CHEYENNE MANOR
CARING & SHARING
A SENIOR CARE FACILITY

561 West 1st North
PO Box 938
Cheyenne Wells, CO 80810
719-767-5602

DOCUMENTATION NEEDED PRIOR TO

OR

ON THE DAY OF ADMISSION TO THE FACILITY

- COPY OF PHOTO ID OF RESIDENT (IF AVAILABLE)
- COPY OF SOCIAL SECURITY CARD
- MEDICARE CARD
- MEDICARE PART D OR PRESCRIPTION DRUG COVERAGE CARDS
- MEDICAID CARD (IF APPLICABLE)
- SUPPLEMENTAL INSURANCE CARD (IF APPLICABLE)
- ADVANCED DIRECTIVES OR MOST FORM COMPLETED (PREFERRED)
- MOST CURRENT MEDICAL/DURABLE POWER OF ATTORNEY
- COMPLETE CONTACT INFORMATION FOR ALL EMERGENCY AND FAMILY (OR OTHER) MEMBERS
- FINANCIALLY RESPONSIBLE PARTY MUST BE PRESENT UPON ADMISSION

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ADMISSIONS AGREEMENTS

The following Agreements made between Cheyenne County Hospital District, dba Cheyenne Manor (Facility) and _____ (Resident) on this _____ day of _____, 20___.

Admissions Process

Admissions to Cheyenne Manor are based on the ability of the Facility to meet the needs of the resident through services available and services provided. The physician and Facility's administrative staff are the parties who determine suitability for placement at the Facility. In addition, there is certain state and federal regulatory requirements the Facility must follow to accept and admit new residents to this Facility.

There are required steps that must occur prior to admission into Cheyenne Manor;

Step I: **Physician orders are required** for any admission into any long-term care Facility. Without physician orders, Cheyenne Manor may not accept any person into the Facility as a resident.

Step II: **Pre-admission assessments (ULTC 100.2 and PASRR forms - as applicable) must be completed and approvals received from the proper agencies prior to admissions**. Therefore, the Facility must have a minimum 48 hours advanced notice for admission to Cheyenne Manor, (unless specific arrangements are made **and** approved by the Primary Care Physician, the Facility***, and*** all regulatory paperwork has already been processed).

With the implementation of the Federal Nursing Home Reform Act of 1987, no "emergency admissions" may occur. An emergency admission includes: immediate placement of a resident into a nursing Facility without *receipt* of the required paperwork and physician orders at the Facility; (Colorado Screening Tool, ULTC 100.2 and PASRR Level I and II (as applicable), physicians' orders for admittance, a history and physical report from the primary physician, and a current medication list – at a minimum).

Step III: **Financial arrangements must be signed by responsible party(ies) prior to admission.** (See Section B).

New admissions to the Facility are permitted Monday through Friday between the hours of 8:00 am and 4:00 pm., unless pre-arranged and approved by the Facility. Readmissions from a hospital to the Facility may occur at other times.

Failure to provide any of the required information, paperwork or the absence of receipt of required regulatory approvals, may result in a denial or delay of admittance to the Facility. Once all required documentation and approvals are received by the Facility, the admittance of the resident to the Facility can occur.

Choice of Physicians

As part of the admissions process, the resident being admitted must designate a primary care physician **(See Addendum A)**. The primary care physician must be available to examine the resident at regular intervals, according to regulatory requirements, and to be able to provide 24-hour coverage for all treatments, diets, special procedures, approved activities and for emergency care. Because this is important to ensure timely and proper care of the resident, physicians should be affiliated with Prairie View Clinic and Keefe Memorial Hospital.

If a resident desires to be affiliated with a physician located outside Cheyenne County, the resident and his or her family members or representatives will need to discuss this with the Facility Nursing Staff to ensure that family members or the resident and his or her primary care physician is able to meet all regulatory requirements for examinations and ongoing provision of care.

Urgent or Emergency Care Agreement

In addition, the resident and his or her family members or representatives must agree to the resident being treated by a physician at Keefe Memorial Hospital or Prairie View Clinic in the event of need for urgent care or for an emergency matter. Urgent or Emergency Care will be provided at either Keefe Memorial Hospital or Prairie View Clinic in Cheyenne Wells, CO., and the resident (patient) may also be transferred from these locations to another Facility along the Front Range for continued care or services, depending on the emergency or urgent care need.

