Nurse/Case Manager (DN/CM).

When the DN/CM completes this entire Resident Assessment Tool, including this box, there is no need to document a separate nursing assessment.

Has a 3-way check (orders, medications, & MAR) been conducted for all of the resident's medications & treatments, including OTCs & PRNs? ☐ Yes ☐ No (explain below)

Were any discrepancies identified? ☐ No ☐ Yes (explain below)

Are medications stored appropriately? ☐ Yes ☐ No (explain below)

Has the caregiver been instructed on monitoring for drug therapy effectiveness, side effects, & drug reactions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below)

Have arrangements been made to obtain ordered labs? ☐ Yes ☐ No (explain below)

Is the resident taking any high risk drugs? ☐ No ☐ Yes (explain below)

For all high risk medications (such as hypoglycemics, anticoagulants, etc), has the caregiver received instructions on special precautions, including how & when to report problems that may occur? ☐ Yes ☐ N/A ☐ No (explain below)

Is the environment safe for the resident? ☐ Yes ☐ No (explain below)
(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture, & assistive devices.)

Comments:

DN/CM's Signature: _____ Date: mm-dd-yy

Print Name:

Six months after this assessment is completed, it must be reviewed.
If significant changes have occurred, a new assessment must be completed.
If there have been no significant changes, simply complete the information below.

Six-Month Review Conducted By:

Signature: _____ *Date:* _____

Print Name & Title: _____

Resident Name:	DOB: mm-dd-yy	Date Completed: mm-dd-yy

PRESCRIBER'S SIGNED ORDERS

(You may attach *signed* prescriber's orders as an alternative to completing this page.)

ALLERGIES (list all):

MEDICATIONS & TREATMENTS:

List all medications & treatments, including PRN, OTC, herbal, & dietary supplements.

Medication/Treatment Name	*Dose*	*Route*	*Frequency*	*Reason for Giving*	*Related Monitoring & Testing (if any)*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					

Resident Name:			DOB: mm-dd-yy	Date Completed: mm-dd-yy	
19.					
20.					
21.					
22.					
23.					
24.					
25.					

LABORATORY SERVICES:

Lab Test	*Reason*	*Frequency*
1.		
2.		
3.		
4.		
5.		
6.		

Total number of medications & treatments listed on these signed orders?

Prescriber's Signature: _____ Date: _____

Office Address: Phone: - -

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Patient's Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 ☐ Male ☐ Female

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

2 ARTIFICIAL VENTILATION

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

3 BLOOD TRANSFUSION

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____ Do not give any blood products.

4 HOSPITAL TRANSFER

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 MEDICAL WORKUP

5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

6 ANTIBIOTICS

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

8 DIALYSIS

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

9 OTHER ORDERS _____

_____

_____

_____

_____

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

INSTRUCTIONS

Completing the Form: The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician or nurse practitioner signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option. Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers.* Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR. Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians or nurse practitioners shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician or nurse practitioner shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, the physician or nurse practitioner shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician or nurse practitioner to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

How to Obtain This Form: Call 410-706-4367 or go to marylandmolst.org

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician or NP sign, cut off strip, fold, and insert in bracelet or necklace.	☐ DNR A-1 Intubate ☐ DNR A-2 Do Not Intubate ☐ DNR B Pt. Name _____ DOB _____ Phys./NP Name _____ Date _____ Phys./NP Signature _____ Phone _____