BAYWIND VILLAGE Care Center
411 Alabama
League City, Texas 77573
281-332-9588
Fax: 281-316-2715

Baywind Village is a beautiful, family owned 107-bed facility located in the heart of League City, Texas. Here at Baywind Village all patients can expect quality care, clean attractive surroundings and a courteous staff with a positive attitude for healing. We strive to personalize each patient's experience to optimize their recovery and get them back to their prior level of function faster. Our skilled nursing and rehabilitation staff will adjust patient goals and modify rehabilitation plans during weekly meetings that address patient's changing needs. We have 24-hour specialized nursing care to ensure the health and well-being of each of our patients. Our physicians, therapists, nurses and other professional staff are here to offer you the perfect combination of professionalism and compassion.

Baywind Village Skilled Nursing and Rehabilitation serves patients needing physical rehabilitation or complex nursing care. Our highly qualified, caring staff provides care in a beautiful atmosphere to help our patients achieve strength and functionality. Skilled nursing care, family involvement, psychological care and discharge planning complement a well-rounded, individualized program and encourage each patient's transition to their highest functional level with state-of-the-art equipment. Our physician-driven care plan is designed to maximize the quality of our care.

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

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

Thank You and Welcome to Baywind,

Chris Barcelo

Administration and Staff of Baywind Village

BAYWIND VILLAGE SKILLED NURSING & REHABILITATION FACILITY ADMISSION AGREEMENT. THIS AGREEMENT IS A CONTRACT BETWEEN THE RESIDENT (HEREINAFTER REFERRED TO AS "YOU", "RESPONSIBLE PARTY", "RESIDENT" OR "YOUR" AND BAYWIND VILLAGE, INC. (HEREINAFTER REFERRED TO AS "WE", "OUR", "US", OR THE "FACILITY", "FACILITY REPRESENTATIVE" THIS IS A LEGAL DOCUMENT CREATING RIGHTS AND OBLIGATIONS FOR EACH PERSON OR PARTY SIGNING THE AGREEMENT. PLEASE READ THE AGREEMENT CAREFULLY BEFORE YOU SIGN IT. IF YOU DO NOT UNDERSTAND ANY PROVISION OF THIS AGREEMENT, YOU SHOULD NOT SIGN THE AGREEMENT UNTIL YOU OBTAIN CLARIFICATION OF THE PROVISION YOU DO NOT UNDERSTAND.

1. **REFERENCES TO THE PARTIES**

WE BELIEVE THAT THIS AGREEMENT WILL BE MORE EASILY UNDERSTOOD IF WE USE, WHERE PRACTICAL, PERSONAL PRONOUNS IN REFERRING TO THE PARTIES OF THIS AGREEMENT.

REFERENCES TO "WE", "OUR", THE "FACILITY", AND "OUR FACILITY" ARE REFERENCES TO BAYWIND VILLAGE SKILLED NURSING AND REHABILITATION. REFERENCES TO "YOU" AND "YOUR" ARE REFERENCES TO ANY PERSON SIGNING THIS AGREEMENT AS RESIDENT. THERE ARE ALSO SPACES FOR THIS AGREEMENT TO BE SIGNED BY A LEGAL REPRESENTATIVE AND RESPONSIBLE PARTY IF APPLICABLE.

A **LEGAL REPRESENTATIVE** IS AN INDIVIDUAL WHO, UNDER THE INDEPENDENT LEGAL AUTHORITY, SUCH AS A COURT ORDER HAS THE AUTHORITY TO ACT ON THE RESIDENT'S BEHALF. EXAMPLES OF A LEGAL REPRESENTATIVE INCLUDE A GUARDIAN, A CONSERVATOR, AND THE HOLDER OF DURABLE POWER OF ATTORNEY EXECUTED BY THE RESIDENT. DOCUMENTS EVIDENCING A PERSON'S LEGAL REPRESENTATIVE STATUS MUST BE PROVIDED TO US. IF YOU HAVE A COURT APPOINTED GUARDIAN OR CONSERVATOR, HE OR SHE MUST SIGN THIS AGREEMENT FOR IT TO BE VALID.

A **RESPONSIBLE PARTY** IS AN INDIVIDUAL WHO VOLUNTARILY AGREES TO HONOR CERTAIN SPECIFIED OBLIGATIONS OF THE RESIDENT UNDER THIS AGREEMENT. EXAMPLES OF A RESPONSIBLE PARTY INCLUDE A RELATIVE OR A FRIEND OF THE RESIDENT. WE MAY DECLINE TO ADMIT ANY RESIDENT WHO HAS NO SOURCE OF PAYMENT FOR ALL OR PART OF THE RESIDENT'S STAY.

2. **OBLIGATIONS OF A LEGAL REPRESENTATIVE** OR RESPONSIBLE PARTY UNDER THE AGREEMENT. IF YOU SIGN THIS AGREEMENT AS A LEGAL REPRESENTATIVE OR RESPONSIBLE PARTY, YOU AGREE TO USE THE RESIDENT'S AVAILABLE INCOME AND RESOURCES TO PAY FOR THE RESIDENT'S CARE AND SERVICES.

BY SIGNING THIS AGREEMENT AS A LEGAL REPRESENTATIVE OR RESPONSIBLE PARTY, YOU ALSO AGREE TO APPLY FOR BENEFITS TO WHICH THE RESIDENT MAY BE ENTITLED, SUCH AS MEDICAID PROGRAM BENEFITS, AND TO FURNISH THIRD PARTY PAYORS, INCLUDING THE MEDICAID PROGRAM, WITH INFORMATION AND DOCUMENTATION CONCERNING THE RESIDENT WHICH IS NECESSARY TO THE PROCESSING OF THE RESIDENT'S APPLICATION FOR THIRD PARTY PAYOR BENEFITS. YOU ALSO UNDERSTAND THAT THE FACILITY IS RELYING ON THESE REPRESENTATIONS AS A SOURCE OF PAYMENT FOR THE RESIDENT'S CARE.

3. **RIGHTS OF LEGAL REPRESENTATIVE** OR RESPONSIBLE PARTY UNDER THIS AGREEMENT. BY SIGNING THIS AGREEMENT AS A LEGAL REPRESENTATIVE OR RESPONSIBLE PARTY, YOU HAVE THE RIGHT TO PARTICIPATE IN THE CARE PLANNING PROCESS OF THE RESIDENT, AND WE AGREE TO NOTIFY YOU WHEN 1 THERE IS AN ACCIDENT INVOLVING THE RESIDENT THAT RESULTS IN INJURY AND HAS THE POTENTIAL OF REQUIRING PHYSICIAN INTERVENTION, 2 A SIGNIFICANT CHANGE IN THE RESIDENT'S PHYSICAL, MENTAL OR PSYCHOSOCIAL STATUS, OR 3 A NEED TO ALTER TREATMENT SIGNIFICANTLY. YOU ARE ALSO ENTITLES TO RECEIVE ALL NOTICES REQUIRED TO BE SENT TO THE RESIDENT.

Clear Form

A. IDENTIFICATION OF PARTIES TO THIS AGREEMENT

RESIDENT'S NAME _____ _____
RESIDENT'S NAME **DATE**

FACILITY REPRESENTATIVE _____ _____
FACILITY REP NAME **DATE**

RESPONSIBLE PARTY _____ _____
RESPONSIBLE PARTY'S NAME **DATE**

RELATIONSHIP TO RESIDENT _____

☐ **I/We agree to follow and comply with the rules of Baywind Village**

THE FOLLOWING DAILY ROOM RATE IS _____. THE RATE MAY CHANGE AS REFERENCED ELSEWHERE IN THIS AGREEMENT.