It is understood and agreed to by all parties, that once urgent or emergency care begins, the attending/emergency physician(s) or medical specialists will be responsible for the resident's total care until fully recovered and discharged back to the Facility or once treatment for the condition has concluded. Once the resident returns to the Facility and has been released by the attending or specialist, the resident can then schedule follow-up visits with their primary care physician.

Categories of Care

Admission arrangements can be made at the Facility for long-term care, short-term rehabilitation, adult day care, respite care (limited number of days permitted before regulation requires conversion to long-term care), and hospice care (permitted in cooperation and conjunction with a licensed hospice organization or program).

Financial Agreements, Policies and Procedures:

Private Pay Residents

1. Payments are prorated for any partial month stay at the Facility, except for respite care, and payment is due on the day of admission to the Facility.
2. Thereafter, room rental payments are due (in advance) and on the **first day of each month** for each consecutive month stay. Any unused portion of the month will be returned within thirty (30) days of discharge.
3. The resident, their family members and representatives understand that they are responsible for taking the resident to and from their visits with their primary care physician, and any specialty clinics and services in or outside of Cheyenne County.
4. The Facility has a regulatory requirement to arrange transportation for residents to and from the hospital and doctor visits; it does not have the obligation to provide or to pay for transportation. - Therefore, if the Facility needs to provide transportation, the cost of transportation services will be billed to all private pay residents at the current IRS allowable rates for mileage, plus the hourly wage per employee needed to attend to the resident while out of the facility, for the entire time the employees are away from the Facility. The starting time will be from the time the employee leaves the facility and returns to the facility with the resident.
5. Costs for reimbursable expenses and purchases made by the facility for private pay residents will be billed with the next regular billing cycle. Payment in full for additional expenses are due at the same time as the rental rate or are subject to late fees and interest.
6. Payments received in our office after the 5th day of the month will result in a late fee equal to 3% of the total balance due. In addition, interest of 18% per annum will accrue until the unpaid balance has been paid in full.

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7. No partial or installment payments (such as weekly or bi-weekly payments) are permissible (except for respite care). Therefore, any partial amounts received less than the full amount due and invoiced is subject to late fees and interest. Payments not received by the 15th of the month may be subject to termination of this agreement and discharge from the Facility.
8. Private pay residents receiving Respite Care from the facility may pay for care on a weekly basis, providing payment is received every Monday morning before noon (12:00 pm). Payment not received by noon (12:00pm) on Monday will be subject to late fees of 3%, and termination of agreement and discharge from the Facility.
9. Any unpaid balance of room rates, late fees, interest or any additional charges are subject to collection or other civil action in accordance with Colorado State Law. Residents and/or his or her representatives will be responsible for all legal costs associated with collection or civil actions necessary for the Facility to recoup payment for services rendered.
10. The Facility also retains the right to terminate this Agreement and discharge or evict any resident for non-payment of room and board, late fees, interest, and any other charge assessed to the resident, as permitted by law.

Private Insurance Payments

Residents, their families or representatives must pay the monthly room rate fees up front to the Facility as described above for Private Pay Residents, and then submit for reimbursement directly to the insurance company. All agreements listed above for private pay residents apply for residents receiving private insurance reimbursements.

Medicaid Reimbursements

1. Are paid through the State of Colorado. The Facility bills the state directly for the monthly room rates *except* for the patient portion owed.
2. The patient portion owed is due on the first (1st) day of each month, and is late effective the fifth (5th) day of the month. Payments not received by the 10th day of each month will be reported to the Human Service Office for potential fraud investigation as required.
3. Admissions occurring after the 10th day of the month are not subject to a patient portion being owed to this Facility, the prorated portion will be billed directly to the state in accordance with Colorado Medicaid Rules.
4. POA's and family members may ***not*** prepay patient payment portions that would result in the Facility holding funds for longer than thirty (30) days before they are applied to any balance, otherwise the Facility must turn these prepayments over to Medicaid as required.

Medicare Reimbursements

Cheyenne Manor does not currently accept Medicare Reimbursements, as the Facility is not Medicare Certified.

Additional Financial Agreements

1. Per regulatory statutes, at no time will the Facility, its representatives or assigns require any resident or potential resident to waive his or her rights to Medicare or Medicaid.
2. Nor will the Facility, its representatives or agents require that a resident agree to any promise to remain as a private pay resident for any length of time, or require any third party or person to accept personal financial responsibility for payment of services to the Facility for a resident's stay or expenses.

