

Admission Packet

Resident Name:

Admission Date:

Nananom Assisted Living

Resident Contacts for Coordination of Communication

Resident's Name: _____

Sex: M/F Marital Status: _____ Date of Admission: _____

Medicare number: _____ Medicaid # _____

1st Emergency contact: _____ Relationship: _____

Address: _____ Phone #: _____

2nd Emergency contact: _____ Relationship: _____

Address: _____ Phone #: _____

Representative or POA: _____ Phone #: _____

Fiduciary/Guardian: _____ Phone #: _____

Case Manager (if applicable): _____ Phone #: _____

Primary Care Provider: _____ Phone #: _____

Home health: _____ Phone #: _____

Hospice: _____ Phone #: _____

Therapist: _____ Phone #: _____

Family Member: _____ Phone #: _____

Other: _____ Phone #: _____

Other: _____ Phone #: _____

Part

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Nananom Assisted Living

Resident Admission Checklist

Resident's Name: _____ Date: _____

The following documents are received/completed and placed in the resident's file. A copy should also be given to the resident/representative.

Date Completed:		Initial:
_____	Pre-Admission Determination within 90 days (sign before day of admit)	_____
_____	Determination Continued Residency within 30 days	_____
_____	Client Information Face Sheet (day of admit or before)	_____
_____	Proof of Freedom from TB (day of admit or before)	_____
_____	Doctor's Order initiated (day of admit)	_____
_____	Service Plan (Started day of admit, signed by RN within 14 days)	_____
_____	Residency Agreement (day of admit or within 5 days)	_____
_____	Physician's Orders for medications and treatments. This includes authorization to administer medications and treatments, special diets, orders to put meds in food or drink (if indicated), limitations on activities (if indicated), any other special considerations noted by the doctor or the facility Manager (day of admit or before).	_____
_____	Advance Directives Documentation	_____
_____	Orientation (within 24 hours of admittance)	_____
_____	History & Physical, if available (day of admit or before)	_____
_____	Admit orders from ALTCS, if applicable (day of admit or before)	_____
_____	Facility Intake Packet: <u>Resident Rights, House Rules, Receipt of ADHS mandated phone numbers, information on Health Care Directives, food preferences, Evacuation Plan Orientation</u> (day of admit within 24 hrs.)	_____
_____	For ALTCS members only: Did you receive the Case Manager's full assessment (approx. 20 pages) and Assessment tool (UAT) (Prior to Admit) () N/A	_____
_____	ALTCS members: Did you receive a Residency Placement Agreement? () N/A	_____
_____	Referral Agency with Disclosure Agreement (if applicable) () N/A	_____

I/We hereby acknowledged that we receive copies of above documents.

Resident/Representative Signature: _____ Date: _____

Resident or Representative Name: _____

Manager/Designee: _____ Date: _____

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Pre-Admission Determination

Nananom Assisted Living screens and assesses individuals for admission into our assisted living facility to ensure we can provide the qualified staff and services needed. We are a facility exclusively for end of life, comfort care purposes. Each resident is required to have a hospice agency to manage their medical issues. Nananom Assisted Living is NOT a medical facility and provides short term end of life care (30-45 days).

Adhering to Arizona Department of Health Services Division of Assisted Living licensing (ADHS) definitions, rules, and regulations, we need to obtain a document and orders prior to allowing an individual to move in and receive services.

ADHS requires every individual accepted into an assisted living facility to have documentation that is dated within 90 calendar days before an individual is accepted that states the level of care an individual is expected to receive, as well as the determination that the individual does or does not need certain services provided.

Resident's Name _____ DOB _____

Has been assessed to be appropriate for assisted living and Nananom Assisted Living has the staff and qualifications available to provide the services and care needed. Please see our assisted living facility Scope of Services attached. **Please review the information below, sign and date and return this form to us as soon as possible. We are unable to accept the resident to our facility until we receive this form.**

Expected Level of Care:

- SUPERVISORY CARE SERVICES
- PERSONAL CARE SERVICES
- DIRECTED CARE SERVICES**

Please Check Yes or No	YES	NO
Continuous 24-hour Medical Services (acute care):		
Continuous 24-hour Intermittent Nursing Services:		
Intermittent Nursing Services: If yes, the agency providing the service is: _____ Phone: _____		
Restraints (Physical or medication):		
Continuous Behavioral Health Services:		

Signature of Physician, Registered Nurse Practitioner,
Register Nurse, or Physician's Assistant

Date

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Determination for Residency to Continue in the Facility

Arizona State Regulation R9-10-814.B requires the resident’s Primary Care Provider (PCP) to review the facility’s Scope of Services and agrees the resident’s needs can be met by the assisted living facility’s Scope of Services. The PCP is required to examine the resident at the onset of the condition or within 30 calendar days before acceptance and at least once every six (6) months throughout the duration of the resident’s condition(s).

Resident’s Name: _____ DOB: _____

The resident/representative _____ requests that this resident be accepted by the facility or remains in the facility because of one or more of the following conditions:

_____ The resident is unable to ambulate even with assistance and is confined to a bed or a chair.

_____ The resident has a stage 3 or 4 pressure sore, as determined by a registered nurse or medical practitioner. If checked, Hospice or Home Health has been ordered by the physician for this person’s woundcare: _____

Resident/Representative’s Signature: _____ Date: _____

Primary Care Provider’s Determination of Residency

I have examined the resident at the onset of their condition(s) or within 30 days of acceptance into the facility.

Date Last Examined: _____

I have reviewed the facility’s Scope of Services (see attached) and have determined that the resident’s needs for the above condition(s) can be met by this assisted living facility and I authorize this resident to remain in this facility.

PCP Signature: _____ Date: _____

Phone Number: _____ Email: _____

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Consent and Authorization of Resident Photo Release

Resident's Name: _____ Date: _____

Specific authorization is required for the following and must be agreed to by either the resident or their legal representative.

I, _____ hereby consent and
Resident/Representative

authorize Nananom Assisted Living to take and release photographs of the above resident. I agree to permit photographs to be used for the following purposes by circling either **Yes** or **No**.

Yes No To memorialize the resident's participation in activities, parties or event to be viewed by the public.

Yes No To assist in helping to locate the resident in the event of an unauthorized absence from the community or while participating in off-site activities.

Yes No To reproduce and use in a variety of public relations mediums, such as, newspapers or editorial use, advertising and promoting, audiovisual presentations, displays, videotaping, exhibition materials, education and research purposes.

Yes No To post photographs on bulletin boards, shadowboxes, scrapbooks, websites, Face Book or other placements for advertising and promotional purposes.

Yes No In addition, photos will be taken of each resident and will be kept confidential. The photos will be placed in the resident's record in the facility.

Resident/Representative Signature: _____ Date: _____

Manager/Designee Signature: _____ Date: _____

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Acknowledgement

Dear Resident/Family Member/Representative/Guardian:

The Arizona Department of Health Services requires that any person residing in an assisted living facility or group home must have a TB test at the time of admission, a health care needs assessment and a Service Plan done within 14 days of admission to the home or facility. The average costs of these services which are usually done by a registered nurse are _____ for TB test and _____ for Service Plans. The TB test must be done yearly, and the frequency of the service plan depends on the individual resident's level of care:

Directed Care – Every 3 months.

Personal Care – Every 6 months.

Supervisory Care – Every 12 months.

These costs are not included in the monthly care fee. They are billed directly to the resident or his/her financial representative. ALTCS residents are exempt for service plan fee.

**All residents at Nananom Assisted Living are on hospice services. Hospice covers TB testing prior to admission and the Hospice Case Manager (RN) signs the Service Plan on admission. The length of stay at Nananom Assisted Living is up to 30-45 days.

A copy of the Service Plan must be kept in the resident's file and is available for your review.