Clear Form

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

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

The facility **does not** provide one on one nursing care. Should your condition become such that one on one nursing care is required, the Facility will not long be able to meet your needs and will assist you in making arrangements for transfer to another facility. Should your condition become such that assistance is needed with feeding, your family members or friends will not be allowed to assist with that feeding due to requirements of the Texas Department of Human Services. Futhermore, your family members or friends will not be allowed to render nursing care or other health care to you regardless of any license or certification they may hold.

II. A. You may choose any licensed physician to provide medical services to you, as long as your physician agrees to follow all medical staff policies and procedures required by the Facility or the Texas Health and Human Services Commission, Texas Department of Aging and Disability Services, Centers for Medicare and Medicaid Services or any other governmental entity or any requirements of your third party payor. Should your physician fail to follow any of the above, you agree to retain a licensed physician who will comply with the policies and procedures referred to above.

Physician:
Pharmacy: Advance Pharmacy of Houston
Dentist: Home Dental

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

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

Charges and Fees:

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

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

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

had before leaving the Facility. If requested, the Facility will assist you with a Medicaid application.

iii. Medicare Part A: If you are admitted to the Facility as a Medicare Part A recipient, you agree to pay all deductibles and co-payments amounts directly to the Facility. Our facility Medicare Intermediary is Mutual of Omaha. Should you have an insurance policy which pays all or a portion of your obligation to pay any deductible or co-payment, the Facility may, at its option, bill your insurance carrier directly for such payment. However, any such billing will not relieve you of your obligation for payment any unpaid amount your insurer fails for any reason to pay. Should your eligibility under Medicare Part A terminate while you are a resident of the facility, you may elect to leave the facility or continue your residency under the terms specified in this Agreement as either a Private Pay resident or Medicaid resident, if applicable. If you are originally admitted as a Medicare Part A and wish to continue as a resident after you no longer qualify under Medicare Part A but cannot pay for your care at the Facility, you should apply for Medicaid benefits. The Facility is certified to participate in the Medicaid program and will accept Medicaid payments. The facility does not accept pending Medicaid. If you are applying for Medicaid after your Medicare or third payor benefits have expired you can either pay privately or transfer to another facility.

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

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

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

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

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

B. Termination, Transfer or Discharge:

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

b. The Facility may terminate this contract without your consent for any one of the following reasons:
   1. The resident's needs cannot be met in the Facility;
   2. The safety or health of the Resident or other residents in the Facility are compromised by the continued Resident's placement in the Facility;
   3. The Facility ceases to operate; or
   4. Non-payment of any amounts due to the Facility for the Resident's care.

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

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

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

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

Clear Form

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

F. Non-Discrimination: The Facility strives to comply with Title VI of the Civil Rights Act of 1964 and sections 503-504 of the Rehabilitation Act of 1973 and all laws and regulations promulgated pursuant to those acts.

G. Employee Drug Testing Policy: Though it is regrettable, it is a fact of life in today's society that drug abuse is an ever present danger in all walks of life. In an effort to better insure the safety of our residents and improve the care they receive, this Facility has enacted a drug testing policy for our employees. If you are interested in a more detailed description of our drug testing policy, please ask us and we will be happy to supply you with a copy of our policy for employee drug tests.

H. Non-solicitation: During the term of this Agreement and for one (1) year following termination, you and/or your Responsible Party will not, directly or indirectly (e.g., by hiring or using another individual or entity that hires Facility's employees), employ or contract with any Facility employee who was employed by Facility during the time you were a resident of the Facility. You will not induce any Facility employee to terminate his/her relationship with the Facility. If you violate this provision you will pay the Facility a fee equal to the last 180 days compensation paid to the employee prior to the employment by you or your Responsible Party. The fee shall be due and payable on the first day of employment of the individual by you or your Responsible Party. The Facility may consider a waiver of this non-solicitation provision but any such waiver must be in writing in order to be effective or valid.

FINANCIAL AGREEMENT

The daily room rate for admission of the below named individual as a resident of BayWind Village (the Facility has been provided to the Resident and RESPONSIBLE PARTY. The resident will be admitted under one of the payment schemes set out below. The Facility must rely on the Resident and/or Responsible Party to assure that all applications or other documentation required of Medicaid, Medicare or any other third party payors and must rely on the resident and /or Responsible Party for assuring that payments for Resident's that are admitted as a private payor are made in a timely manner. The Resident and /or Responsible Party hereby express their understanding that the Facility will be damaged if the Resident and /or Responsible Party fail to meet these responsibilities.

If the Resident is admitted or becomes a qualified Medicaid recipient: The Resident and RESPONSIBLE PARTY agree to make payment of any applied income amounts which are to be paid in addition to reimbursement received from Medicaid. If the Resident is making application to Medicaid, the Resident and RESPONSIBLE PARTY acting on behalf of the Resident. will be responsible for payment of any charges which are not covered by Medicaid during the application process unless Medicaid retroactively covers those charges. Furthermore, if the Resident does not elect to have the applied income directly forwarded to the Facility, the Resident and RESPONSIBLE PARTY represent that RESPONSIBLE PARTY has control over that applied income and accepts responsibility for payment to the Facility. The Facility may assist the Resident or RESPONSIBLE PARTY in the application process for Medicaid, but the ultimate responsibility for application lies with the Resident and RESPONSIBLE PARTY. This provision includes the Responsible Parties for Residents who are admitted under Medicare, private pay or some other payor program and later qualify as Medicaid recipients. The Facility does not accept pending Medicaid. If the Resident is applying for Medicaid after his or her Medicare, other third party payor benefits or private pay funds have been exhausted the Resident must pay privately while the Medicaid application is being processed or transfer to another facility during that time period.

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

If the Resident is admitted under any program of private insurance or as a private payor: The Facility may assist in submitting charges for such payment, but ultimate responsibility for payment will remain the responsibility of the Resident and RESPONSIBLE PARTY. If the Resident is otherwise admitted to the Facility, the Resident and RESPONSIBLE PARTY agree to make payment of the daily room rate and charges for any other services requested by RESPONSIBLE PARTY or ordered by the Resident's physician which are supplied by the Facility or the Facility's contract services.

THE RESPONSIBLE PARTY IS RESPONSIBLE ONLY TO THE DEGREE WHICH THE RESPONSIBLE PARTY HAS LEGAL ACCESS TO THE RESIDENT'S INCOME OR RESOURCES.

Insurance Acknowledgement

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

I understand that my insurance provider _____ will only pay 100% for the first ____ days.

Beginning on day _____, I understand that I will be responsible for a co-payment in the amount of $_____ per day due to the facility if a co-insurance does not exist or if there are no skilled nursing benefits available through that insurance company.

Assignment of Benefits Form

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

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

TODAY'S DATE: _____

BENEFICIARY'S NAME: _____

BENEFICIARY'S HIC #: _____

ADMISSION SIGN DATE: _____

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

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

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

Continuation of therapy:

Your Insurance Company will follow your stay while here at Baywind. Every week all clinical information and therapy documentation will be reviewed and it will be determined if the care you are receiving needs to continue here or if you are ready to continue your care in the community. Upon discharge, your doctor may order Home Health Services that may include both Nursing and Therapy Intervention. If you request we will assist you in setting up these arrangements. If during your stay here you have any questions about this process, please contact the Discharge Planning Office.

FACILITY POLICIES

Admission Policies

1. Residents are admitted only upon the recommendation of a licensed physician, and must remain under the continuous care of a physician. At admission the resident must bring from his physician the following documentation:
   A. A history and physical including current medical findings, diagnosis, orders for immediate care and the resident's discharge and rehabilitation potential or
   B. A copy of a recent hospital discharge summary of history and physical examination report which contains all of the required information listed in above.
   If the admitting physician is not the attending physician the attending physician must see the resident within seven (7) days after admission and prepare a history and physical report to acknowledge the appropriate report from the hospital.
2. The attending physician must agree to visit the patient at admission and to conform to the following schedule:
   A. Visit resident in the Medicare facility at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter.
   B. For all other residents, visit every 30 days for the first 90 days and every 60 days thereafter.

