Welcome to Good Samaritan Retirement Home. We are pleased that you have chosen our community as your new home. We want your stay with us to be a memorable time for you. Your happiness and well-being are our primary concern.

The length of the orientation period depends on how well the new resident settles in. This gives the new resident time to adjust to the surrounding, routines and schedules. Family members and friends should all be aware of this adjustment period and may be asked to schedule your visits accordingly. As soon as the adjustment period passes, family members and friends can come visit during regular visiting hours.

**RESIDENT SERVICE AGREEMENT**

**PARTIES**

1. This agreement is between GOOD SAMARITAN RETIREMENT HOME and

/ .

Resident Resident’s Representative

**LEVEL OF CARE**

1. Good Samaritan Retirement Home is licensed for Level 3 Care.
2. Based on information provided by your Doctor and an assessment performed by this facility, you require:

Independent Care Intermediate Care Advanced Care Respite Care

x

|  |  |
| --- | --- |
| 1. Independent Care  * Room * Three meals a day * Emotional Security * Assistance with securing health care * Assistance in ordering supplies * Leisure Activities Advanced Care | 1. Intermediate Care  * Occasional assistance with feeding * Occasional assistance with bathing * Occasional assistance with dressing * Occasional assistance with toilet * Occasional assistance with ambulation * Supervision of self-administered medication |
| 1. Advanced Care  * Regular assistance with feeding * Regular assistance with bathing * Regular assistance with dressing * Regular assistance with toilet * Regular assistance with ambulation * Supervision of self-administered medication |  |

1. Services not provided by facility but through third party (contract) by resident or his/her representative

* Care of wounds (dressing) • Venipuncture (Lab work) • Change of Catheter
* Physical Therapy • Fitting and adjusting of ostomy appliance

**FEES**

* The monthly fee at Good Samaritan Retirement Home based on independent care as described:

Semi-Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private w/Semi Bath: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

The weekly rate at Good Samaritan Retirement Home is: Semi-Private: \_\_\_\_\_\_\_\_\_\_\_\_

Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The daily rate at Good Samaritan Retirement Home is: Semi-Private: \_\_\_\_\_\_\_\_\_\_\_\_

Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* The monthly fee for your Memory Care at Good Samaritan Retirement Home is:

Semi-Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The weekly rate for your Memory Care: Semi- Private \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The daily rate for your Memory Care: Semi- Private \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charges will be billed to the resident to be paid with the following month’s fee.

**SERVICES**

1. In consideration of your monthly payment, the facility agrees to provide the following services:
   1. A room which includes a bed, bedside table and lamp, chair, dresser, bath linens, bed linens and blinds.
   2. Meals which includes three meals a day and additional snacks:
   3. Personal care services which include assistance with eating, personal hygiene, transferring, toileting and dressing.
   4. Laundry and housekeeping services.
   5. Assistance with access to health care, social services, and scheduling of appointments.
   6. Social activities
   7. Physical assistance to residents who can self-administer medications.
   8. 24 Hour Supervision
   9. Medication Supervision