Resident/Representative Signature: _____

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Initial In-House Assessment
(Optional Pre-Service Plan Assessment)

This form is to be completed by the manager during the first couple days of admission. The initial assessment maybe utilized by the individual completing the care plan if desired.

Resident Name: _____ Date: _____

Projected Date of Admission: _____

Current Weight: _____ Height: _____

General Assessment of Functional Level

Dietary:

Special Diets: _____

Food Allergies: _____

Food Preferences: _____

Food Dislikes/Intolerances: _____

What level of assistance is required for eating?

Independent: () Yes () No Cueing: () Yes () No Dependent: () Yes () No

Does the resident use or might he/she benefit from specifically adapted eating utensils?

Other Information: _____

Ambulation and Transfers:

Is the resident ambulatory? () Yes () No

Does the resident use a walker? () Yes () No Cane: () Yes () No

Wheelchair: () Yes () No

Other assistive devices: _____

What level of assistance is required for ambulation: _____

What level of assistance is required for transfers: _____

Problems and other information: _____

Toileting:

Is the resident incontinent of bowel? () Yes () No Bladder? () Yes () No

Does the resident have a catheter? () Yes () No Ostomy? () Yes () No

Does the Physician require any special monitoring of bowel or bladder? () Yes () No

Other information: _____

What is the level of assistance required for toileting?

Independent: () Yes () No Cuing: () Yes () No Dependent: () Yes () No

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Other Activities of Daily Living:

What level of assistance is required for the following ADL's?

Dressing: Independent: () Yes () No Cuing: () Yes () No Dependent: () Yes () No

Grooming/Personal Hygiene:

Bathing: Independent: () Yes () No Cuing: () Yes () No Dependent: () Yes () No

Others: _____

Notes: _____

Recreation/Hobbies:

Does the resident have any hobbies? () Yes () No

If yes, what hobbies? _____

Does the resident do any special for recreation? () Yes () No

If yes, what recreation? _____

Special Needs for:

Medical Status:

Diagnosis: _____

Observed Health Problems: _____

Are there any problems with medication and/or treatments? _____

If so, what? _____

Does the resident wear glasses? () Yes () No

Does the resident wear a hearing aid? () Yes () No If yes, type? _____

Does the resident have difficulty speaking? () Yes () No

Notes on resident's health: _____

Mental Health:

Does the resident show signs of agitation? () Yes () No

Confusion? () Yes () No Combativeness? () Yes () No

Depression? () Yes () No Anxiety? () Yes () No Paranoia? () Yes () No

Wandering? () Yes () No Retardation? () Yes () No

Other? _____

Social Status:

Does the resident interact with others in the home? () Yes () No

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Outside of the home? () Yes () No

What activities does the resident take part in? _____

What social needs does this person appear to have? _____

Additional special needs not previously addressed: _____

Other Information: _____

Vital Signs:

Blood Pressure: _____

Is this value normal? () Yes () No

Temperature: _____

Is this value normal? () Yes () No

Pulse: _____

Is this value normal? () Yes () No

Respirations: _____

Is this value normal? () Yes () No

Notes: _____

Additional observations/concerns/comments:

Initial Assessment Completed by: _____

Title: _____ Date: _____

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Health Care Directives Policy and Procedure

Resident's Name: _____

Policy: Health Care Directives

Purpose: Upon move-in to Nananom Assisted Living, all residents are given a Health Care Directives document and they are provided with information indicating their Advance Directives instructions. Adults who can make health care decisions generally have the right to say “yes” or “no” to medical treatment. They also have the right to prepare a document known as an “Advance Directive”. This document tells what medical treatment the individual would want in the event they are unable to communicate that decision due to illness or injury. This will also ensure Nananom Assisted Living staff members are informed about the existence and terms of the resident's Advance Directives.

Procedure:

1. Nananom Assisted Living shall provide residents with information about advance directives, in accordance with Arizona Department of Health Services (ADHS) rules and regulations.
2. If an Advance Directive(s) exists, the manager/designee shall request a copy from the resident/representative and ensure it is placed in the resident's records. The original Advance Directive(s) shall be kept with the resident/representative.
3. The manager/designee shall ask the resident/representative for a copy of any revisions or revocations made to the Advance Directive(s) during admittance to Nananom Assisted Living.
4. When individuals are incapacitated and unable to receive information due to a mental disorder or an incapacitating condition, or if they are unable to articulate whether they have an Advance Directive, information may be given to the family or surrogate instead. However, the information must be given to the individual directly once he/she is no longer incapacitated.
5. Whenever family wishes vary from those expressed by the resident in a valid Advance Directive, the wishes of the resident will be followed.
6. As prohibited by federal and state law, Nananom Assisted Living shall not require residents to complete any Advance Directive forms, as a prerequisite for service. This does not mean the facility is required to provide care that conflicts with an existing Advance Directive.
7. Nananom Assisted Living recognizes that when the resident is not legally responsible, the surrogate decision maker has the right to refuse care, treatment and services on the resident's behalf.
8. Nananom Assisted Living recognizes the importance of residents participating in planning their care and their right to accept or refuse services, care or treatment.
9. Nananom Assisted Living shall provide care according to the Service Plan established by the physician, the hospice agency and in consultation with the resident/representative when an Advance Directive does not exist.
10. Nananom Assisted Living recognizes the resident has the right to revoke or change an Advance Directive at any time.
11. Nananom Assisted Living shall document any changes in Advance Directives in the resident's record and communicate such changes to relevant caregivers and staff.
12. Nananom Assisted Living staff shall not act as a witness for any Advance Directives.

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13. Nananom Assisted Living shall advise its staff to initiate CPR only if the resident does not have a legally signed order should a Cardiopulmonary Arrest occur. Our staff shall initiate CPR and notify 911 only if the resident/representative have made it known CPR is their preference. If CPR is started, the resident's PCP will be notified of the situation and that emergency services have been activated.

By signing below, the signer has read and understands this statement:

I acknowledge that the above information about Health Care Advance Directives have been explained to me.

Resident/Representative Signature: _____ Date: _____

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Emergency Form

Resident's Name: _____ Referral Source: _____

DOB: _____ SS #: _____ Medicare #: _____

Religion: _____ Allergies: _____

Payer: _____

Next of Kin: _____

Tel. #: _____ Address: _____

Diet: _____

Physician: _____

Tel. #: _____ Fax #: _____

Address: _____

Medication:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diagnosis (On file): _____

Emergency Remarks: _____

Mortuary: _____

Tel. #: _____

Address: _____

Code Status: _____

Prepared by: _____ Date: _____

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Resident Face Sheet

Resident's Name: _____ Referral Source: _____

Previous Address: _____ City: _____ State: _____ Zip : _____

Social Security Number: _____ Date of Birth: _____

Sex: () M () F Marital Status: _____ Date of Admission: _____

Code Status: _____

Medicare #: _____ Medicaid #: _____

Resident's Case Manager (if applicable): _____ Phone #: _____

Primary Care Provider: _____ Phone #: _____

Hospice: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone #: _____

Resident's Representative/POA: _____ Phone #: _____

2nd Emergency Contact: _____ Phone #: _____

Religious Preference: _____ Name of Clergy: _____

Phone #: _____

Pharmacy: _____ Phone #: _____

Mortuary: _____ Phone #: _____

Medical Equipment Company: _____ Phone #: _____

Diagnosis: _____

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Admission Data (Resident Information)

Name: _____ Other Name: _____ (if any)

Last Address: _____

Social Security #: _____ Date of Birth: _____

Sex: () Female () Male

Admission Date: _____ Time: _____

Source of Referral: _____ Phone #: _____

Referral Disclosure Form Completed: () Yes () No () N/A

Discharging Facility: _____

Address: _____

Contact: _____ Phone No.: _____

Representative/Guardian/POA (Required at DLC otherwise optional)