3. The attending physician must provide or arrange for provision of physician services 24 hours a day in case of an emergency.

4. At the option of the physician required visits after the initial visit any alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

5. A written agreement must be signed at the time of admission by RESPONSIBLE PARTY and facility representative covering medical care, charges and refund policy. A copy will be furnished to the resident and /or RESPONSIBLE PARTY and/or legal representative.

6. The patient must bring adequate changes of clothing. All clothing and other personal items must be clearly marked with the patient's name and re-labeled as needed. The nursing home cannot assume responsibility for loss or damage to personal items.

7. The patient will have to the extent possible freedom of choice of rooms, pharmacy, and physician and all other health care services and providers. The facility reserves the right to re-assign residents to rooms according to the resident's medical needs.

Personal Laundry

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

Medications

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

Food

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

Transportation

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

Religion

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

Visitors

1. Visitors hours are 7 a.m. – 9 p.m.
2. Visitors are welcome. Residents are permitted to receive visitors and to associate freely inside or outside the facility with persons and groups of their choice unless medically contraindicated and documented in the resident's medical record by the attending physician.
3. Pets are allowed to visit once a copy of their current shot record has been provided to the facility. Pets must be kept on a leash and must be removed from the facility if loud barking or aggressive behavior occurs.

Social Care - Activities

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

Employees

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

Notification of Change

1. Except in a medical emergency or when the resident is incompetent, the facility must consult with the resident immediately and notify the resident's legal representative and/or RESPONSIBLE PARTY within 24 hours when any of the following occurs:
   a. An incident involving the resident which results in injury.
   b. A significant change in the resident's physical, mental, or psychosocial status.
   c. A need to alter treatment significantly or;
   d. A decision to transfer or discharge the resident.
   e. A room change.
2. The resident's physician is notified if there is a medical problem or any change in the resident's condition or in an emergency. If the attending physician or his designated alternate is not available the facility reserves the right to call the medical director to handle the emergency.

The resident and/or RESPONSIBLE PARTY and/or legal representative will be consulted when possible before contacting the medical director.

Valuables

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

Health, Safety, and Personal Rights

1. The health and safety of each resident is of major concern to this facility. All work procedures stress both sanitation and safety.
2. BayWind Village is a non smoking facility and therefore will not admit any smokers into the facility. ***This includes E-cigarettes.**
3. Smoking is not allowed in any area of the nursing home including the facility grounds.
4. The resident is not allowed to keep matches, cigarette lighters or other smoking paraphernalia in the room.

Rates and Billing Procedures

1. Rates are quoted on a daily basis and must be paid in advance upon billing.
2. Charges are made for the day of admission regardless of the time of admission.
3. For private pay clients, charges are also made for the day of discharge regardless of the time of discharge.
4. Accounts are due and payable on the first day of the month. A service charge of $50.00 will be assessed if payment is not made by the 10th of the month.
5. Medicaid residents are responsible only for the budgeted amount according to State and Federal guidelines.

Refund Procedure

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

Discharge - Transfers

1. Residents may be discharged only on physician's orders.
2. Accounts must be paid in full at the time of discharge.
3. A pre-discharge conference will be held with the discharge planner and family or RESPONSIBLE PARTY upon request.
4. All personal effects must be picked up from the facility immediately after discharge. Those effects not removed within 5 days will be discarded.
5. Married residents will be allowed to share rooms except where the physician documents medical reasons why this should not be done.
6. Transfers within the facility may be made at the request of the resident and/or RESPONSIBLE PARTY and/or legal representative. The facility will transfer or discharge a resident from the facility, or within the facility only under the following conditions:
    a. When the resident's needs cannot be met by the facility or in the section of the facility where she/he is located.
    b. The resident's health has improved and she/he no longer needs the services of the facility, or the section of the facility in which she/he is located.
    c. The safety and/or health of individuals in the facility is endangered.

d. Failure to pay the bill after reasonable notice.
e. The facility ceases to operate.
f. The resident and/or RESPONSIBLE PARTY and/or his legal representative request the transfer or discharge.

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

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

7. A resident is relocated to another room in the facility only when absolutely necessary in accordance with the reasons in #6. The relocation is made in accordance with the facility's relocation Resident Policy.

Wandering Residents

The resident and/or RESPONSIBLE PARTY fully understands that BayWind Village does not admit and does not retain residents who may wander off the grounds of the facility. This policy is for the ultimate protection of the resident.

Consequently, if a resident is admitted and at any time after the admission develops a behavioral problem where he/she is a threat to wander away from the facility the following action will be taken.

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

Holding Rooms

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

Grievance and Complaint Procedure

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

Discrimination Policy

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

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

Clear Form

Outside Appointments

Our staff must be informed of all outside appointments scheduled while at Baywind. Notify the **Charge Nurse** of who the appointment is with, date, time and location. This includes appointments that do not require facility transportation. Please give as much advance notice as possible of appointments. All outside appointments must be related to the diagnosis you are currently being skilled for and must be approved by our Director of Nursing. If approved and transportation is needed, notify the charge nurse so arrangements can be made.

If approved and transportation is not required, sign out with the Charge Nurse and get the "Outside Appointment Packet" that will be sent to all appointments.

BEDHOLD AND READMISSION POLICY

After placement in the nursing home, it may be necessary for the resident to go out of the facility for brief periods of hospitalization or therapeutic home visits. The facility will hold beds and readmit resident's under the following policies:

A. PRIVATE PAY

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

B. MEDICAID RECIPIENTS

While on therapeutic visits, the Medicaid program allows each resident to leave the facility for up to 72 consecutive hours at any one time. The days are counted in 24 hour periods from midnight to midnight. The resident is not charged a bedhold during the therapeutic leave. When the Medicaid resident is admitted to a hospital for a period in excess of 24 hours the Medicaid portion of the resident's bill must be paid by the resident in order for a bed to be held.

C. BEDHOLD POLICIES

A bed will be reserved for a resident for as long as the bedhold charges are paid when he/she is out of the facility. Bedhold charges may be discontinued at any time if the resident and/or the RESPONSIBLE PARTY notifies the Administrator's office and all the residents personal belongings are removed from the room. For a Medicaid recipient who does not hold a bed during his/her hospitalization, the resident may be admitted to the facility immediately upon the first available bed in a semi-private room in the Medicaid section of the facility. Bedhold is not available for Medicare residents.

WHEN THE FACILITY HOLDS A BED IT WILL NOT HOLD A SPECIFIC BED BUT WILL HOLD A BED IN THE FACILIY APPROPRIATE FOR THE RESIDENT'S READMISSION. THE FACILITY MAY REMOVE THE RESIDENT'S BELONGINGS TO A MORE SECURE LOCATION WHILE THE RESIDENT IS OUT OF THE FACILITY WHILE A BEDHOLD IS PAID.

WHEN A RESIDENT IS DISCHARGED FROM THE FACILITY (a resident is not considered d/c'd while on therapeutic leave or while a bedhold is being paid **THE RESIDENT'S PERSONAL BELONGINGS SHOULD BE REMOVED ASAP**. THE FACILITY MAY MOVE THE PERSONAL BELONGINGS TO A MORE SECURE LOCATION TO AWAIT THE REMOVAL BY THE R.P. OR FAMILY MEMBER. THE RESIDENT AND RESPONSIBLE PARTY GIVE THE FACILITY PERMISSION TO DISPOSE OF ANY PROPERTY LEFT AT THE FACILITY FOR OVER 5 DAYS AFTER DISCHARGE.

_____ I HAVE READ AND ACKNOWLEDGED THIS BEDHOLD POLICY AND REQUEST THAT THE FACILITY HOLD A BED FOR THE RESIDENT DURING ANY STAY AWAY FROM THE FACILITY. I AGREE TO PAY THE RATE DESCRIBED ABOVE TO HOLD THE BED.