**OCCUPANCY PROVISIONS**

1. You are assigned to Bedroom #: \_\_\_\_\_\_\_\_\_\_\_\_\_
2. If it becomes necessary because of health safety or other considerations to move your bedroom or bed assignment, the facility will give you at least 5 days advance written notice. The facility will provide all labor for moving you in this circumstance:
   1. If the resident desires to move to a different room and the facility can provide this room, the resident must pay for the move.
3. If your care needs becomes greater than the facility can safely handle, it may become necessary to transfer you to another facility. You will be given a 45 day notice. Communicable illness, inability to transfer, lack of ability to feed self, full time nursing needs.
4. Locks are available for your use in securing personal belongings.
5. This facility follows security provisions to ensure your safety and well-being:
   1. Security cameras monitored 24 hours
   2. Alarmed entry and exits
   3. Requirement to notify staff when leaving facility and length of absence.
   4. Locks on resident’s room doors.
   5. Visitation Hours: 9 AM to 9 PM
6. Residents have full use of their own room and the common area of the facility.
   1. We provide many comforts to make your life more convenient.
   2. Our beauty/barber shop is open one day a week for any resident who desires this service
      1. This service is billed to your account each month. Please make an appointment only.
   3. We have a conveniently located soda machine.
   4. Snacks are provided by the kitchen at 8 pm.
   5. There is a television in the activity room and one in the living room, both with cable service. The residents decide on the programming. Cable service is available at a discounted rate of $20 per room.
7. We have a full time Activity Director who plans activities for the month and encourages the resident to participate. An activity calendar is posted monthly in the activity room.
8. The meal times are as follows: **Breakfast is served at 8 AM, Lunch at 12:00 PM and Dinner at 5 PM**. If plans are made to be away from the facility, please notify our staff in advance. Resident meals are maintained on a structured schedule and should the resident be away during one of the meals, we ask that the family member / responsible party provide that meal. If the resident has not had a meal while out, please inform us when you arrive back at the facility.

* In compliance with Chapter 429, Florida Statutes and Chapter 58A-5 of Florida Administrative Code. We will be able to serve the following therapeutic diets. Regular diet with LOW FAT / LOW CHOLESTEROL, NO CONCENTRATED SWEETS, NO ADDED SALT, PUREE, AND MECHANICAL SOFT DIET.

1. Residents may freely send or receive mail. The front office sells stamps during regular business hours.
2. Resident will be assisted with phone calls upon request. Please limit the number and length of your calls. If personal calls by long distance need to be made, the resident or his/her representative will be billed and payable by the next month’s bill.
3. The building has central heat and air, which is kept at a consistent 78° Degrees.
4. 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.
5. Smoking is only permitted in designated area and is not allowed in the facility at any time. Safe smoking assessment will be completed on residents who smoke to determine if they can be safe with smoking materials on their person. If the assessment determines that the resident is not safe, all smoking materials will be taken from them. If the smoking policy is violated, the resident will be given a 45 day notification for discharge.
6. In the event you are on leave of absence from the facility for a hospitalization, vacation or other reason, the facility will hold your bed until you give written notice you will be vacating permanently.
7. In the event of an emergency situation which could make it unsafe or unhealthy to continue to provide services at the facility, the facility will make arrangements to temporarily relocate you to one of our host facilities: Williston Rehab & Nursing Center, Dayspring Village of Mount Dora, and Tri County Hospital of Williston.
8. Monthly rents are non-refundable upon payment.
9. Resident rules:

By signing this agreement, you have indicated acknowledgement and receipt of the resident rules and agree to abide by these rules.

**POLICY AND PROCEDURE FOR RENT PAYMENT DUE DATES**

1. Rent payments are due on the same day as admission day, unless prorated to the beginning of the month.
2. Non-sufficient funds / returned check charge is $35.00

**ADMISSION & DISCHARGE POLICIES**

1. You may be discharged from the facility for the following reasons:
   1. The resident requires care of services that the provider is not licensed to provide pursuant to the applicable laws or regulations
   2. The provider has determined that the resident has a physical, psychological or psychiatric condition that requires skilled observation or treatment by a licensed professional that the prover cannot monitor between visits by the licensed professional;
   3. The resident suffers from a mental condition that may cause danger to himself/herself or others.
   4. The resident has health or personal needs that the provider cannot meet; the resident is regularly disruptive, causes unsafe conditions or physically or verbally abuses residents or staff or refuses to cooperate with the provider’s procedures for resolving such matters.
   5. The resident fails to pay charges when due and owing or braches any representation covenant, agreement or obligation of this agreement, including any special attachments added to this agreement at the time of admittance.
   6. The resident has, for health reasons, been transferred to a skilled nursing facility or hospital, has remained in such facility or facility for at least thirty (30) days and the provider determines that the resident’s absence will be of a prolonged or permanent nature, the provider may determine that the resident has been permanently transferred to such other facility.
   7. The resident displays physical or verbal threats to other residents or staff.
   8. The resident becomes infected with a communicable illness.
   9. The resident is bedridden for more than 7 consecutive days.
   10. The facility cannot accommodate the resident’s dietary needs.
2. In the event the facility the facility decides to discharge you, you will be given at least 45 day Advance notice prior to the date of discharge. In the event you are discharged because of health emergency; the facility may not be able to provide you 45 day notice.
3. If you wish to leave the facility, you are required to give 30 days prior written notice of the date you wish to terminate this agreement; however, if you are leaving due to a health emergency, 30 days advance notice is not required, although your intentions must be received in writing.
4. Discharge is executed when all the former resident’s belongings are removed from the premises. If personal property remains in the room, the daily rate will take effect.
5. Thirty (30) day notice will be given for rate increase.