Acceptable forms of payment include personal checks, bank issued checks or money orders. Please be aware that cash is never a preferred payment method at this Facility.

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The room chosen by _____ is _____ and rent is based on the resident being (check one):

_____ a private pay source
_____ a private insurance source
_____ a Medicaid reimbursement recipient
_____ a VA reimbursed recipient.

The current daily rental rate for this room is: _____, and is subject to change.

Room Charges Inclusions

The Facility agrees to include the following items in the daily rental rate for all residents:

A semi-private room with up to two (2) occupants, the linens and basic bedding, three meals per day plus nutritional snacks, dietary supplements as prescribed, laundry services (does not include dry cleaning), daily housekeeping services, basic personal hygiene items, nursing care and personal care as may be required for the health, safety, hygiene and overall well-being of the resident.

Room Charge Exclusions

1. **Private Pay Residents** understand that the following items must be paid for by the resident or will be charged back to the resident and are not included in the daily rental rates: haircuts, perms, coloring, etc.; eyeglasses, eye exams, personal telephones, televisions, radios, clothing, smoking apparatus, tobacco products, products to help quit smoking, cosmetics, dry cleaning, hearing aids and batteries, dentures and denture products, computers, printers, software, internet connections, assistive devices (all), personal hygiene items (if not using the brand or kind provided by the Facility), mileage and staff time to transport resident to and from appointments, doctors' visits or specialty clinics ***outside Cheyenne County***, hospital charges and co-payments for medications and doctor visits, medications (all), copies or faxes, specialty foods and supplements (not prescribed by physician).
2. **Medicaid Residents** daily rates include all services and costs associated with total care except for: personal telephones, beauty or barber shop services, clothing, cigarettes, cigars, pipes, tobacco, etc., cosmetics, dry cleaning, eye examinations, eye glasses and repairs, hearing aids and batteries, dentures and denture wipes, cleansers or adhesives, televisions, stereos, computers, copies or faxes.
   Please see attached Medicaid Long Term Care Covered Items and Service provided in the Addenda.

Rooms Types, Changes and Leaves of Absence

ALL ROOMS ARE SEMI-PRIVATE rooms per Medicaid requirements, and:

1. Residents are not guaranteed that they will be the only occupant of the room.
2. Rental rates are subject to change with notice for private pay residents. A notice of room rate increase (or decrease) will be mailed to the resident and/or his or her representative at least thirty (30) days in advanced of any change occurring. The new room rates will take effect on the first day of the month following a thirty (30) day notice.
3. Residents who receive Medicaid assistance are subject to changes in their patient portion of the room rates as Health and Human Services receives information and modifies the state Medicaid 5615 form. Notification of the changes are mailed from Health and Human Services to the resident and/or his or her representatives. These changes are effective the date indicated on the form under "Effective Date" and the Facility must make adjustments either retroactively or effectively as determined by Health and Human

Services. Therefore, residents and their representatives do not always receive a thirty (30) day notice for changes in their patient portion of the rent. Notification of daily room rate changes (per diem rates) will be provided to all residents as information is provided by the state to the Facility.

4. Residents *may* be required to change rooms during their stay in the interest of the individual residents' health, safety and well-being, or in the interest of another resident's health, safety or well-being. Residents and/or their representatives will be involved in all decisions made with respect to room moves or relocations.

BED HOLDS for hospital stays, therapeutic leaves and other reasons are subject to Facility policy and regulatory statutes.

1. Private pay residents are charged for each day in or out of the Facility, if they wish to have their room/bed held for their return. A copy of the Facility's bed hold policy will be provided to the resident upon transfer to a hospital, rehab or other Facility. If charges are not paid in accordance with Section B, the Facility may at its own discretion, release and vacate the room for another resident rental.
2. Medicaid does not pay for bed holds. Any Medicaid recipient who is out of the Facility for more than thirty (30) days must be discharged in accordance with Medicaid rules. Medicaid recipients wishing to return to the Facility after thirty (30) days of being out of the Facility must be readmitted, according to the admission requirements.
3. Therapeutic leaves are leaves away from the Facility with intent to return in a couple of hours or a few days. Private pay residents will be charged full rates and Medicaid residents are billable at regular rates. Medicaid recipients must understand that the maximum number of days per year that are permitted for therapeutic leaves is 42 (18 regular days and 24 therapeutic days). Medicaid recipients out of Facility more than the allotted days will become ineligible for Medicaid benefits and will need to reapply with Health and Human Services.
4. All therapeutic leaves must be pre-approved and in writing by the attending or primary care physician in advance.