Name: _____ Phone #: _____

Address: _____

Physician – PCP (Required)

Name: _____ Phone #: _____

Address: _____

Case Manager (Optional)

Name: _____ Phone #: _____

Address: _____

Emergency Contact (Required)

Name: _____ Phone #: _____

Address: _____

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Payee:

Representative Guardian POA Emergency Contact Resident Friend

Name: _____

Phone No.: _____ Email: _____

Address: _____

Other Medical Specialty Services:

Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

AHCCCS: Yes No N/A

If yes, AHCCCS #: _____

Contract Provider: _____ Phone #: _____

Contact Person: _____ Email _____

Hospice:

Hospice Agency: _____ Phone #: _____

Contact Person: _____ Email: _____

Pharmacy:

Name: _____

Phone #: _____ Fax #: _____

Address: _____

Religious Preference: _____

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Clergy Name: _____ Phone #: _____

Family:

Name: _____ Relation: _____

Phone #: _____ Email: _____

Name: _____ Relation: _____

Phone #: _____ Email: _____

Name: _____ Relation: _____

Phone #: _____ Email: _____

Does this resident have a Health Care Directive? () Yes () No

If no, do you wish to have assistance in obtaining one? () Yes () No

Note: Health Care Directives may be called Living Wills, Advance Directives or Do Not Resuscitate Orders

Does this resident have a General Consent or Informed Consent? () Yes () No

Termination of Residency: *(Required once residency is terminated)*

Date: _____ Time: _____

(If relocating to a different facility complete below)

New Place of Residency: _____

Phone #: _____ Fax #: _____

Address: _____

Resident/Representative's Signature: _____

Date: _____

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Resident Emergency Orientation

The following resident has been oriented to the Emergency Policies and Procedures of Nananom Assisted Living within **twenty-four hours** of admission. This orientation includes but is not limited to:

- ✓ Exit and Entry Doors
- ✓ Opening and Closing Windows
- ✓ Smoke Alarm Location and Use
- ✓ Phone Location and Use
- ✓ Location of Evacuation Maps in the Home
- ✓ Evacuation Procedures Including Assembly Areas
- ✓ Emergency Phone Numbers
- ✓ Fire Drill Participation
- ✓ Disaster Relocation or Evacuation Plan

I, _____ acknowledge that I have been oriented in these areas of the Emergency Policy and Procedures **within 24 hours** of admission.

Resident/Representative Signature: _____ Date: _____

Manager/Designee Signature: _____ Date: _____

SS#

ID

Driver's License

(Please Attach Copy)

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Residency Agreement

The purpose of this admission contract is to clarify the responsibilities between the facility, resident and resident representative who is legally empowered to incur, discharge, and conduct the personal and legal affairs of all parties involved with the resident's name stated in this contract.

The parties to this contract are:

- a. Nananom Assisted Living, hereafter, “**The Home or Facility**”
- b. _____, hereafter, “**The Resident/s**”
- c. _____, hereafter, “**The Responsible Party**”

Non Discrimination Policy:

Nananom Assisted Living does not, and always has, admitted persons regardless of race, creed, color, religious persuasion or sexual preferences. Admissions or discharges will not be based upon such factors.

Confidentiality:

Information obtained for medical and admission records will remain confidential. The use of this information shall be limited to the staff of the facility, the home, as well as authorized individuals from surveying or accrediting organizations. At no time may clinical records or other confidential information relative to the resident be utilized in any way other than that accepted as essential for the provision of care, and the billing of such care.

The basic monthly fee is not set and is based on the type and amount of care required by the resident as described on the Preliminary Admission and Resident Health Status forms. The monthly fee is subject to increase or the resident may be referred to a facility where appropriate care is available.

Facility Responsibility:

The basic fee of \$_____ per month provides for a private room with appropriate furnishing including a hospital bed (provided through hospice services if applicable), dresser, closet space, bed & bathing linens, personal care needs, all meals and snacks as provided for on the facility’s menus (and resident preferences), a laundry service, housekeeping, including room cleaning and daily maintenance as needed or required, social and recreational activities (if appropriate), generic toiletries (shampoo, soaps, tissues, and toilet paper), medication control and administration (if needed), access to common areas of the facility (dining room, living rooms, social areas, patios, and yard area) and input (if desired) to menu and/or activity calendar planning.

Resident Responsibility:

The resident/representative/hospice is responsible for all required medications including prescription and nonprescription drugs, food supplements, and vitamins. Nursing services will be provided by the resident’s PCP, and they will assist in the development and review of the resident’s Service Plan. There is no additional fee for this service. Medical and treatment supplies, incontinence supplies (including garments, skin barriers, special cleansing soaps or lotions, indwelling or external catheters and related supplies), mobility devices and their routine cleaning, maintenance and repair, supplies and equipment needed to maintain independence in performance of Activities of Daily Living, personal toiletries (including but not limited to combs, hairbrushes, hairspray, hairnets, toothbrush, toothpaste, denture cup, denture cleaning supplies, deodorants, skin lotions and creams and utensils for cleaning nails and ears), special equipment for eating or instilling liquid nutrition, special activities outside the facility, and any transportation needs will be arranged and provided by the resident/representative or through the hospice agency.

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Date of Admission:

The monthly charge shall begin on the _____ (day) of _____ (month) _____ (year) the first day of residency and will be prorated to the beginning of the month. The resident or resident's representative agrees to pay a monthly fee on or before the due date, which will fall on the 1st day of each month.

Late Fees:

There is no charge for late fees. If there is a financial challenge, please discuss the situation with the manager.

Services:

Services to be provided to the resident: *(Check all that apply)*

Facility:

Level of Care:

- Supervisory Personal Directed Respite

- Resident room Climate control Emergency Services Dining area with table and chairs
- Transferring devices Allowance for pet Bathroom accessible from a common area
- Housekeeping services Exterior door ramps Outside activity space Laundry services
- Meal services Meal planning Special diets Safety devices
- Copy/Fax services Internet services Phone

Bedroom:

- Bed (36 inches x 72 inches or larger, with frame and mattress)
- Individual storage space for personal effects Storage space for clothing
- Private bathroom Semi-private bathroom Cable TV in room Internet service
- Clean linen Light for reading Phone Copy/Fax services

Activities of Daily Living Service:

- Assistance with dressing Assistance with grooming Assistance with bathing
- Assistance with eating Assistance with toileting Assistance with ambulation
- Assistance with transferring Assistance with prosthetics Assistance with orthotics
- Assistance with activities (Including activity supplies) Assistance with exercising

Medical Services:

- Medication (Control, procurement, ordering, refilling, disposal and record keeping)
- Medication storage Medication assistance in self-administration
- Medication administration Vitals measurements and recording Assistance with treatments

Additional available services which may be covered by hospice or your insurance:

- Hospice Home Health Companion Mobile physician Lab draws Dry cleaning
- Mobile X-Ray Physical Therapy Occupational Therapy Speech Therapy TB test service
- Mobile Dentist Beauty services Nail services Pet services Private phone
- Internet service Copy/Fax services

Security/early termination deposits:

() No security deposit is required. () Deposit of not more than one month's fee of \$ _____

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Resident Personal Funds:

- This facility will not be responsible for personal funds
- A personal fund may be set up and managed for the resident under the terms and conditions outlined in the policy and procedure of the facility and available upon request of the resident's representative.