**REFUND POLICY**

1. The resident or his/her representative shall be due a pro-rated refund based on the daily rate which is higher than the monthly rate for any unused portion of payment beyond the time of transfer or dismissal, provided a thirty (30) day notice has been given to the provider.
2. An exception to this policy is in the case of death or emergency placement.
3. Any outstanding charges, including the cost of damages to the residential units resulting from circumstances other than normal use, will be deducted before the refund is paid.
4. Refund will be returned within 45 days upon receipt of notice.
5. Any claims made by resident or facility must be claimed in written form. There will be 14 days to respond to any claim.

**WRITTEN NOTIFICATION OF CLAIM**

1. The resident agrees to pay for all damages to the facility property that is incurred by them.
2. Damages are assessed to those units that require repair beyond normal wear and tear
3. All documented damages shall be identified and a list given to the resident or responsible party.
4. Damages must be paid within 14 days of claim prior to being issued any refunds
5. Any claims made by the resident or facility must be claimed in written form. There will be 14 days to respond to any claim.

**RETENTION POLICY**

1. All records of resident shall be kept on file for five (5) years. Records shall be accessible to facility and department staff.
2. An admission and discharge register is kept with all pertinent information thereon. This document will be maintained and separate from the individual resident file. This is also done for temporary admission.
3. Accident and incident records are kept and available for inspection.
4. Daily Medication records are kept on file except of those residents who keep their medicines in their rooms and are not supervised.
5. Personnel records are kept and available for inspection by authorized persons.
6. All records shall be kept and made available for inspection.

**COMPLAINT AND GRIEVANCE PROCEDURES**

1. A copy of the resident’s rights is attached and incorporated by reference into this agreement. This facility will honor and respect your rights.
2. You have the right to make suggestions, register complaints or present grievances about the care or service your or another resident receives here. You may address these concerns through the following avenues:
   1. Resident Council Meeting – Held the last Thursday of every other month. This meeting is open for all residents to attend. This is an open meeting where residents can voice concerns and ideas. The Activity Director will direct this meeting, with the minutes delivered to the Administrator for follow-up.
   2. Written Grievance Form – Can be obtained at the front desk. Staff will assist you in filling one out should you need assistance
3. If your concern is directed to the Administrator, you will receive a response to your concern within 5 days, unless the situation dictates otherwise.
4. The consumer is to complete a letter stating his or her complaint or problem; this may be completed with assistance from friends, family and staff. They may inform verbally if this is what they choose.
5. The grievance is to be forwarded to the administrator of the facility or his/her appointed manager.
6. Once the grievance is received, the administrator will meet with the client to discuss the complaint.
7. Grievances received verbally or in writing will be responded to within 45 days in which a response will be explained to the individual in a language that they understand.
8. Grievances will be placed in the resident’s individual file. The log serves to maintain a record of grievances, disposition and action taken to prevent re-occurrence.
9. In the event that resolution cannot be met by the Administrator:
   1. You may also speak with the admission/support coordinator and let them know your concerns.
   2. If you are not satisfied with this, you may resubmit grievances to be re-evaluated by Owner(s) of the Facility.
   3. These will be reviewed annually with the resident and/or their family.
   4. All allegations of abuse, neglect or exploitation of the resident shall be immediately reported to the proper agency.