Personal Information, HIPAA and Releases

1. In compliance with HIPAA and Privacy Laws, the Facility must have a release by the patient and/or his or her personal representative to release or post any information about a resident. This includes verifying to any person whether he or she is a resident in the facility, placing his or her name on the door, posting birthday notices, or using the resident's name or likeness in the local newspaper or newsletters or other forms of publications. Residents and/or their representatives must complete **Addendum B** in order for the Facility to release any information. The resident and/or his or her representative has the right to refuse, or to choose what information and what format they will permit information to be distributed, if any.
2. The resident hereby agrees and gives express permission (signature below) to transfer and share any pertinent health care and personal information needed to other health care facilities for the purpose of providing diagnostic treatments, direct health care, rehabilitation, medications, etc., as needed to ensure the proper care of the resident while outside the Facility and in the care of another health care Facility.

   Resident/Representative Signature _____Date_____
3. The Facility agrees to comply with all state and federal regulations regarding resident rights to privacy, to HIPAA regulations regarding personal private health and other information.

Resident Records

1. Residents and his or her representatives, assigns, heirs, agents, etc. agree to pay reasonable charges for copies of any and all resident's records in accordance with state statutes.
2. In addition, requests for records must be submitted in writing to the Facility and signed by resident and his or her representatives, et al

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3. The Facility agrees to comply with all state and federal regulations regarding resident rights to privacy, to HIPAA regulations regarding personal private health and other information.

Resident Care Agreements

1. The resident and his or her representative(s) do hereby understand and agree that the resident's care while living at the Facility is under the direction and control of the primary care or attending physician.
2. Further, the resident and his or her representative understand that the Facility provides only the nursing care provided by law as an Intermediate Nursing Care Facility and is not licensed as a Skilled Nursing Facility.
3. If in the opinion of the charge nurse emergency medical treatment is necessary for the health or general welfare of the resident, and the resident is unable to give consent for treatment because of his or her condition, the Facility is hereby granted express consent to provide or seek medical treatment for the resident (unless otherwise directed by the Advanced Directives, a M.O.S.T. form or other legal documentation providing detailed instructions for the resident's care).
4. Residents must provide the Facility with copies of all legal documentation from POA's Guardians, Advanced Directives, etc. upon admission. Residents and their representatives should know that in the State of Colorado, the M.O.S.T. form is the prevalent legal document for advanced directives, and the Facility prefers to have this form of documentation to protect the resident's wishes and rights, and to protect the facility from any misunderstandings regarding care.
5. Care plans are a required part of the ongoing care of a resident within nursing facilities. A copy of the Care Plan Informed Consent is attached as Addendum H for resident or representative signature.
6. Resident and his or her representative acknowledge that the Facility provides day trips and ongoing activities that could take the resident out of the Facility for several hours, if the resident chooses and is able to participate. A signed consent and release must be obtained before residents can participate in activities outside the Facility **(See Addendum C).**

Pharmacy and Medication Agreements

1. The Facility as a general practice and for ease of ordering uses Arkansas Valley Accumed for all prescription and over the counter medications. However, residents are permitted to use the local Pharmacy or another pharmacy of their choice for their medications. If choosing a pharmacy other than the one utilized by the Facility, a Pharmacy Notification must be completed and signed by the resident and/or his or her representative (See Addendum G). The Facility is not responsible for delays in receipt of, or administration of medications when selecting a source other than Accumed.
2. Medication administration is performed by the nursing staff of the Facility, unless other arrangements are made and approved by the primary care or attending physician and the nursing staff. Please see the Medication Administration, (Addendum G). Residents acknowledge and agree that they may not bring in or have brought in by other parties any medications/drugs (legal or illegal) or supplements of any kind into the Facility, unless they are immediately delivered to the charge nurse.