_____ The resident does not wish to have a bed held under this policy.

Clear Form

Pharmacy Services Acknowledgement

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

PATIENTS RESIDING IN THE SKILLED UNIT:

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

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

_____Phone # of Pharmacy: _____

STATEMENT OF RESIDENT RIGHTS

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

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

You have a right:

1. to all care necessary for you to have the highest possible level of health;
2. to safe, decent and clean conditions;
3. to be free from abuse and exploitation;
4. to be treated with courtesy, consideration, and respect;
5. to be free from discrimination based on age, race, religion, sex, nationality, or disability and to practice your own religious beliefs; to have access to a translator if non English speaking.
6. to privacy, including privacy during visits and telephone calls;
7. to participate in a resident council if such a council has been organized or, if no council exists, to organize a council with the families of other residents.

8. to have facility information about you maintained as confidential;
9. to retain the services of a physician of your choice, at your own expense or through a health care plan, and to have a physician explain to you, in language you understand, your complete medical condition, the recommended treatment, and the expected results of the treatment;
10. to participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research;
11. to a written statement or admission agreement describing the services provided by the facility and the related charges;
12. to manage your own finance or to delegate that responsibility to another person;
13. to access money and property you have deposited with the facility and to an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on behalf of you;
14. to keep and use personal property, secure from theft or loss;
15. to not be relocated within the facility, except in accordance with nursing facility regulations;
16. to receive visitors;
17. to receive unopened mail and to receive assistance in reading or writing correspondence;
18. to participate in activities inside and outside the facility;
19. to wear your own clothes;
20. to discharge yourself from the facility unless you have been adjudicated mentally incompetent;
21. to not be discharged from the facility, except as provided in the nursing facility regulations;
22. to be free from any physical or chemical restraints for the purposes of discipline or convenience and not required to treat your medical symptoms.
23. receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee, to have any psychoactive medications prescribed and administered in a responsible manner, as mandated by the Health and Safety Code, 242.505, and to refuse to consent to the prescription of psychoactive medications; and
24. place an electronic monitoring device in your room that is owned and operated by you or provided by your guardian or legal representative.

Your rights may be restricted only to the extent necessary to protect you or another person from danger or harm or to protect a right of another resident, particularly those relating to privacy and confidentiality.

☐ I have received a copy of the above list of Resident's Rights.

Clear Form

RESIDENT ABUSE/NEGLECT REPORTING

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

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

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

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

If both the Director of Nursing and Administrator are unavailable the report should be made to the charge nurse: the charge nurse will be responsible for contacting the Director of Nursing or Administrator.

As applied in this policy, the following words have the following meaning:

Abuse – Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes verbal, sexual, mental, psychological, physical abuse (including corporal punishment, involuntary seclusion or any other mistreatment within this definition.

Verbal Abuse – The use of any oral, written, or gestured language that includes disparaging or derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability.

Sexual Abuse – Any touching or exposure of the anus, breast, or any part of the genitals of a resident without the voluntary, informed consent of the resident, and with the intent to arouse or gratify the sexual desire of any person, and includes but is not limited to sexual harassment, sexual coercion, or sexual assault.

Physical Abuse – Physical action within the definition of abuse in this paragraph which includes, but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

Involuntary Seclusion – The separation of a resident from others or from his or her room against his or her will or the will of his or her legal representative. Temporary monitored separation from other residents will be considered involuntary seclusion and may be permitted if used as a therapeutic intervention as determined by professional staff and consistent with the residents plan of care.

Mental/Psychological Abuse – The mistreatment within the definition of abuse in this paragraph which does not result in physical harm and includes, but not limited to, humiliation, harassment, threats of punishment, deprivation, or intimidation.
Exploitation – The illegal or improper act or process of a caretaker using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain.
Neglect – A deprivation of life's necessities of food, water or shelter, or failure of an individual to provide services, treatment or care to a resident which causes mental physical injury or harm or death to the resident.
An employee who fails to report an incident of abuse, neglect or exploitation will be subject to disciplinary action up to and including termination. Failure to report such an incident of abuse, neglect or exploitation may subject the individual to criminal prosecution.

Per the State's Operation Manual, the facility will report the allegation to the Intake Coordinator, Investigations Section, Long Term Care – Regulatory at 1-800-458-9858. Allegations occurring after 5:00 p.m., or on weekends or holidays, are reported by calling 1-800-458-9858 and leaving a message.

An employee accused of resident abuse/neglect will be removed from the schedule immediately.

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

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

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

All reports of alleged abuse shall be kept confidential.

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

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

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

As part of the admissions process I have received and reviewed a copy of the facility policy and procedure regarding abuse prevention, reporting, and documentation and I have been made aware that the Facility Administrator, Chris Barcelo, is the Abuse Coordinator.

ACKNOWLEDGEMENT

-ADVANCED DIRECTIVES-

Resident's Name: _____ Social Security Number: _____

Medical Record Number: _____ Date of Birth: _____

PLEASE READ THE FOLLOWING STATEMENTS.

1. I have been given written materials about my rights to refuse or accept medical treatment.
2. I have been informed of my rights to formulate Advance Directives.
3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this facility.
4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK AND INITIAL ONE OF THE FOLLOWING STATEMENTS:

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

☐ _____ I **HAVE NOT** executed an Advance Directive.

PLEASE CHECK AND INITIAL ONE OF THE FOLLOWING STATEMENTS:

☐ _____ **DO NOT RESUSCITATE**

☐ _____ **RESUSCITATE**

RESIDENT: _____
RESPONSIBLE PARTY:

_____ _____
RP SIGNED NAME SIGN DATE

FACILITY REPRESENTATIVE:

_____ _____
FACILITY REP SIGN DATE

ADVANCE CARE PLANNING EDUCATIONAL MATERIAL

PLEASE READ THE FOLLOWING STATEMENT

I HAVE RECEIVED A COPY OF THE DADS HANDOUT ON ***"FREQUENTLY ASKED QUESTIONS ABOUT ADVANCED CARE PLANNING"***. THE HANDOUT WAS DISCUSSED AND ALL QUESTIONS WERE ANSWERED.

FREQUENTLY ASKED QUESTIONS ABOUT ADVANCED CARE PLANNING

WHAT IS ADVANCED CARE PLANNING

ADVANCED CARE PLANNING MEANS PLANNING AHEAD FOR HOW YOU WANT TO BE TREATED IF YOU ARE VERY ILL OR NEAR DEATH. SOMETIMES WHEN PEOPLE ARE IN AN ACCIDENT OR HAVE AN ILLNESS THAT WILL CAUSE THEM TO DIE THEY ARE NOT ABLE TO TALK OR LET OTHERS KNOW HOW THEY FEEL. TEXAS LAW ALLOWS YOU TO TELL YOUR DOCTOR HOW YOU WANT TO BE TREATED BY USING AN ADVANCED DIRECTIVE. CHAPTER 165 OF THE TEXAS HEALTH AND SAFETY CODE IS THE STATE LAW ON ADVANCE CARE PLANNING THROUGH ADVANCE DIRECTIVES. CHAPTER 165 EXPLAINS ADVANCE DIRECTIVES, INCLUDES FORMS TO USE FOR ADVANCE DIRECTIVES AND STATES HOW MEDICAL DECISIONS CAN BE MADE WHEN A PERSON DOES NOT HAVE AN ADVANCE DIRECTIVE.

ADVANCE CARE PLANNING IS A 5 STEP PROCESS.

*THINK ABOUT WHAT YOU WOULD WANT TO HAPPEN IF YOU COULD NOT TALK OR COMMUNICATE WITH ANYONE.

*FINDING OUT ABOUT WHAT KIND OF CHOICES YOU WILL NEED TO MAKE IF YOU BECOME VERY ILL AT HOME, IN A NURSING HOME OR IN A HOSPITAL.