**ELOPEMENT POLICY & PROCEDURE**

1. POLICY: The purpose of this policy is to provide a safe and secure environment for all residents:
   1. Elopement occurs when COGNITIVELY IMPAIRED resident leaves the facility without the staff knowledge.
   2. The facility will conduct a minimum of two (2) resident elopement prevention and response drills per year. The Administrator, office staff, Kitchen, Laundry, HR Staff must participate in the drills which shall include review of the elopement policies and procedures.
2. PROCEDURES:
   1. Evaluate all residents on admission, annually and as need for risk of elopement.
   2. Obtain a current photograph of resident identified as an elopement risk and file it on the elopement log book together with the demographic data sheet.
   3. Initiate individualized intervention to all staff.
   4. Evaluate and document effectiveness of intervention and modify as needed.
3. ELOPEMENT PREVENTION:
   1. Staff should know the whereabouts of all elopement risk residents at all times.
   2. Doors should be locked at all times and checked during rounds.
   3. Residents that are high risk for elopement:
      1. Should be checked at regular intervals to ensure safety during meals and before the end of each shift. Night shift does their rounds every hour.
      2. Should be supervised when they are out of the facility.
      3. Request family for bracelet or necklace or anything that the resident can keep on themselves that has their name, address and phone number on it.
   4. Posted reminders on exit doors and entrance doors to not let anyone out
   5. Residents’ family or friends should sign out in the log book when going out, stating where they are going, expected time of return and phone number.
4. IN CASE OF AN ELOPEMENT:
   1. Caregiver who discovered that a resident is missing should notify the Administrator and/or the Supervisor/Staff in charge of the facility IMMEDIATELY.
   2. Administrator/Supervisor/Staff in charge will announce overhead –CODE YELLOW to get all staff to the office. One team searches all areas of the facility entering all rooms, checking all closets, bathrooms, under the bed, and all common areas including kitchen, library, shower rooms offices and courtyards. Another team will search immediate surroundings. One will stay with the residents.
   3. If resident is not found within 30 minutes, the Administrator, the Supervisor or the staff in charge will:
      1. Call 911, be able to give detailed description of the missing resident.
      2. Inform Administrator if not informed
      3. Inform family/resident representative and health care provider
      4. Pull out elopement log book to get picture of missing resident.
   4. When resident is found, the Administrator/the Supervisor/ Staff in charge:
      1. Will notify all parties: family, police, Physician and Administrator.
      2. Check the resident to determine if any treatment is required.
      3. Complete incident report and send report to the state as required.
   5. Administrator and staff will review and revise policy and procedures as needed.
5. SEARCH PARTY ASSIGNMENTS:
   1. 7 AM – 7 PM SHIFT
      1. Administrator/Supervisor/Staff in charge is the search party Commander.
      2. Kitchen staff will search kitchen area and west courtyard.
      3. Laundry staff will search laundry area and east courtyard.
      4. Receptionist will check camera/liaison between family, facility and police.
      5. Two caregivers, the Housekeeper and Activity Director will check the rooms and will be assigned which wing. Checked rooms will be locked and a pillow will be place on the door to mark a thoroughly searched room.
      6. One staff will stay with the resident.
   2. 7 PM – 7 AM SHIFT
      1. Staff in charge is the search party Commander and will notify Administrator at once.
      2. Staff in charge will call live-in staff for assistance.
      3. Two staff will search all rooms. Checked rooms will be locked and a pillow will be places on the door to mark a thoroughly searched room.
      4. One staff will search kitchen area, laundry area and the east and west courtyard.
      5. One will stay with the residents.