Refunds:

1. To receive full refund of the security deposit, the resident or resident's representative must give a full 30-day written notice in writing to owner or manager of (facility) of intent to terminate the Residency Agreement, by moving the resident from the facility in a timely manner and in addition, there must be no damage to the facility beyond the normal wear and tear of the resident's area. Failure to give 30-days notice of termination of the Residency Agreement will result in funds being deducted from the deposit on a pro-rated basis until the census position the resident has vacated is filled by another resident or the amount of the deposit is exhausted, whichever comes first.
2. **NO REFUNDS:** Hospice Patients or End of life patients referred to this facility are not eligible to a full refund.
3. The management recognizes that in some instance a 30 calendar days written notice to terminate the Residency Agreement may not be possible and will give a full refund of the deposit for the following circumstances:
 - a. The demise of the resident.
 - b. The discharge of a resident who has changes in physical, mental, emotional, or functional status which places them at a level of care beyond the scope of practice allowed by the facility's license.
 - c. The resident's behavior or health possesses a threat to the health or safety of other individuals in the facility.
 - d. The resident or resident's representative terminates the resident's Residency Agreement immediately for abuse, neglect, or exploitation as substantiated by a governmental agency.
 - e. The resident or resident's representative may terminate the Residency Agreement after providing 14 calendar days written notice for the facility's failure to comply with the resident's Service Plan or Residency Agreement.
 - f. The manager requests the termination of the contract with 14 calendar days written notice because the resident's or resident's representative's failure to pay fees.
 - g. By mutual agreement of all parties to this agreement.

Resident/representative will be asked to pay for any of the following:

- Damage to the facility that exceeds normal wear and tear (e.g., broken windows, doors, furnishing, light fixtures, damage to walls or paneling, moldings, drapes, curtains, etc.) caused by any action out of the abnormal behavior.
- Any outstanding cost for beautician services, medical supplies, nutritional supplements, incontinence garments, clothing, medications, or personal toiletries incurred by the facility at the request of the resident or resident's representative on the behalf of the resident.
- Fees will not be requested for routine cleaning of carpets, floors, painting of the walls, cleaning of furnishings, or other items considered as normal wear and tear in the facility.

Termination:

Termination initiated by a resident or the resident's representative:

- Resident/representative must notify the facility of termination in writing with at least 30-day notice or arranged with the manager in advance.

A manager may terminate residency of a resident as follows:

- A. **Without notice**, if the resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in an assisted living facility.

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- B. With a **14-calendar day** written notice of termination of residency:
1. For nonpayment of fees, charges, or deposit.
 2. Under any of the conditions in subsection (C).
 - i. The individual requires continuous medical services, nursing services or behavioral health services.
 - ii. The assisted living services needed by the individual are not within the assisted living facility's scope of services;
 - iii. The individual requires restraints, including the use of bedrails
- C. With a **30-calendar day** written notice of termination of residency, for any other reason.
- D. A manager shall ensure that a written notice of termination of residency includes:
1. The date of notice.
 2. The reason for termination.
 3. The policy for refunding fees, charges, or deposits.
 4. The deposition of a resident's fees, charges, and deposits.
 5. Contact information for the State Long-Term Care Ombudsman.
- E. A manager shall provide the following to a resident when the manager provides a written notice of termination of residency:
1. A copy of the resident's current Service Plan.
 2. Documentation of the resident's freedom from infectious tuberculosis.
- F. A manager shall not accept or retain an individual who is not within the Scope of Services or does not have the ability to provide for the needs of the individual, which includes restraints and the use of bedrails.

Transportation Services: This facility does not provide transportation for the residents. Transportation can be arranged by family members, friends or the resident's hospice social worker/case manager.

Temporary Absence from the Facility:

During short periods of absence from Nananom Assisted Living for recreational or medical reasons, the daily routine continues uninterrupted until such time notice is given that the resident will not be returning to the facility. Once the facility is notified that the resident will not be returning, the storage fee for storage of the resident's belongings will be a daily fee. The storage fee will terminate once the belongings are removed from the facility or the resident's representative grants written permission for disposal of the belongings. The fee will only be waived if not allowed by contract from another agency or prearrangements have been made with Nananom Assisted Living manager/designee.

Rate and Fee Increase:

Nananom Assisted Living is a limited Liability Corporation in Arizona. We are anticipating a rate increase depends on the level of care services provided to resident, but we will provide a minimum of 30-days advance written notice before any fee increases for any service or care the resident receives while living in the facility. All written notification will include the effective date and the reason(s) for the fee increase.

Disclaimers:

Nananom Assisted Living does not assume responsibility for jewelry or other valuables of the resident. Please do not leave cash, expensive jewelry, etc. with the resident.

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Nananom Assisted Living management will ensure that the resident lives in a clean and safe environment with nutritious food and a caring and pleasant staff. Nananom Assisted Living staff will comply with the Internal Facility Rules, Primary Care Physician and hospice medical provider's orders, and the individualized Service Plan.

Governing Law:

This Residency Agreement shall be construed in accordance with the laws of the State of Arizona.

Complaints/Grievances:

The resident/representative has the right to file a complaint/grievance against any management decision to terminate the Residency Agreement or any other issue affecting the care of the resident.

Step 1:

- A. A resident or resident's representative shall explain in writing the grievance to the manager of record or of the time or of that shift. The written complaint/grievance must be brought within 10-working days from the day the decisions, services or lack of service was observed.
- B. The manager, either alone or in collaboration with the licensee (owner), if the two positions are distinct and separate, shall reach the decision or communicate it in writing to the resident or resident's representative within 10-working days of receipt of the written grievance.

Every effort should be made to settle complaint/grievance at this stage.

Step 2:

- A. If the resident or resident's representative feel the decision of the manager and/or licensee is still unfair, the resident or resident's representative shall respond in writing within 10-working days, requesting reconsideration of the issue.
- B. The response should again offer suggestions on what would be considered a fair compromise of the situation.
- C. The manager shall then form a committee of three individuals including the manager, the individual who developed the service plan (if different from the manager) or a nurse and another individual affiliated with the facility (e.g., resident, caregiver, volunteer) to meet and review the grievance.
- D. The manager will make a written reply of the committee's decision to the resident or resident's representative second written response within 10-working days.
- E. The resident/representative may choose to be present during the committee meeting to represent the case of the resident.

Step 3:

- A. If the resident or resident's representative still feels the decision of the management has not resolved the problems, he or she should seek outside counsel through the Arizona Department of Health Service office of Home and Community Based Licensure or through the DES Long Term Care Ombudsman or any other persons or resident advocacy agencies.*

*Any reply which is not appealed by the resident/representative within the time allowed at each level shall be considered settled and binding on the part of the resident/representative and the facility.

Initial the items below signifying they were given or explained to the resident or resident's representative.

- _____ A copy of the Internal Facility Requirements was provided and explained.
- _____ A copy of the Resident's Right was provided and explained.
- _____ Agency phone numbers as required by ADHS was provided and explained.
- _____ The evacuation plan was reviewed and explained.
- _____ A copy of Residency Agreement
- _____ A copy of the Advance Directives

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Photo Consent:

Permission is granted for photographs to be taken and used for identification purposes and/or for the home's album of activities and home promotion on social media (e.g., Facebook, webpage, etc.). () Yes () No

Secured Facility:

The residents will not be allowed to leave the premises without prior consent from the responsible party. A Release of Responsibility Form must be signed each time a resident leaves the premises.

Please Initial:

_____ I give permission for the resident named in this contract to leave with family and friends.

_____ The resident named in this contract may only leave the premises with the following people:

Pets: Please check with management

() We do not accept pets () we accept pets for additional fee () Pets visitation only

Health Care Directives:

The Life Care Planning program developed by the Arizona Office of the Attorney General publishes the rules of Arizona on "Health Care Directives". Please review the video on Health Care Directives found at <https://www.azag.gov/seniors/life-care-planning>. Healthcare planning forms are available at this link.