Liability Limitations

1. Injuries are inherent as the nature of the business of the Facility includes caring for residents whose mental or physical health is already compromised upon arrival and which may continue while residing in the facility. The resident, his or her representative, family members, etc. understand and acknowledge that it is likely that the resident could fall or otherwise injure him or herself while in the care of the Facility.
2. The Facility hereby agrees to use best practices and exercise such reasonable care in administering physician orders and in providing care to residents. However, neither the Facility nor the staff can guarantee a resident's safety while staying in the Facility, and is no insurer of his or her safety or welfare.
3. The Facility cannot mandate any waivers of liability for any injury suffered by a resident or visitor or family member or representative, etc. as a result of negligence on the part of any employee of the District.

However, the resident, representatives, et al hereby agree to limit responsibility and liability to any injury suffered as a direct result of an act or directly caused by an employee of the District.

4. This agreement shall not be construed as to relieve the Facility of any obligations imposed upon it by laws, standards, rules and regulations of the state or the Department of Health and Public Finance, or the Centers for Medicare and Medicaid Services.

Personal Needs Accounts

1. Each resident has the option to place funds in a personal needs account with the Facility. Under the law, the Facility must safeguard the funds against theft, and misuse by staff. In addition, the Facility must pay interest on the funds held and provide an accounting to each resident and his or her representative at least quarterly.
2. Residents receiving Medicaid reimbursements (and/or his or her representative) must review the accounting provided, approve of the expenses and sign the accounting and return it to the Facility for the state Medicaid records, within ten days of receipt.
3. Any resident receiving Medicaid benefits is not permitted to keep more than $89.55 per month from their income source, nor accumulate more than $2,000.00 in assets. Total assets include but are not limited to the Personal Needs Account at the Facility, personal bank accounts, cash held by family or the resident, and other assets as defined by the Centers for Medicare and Medicaid Services and Health and Human Services Department.
4. The Facility agrees to notify the resident and/or his or her representative if the total known assets in the resident's personal need account, exceeds or is nearing $1500.00, so that the resident or representative can make plans to spend down the assets on the resident's needs.
5. The Facility will not permit borrowing against future receipts of personal needs funds, will not loan or otherwise provide payment for any item that the resident does not have personal needs funds on hand for, at the time of purchase.

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Discharges

1. If after admission, the Facility determines that it is in the resident's best interest because the Facility cannot properly care for the resident or meet his or her needs, the Facility will provide a thirty day (30) notice of discharge to the resident and/or his or her representative; unless his or her health is in immediate jeopardy, or the life or health and wellbeing of the other residents is at risk. The Facility will assist the resident and representative in locating a Facility that is appropriate and that can meet the needs of the resident. Any funds pre-paid to the Facility will be refunded within thirty (30) days, including any balance in the resident's personal needs account, plus interest. Residents have the right to protest any discharge. **(See Addendum D)** for more information.
2. Residents who have expired are discharged from the Facility effective the date pronounced. Any prepayment of rent and personal needs are refunded within thirty (30) days of discharge to the estate of the person who is deceased. The Facility cannot make checks payable to any person other than the person who has expired.
3. Voluntary Discharges from the Facility must provide a minimum of two days advanced notice of termination of services. Should the Facility received less than two days advanced notice, the Facility retains the right to charge for the two days.
4. All discharges must have signed consent from the attending or primary care physician prior to discharge.
5. The Facility agrees to arrange for transfers from the Facility to another health care Facility or hospital. However, the Facility is not responsible to transfer the resident itself. Any costs associated with transfers are the sole responsibility of the resident as outlined in paragraph **Titled Financial Agreements, Policies & Procedure**.
6. Either party may terminate this contract with cause. However, the Facility must show reasonable cause for termination; and must inform the Ombudsman of the Facility's decision, must provide the resident the opportunity to file a formal objection for termination if he or she so desires with the state. Once an objection is filed with the state, the Facility may not continue with an eviction or termination until a determination from the state has been received.

Rules and Regulations

The Facility establishes Rules and Regulations to ensure the comfort and safety of all residents, visitors and staff. Failure to follow established Rules and Regulations of the Facility could result in fees or fines, discharge or eviction. See Addendum E. for Rules and Regulations.