**MISCELLANEOUS PROVISIONS**

1. Good Samaritan Retirement Home is responsible for arranging for or overseeing your care and for contracting for services including equipment and supplies not provided by the facility. Payment for said services and equipment are resident responsibility.
2. Good Samaritan Retirement Home is responsible for monitoring your health status.
3. Fire drills will be conducted annually and full evacuation drills will be conducted annually. You are expected to participate in these drills for your own safety.
4. The resident must furnish the provider a report of a physical examination done within thirty (30) days prior to admission. A form including the necessary information will be provided by this facility for the convenience of the resident.
5. This facility is not affiliated with any specific religious organization, but is committed to Christian principles or care and conduct for management, staff and residents.
6. Staff members are not allowed to accept gifts or tips from residents or their families. Please do not embarrass the staff by offering tips or gifts. This places them in an awkward position. Personal favors are not part of the staff member’s normal duties. The Activities Director will assist with personal shopping for the residents upon request.
7. The facility will handle up to $200 of your finances for you if you are unable.
8. Payments of all fees are the responsibility of the resident.
9. We recommend you have your attorney review this agreement thoroughly.

IN WITNESS WHEREOF, THE PARTIES HAVE EXECUTED THIS AGREEMENT on this \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_.

THE ABOVE TERMS ARE HEREBY AGREED TO AS INDICATED BY THE SIGNATURES BELOW.

In the event resident is not able to act for himself/herself, a copy or power of attorney shall be attached, or a statement assigning responsibility to his/her representative.

RESIDENT AGREED THAT HE/SHE HAS READ THE CONTRACT AND UNDERSTANDS OR THE REPRESENTATIVE HAS READ AND UNDERSTANDS:

RESIDENT OR RESPONSIBLE PARTY GOOD SAMARITAN RETIREMENT HOME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(SIGNATURE) (SIGNATURE)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT NAME) (PRINTED NAME)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE DATE

**RESIDENT’S POLICIES AND PROCEDURES**

1. Residents are required to submit a physical examination by a Medical Doctor certifying them free of any communicable diseases and are able to live with assistance.
2. An inventory check-in and check-out form will be signed by the resident upon admission and upon termination of stay.
3. Residents in private rooms are allowed to bring their own furniture, or they may fully furnish their room.
4. All personal belongings of residents will be inventoried upon admission. All clothing should be properly marked.
5. The management can be responsible for any belongings or money by resident’s request only.
6. The residents are encouraged not to smoke, but if they chose to do so, they may only smoke in the patio. Smoking is definitely not allowed in the bedroom or bathroom.
7. Firearms of any kind are not allowed in the premises at any time.
8. Residents in semi-private rooms are allowed to bring only one piece of furniture, one that should not occupy too much space or inconvenience his or her roommate.
9. The first month rents and the $200.00 retainer fee should be paid in full upon signing the contract.
10. Residents are requested to report any maintenance work need in their respective room to the administrator.
11. Residents are allowed to invite visitors for lunch as long as prior arrangement is made with the Dietary Department. Lunch for a guest is $5.00 per meal. Please pre-pay when guest meal arrangement is made.
12. The licensure report for the last five (5) years is retained for public inspection. The facility will provide upon request a copy of the inspection report to any applicant.
13. The last inspection report, the current license, the city license, the District Long Term Care Ombudsman Council poster, and the Resident’s Bill of Rights are posted in the hallway near the dining room area.

The following confirms that I have received a copy of the resident rights

And, the resident’s rule

BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(SIGNATURE)

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINTED NAME)

Good Samaritan Retirement Home is a non-smoking environment

**ADMISSION FEES**

RESIDENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following procedure will apply with a new resident moves into Good Samaritan Retirement Home, Williston, FL.

Rental Fees will be pro-rated from the date of move-in. If resident is moving in/after the 25th of the month, they will be charged for the remainder of the month and will pay for the following month.