Attorney Fees:

In the event of a legal case which might arise out of this agreement, the resident/representative will become personally liable for all legal costs associated with the enforcement of this agreement to include, but not limited to the attorney's fees.

R9-10-806(B) states:

At least the manager or a caregiver is present at an assisted living home when a resident is present in the assisted living home and:

- A. Except for nighttime hours, the manager or caregiver is awake; and
- B. If the manager or caregiver is not awake during nighttime hours:
 - 1. The manager or caregiver can hear and respond to a resident needing assistance; and
 - 2. If the assisted living home is authorized to provide directed care licenses, policies and procedures are developed, documented, and implemented to establish a process for checking on a resident receiving directed care services during nighttime hours to ensure the resident's health and safety.

Awake Staff:

Nananom Assisted Living has staff awake at night. Nananom Assisted Living shall provide, if approved, a monitoring system such as baby monitor or body alarm (if necessary) to residents receiving directed care.

By signing below, I _____, acknowledge and accept all the information presented to me.

Resident/Representative: _____ Date: _____

Manager/Designee: _____ Date: _____

Part 2

Resident Bill of Rights

A manager shall ensure that:

- A. A resident is treated with dignity, respect, and consideration.
- B. A resident is not subjected to:
 - 1. Abuse
 - 2. Neglect
 - 3. Exploitation
 - 4. Coercion
 - 5. Manipulation
 - 6. Sexual abuse
 - 7. Sexual Assault
 - 8. Seclusion
 - 9. Restraints
 - 10. Retaliation for submitting a complaint to the Department or other entity.
 - 11. Misappropriation of personal and private property by the assisted living facility manager, caregivers, assistant care givers, employees or volunteers.
- C. A resident or the resident's representative is informed of the policy on Health Care Directives, and the Resident Complaint Process.
- D. Consents to photographs of the resident before the resident is photographed, except that a resident may be photographed when admitted to an assisted living facility for identification and administrative purposes.
- E. Except as otherwise permitted by law, the resident or representative provides written consent before the release of information in the resident's medical record, or financial records.
- F. They may request or consent to relocation within the assisted living facility except when relocation is necessary based on a change in the resident's condition as documented in the resident's service plan, refuse relocation within the assisted living facility.
- G. They have access to their records during normal business hours or at a time agreed upon by the resident or resident's representative and the manager.
- H. They are informed of the rates and charges for services before the services are initiated and if a change in rates, at least 30 calendar days' notice before the change is implemented, unless the change in rates or charges results from a change in services and change in services at least 30 calendar days before the change is implemented, unless the resident's service plan changes.

A resident has the following rights:

- A. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
- B. To receive assisted living services that support and respect the resident's individuality, choices, strengths, and abilities.

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- C. To receive privacy in care for personal needs, correspondence, communications and visitation, and financial and personal affairs.
- D. To maintain, use, and display personal items unless the personal items constitute a hazard.
- E. To choose to participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities.
- F. To review, upon written request, the resident's own medical record.
- G. To receive a referral to another health care institution if the assisted living facility is not authorized or not able to provide physical health services or behavioral health services for the resident.
- H. To choose to access services from a health care provider, health care institution, or pharmacy other than the assisted living facility where the resident is residing and receiving services or a health care provider, health care institution, or pharmacy recommended by the assisted living facility.
- I. To participate or have the resident's representative participate in the development of, or decisions concerning the resident's service plan.
- J. To receive assistance from a family member, resident's representative, or other individual in understanding, protecting, or exercising the resident's rights.

I acknowledge that I have read these rights, or had them read to me, and that I have received a copy of them. I understand that it is the responsibility of all the staff of the facility to assist in exercising my rights.

Resident's/Representative Signature

Manager/Designee Signature

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Complaint Process

Purpose:

It is the intention of this facility to fairly administer its policies, procedures and home rules. The facility does recognize, however that residents may at times feel these policies or rules are misapplied or misinterpreted and as a result, would like a formal review of any controversy, dispute or misunderstanding. The guidelines that follow outline this formal complaint process.

Guidelines:

- The resident or representative should be familiar with the home rules and policies, or at least the specific policy/rule or action which is in question.
- An established facility policy or procedure is not in itself subject to the grievance procedure. It is only the interpretation or execution of these policies that creates a formal complaint.
- A resident/representative who has a concern, complaint or grievance is encouraged to discuss their concerns with the manager and/or owner of the facility.
- This meeting is to be held within 5 days of the grievance request in the event a 14- or 30-day notice of termination, or prior to termination in all other cases.
- Another opportunity for a resident and/or representative to communicate concerns, complaints and/or grievances are through service plan meetings.
- Nananom Assisted Living encourages open communication between the resident, representative, friends and/or family and the facility staff, manager, and/or owner at all times.
- If the grievance is not resolved at the meeting with the facility manager and/or owner, the resident and/or representative may report the concerns and issues to the D.E.S. Long Term Care Ombudsman at 602-542-6454 and/or the Adult Protective Services at 877-767-2385.

Nananom Assisted Living manager/designee or owner shall document all concern, complaint or grievance issues in the resident's file and the outcome of any discussions and/or meetings.

Resident/Representative Signature: _____ Date: _____

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House Rules

1. **Nananom Assisted Living** has open visiting hours. The house doors are unlocked at 0800 and will be locked at 2000. Anyone visiting after the doors are locked should call or knock and the caregiver on duty will verify and authorize admittance.
2. The number of visitors is not generally restricted by staff. However, due to the resident's room size we ask you to limit the number of visitors to 3-4 visitors at one time. If you wish to bring a larger group, please notify the manager so arrangement can be made.
3. Visits may be held in the community areas or in the resident's room if the rights of other residents are not being violated.
4. There will be no smoking allowed in Nananom Assisted Living, either by residents, visitors or staff. This rule is per **ARS 36-610.01**. Please call 1-877-297-8677 should you have question or concern. **Nananom Assisted Living** has a smoking area out back. Individualized Service Plans and resident requests will be on a case-by-case basis approved by **Nananom Assisted Living** manager/designee.
5. Meals are offered/served at the following times:
 - Breakfast: 0630 - 0800
 - Lunch: 1100 - 1300
 - Dinner: 1630 - 1800
 - Snacks: In between meals and throughout the day.
6. Alcohol may be consumed by the resident in **Nananom Assisted Living** with expressed written consent from the resident's physician and/or the resident's representative. Alcohol will be kept in a locked cabinet by the manager or caregiver and can be released upon request.
7. Personal items and decorations are encouraged to make the resident's room more comfortable. Please discuss any items you would like to bring in with the staff so we can maintain your possessions on a Personal Possessions Form.
8. Cleaning Schedules may occur as follows:
 - Common areas: Daily
 - Bedrooms/Linen: 2x a week or as needed.
 - Laundry: Weekly or as needed.
9. We ask you not to share personal items such as clothing, brushes, combs, razors, toothbrushes, etc. among residents. If you need an item, please check with the caregiver on duty to see if can provide the item.
10. The resident and their visitors are expected to have respect for other residents in the home. This includes, but is not limited to the following:
 - Keeping noise levels to a minimum.
 - Observance of normal sleeping hours.
 - Respect for the personal belongings of others.
 - Alerting the staff of any emergency situations involving another resident.
 - Encouraging visitors to abide by the rules of the house.
 - Maintaining and respecting other's privacy.
11. Any illnesses, accidents, injuries or other incidents should be reported to the staff on duty or the manager immediately.
12. The resident is responsible for any cash and/or items of value that are brought into the house. The home will not accept responsibility for lost or stolen items.
13. Residents are allowed to leave the premises, if this is not contraindicated, and the staff is notified. A Release of Responsibility Form will be signed each time the resident leaves the facility.
14. A house phone is available for local calls. If a resident wishes to make a long-distance call, it is recommended that a personal cell phone be used.
15. To reduce the spread of infection, the resident and their visitors should avoid direct contact with another resident in the facility.
16. The resident or visitors are asked to alert the staff of any unsafe or unsanitary conditions in the home.