*TALKING WITH YOUR FAMILY AND YOUR DOCTOR ABOUT HOW YOU WANT TO BE TREATED.

*FILLING OUT PAPERS THAT SPELL OUT WHAT YOU WANT IF YOU ARE IN AN ACCIDENT OR BECOME ILL.

*TELLING PEOPLE WHAT YOU HAVE DECIDED.

QUESTIONS AND ANSWERS ABOUT ADVANCE CARE PLANNING

IF I GET TOO SICK TO SAY WHAT KIND OF HELP I WANT FROM DOCTORS OR NURSES, WHAT CAN I DO?

PUTTING YOUR WISHES IN WRITING MAKES SURE THAT EVERYONE KNOWS WHAT YOU WANT. YOU CAN DO THIS BY USING A FORM CALLED *DIRECTIVE TO PHYSICIANS, FAMILY AND SURROGATES.* THE FORM IS ALSO SOMETIMES CALLED A *LIVING WILL.* THE FORM TELLS DOCTORS, FAMILY MEMBERS OR OTHER PEOPLE WHO ARE CLOSE TO YOU THE TYPE OF HELP YOU WANT WHEN YOU ARE SICK AND HOW YOU WANT TO BE TREATED. THE DOCUMENT INCLUDES WRITTEN INSTRUCTIONS ON THINGS THAT YOU WANT AND DO NOT WANT DONE TO YOU.

DO I HAVE TO FILL OUT THIS FORM?

NO. NO ONE CAN MAKE YOU FILL OUT THIS FORM BUT WITH IT THE PEOPLE HELPING YOU WILL KNOW WHAT YOU WANT IF YOU CAN'T TELL THEM.

CAN I CHANGE MY MIND ABOUT WHAT I SAY ON THE FORM?

YES. YOU CAN DO THAT AT ANY TIME YOU WANT. IF YOU CHANGE YOUR MIND, YOU MUST MAKE OUT A NEW FORM AND THROW AWAY THE OLD ONE RATHER THAN MAKE THE CHANGES ON THE OLD

FORM. THAT WAY, NO ONE MAKES A MISTAKE WHEN THEY ARE TRYING TO HELP YOU. *IT'S ALSO A GOOD IDEA TO TELL YOUR FAMILY AND DOCTOR THAT YOU HAVE CHANGES YOUR WISHES. **REMEMBER**, THIS FORM CAN ONLY BE USED WHEN YOU CAN'T TELL PEOPLE WHAT YOU WANT. IF YOU ARE AWAKE AND ABLE TO SAY WHAT YOU WANT, THEN THAT IS THE ONLY THING THAT MATTERS.

CAN SOMEONE SPEAK FOR ME IF I AM NOT ABLE TO SAY WHAT I WANT?

YES. YOU CAN FILL OUT A FORM CALLED A *MEDICAL POWER OF ATTORNEY.* THIS FORM LETS YOU NAME SOMEONE TO SPEAK FOR YOU. THE PERSON YOU NAME IS CALLED AN AGENT ON THE FORM. YOU CAN CHOOSE ANYONE YOU WANT TO BE YOUR AGENT. IT DOES NOT HAVE TO BE A MEMBER OF YOUR FAMILY. BUT REMEMBER, IT IS ALWAYS IMPORTANT FOR YOUR FAMILY TO KNOW WHAT YOU WANT BEFORE SOMETHING HAPPENS TO YOU. *IF YOU DON'T NAME SOMEONE TO BE YOUR AGENT, THEN THE STATE LAW HAS A SET OF RULES FOR HOW DECISIONS WILL BE MADE FOR YOU.

WHAT ARE THE RULES?

DO I NEED A LAWYER TO FILL OUT ANY OF THESE FORMS?

NO. YOU CAN FILL THEM OUT YOURSELF. YOU CAN ASK A LAWYER TO HELP YOU, BUT YOU DO NOT HAVE TO. ONCE YOU HAVE FILLED OUT THE FORMS ALL YOU HAVE TO DO TO MAKE THEM LEGAL IS SIGN THEM IN FRONT OF THE PROPER WITNESSES. YOU DO NOT NEED A NOTARY PUBLIC.

DO DOCTORS, NURSES AND HOSPITALS HAVE TO FOLLOW MY INSTRUCTIONS?

YES, UNLESS THEY INFORM YOU IN ADVANCE THAT THEY CANNOT. IF THEY DO NOT INTEND TO HONOR YOUR WISHES, THEY ARE REQUIRED TO GIVE YOU A REASONABLE OPPORTUNITY TO OR ASSIST YOU TO TRANSFER TO A PHYSICIAN OR HEALTH CARE PROVIDER WHO WILL COMPLY WITH YOUR WISHES. HEALTH CARE PROFESSIONALS CANNOT SIMPLY IGNORE YOUR WISHES.

OTHER QUESTIONS ABOUT HOSPITALS, NURSING FACILITIES AND THE TREATMENT AT THE END OF LIFE

SOMETIMES PEOPLE HAVE QUESTIONS ABOUT WHEN IT MAKES SENSE FOR THEM TO MOVE FROM A NURSING FACILITY TO A HOSPITAL. THE FOLLOWING INFORMATION TRIES TO ANSWER SOME OF THESE QUESTIONS.

IF I'M IN A NURSING FACILITY AND GET VERY SICK, SHOULD I STAY WHERE I AM OR GO TO THE HOSPITAL?

THIS IS A CHOICE YOU WILL HAVE TO MAKE AFTER YOU TALK TO YOUR DOCTOR OR FAMILY MEMBERS. I F YOU CAN GET THE CARE YOU NEED WHERE YOU ARE, IT IS OFTEN SAFER AND MORE COMFORTABLE TO STAY IN THE NURSING FACILITY. MOVING TO THE HOSPITAL CAN CAUSE PROBLEMS BECAUSE THE PEOPLE WORKING THERE DO NOT KNOW EVERYTHING ABOUT YOU. SOMETIMES THIS LEADS TO PROBLEMS WITH MEDICATIONS, PRESSURE SORES AND INFECTIONS. ASK YOUR DOCTOR IF THERE ARE THINGS YOU NEED THAT THE NURSING FACILITY CAN'T DO FOR YOU. MAKE SURE YOU UNDERSTAND ALL THE RISKS IN MOVING OR STAYING WHERE YOU ARE.

WHAT IS AN OUT-OF-HOSPITAL DO NOT RESUSCITATE ORDER (OOHDNR)?

THIS FORM IS FOR USE WHEN YOU ARE NOT IN THE HOSPITAL. IT LETS YOU TELL HEALTH CARE WORKERS, INCLUDING EMERGENCY MEDICAL SERVICES (EMS WORKERS, NOT TO DO SOME THINGS IF YOU STOP BREATHING OR YOUR HEART STOPS. IF YOU DON'T HAVE ONE OF THESE FORMS FILLED OUT, EMS WORKERS WILL ALWAYS GIVE YOU CPR OR ADVANCED LIFE SUPPORT EVEN IF ADVANCE CARE PLANNING FORMS SAY NOT TO. YOU SHOULD COMPLETE THIS FORM AS WELL AS THE DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES AND THE MEDICAL POWER OF ATTORNEY FORM IF YOU DON'T WANT CPR.

WHAT IS CARDIOPULMONARY RESUSCITATION (CPR)?

Clear Form

YOU HAVE PROBABLY SEEN THIS ON TV. CPR IS PRESSING ON YOUR CHEST TO KEEP BLOOD FLOWING AND ALSO ASSISTANCE WITH BREATHING, SUCH AS MOUTH TO MOUTH ASSISTANCE. SOMETIMES ELECTRICAL SHOCKS ARE USED TO HELP START THE HEART. CPR IS ONLY USED FOR SHORT PERIODS UNTIL A PERSON CAN GET TO THE HOSPITAL.

DOES CPR ALWAYS WORK?