Monthly Rental Fee $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of days remaining in the month \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at $\_\_\_\_\_\_\_\_\_\_\_\_\_= $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicable Fee $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Monthly Fee if applicable $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident/POA Administrator

**PERSONAL EFFECTS INVENTORY**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family or Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| QTY | LADIES’ ARTICLES | QTY | MEN’S ARTICLES |
|  | Blouses |  | Belt/Suspenders |
|  | Brassieres |  | Gloves |
|  | Coats |  | Handkerchiefs |
|  | Dresses |  | Hats |
|  | Foundation (Panties) |  | Jackets/Sports Coats |
|  | Furs |  | Pajamas |
|  | Gloves |  | Robes |
|  | Handkerchiefs |  | Shaving Kits |
|  | Hats |  | Shoes |
|  | Hose |  | Shirts |
|  | House coats/robes |  | Slacks |
|  | House slippers |  | Slippers |
|  | Nightgown |  | Socks |
|  | Overnight case |  | Suits |
|  | Pocket Books |  | Ties |
|  | Shoes |  | Topcoats |
|  | Slips |  | Travel Bags |
|  | Suits |  | Undershirts |
|  | Other |  | Other |
|  | Other |  | Other |
|  | Other |  | Other |
|  | Other |  | Other |

Extra Items/Remarks:

ITEMS OF SPECIFIC VALUE: ACQUIRED AFTER ORIGNIAL ENTRY

DESCRIPTION VALUE DATE ITEM HOW REC’D

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REMARKS:

CERTIFICATE OF RECEIPT

ON ADMISSION ON DISCHARGE

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident/Responsible Party Resident/Responsible Party

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Date Title Date

Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement that Resident and Facility Received Important**

**Phone Numbers and Information**

In signing this statement, I acknowledge that the staff at Good Samaritan Retirement Home has given me all information about:

* Resident policy
* Resident Bill of Rights
* Elder Abuse Hotline
* Emergency Phone Number
* Long-Term Care Ombudsman Council Packet
* Human Rights Advocacy Council Toll-Free Number
* Department of Elder Affairs Number
* Advocacy Center for Person with Disabilities Number
* Agency for Health Care Administration Number

Admission Date:

Signature of Resident/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Admitting Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent Form for Publication

I, , give Good Samaritan Retirement Home the permission to use pictures that I am included in to be posted in frames around the home as well as possible being used in publications such as: Brochures, pamphlet, advertising, newsletters or any other type of publication that the *Good Samaritan Retirement Home* publishes.

Resident:

Date:

Staff:

**Acknowledgement of Privacy Practices**

I give Good Samaritan Retirement Home my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Good Samaritan Retirement Home *Notice of Privacy Practice* (for a complete description of uses and disclosures) before signing this consent. I also may refuse to sign acknowledgement if I wish.

I understand that Good Samaritan Retirement Home has the right to change their privacy practices and that I may obtain any revised notices at Good Samaritan Retirement Home.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Good Samaritan Retirement Home is not required to agree to the request. If Good Samaritan Retirement Home agrees to my requested restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature of Resident/Responsible Party Date

HIPAA Acknowledgement of Receipt of the *Notice of Privacy Practice*s

*This form does not constitute legal advice and covers only Federal, not State law*

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally kept properly confidential. This ACT gives you, the patient, significant new right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations;

* TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
* PAYEMENT means such activities as obtaining and reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill of your visit to your insurance company for payment.
* HEALTH CARE OPERATIONS include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

* The right to request restriction on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we so agree to a restriction, we must abide by it unless you agree in writing to remove it.
* The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
* The right to inspect and copy your protected health information.
* The right to amend your protected health information.
* The right to receive an accounting of disclosures or protected health information
* The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
* The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy with respect to protected health information.

This notice is effective as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make all new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you felt that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information For more information about HIPAA or to file a complaint:

Privacy Officer The US Department of Health & Human Services

Good Samaritan Retirement Home Office of Civil Rights

507 S.E. 1st Avenue 200 Independence Ave, S.W.

Williston, FL 32696 Washington, DC 20201

Tel. # 352-528-2722 Tel. # 202-619-0257

Toll Free # 1-877-696-6775

**BENEFICIARY DESIGNATION**

In the event of my death while a resident of this facility, all refunds, funds and property held in trust shall be returned to my personal representative if one has been appointed at the time the facility disburses such funds.