Other Agreements

_____

_____

_____

_____

_____

_____

_____

_____

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Definitions

1. PASRR Level I and II = Preadmission Screening and resident Review form – required submittal to the approved state processing center for approval prior to admissions to a long term care Facility for a Level II- this process can take up to 48 hours. This is required prior to all admissions to a nursing Facility, regardless of payer source.
2. Single Entry Points are agencies appointed by the state to determine eligibility of persons wishing or needing entry into a nursing Facility
3. ULTC 100.2 = Colorado Screening Tool ULTC 100.2 (A Medicaid Program requirement) and include the Long Term Care Assessment for Instrumental Activities of Daily Living Form and the Initial Screening and Intake Form. This form is typically completed by the Single Entry Point (SEP), Admissions Coordinator or Director of Nursing.

   *These lists are representative of what items are not included in the daily rental rates. They are not intended to be all-inclusive, and additional charges may be added to the daily rate for items that are not deemed part of the included covered costs.

Signatures

The parties signing this Agreement on this _____ day of _____, 20___ do hereby acknowledge and agree that this document represents all agreements made for Admissions to Cheyenne Count Hospital District dba Cheyenne Manor to date, and that no other verbal or written Agreements or representations have been made other than what is in this written document.

Both Parties agree that any alterations, additions or changes to this document must be done so in a new Agreement or by an Addendum that has been initialed and signed by all parties. Any unsigned documents, agreements or representations will be considered non-valid, and non-binding by all parties.

Further, all parties agree that should any clause or portion of the Agreement be considered unenforceable or invalid, only that clause or sentence that is unenforceable or invalid will be deleted and will not cause this Agreement to be invalid or unenforceable.

_____ _____

Signature of Resident Date

_____ _____

Signature of Legal Representative Date

_____ _____

Signature of Nursing Home Administrator Date

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ADDENDUM A
PRIMARY CARE DESIGNATION

I, _____ hereby choose the following person as my primary care physician in accordance with the duties, rights and responsibilities as my attending:

Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

_____

Telephone number: _____

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

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ADDENDUM B
USE OF RESIDENT INFORMATION APPROVAL FORM

As indicated below by my initials or the initials of my POA or MDPOA, I agree and consent to permitting the following information be used or released by the Facility, only as described below.

- I allow my name to be posted on the door to my room _____
- I allow my name and birthday to be posted on the Activity Board _____
- I allow my name and birthday to be posted in the newsletter _____
- I permit my photograph, likeness, name, activities, birthday, etc. be posted in the local newspaper (Range Ledger, BurlingtonRecord, Kiowa County Independent) _____
- I consent to being photographed for identification purposes for my chart, medical records and emergency manual _____
- I consent to permit the Facility to use my photograph, name Likeness, quotes, etc. in marketing and brochures promoting Cheyenne Manor and the services they provide _____
- I consent to permit the Facility to use my photograph, name Likeness, quotes, etc. on the facility Facebook page. _____
- I consent to permit the Facility to use my photograph, name Likeness, quotes, etc. on the facility website. _____
- I approve and consent to the staff confirming that I am residing in the Facility to anyone inquiring about my location (only) without providing any details as to my health information _____
- I understand that any or all of these permissions can be Revoked at any time by myself or my representative by Signing a new Addendum B _____
- I would like to be informed each time my name or likeness is going to be used for any marketing and I want to approve all marketing materials using my likeness, words, etc. _____

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

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ADDENDUM C

DAY TRIPS AND ACTIVITIES OUT OF FACILITY

The Facility provides periodic opportunities for residents to leave the Facility in group settings with qualified staff. Some activities and outings are planned and some are spontaneous. Outings can include shopping trips, riding around in and out of town, driving to the mountains, eating at restaurants in various locations, etc.

While the Facility has a responsibility for the well-being of the residents while in their care, the resident and his or her representatives, heirs, assigns, agents, etc., understand and acknowledge that there are inherent risks to health and life associated with travel outside the Facility that may not be the fault or within the control of the Facility, the qualified staff driving or assisting residents while outside the Facility.

Therefore, residents desiring to attend outings away from the Facility agree to hold the Facility harmless for any injury or damage to person or property caused by or associated with the transportation or that occur during an activity held outside the Facility. In addition, the resident and his or her assigns, agents, representatives, etc. hereby absolve the Facility of any wrong-doing, liability, damages, etc. if an accident or injury occurs to a resident while on an outing caused by a third party.

This waiver does not exempt the Facility or staff from accidents or injury caused by gross negligence on the part of the caregivers, persons' driving or other qualified staff with the residents on the outings.