NO IT DEPENDS ON OTHER THINGS, INCLUDING YOUR OVERALL HEALTH AND YOUR AGE. EVERYONE IS DIFFERENT. IT DOES NOT WORK VERY WELL FOR MOST PEOPLE WHO HAVE A LIFE-THREATENING ILLNESS OR ARE OVER 80. YOU SHOULD TALK ABOUT CPR WITH YOUR DOCTOR AND DISCUSS WHAT IS BEST FOR YOU AND WHAT BEST FITS WITH YOUR PERSONAL VALUES AND GOALS.

WHAT IS ARTIFICIAL RESPIRATION OR VENTILATION?

THIS MEANS GETTING ASSISTANCE WITH BREATHING WHEN YOU CAN'T BREATHE ON YOUR OWN. A TUBE IS PUT INTO YOUR NOSE OR MOUTH OR INTO YOUR WINDPIPE. IF THIS TUBE IS NEEDED FOR MORE THAN A FEW WEEKS, A SURGEON WILL PROBABLY NEED TO PUT THE TUBE DIRECTLY INTO YOUR THROAT. DOING THIS CAUSES PROBLEMS WITH TALKING, EATING AND DRINKING. THE TUBE IS ALSO ATTACHED TO A MACHINE, WHICH MAKES IT HARDER TO MOVE AROUND.

EATING, DRINKING AND PAIN DURING A TERMINAL ILLNESS

WHAT IS ARTIFICIAL NUTRITION AND HYDRATION?

THESE ARE MEDICAL TREATMENTS THAT ALLOW A PERSON TO GET FOOD AND WATER WHEN THEY CANNOT EAT OR DRINK. FLUIDS CAN BE GIVEN THROUGH A NEEDLE PLACED IN A VEIN (IV. THIS IS USUALLY DONE FOR ONLY A FEW DAYS BECAUSE OF THE RISK OF INFECTION AND BECAUSE IT IS HARD TO KEEP THE NEEDLE IN PLACE. SOMETIMES FOOD AND WATER ARE GIVEN THROUGH A TUBE THAT GOES DOWN THE NOSE AND THROAT INTO THE STOMACH. IF THE TUBE NEEDS TO BE IN PLACE FOR A LONG TIME, IT IS PLACED DIRECTLY INTO THE STOMACH BY A SURGEON.

THESE DIFFERENT KINDS OF TUBE FEEDINGS ARE DIFFERENT FROM ORDINARY EATING AND DRINKING BECAUSE THEY DON'T LET THE PERSON TASTE OR FEEL FOOD AND LIQUIDS LIKE THEY ARE USED TO DOING. ALSO, THE PERSON IS NOT IN CONTROL OF THEIR FOOD OR LIQUID INTAKE. DOCTORS AND NURSES DECIDE HOW MUCH FOOD AND WATER THEY SHOULD HAVE IN THIS WAY.

DO ARTIFICIAL NUTRITION AND HYDRATION MAKE PEOPLE LIVE LONGER?

SOMETIMES, BUT NOT ALWAYS. HOW EFFECTIVE THESE KINDS OF TREATMENTS ARE DEPENDS ON OTHER MEDICAL PROBLEMS. WHEN A PERSON WITH A TERMINAL ILLNESS CAN'T EAT OR DRINK IT USUALLY MEANS THAT THE BODY HAS STOPPED WORKING LIKE IT SHOULD AND IT WILL NOT IMPROVE. IF THIS IS THE CASE, TUBE FEEDINGS ALONE WILL NOT MAKE THE PERSON HEALTHY AGAIN. IT MAY EVEN MAKE THE PERSON UNCOMFORTABLE DURING THEIR FINAL DAYS.

WHAT ABOUT PAIN AND CONTROL?

IF A PERSON HAS A MEDICAL PROBLEM THAT WILL CAUSE THEM TO DIE AND THEY DON'T WANT ARTIFICIAL TREATMENT, THEY CAN STILL BE COMFORTABLE. MAKING PEOPLE COMFORTABLE DURING THE FINAL PART OF THEIR LIFE IS CALLED *PALLIATIVE CARE*. EVEN IF THERE IS NO CURE FOR A CONDITION, DOCTORS CAN TREAT PAIN, NAUSEA AND DISCOMFORT. COMFORT SHOULD ALWAYS BE PART OF THE TREATMENT PLAN THAT A DOCTOR DISCUSSES WITH A PATIENT OR FAMILY.

THE IMPORTANCE OF ADVANCE CARE PLANNING

EVERYONE IS GOING TO DIE SOMETIME, BUT NOT EVERYONE GETS TO CHOOSE HOW THEY ARE TREATED AT THE END OF THEIR LIVES. TAKING THE TIME TO DO ADVANCE CARE PLANNING CAN HELP FAMILY MEMBERS AND MEDICAL STAFF ACT FOR YOU. THEY WILL BE FACED WITH HARD DECISIONS NEAR THE TIME OF YOUR DEATH. HAVING AN ADVANCE CARE PLAN LETS YOU MAKE SURE THAT YOU ARE TREATED ACCORDING TO YOUR VALUES AND WISHES REGARDLESS OF WHETHER YOU CAN SPEAK FOR YOURSELF.

Clear Form

Grievance Reporting

POLICY:

Grievance Reporting

PROCEDURE:

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

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

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

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

(4 If the grievance is not handled in a timely manner or in a manner satisfactory to the resident or the representative, the resident or representative may contact the Ombudsmen responsible for this facility. The Ombudsmen is a specially trained volunteer who can provide information to residents and their representatives about the rights of the resident and procedures regarding the resident's care. The Ombudsmen can work with residents and facility staff to resolve complaints or difficulties. The Ombudsmen may be contacted through the State Ombudsmen Program at 800.437.7396

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

Clear Form

Lost and Found Personal Belongings

Upon admission the Resident/RESPONSIBLE PARTY will be informed that the Facility cannot assume responsibility for the loss or theft of valuables.

It is the policy of this facility to make every effort possible to prevent loss or damage to a resident's personal belongings.

All personal property brought into the facility must be clearly marked with RESIDENT'S NAME and placed on the resident's inventory sheet.

The inventory sheet is located in the resident's chart. The Resident/RESPONSIBLE PARTY should inform the nurse when bringing in any personal property or when personal property is removed from the facility.

The following procedure should be followed when an item is reported missing:
**A Missing Item Report form must be completed as soon as the item(s is known to be missing. Forms are available at the nurse's station.
**The Activities Director, when available, will search for the personal property, clothing, etc.
**Responsible Parties shall not be allowed to search other resident rooms under any condition.
**If the missing item is located, the resident/RESPONSIBLE PARTY is notified immediately.
**If after an extensive search the missing item cannot be located, then the Resident/RESPONSIBLE PARTY will be notified.

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

Clear Form

Restraint Proper Environment

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

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

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

Restraint Proper Environment
Statement of Understanding

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

PERMISSION FOR USE OF RESTRAINTS

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

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

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

Clear Form

CONSENT FOR PODIATRY CARE

I, a current resident at BAYWIND VILLAGE hereby authorize the attending physician or other designated person(s) to order the following services as deemed necessary:

1. Consent for a Podiatrist to provide evaluation that deals with the prevention, diagnosis, treatment of medical and surgical conditions of the feet and lower limbs.
2. Evaluation and treatment of the foot which include trimming nails, corns and calluses.
3. Assessment and management of wounds, ingrown toenails and ulcers that occur on the foot.
4. Evaluation and treatment for debridement and surgery as needed.
5. Evaluation and treatment for other needed podiatry care.

CONSENT FOR EYE EXAMS

I, RESIDENT'S NAME, a current resident at Baywind Village hereby authorize the attending physician or other designated person(s) to order the following services as deemed necessary:

1. Quarterly examinations by an optometrist to identify defects in vision and eye disorders in order to prescribe corrective lenses or other appropriate treatment.
2. Perform complete dilated eye exams to include a glaucoma check.
3. Perform diagnostic tests needed to determine diagnosis.
4. Provide prescriptions for eye glasses.
5. Ophthalmology needs will be referred to the attending physician.