If a personal representative has not been appointed at the time the facility disburses such funds, the Administrator is authorized to return all refunds, funds and other property to my spouse or to

, an adult next of kin.

In the event I do not have a spouse or adult next of kin, or such person cannot be located, the fund due my estate shall be placed in an interest bearing account and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Federal Probate Code.

Resident and/or Legal Representative Signature Signed Date

Beneficiary Designation –Full Name – Address and Phone Number

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Funds and property as specified above were returned to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Receiving Date Received

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Facility Representative Date Received

**TRANSPORTATION RELEASE FORM**

I understand that Good Samaritan Retirement Home provides transportation for residents for Doctor’s appointments and social activities and, hereby, provide Good Samaritan Retirement Home with permission to transport the resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, via company or employee vehicles. I understand the transportation for residents – which included (1) moving the resident to or from their resident via walking or wheelchair, (2) transferring into or from the vehicle, and (3) moving the resident to or from their destination – increase the risk of serious injury to the resident. I understand these increased risks and release Good Samaritan Retirement Home of liability associated with injury resulting from the transportation of residents.

Residents Signature or Responsible Party Date Signed

**PHARMACY OF CHOICE**

Good Samaritan Retirement home has chosen to provide pharmacy services for the residents. I authorize Good Samaritan Retirement Home to coordinate pharmacy services on my behalf. I assume financial responsibility for all physician-ordered medicine.

**[ ]**

I/my responsible party, will use a pharmacy which does not usually service the community. I assume full responsibility for the timely pick-up, payment and delivery for all continuous PRN and stat medication

**[ ]**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Signature Responsible Party for the Resident

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

**BED HOLD POLICY**

Good Samaritan Retirement Home agrees to reserve a bed for a resident who is temporarily admitted to a nursing home or health care facility or during any other temporary absence. The resident or responsible party shall notify Good Samaritan Retirement Home in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, a full rate of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be charged by Good Samaritan Retirement home to hold the bed.

PROVIDER RESIDENT OR FOR THE RESIDENT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Administrator or Manager Resident

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Legal Representative of Resident

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**HALF SLIDE RAIL AUTHORIZATION FORM**

Name of Resident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assisted living Facility Law permits the use of physical restraints limited to half-bed rail and only upon written order by the resident’s physician who shall review the order bi-annually, and the consent of the resident or the resident’s representative (58A-5.0182(6)(b), FAC)

If deemed necessary and approved by the above named Resident’s Health Care Provider, half side rails may be place on the Resident’s bed to assist with the turning and positioning while sleeping or resting

Please indicate below whether or not you grant permission for the use of half rails **only** as ordered by a physician

\_\_\_\_\_\_ YES, permission is granted.

\_\_\_\_\_\_ NO, permission is not granted

**DNR / ADVANCED DIRECTIVE Policy and Procedure**

According to the Statute 64E-2.031, an EMT or Paramedic is the only one that can honor a Do Not Resuscitate Order (DNRO). If a resident has a DNRO on file and the cause arise, Basic Life Support (CPR) will be administered by the staff of Good Samaritan Retirement Home until one of the above listed health personnel arrive at which time the DNRO will be supplied to them. (Exception – Hospice patients will be subject to Hospice Guideline for DNRO)

This is to certify that I have read and understand the above addendum to the contract of Good Samaritan Retirement Home.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident/Responsible Party Facility Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Resident Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

**DIETARY SLIP**

Name of Resident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet Ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D,O,P. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent to Assistance with Medication by Unlicensed Personnel**

Assisted Living Facility (ALF) law permits an ALF to administer medications to residents if the facility has a licensed nurse on staff, or to assist residents with self-administered medications (400.4256, F.S.).

Under ALF law, “assistance with self-administered medications” means that trained unlicensed staff can help a person to self-administer their medications by performing such tasks as bringing the resident’s medication to the resident; reading a prescription label and removing a prescribed amount of medication from the container; placing the medication in the resident’s hand or in another container and helping the resident to lift it to their mouth; applying topical medications; returning the medication to storage; and keeping a record of medications that the resident has self-administered.