I hereby acknowledge that I have read (or have had them read to me) the following House Rules. I understand the rules of **Nananom Assisted Living** and agree to abide by them. I understand that failure to abide by the House Rules may result in termination of my Admission Agreement.

Resident/Representative Signature: _____ Date: _____

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Important Phone Numbers

The telephone numbers listed below must be provided to each resident/representative upon acceptance into an assisted living facility.

- Emergency Medical Services: 9-1-1
- Police Department (Non-emergency number): Phoenix: _____
- Fire Department (Non-emergency number): Phoenix: _____

The Arizona Department of Health Services’
Bureau of Residential Facilities Licensing:
Phone: 602-364-2639
<https://www.azdhs.gov/licensing/index.php#azcarecheck>

Adult Protective Services (APS) in the
Arizona Department of Economic Security:
Phone: 1-877-SOS-ADULT (767-2385)
<https://www.azdes.gov/daas/aps/>

The State Long Term Care Ombudsman:
Phone: 602-542-6454
<https://www.azdes.gov/daas/lcco/>

The Arizona Center for Disability Law:
Phone: 602-274-6287
www.acdl.com

Arizona Attorney General’s Office
Phone: 602-542-5025
www.azsos.gov

Arizona Advance Directive Registry
Phone: 602-542-6187
www.azag.gov/seniors/life-care-planning

Medical Transport: Rural Metro (928)782-4757

Resident/Representative Signature: _____ Date: _____

Referral Agency Disclosure

Resident Name: _____ Representative: _____
Referral Agency: _____ Phone: _____
Facility Manager: _____ Phone: _____

R4-33-408. Referral Requirements

- A. A manager who is employed by an assisted living facility that pays a fee to an individual or entity for referral of a resident to the assisted living facility shall ensure that the assisted living facility:
 - 1. Has on file a contract with the individual or entity making the referral.
 - 2. Maintains a file of the names of the residents referred by the individual or entity.
 - 3. Obtains at the time of admission and maintains a statement, signed by the resident or the resident’s representative or legal guardian, which discloses that:
 - a. A fee was paid for referring the resident to the assisted living facility.
 - b. The resident or the resident’s representative or legal guardian was informed of the fee arrangement.
 - c. The resident or the resident’s representative or legal guardian was informed of any ownership interest between the assisted living facility and the individual or entity making the referral.
- B. A manger shall maintain the records required under subsection (A)(1) for five years and shall maintain the records required under subsections (A)(2) and (A)(3) for five years after the resident ceases to reside in the assisted living facility.
- C. A manager shall make the records required under this Section available for review upon request by the Board.

HB 2529 36-446.14. Referral agencies; requirements; civil penalty; definitions

- A. A referral agency shall disclose to any prospective resident or representative of a prospective resident at the time or before any referral is made for care at an assisted living facility both of the following:
 - 1. The existence of any current business relationship between the referral agency and the assisted living facility, including any common ownership or control and any other financial, business, management or familial relationship that exists between the referral agency and the assisted living facility.
 - 2. That the assisted living facility pays a fee to the referral agency in connection with the referral.
- B. The referral agency shall disclose to a new resident or the resident's representative either before or at the time of the resident's admission date the amount of the fee or a good faith estimate of the fee to be paid by the assisted living facility to the referral agency.
- C. Both the referral agency and the prospective resident or the prospective resident's representative shall sign and date or electronically acknowledge and date the disclosures required by subsections a and b of this section. the referral agency shall provide the prospective resident or the prospective resident's representative a copy of the disclosures either electronically or in a hard copy. the referral agency shall provide the assisted living facility a copy of the signed and dated or electronically acknowledged and dated disclosures at the same **time** the resident

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receives the disclosures, and the assisted living facility shall maintain a copy of the disclosures on file at the facility.

- D. The assisted living facility may not pay any referral fee associated with a resident until the assisted living facility receives the disclosures required by subsections a and b of this section.
- E. A referral agency that violates this section is subject to a civil penalty of up to one thousand dollars for each violation. The attorney general or a county attorney may institute a proceeding in superior court to recover the civil penalty under this subsection and to restrain and enjoin a violation of this section. Any civil penalty recovered pursuant to this subsection shall be deposited in the general fund of the jurisdiction that prosecuted the violation.
- F. For the purposes of this section:
 - 1. "Electronically" includes an audio recording that conforms with the Arizona rules of evidence, that is maintained by the referral agency and that is transmitted to the assisted living facility and the resident or the resident's representative in a format that can be downloaded.
 - 2. "Referral agency":
 - a. Means a person or entity that provides referrals for a fee that is collected from either the patient or the assisted living facility.
 - b. Does not include either:
 - i. An assisted living facility or its employees.
 - ii. A resident, a resident's family member or a patron of an assisted living facility who refers a prospective resident to an assisted living facility and receives a discount or other remuneration from the assisted living facility.

I/We, do hereby acknowledge the items above were disclosed.

Resident: _____ Date: _____

Representative: _____ Date: _____

Referral Agency: _____ Date: _____

Manager/designee: _____ Date: _____

Part 3

Nananom Assisted Living

Resident Medical Release Form
Authorization to Release Resident's Medical Information

Facility: _____
Address: _____
Phone: _____ Fax _____
Email Address: _____

Resident's Name: _____ Date: _____

Dear _____,

I hereby authorize and request that you release and deliver to the above address all my medical records, charts, files, progress notes, reports, service plans and other such information relative to the treatment provided to the resident while under your care and all to the extent said information is available and within your possession. You are further requested not to disclose any information concerning the resident's past/present medical condition or personal information to any other person without my express written permission.

The facility is permitted to release the above materials to contracted parties involved with the resident's Service Plan.

Thank you for your cooperation,

Resident/Representative Signature: _____ Date: _____

Manager/Designee Signature: _____ Date: _____

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Physician's Order for Caregivers to Administer Medications and fill Medication Organizers

Resident's Name: _____ Date: _____

Dear _____,

To be compliant with the Arizona Department of Health Services, we need to have Nananom Assisted Living's policies involving medications reviewed by the resident's Physician/PCP. In addition, we need a signed order from each Physician/PCP stating that a certified manager may set up the medication organizers (mediset) and a certified manager and certified caregivers may administer the medication from the medication organizers as per physician/PCP instructions. Please sign below signifying you are aware of our policies and the orders listed below.

The following Manager/Caregivers may administer the resident's medication and set up the mediset:

_____	_____
_____	_____
_____	_____
_____	_____

- A. The certified manager/caregivers will accept the Physician/PCP order from the resident's Physician/PCP.
- B. The certified manager may set up the medication organizer for the above-named resident according to Administration Policy and Procedure.
- C. The certified manager/caregivers listed above may administer medication to the resident from the medication organizer and PRN medication according to the Administration Policy and Procedure. All prescribed treatments may also be administered by caregivers at Nananom Assisted Living.