Baywind Village

411 Alabama Avenue
League City, Texas 77573

CONSENT TO PHOTOGRAPHY

I, a current resident at Baywind Village hereby authorize the attending physician or other designated person(s) to take: (Please check yes or no below)

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

Clear Form

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

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

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year_____

ADDRESS _____

_____

CITY _____ **STATE**_____ **ZIP**_____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

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

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

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

Your initials are required to release the following information:

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

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 44 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

Clear Form

Resident Influenza Vaccine
Informed Consent Form

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

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

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

Special Precautions. Influenza vaccine virus is grown in eggs. Persons who are allergic to eggs, chicken feathers or chicken dander should not receive this vaccine. Persons with fever should not receive this vaccine. Persons who have received another type of vaccine within the last 14 days should see their personal physician before receiving this vaccine. If you have ever had Guillain-Barre Syndrome (a severe paralytic illness), you should check with your personal physician before receiving the vaccine.

Residents will be monitored for side effects for 24 hours. If a resident has a reaction, his or her personal physician will be notified immediately. If you have any questions, please ask.

Consent / Declination

I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the Influenza Vaccine as described.

I request the Influenza Vaccine be given _☐___.

I request the Influenza Vaccine **not** be given _☐__.

Resident has already had the Flu Vaccine this season. _☐___ When _____

The 2015-2016 **CDC Vaccine Information Statement for Influenza (VIS) was provided to me on SIGN DATE**

Verbal consent: The Responsible Party instructed to sign consent as soon as possible. ___

Nurse's Signature _____ Date: _____ Time: _____

Clear Form

Resident Pneumonia Vaccine
Informed Consent Form

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

The Vaccine. PPV is relatively safe. The vaccine contains purified proteins from 23 serotypes of inactivated or destroyed pneumococcal bacteria. Getting vaccinated is particularly important since penicillin and other antibiotics that once eradicated these infections are no longer as effective as they once were. Usually one dose is all that is needed. Another dose can be given to those over 65 if 5 or more years have passed since the last dose. PPV may be less effective in some people, especially those with lower resistance to infection. These people should still be vaccinated, because they are more likely to get seriously ill from pneumococcal disease.

Risks and Possible Side Effects. The most common reactions include soreness, warmth, erythema, swelling and induration (localized hardening) at the injection site. A fever less than 102 degrees has also been reported in less than 1% receiving this vaccine. Severe allergic reactions are rare; which are hives and difficulty breathing.

Residents will be monitored for side effects for 24 hours. If a resident has a reaction, his or her personal physician will be notified immediately. If you have any questions, please ask.

Consent / Declination

I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the pneumonia vaccine as described.

I request the Pneumonia Vaccine be given _☐_.

I request the Pneumonia Vaccine **not** be given _☐_.

Resident has already had the Pneumonia Vaccine. _☐_ When _____

The **CDC Vaccine Information Statement for Pneumonia (VIS) was provided to me on SIGN DATE**

Clear Form

Resident Tuberculosis Screening
BAYWIND VILLAGE CARE CENTER
411 Alabama
League City, TX 77593

Information:

Mycobacterium tuberculosis (TB) is a disease which is carried through the air in small particles when people who have active TB cough, speak or sing. It typically affects the lungs but can also affect the heart, kidneys, bones, and other organs of the body. The Tuberculosis skin test is one way of identifying TB infection. You cannot get TB from the skin test. All residents (short/ long-term) are required to have a TB test upon admission and once yearly for as long as they reside with us. If the RESPONSIBLE PARTY or resident refuses to have a TB test done, the Dr. will order a chest x-ray be done.

Side Effects:

If you have been exposed to TB in the past, than you can expect swelling and redness To develop at the test site. A blister or scar may also result. Some individuals may complain that the site is itchy. If there is a positive reaction to the TB test Baywind Village administers, a chest x-ray will then be done to rule out active disease.

Precautions:

The TB skin test will not be given to any person(s) who have had a positive reaction in the past, who have had an active case of TB, or who have taken TB medications in the past. If any of this applies to the resident, please tell the nurses upon admission.

If you have ever received a BCG (bacilli Calmette-Guerin) vaccine (given in foreign countries), it is not a contraindication for receiving the TB skin test. The test shall be given and interpreted routinely.

The nurse will administer the test to the forearm and the site will be read in 2-3 days (no less than 48 hrs & no greater than 72 hrs).

☐ **I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION ON THIS FORM ABOUT TUBERCULOSIS SKIN TEST. I GIVE MY CONSENT TO HAVE THIS TEST PERFORMED.**

Clear Form

"Inspection of Records Policy"

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

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

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

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

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

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

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.

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

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

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

a. Uses and disclosures required by law;
b. Uses and disclosures for public health activities;
c. Disclosures about victims of abuse, neglect or domestic violence;
d. Uses and disclosures for health oversight activities;
e. Disclosures for judicial and administrative proceedings;
f. Disclosures for law enforcement purposes;
g. Uses and disclosures about decedents;

Clear Form

h. Uses and disclosures required for cadaveric organ, eye or tissue donation purposes;
i. Uses and disclosures for research purposes;
j. Uses and disclosures to advert a serious threat to health or safety;
k. Uses and disclosures for specialized government functions; and
l. Disclosures for workers compensation.

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

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

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

a. Requesting restrictions on certain uses and disclosures of protected health information;
b. BayWind Village is not required to agree to a requested restriction;
c. The individual's right to receive confidential communications of protected health information, as applicable;
d. The individual may exercise his/her right to inspect, copy, amend, and receive an accounting of disclosure of protected health information as provided in the Facility's policies;
e. The individual may exercise his/her right to obtain a paper copy of the notice from the covered entity, even if the individual has agreed to receive the notice electronically, as provided by the Facility's policies;
f. BayWind Village is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
g. BayWind Village is required to abide by the terms of the notice that is currently in effect;
h. For protected health information that is created or received prior to issuing a revised notice, BayWind Village reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains;
i. BayWind Village will promptly revise and distribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, the covered entity's legal duties, or other privacy practices stated in the notice, and how it will provide individuals with the revised notice;
j. Individuals may complain to BayWind Village and to the Department of Health and Human Services if they believe their privacy rights have been violated.
k. An individual may file a complaint with BayWind Village by contacting the Administrator, his/her designee or the Director of Nurses;
l. BayWind Village will not retaliate against the individual for filing a complaint;
m. An individual may contact the Facility's Administrator or Director of Nursing for further information concerning the notice of privacy practices.

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

BayWind Village will promptly revise and redistribute its notice whenever there is a material change to the uses or disclosures, the individual's rights, BayWind Village legal duties, or other privacy practices stated in the notice.
Knowledge of a violation or potential violation of this policy must be reported directly to the Facility Administrator, his/her designee or the Director of Nursing.

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

HIPPA Compliance Officer
Chris Barcelo, Administrator
411 Alabama League City, Texas 77573
Phone # 281-332-9588 Fax# 281-316-2715

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

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

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

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

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

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

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

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

_☐_ Placement of RESIDENT'S NAME on or near the resident's door designating the resident's room.
_☐_ Disclosure of the fact that the resident resides at the Facility.