“Assistance with self-administration” does not include calculating medication dosages; putting medication in a resident’s mouth; preparing or administering injections; applying rectal, urethral, or vaginal preparations; administering medications by way of a tube inserted in a body cavity; administering parenteral preparations; conducting irrigations or using debriding agents for treating the skin conditions; administering medications through intermittent positive pressure breathing machines or nebulizers; or performing any medication task which requires judgement or discretion. The unlicensed individual who will be providing “assistance” must have completed a four hour training course and has demonstrated their ability to assist you.

In Good Samaritan Retirement Home, staff assisting residents with self-administration will not be overseen by a licensed nurse.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has been informed of this policy and agree to have trained and unlicensed facility staff provide me with assistance in self-administering my medication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (resident or representative) Date

**RESIDENT BILL OF RIGHTS**

**No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility has the right to:**

1. Live in a safe and decent living environment, free from abuse and neglect.
2. Be treated with consideration and respect and with due recognition of personal dignity.
3. Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
4. Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone and visiting with any person of his or her choice, at any time between the hours of 9 AM and 9 PM at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
5. Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction with the community.
6. Manage his or her financial affairs unless the resident or, if applicable, the resident’s representative, designee, surrogate, guardian or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s.429.27
7. Share a room with his or her spouse if both are resident of the facility.
8. Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
9. Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
10. Access to adequate and appropriate health care consistent with established and recognized standards within the community.
11. At least 45 days’ notice of relocation or termination of residency from the facility unless for medical reasons the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to the other residents. In the case of a resident who has been adjudicated, mentally incapacitated, the guardian shall be given at least 45 days’ notice of a non-emergency relocation or residency termination. Reasons for relocation shall be set forth in writing in order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
12. Present grievances and recommend changes in policy, procedures and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents’ exercise of this right. This right includes access to ombudsman, volunteers, and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest group.

**RESIDENT POLICY AND PROCEDURE**

1. Residents are required to submit a physical examination by a Medical Doctor certifying them free of any communicable diseases and are able to live with assistance.
2. An inventory check-in and check-out form will be signed by the resident upon admission and upon termination of stay.
3. Residents in private rooms are allowed to bring their own furniture, or they may fully furnish their room.
4. All personal belongings of residents will be inventoried upon admission. All clothing should be properly marked.
5. The management can be responsible for any belongings or money by resident’s request only.
6. The residents are encouraged not to smoke, but if they chose to do so, they may only smoke in the patio. Smoking is definitely not allowed in the bedroom or bathroom.
7. Firearms of any kind are not allowed in the premises at any time.
8. Residents in semi-private rooms are allowed to bring only one piece of furniture, one that should not occupy too much space or inconvenience his or her roommate.
9. The first month rents and the $200.00 retainer fee should be paid in full upon signing the contract.
10. Residents are requested to report any maintenance work need in their respective room to the administrator.
11. Residents are allowed to invite visitors for lunch as long as prior arrangement is made with the Dietary Department. Lunch for a guest is $5.00 per meal. Please pre-pay when guest meal arrangement is made.
12. The licensure report for the last five (5) years is retained for public inspection. The facility will provide upon request a copy of the inspection report to any applicant.
13. The last inspection report, the current license, the city license, the District Long Term Care Ombudsman Council poster, and the Resident’s Bill of Rights are posted in the hallway near the dining room area.

**IMPORTANT NUMBERS**

* District Long Term Care Ombudsman Council:…1-888-831-0404
* Advocacy Center for Persons with Disabilities:…1-800-342-0823
* Florida Local Advocacy Council: ……………...1-800-342-0825
* Agency Consumer Hotline:……………………...1-888-419-3456
* Statewide Toll Free Florida Abuse Hotline:…….1-800-962-2873
* Human Right Advocacy Council:………………1-800-342-0825
* Department of Elder Affairs…………………….1-850-414-2000
* Agency for Health Care Administration:………..1-888-419-2456