Physician/PCP Signature: _____ Date: _____

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Approval of Continued Residency

Completed by PCP (every 6 months)

The Arizona Department of Health Services (ADHS) concerning Licensure of Assisted Living Facilities Rules/ Regulations R9-10-814.B.2.i-iii requires that a facility is unable to accept or retain a resident who is bedbound, or wheelchair bound unless:

A manager of an assisted living facility licensed to provide personal care services may accept or retain a resident who is confined to a bed or chair because of an inability to ambulate even with assistance if:

1. The condition is a result of a short-term illness or injury.
2. The following requirements are met at the onset of the condition or when the resident is accepted by the assisted living facility:
 - a. The resident or resident's representative requests that the resident be accepted by or remain in the assisted living facility.
 - b. The resident's primary care provider or other medical practitioner:
 - i. Examines the resident at the onset of the condition or within 30 calendar days before acceptance and at least once every six months throughout the duration of the resident's condition.
 - ii. Reviews the assisted living facility's scope of services.
 - iii. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

Therefore, please complete this form for _____.
(Resident's name)

I _____ hereby approve to the continued residency of
(PCP's name)

_____, who is my patient and whose care requires an increased need for
(Resident's name)

services, or who is bedbound in Nananom Assisted Living, an assisted living facility

located at _____. In lieu of placement

in a skilled nursing facility or other acute care facility, I hereby authorize care to be given to my patient

_____ (Resident's name) at Nananom Assisted Living

Living. I last examined this patient on _____.
(Date)

PCP's Name: _____ Date _____

PCP's Signature: _____ Phone: _____

Nananom Assisted Living

Approval of Continued Residency (Non-ambulatory)
Completed by the resident/representative (every 12 months)

The Arizona Department of Health Services (ADHS) concerning Licensure of Assisted Living Facilities Rules/ Regulations R9-10-814.B.2.i-iii requires that a facility is unable to accept or retain a resident who is bedbound, or wheelchair bound unless:

A manager of an assisted living facility licensed to provide personal care services may accept or retain a resident who is confined to a bed or chair because of an inability to ambulate even with assistance if:

1. The condition is a result of a short-term illness or injury.
2. The following requirements are met at the onset of the condition or when the resident is accepted by the assisted living facility:
 - a. The resident or resident's representative requests that the resident be accepted by or remain in the assisted living facility.
 - b. The resident's primary care provider or other medical practitioner:
 - i. Examines the resident at the onset of the condition or within 30 calendar days before acceptance and at least once every six months throughout the duration of the resident's condition.
 - ii. Reviews the assisted living facility's scope of services.
 - iii. Signs and dates a determination stating that the resident's needs can be met by the assisted living facility within the assisted living facility's scope of services and, for retention of a resident, are being met by the assisted living facility.

Therefore, please complete this form for, _____.
(Resident's Name)

I, _____ hereby authorize the continued residency of
(Resident/Representative name)

_____, whose care requires an increased need for services, or
(Resident's name)

who is bed bound in Nananom Assisted Living, an assisted living facility located at

_____. In lieu of placement in a skilled nursing facility or other

acute care facility, I hereby authorize care to be given to _____ at
(Resident's name)

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Resident/Representative Signature: _____ Date: _____

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Flu and Pneumonia Vaccine Election

Resident's Name: _____

ARS 36-406(1) states:

Require as a condition of licensure that nursing care institutions and assisted living facilities make vaccinations for influenza and pneumonia available to residents on site on a yearly basis. The department shall prescribe how the institutions and facilities shall document compliance with this subdivision, including documenting residents who refuse to be immunized. The department shall not impose a violation on a licensee for not making a vaccination available if there is a shortage of that vaccination in this state as determined by the director.

Influenza (flu):

The resident/representative acknowledges receipt of the Centers for Disease Control and Prevention Vaccine Information Sheet on the Influenza vaccination.

- I have had an influenza vaccination on (date): _____
(Proof of vaccination attached)
- I have refused an influenza vaccination until further notice: _____
(Initial if applicable)

Pneumococcal (pneumonia):

The resident/representative acknowledges receipt of the Centers for Disease Control and Prevention Vaccine Information Sheet on Pneumococcal vaccination.

- I have had a pneumococcal vaccination on (date): _____
(Proof of vaccination attached)
- I have refused a pneumococcal vaccination until further notice: _____
(Initial if applicable)

SARS-CoV-2 (COVID-19):

The resident/representative acknowledges receipt of the Centers for Disease Control and Prevention Vaccine Information Sheet on SARS-CoV-2 vaccination.

- I have had a SARS-CoV-2 vaccination on (date): _____
(Proof of vaccination attached)
- I have refused a SARS-CoV-2 vaccination until further notice: _____
(Initial if applicable)

Resident /Representative Signature: _____ Date: _____

Manager/Designee Signature: _____ Date: _____

Nananom Assisted Living

Doctor's Orders Initial Admission

Date: _____

Dear Dr. _____,

Your patient, _____ has recently become a resident of Nananom Assisted Living. For us to provide the best care for this resident, and in order to comply with state regulations regarding the administration of medications, treatments and special diets, please provide the following information: (Additional sheets may be attached, if necessary)

1. Please provide instructions for all current medications this resident is receiving:

Medications Name	Dosage	Route	Time	Notes

2. Please provide complete instruction for all treatments the resident is currently receiving which may require the assistance or supervision of the care home.

Is the resident free from Infectious Tuberculosis? () Yes () No

Flu Vaccine: () Yes () No If yes, date: _____

Pneumonia Vaccine: () Yes () No If yes, date: _____

3. Please list any dietary restrictions, supplements or special diets for this resident along with complete instructions:

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4. Additional instruction or recommendations:

Authorization:

Trained and certified caregivers, those listed below, who are not Registered Nurses may administer medication, pre-fill medication organizers and provide treatment to my patient.

_____	_____
_____	_____
_____	_____
_____	_____

Physician Signature: _____ Date: _____

Thank you for your cooperation. If you have any questions, please feel free to call us at
(____)_____.

Nananom Assisted Living Manager:

Next Appointment Schedule: _____

Please complete the following Vital Signs:

Blood Pressure: _____
Respiration: _____
Temperature: _____
Pulse Rate: _____

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Additional Form for Medications List (if Applicable)

Date: _____

Medications Name	Dosage	Route	Time	Notes/Changes

Physician Name: _____

Physician Signature: _____

Nananom Assisted Living

Doctor's Orders
Subsequent Visits

Resident's Level of Care: () Personal Care () Directed Care

Date: _____

Reason for Visit: **Follow-up**

Dear Dr. _____,

Your patient _____ who is at this time a resident of Nananom Assisted Living and currently receiving the following medications, treatments and diet. Please indicate any changes and return this form with the resident. Thank you for your cooperation.

Nananom Assisted Living Manager:

I. Current Medications:

Medication Name	Dosage	Route	Time	Changes or Notes:

Physician Signature: _____ Date: _____

Nananom Assisted Living

Additional Form for Medications List (if Applicable)

Date: _____

Medications Name	Dosage	Route	Time	Notes/Changes:

Physician Name: _____

Physician Signature: _____

CURRENT TB CLEARANCE

- Date taken: _____
- Written Statement: _____
- Risk Assessment: _____
- Renewal Date: _____
- Annual assessment: _____
- Other: _____

Updated Service Plan

(Please Attach Current Service Plan)

Service Plan review date:	Update date:
Level of Care: _____	
Initial Review: _____	Completed Date: _____

Review Update: _____	Completed Date: _____

Review Update: _____	Completed Date: _____

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ONE PAGE: Signatures Needed for the Service Plan

Note: This page only applies if the Service Plan requires only a signature.

Date Sent: _____

Arizona Department of Health Services regulation R9-10-808.5.a-d states:

- A. Except as required in subsection (B), a manager shall ensure that a resident has a written service plan that:
 - 1. When initially developed and when updated, is signed and dated by:
 - a. The resident or resident’s representative.
 - b. The manager.
 - c. If a review is required in subsection (A)(3)(d), the nurse who reviewed the service plan.
 - d. If a review is required in subsection (A)(3)(e)(ii), the medical practitioner or behavioral health professional who reviewed the service plan.

This also applies to Service Plan updates.