Clear Form

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

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

1. Specific description of information that may be used/disclosed:

MEDICAL INFORMATION AND UPDATES, PLACEMENT OF RESIDENT'S NAME ON DOOR, DISCLOSURE THAT RESIDENT LIVES IN FACILITY, USE OF COMMUNICATION BOARDS IN RESIDENT ROOM, USE OF RESIDENT NAME ON MEDICAL RECORD AT NURSES STATION

2. The information will be used/disclosed for the following purpose(s):

ON A AS NEEDED BASIS

3. Persons/organizations authorized to use or disclose the information:

BAYWIND VILLAGE STAFF, PHYSICIAN AND PHYSICIAN'S STAFF

4. Persons/organizations authorized to receive the information:

_____

_____

5. BayWind Village is restricted from disclosing specific individual identifiable health information as follows:

_____

6. The person/organization authorized to use/disclose the information will NOT receive compensation for doing so.

7. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

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8. If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, BayWind Village reserves the right to deny treatment associated with such research.

9. If the purpose of this authorization is to disclose health information to another party base on health care that is provided solely to obtain such information, and I refuse to sign this authorization, BayWind Village reserves the right to deny that health care.

10. I understand that I may inspect or copy the information used or disclosed

11. I understand that I may revoke this authorization at any time by notifying BayWind Village in writing, except to the extent that:

a. Action has been taken in reliance on this authorization; or
b. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

12. I understand that I have a right to request and receive a Notice of Privacy Practices from BayWind Village.

13. This authorization expires on the day of discharge.

RESIDENT NAME:

RESPONSIBLE PARTY: **SIGN DATE**

_____

FACILITY REPRESENTATIVE: **SIGN DATE**

Clear Form

NURSING FACILITIES
PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

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

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

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

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its Stated purpose. The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-0528, published in the Federal Register at Vol. 72, no. 52/Monday, March 19, 2007. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1)To support agency contractors, consultants or grantees who have been engaged by the agency to assist in accomplishment of a CMS function; (2) assist another Federal or state agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds; (3) assist Quality Improvement Organizations to perform Title XI or Title XVIII functions; (4) assist insurance companies, underwriters, third party administrators, employers, group health plans for purposes of coordination of benefits with the Medicare Program; (6) the Federal Department of Justice, court, or adjudicatory body in litigation; (7) to support a national accrediting organization to enable them to target potential or identified problems with accredited facilities; (8)assist a CMS contractor in the administration of a CMS-administered health benefits program; (9) to assist another Federal agency that administers or that has the authority to investigate potential fraud, waste or abuse in a health benefits program funded in whole or part by Federal funds.

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

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

Clear Form

Authorized Electronic Monitoring

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

If you choose to use AEM please contact the Admissions Manager.

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

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

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

A. Miscellaneous

1. Sewing machines and related equipment
2. Sewing scissors and materials. *Scissors must be blunt nosed*.
3. Hobby tools and equipment.
4. Personal articles – like furniture, books, photos, electric razors, TV's, radios, stereos and telephones.
5. Personal grooming supplies, cosmetics and toiletries to include incased disposable razors.
6. Atomizer sprays.
7. Pump containers such as hair sprays and body deodorant.
8. Medications when approved by the team and with a physician's order. They must be kept in the locked area provided.

B. The administrator should ensure the staff and residents are aware of the following safety concerns.

a) Danger of ingestion, inhalation, or eye contact by spraying the contents in the face.
b) Fire hazard or creation of toxic gas caused by spraying the contents across an open flame.
c) Danger of explosion in the event of a fire.

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

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

The following non-legend, commercially manufactured external, or topical preparations and substances when bearing the manufacturer's label, may be allowed in resident's rooms:

a. Petroleum jelly
b. Analgesic creams, balms, or ointments for topical application
c. Talcum powder
d. Foot powder, foot cream, or foot ointment used for comfort or odor
e. Olive oil
f. Mouthwash used for dental hygiene and toothpaste
g. Medicated facial cream or cold cream
h. Lip balm or ointment used for dry, chapped lips.
i. Cough drops (non-antibiotic and no-decongestant)

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

A. Medications
1. Legend and non-legend drugs except under conditions as noted in items 1.A.8.
2. Liniments
3. Eye, ear, and nasal preparations
4. Any preparation or substance bearing a warning statement except those noted in items 1.A.8.

B. Fuel burning space heaters
C. Portable electric heaters
D. Cooking and ironing equipment
E. Coffee and cup heating elements
F. Throw rugs
G. Razor blades and straight razors (except as permitted in1.A.5.)
H. Chemical products
1. Flammable liquids
2. Laundry and house cleaning products
I. Smoking tobacco, matches, lighters, or other smoking paraphernalia.

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II. The following is a list of the BayWind Village allowable and non-allowable items.

A. Allowable

1. Tooth brush, tooth paste, mouth wash – non-alcohol
2. Perfume with Dabber
3. Liquid Soap
4. Hair brush, comb and pump hair spray
5. Deodorant-Stick
6. Efferdent and Denture Cups

B. Non-allowable

1. Prescription Medication, Over the Counter Drugs, and Supplements/ Vitamins
2. Body Powder
3. Aerosol Hair spray, Air Freshener and Perfume
4. Nail Polish and Remover
5. Mineral Oil
6. Laundry Detergent
7. Outside food

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

BAYWIND VILLAGE

POWER STRIP POLICY

POLICY STATEMENT

The Facility recognizes that certain electrical equipment requires the use of power strips and has enacted this policy to insure the appropriate and safe use of power strips. For purpose of this policy a "power strip" is a surge protector containing one or more plugs.

Policy Interpretation and Implementation

1 Power strips are only allowed for usage by facility staff and residents if they comply with this policy. The term "power strip" as used in this policy only refers to electrical devices containing electrical plugs AND a surge protector. Simple devices meant only to multiply the number of available plugs for an electrical outlet will not be considered a "power strip."

2 Surge protectors may only be used for computers, monitors, printers, certain televisions and other electrical equipment for which a surge protector is recommended by the manufacturer.

3. The total number of items plugged into a power strip will not exceed one plus the number of empty plugs in the electrical outlet in which the power strip is plugged. (eg: If the outlet will accommodate two plugs and the power strip is plugged into one and the other is open, two appropriate items may be plugged into the power strip. If the outlet is completely filled with the power strip plugged in and no open places on the outlet only one item may be plugged into the power strip.)

4. Power strips must be connected to a permanently installed receptacle. If a power strip is near water source the strip must be connected to an outlet with ground fault circuit interruption.

5. Power strips may not be used as an extension cord or for the purpose of accommodating a lack of electrical plugs. (See item 3 above)

6. Power strips may not be used with medical equipment in patient care areas.

7. Power strips are not to be routed through walls, windows, ceilings, floors, or similar openings.

8. Damaged power strips shall be discarded and replaced immediately.

9. The Director of Maintenance will ensure that the above guidelines are adhered to. Any violations of the rules listed above will be reported to the Administrator immediately and corrected.

10. Residents and families who repeatedly violate this policy will pose a risk to residents of this Facility and subject to discharge.

Generic Drug Policy

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

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

Durable Medical Equipment

Upon admission to Baywind Village residents admitted under a skilled nursing stay will be issued durable medical equipment to meet their individual needs. While there is no charge for the use of the equipment during the stay, the equipment must be left with the facility upon discharge. If equipment is taken from the facility at discharge the following charges will be billed to the resident and /or RESPONSIBLE PARTY.

Wound Vac	$7500
CPM Machine	$3000
Wheel Chair	$225.00
Concentrator	$650.00
Nebulizer	$50.00
Walker	$100.00
TV Remote	$15.00

Clear Form

BAYWIND VILLAGE

Baywind Village Skilled Nursing Center
Discharge & Home Health Information Form

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

Date of Discharge Consult: _____
RESIDENT'S NAME_____SS #_____
Equipment Ordered: _____

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

Home Health Providers

Village Home Health* ☐

A-1 Home Health ☐

Memorial Hermann Home Health ☐

Encompass ☐

Coastal Home Health ☐

****Some individuals in the ownership or management of these companies may also be owners or managers of Baywind Village Care.***

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

_____ _____
Patient/Caregiver **Facility Representative**

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

_____ _____
Patient/Caregiver **Facility Representative**