As the person assigned to accomplish this service for (Name of resident) _____ please review the Service Plan and upon receipt:

- A. Complete this form.
- B. Sign and date the signature page of the Service Plan.
- C. Mail this form and the signature page to: Nananom Assisted Living at 210 E. Hunter Dr. Globe, AZ 85501 as soon as possible or
- D. Fax this form and the signature page to this facility as soon as possible to:
 Fax number: _____ Or Email: _____

Date you received this form and reviewed the Service Plan: _____

I am the:

- _____ Representative/ POA
- _____ Manager
- _____ Nurse
- _____ Medical Practitioner

I **agree** with the contents of the Service Plan (please sign): _____ Date: _____

I **disagree** with the contents of this Service Plan and will call Nananom Assisted Living, whose telephone number is _____, immediately for discussion and possible revision.

Thank you for your prompt attention to this important matter.

Nananom Assisted Living Manager Signature:

Part

4

Nananom Assisted Living

Resident Discharge or Transfer Record

- Instructions: 1. Complete for all transfers.
 2. Give original to the facility where the resident is being transferred.
 3. Keep a copy for Nananom Assisted Living record.

Resident's Name: _____ Date: _____

SS #: _____ Date of Birth: _____

Next of Kin: _____

Address: _____

Phone #: _____ Cell #: _____

Physician: _____ Phone #: _____

CURRENT MEDICATIONS:

Medication sent with Resident: () Yes () No () Destroyed Date: _____

Reason for Discharge/Transfer: _____

Date of Transfer/Discharge or Death: _____ Time: _____

Facility Transferred to: _____

Address of Facility: _____

Transferred by: _____ Phone #: _____

Personal property transferred with resident: _____

Resident/Representative Signature: _____ Date: _____

Manager Signature: _____ Date: _____

Nananom Assisted Living

Death Record Form

Date of Death: _____ Time: _____

() Natural Death () Unexpected Death () Suspected Suicidal Death

Resident's Name: _____

Diagnosis: _____

Responsible party notified? () Yes () No Time: _____

Name of Responsible Party: _____

Phone #: _____ Cell #: _____

Hospice Agency notified? () Yes () No Time: _____

Person who received the call: _____

Did you dial 911? () Yes () No Coroner Notified? () Yes () No

Did you contact DHS? () Yes () No Time: _____

Person who received the call: _____

Person who was present at the time of death: _____

The resident was pronounced dead by: _____

Manager: _____ Reported at: _____

Mortuary: _____ Time called: _____ Time body transported: _____

Items sent with the body: _____

Signature of person removing the body: _____

Signature of facility staff member: _____

Incident Report File

Nananom Assisted Living

Incident Report Form
(Physical Injury)

A licensure shall ensure that a manager of an assisted living facility will provide the following information when there is an accident, incident or injury that affects the resident's health and safety.

Resident's Name: _____
Date: _____ Time: _____ Location of Incident/Accident: _____

Notifications: _____ POA/Representative notified (Date and Time): _____
Name of Rep/POA: _____
_____ Assisted Living Manager: _____
_____ Primary care provider (Date and Time) _____
Name of PCP: _____
_____ Manager: _____
_____ Resident Case Manager: _____

Describe the Accident, Incident or Injury:

Identify individuals who observed the accident, incident or injury:

Name(s): _____ Position: _____
_____ _____
_____ _____

Describe actions taken by employees, support staff, or volunteers:

Describe action taken to *prevent* future occurrence of the incident, accident or injury:

Signature/Title of person initiating report: _____

Licensee/Manager Signature: _____

Nananom Assisted Living

Incident Report Form
Abuse, Neglect or Exploitation

Name of involved person: _____

Date and Time of incident: _____

Location of involved person: _____

What is the Illness, Injury or Issue being reported: _____

Description of the Incident or Problem (Please include names of individuals involved, nature of the incident, problem, injury or illness. Give details of what was discovered and how the incident, problem, injury or illness was discovered or happened, if known. If it's an illness, describe what the illness is. List any witnesses, and write a brief narrative of what occurred):

Immediately following the incident, accident, injury or illness you must notify the appropriate people. The follow checklist is to ensure that all people who need to be involved are notified. You must document the date and time you notified each person.

911(if serious):	_____	Date:_____	Time:_____
Manager:	_____	Date:_____	Time:_____
Hospice:	_____	Date:_____	Time:_____
Emergency Contact:	_____	Date:_____	Time:_____
Doctor (if not hospice) :	_____	Date:_____	Time:_____
Case Manager:	_____	Date:_____	Time:_____
Family Member:	_____	Date:_____	Time:_____

Print name of the Person submitting the report: _____ Date: _____

Signature of the Person submitting the report: _____

(Attach additional pages to answer the questions below, if necessary.)

Describe the incident and any injury or adverse effect to the resident(s): _____

What immediate measures were taken to protect the resident(s)? _____

Has this happened before to the same resident(s) or others? () Yes () No If yes, describe: _____

Who else was contacted (such as law enforcement, ombudsman, licensing board, etc.)? _____

How will you prevent this from happening in the future? _____

Reviewed and approved by: _____ Date: _____

Nananom Assisted Living

Human Remains Release Form

Facility Name: _____
Address: _____
Phone #: _____ Fax #: _____

Deceased Person's Name: _____
Date of Birth: _____ Social Security #: _____
Date of Death: _____ Time of Death: _____
Contact Person: _____ Relationship: _____
Phone #: _____ Alternate #: _____

Physician or Nurse Practitioner expected to sign Medical Death Certificate:
Name: _____ Phone #: _____

Person Authorizing Release to Mortuary or Responsible Party:
Name: _____
Phone #: _____ Relationship: _____

The human remains of a person who dies under any of the following circumstances as listed in **A.R.S. 11-593(A)** are required to be referred to the Medical Examiner:

When a person:

- dies not under the care of a Physician or Nurse Practitioner for a potentially fatal illness.
- dies and the attending Physician or Nurse Practitioner is not available to sign the death certificate.
- dies because of violence.
- dies suddenly when in apparent good health.
- dies in a suspicious, unusual or unnatural manner.
- dies and may present a public health hazard.
- dies an unnatural death.

Were the person's remains referred to the Medical Examiner as required in ARS 11-593? () Yes () No

The most recent diagnosis in the person's medical record: _____

The following information if the deceased person's human remains are being released to:

1. Mortuary: Name: _____
Address: _____
Phone #: _____ Contact Person _____
2. Other: _____

Person representing Nananom Assisted Living who released the remains: _____

Print Name: _____ Title: _____

Termination Notice of Residency Agreement

Nananom Assisted Living gives notice of Termination of the Residency Agreement to the resident _____, and their representative _____, on the effective date of _____.

Residency will be terminated for the following reason(s):

The resident/representative has the right to grieve the termination, although the termination date will remain effective during the grievance process. If attempts to resolve complaints and issues directly with the facility owner are unsuccessful, the resident may submit grievances to outside agencies and other individuals without restraint or retaliation.

Private Residents should:

A. Attempt to resolve complaints and issues with the assisted living facility owner.

1. If unable to resolve issues or complaints, the date of residency termination will stand as issued.

B. ALTCS residents should:

1. Attempt to resolve complaints and issues with the Assisted Living Facility Owner/Administrator.

2. File a grievance first with their Program Contractor via their case Administrator. When a grievance is not resolved at this level, the Program Contractor will provide written notice instructing members how to proceed with filing a grievance with AHCCCS.

3. If unable to resolve issues or complaints involving a violation of the Assisted Living Facility regulations, a grievance may be filed with the Arizona Department of Health Services.

4. If unable to resolve issues or complaints, the date of residency termination will stand as issued.

Nananom Assisted Living owner will refund any fees/deposits due the resident within 30 days of the date of Residency Termination. No fees will be retained after a resident's death or after the residency termination effective date.

Owner: _____

Date: _____