As indicated below by my initials or the initials of my POA or MDPOA, I agree and consent to going on outings below:

Community Outings _____

Neighboring Community Outings _____

Shopping Trips _____

Out of Town Day Trips _____

Specific outing instructions or requests:

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

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ADDENDUM D
PROTESTING DISCHARGES FROM FACILITY – PROCEDURE

If any resident has a grievance against an employee of the Facility, the resident has the right to file a grievance without fear of reprimand or repercussion from any employee.

The District and its staff will always attempt to listen to all grievances and take appropriate action to correct any errors, omissions, and grievances presented to the staff willingly and with the best interest of the resident in mind.

Should you have a grievance, the following procedures are in place to address your concern or complaint:

- The full time staff member designated to receive your complaint is the Social Services Director, Janette Wollert.
- The facility has a grievance committee consisting of the Administrator, the Social Services Director, a resident elected by the residents of the facility, and a third person agreed upon by all parties.
- Any resident or a family member or representative may present a grievance orally or in writing within fourteen (14) days of an incident giving rise to the grievance.
- The person receiving the grievance will confer with persons involved and within three (3) days shall provide explanation of findings and proposed remedies to the complaint. The grieving party has the right to also receive a written explanation of the results of the findings if so requested.
- If the complainant is not satisfied with the findings, he or she must submit a written (oral if unable to write or type) notice within ten (10) days of the findings requesting a hearing before the grievance committee.
- Once the request for hearing is received, the Administrator will contact the aggrieved party and make selection for the third party and set a date for the committee and aggrieved party to meet (within ten (10) days unless otherwise specified by the aggrieved party). All parties must inform the other parties present if legal representation is going to be present at the time the meeting is scheduled so that the other party(s) have the opportunity to object or to bring his or her own legal representative.
- If the aggrieved party is still not satisfied with the finding of the committee, he or she has the option of filing a grievance with the executive Director of the State Health Department. The department will investigate the facts and circumstances of the grievance and make written findings of fact, conclusions, and recommendations. These will be provided to both the complainant, aggrieved party and Administrator of the facility.
- As a further step, if any of the parties disagree with or are dissatisfied with the Health Department's finding, they can request a formal hearing by the department pursuant to C.R.S. 24-4-105.
- The names and addresses of the local Ombudsman and the Department of Health to file grievances are posted in the front lobby of the facility.
-

_____	_____
Signature of Resident	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Signature of Facility Representative	Date

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ADDENDUM E
RULES AND REGULATIONS OF CHEYENNE MANOR

1. The Facility is a non-smoking Facility for all guests and residents of the Facility. There is no smoking within 15 feet of any entrance to the Facility and all smoking materials must be extinguished and smoke exhaled at least 15 feet from any entrance to the Facility.
2. The Facility attempts to enforce a quiet time between the hours of 9:00pm and 5:00 am so that residents can rest as needed. Therefore, the Facility requires all televisions, radios, cell phones, etc. to be set to a volume that does not disturb or cause other residents discomfort.
3. The Facility does not have set visitation hours. However, we respectfully request that most visits take place between the hours of 7am – 8pm to permit residents to rest as needed, and for the staff to provide adequate nursing care.
4. Residents, their guests, visitors and family members are not permitted to aide or assist other residents within the Facility to walk, transfer from bed to chair or any other surface, to bathe or dress. If a resident is in need of assistance, we recommend that you seek assistance from one of the many staff members or push the individual's call button to alert staff that assistance is needed.
5. Due to safety issues and the potential for other residents who may not comprehend safety issues and that may enter your room while you are away, no sharp scissors, knives, blades, letter openers, metal nail files, nail clippers, etc. are permitted in the Facility, without administration's permission. Once permission is granted, residents must agree and keep all sharp objects locked in bedside cabinets or drawers to prevent injury to self or others. Failure to follow policy will result in the sharp object being removed from the resident's room as a matter of public and personal safety.
6. Regulations prohibit the use of electric blankets, heating pads, coffee makers, microwaves, curling irons, blow dryers, extension cords and other electrical appliances in resident rooms. When in doubt, please check with the nursing staff or the Director of Social Services.
7. Any time residents leave the Facility, he/she or his or her representative must sign them out at the front nurse's station. Per regulation, any resident who is away from the Facility for more than 4 hours without the Facility knowledge of where he or she is, the Facility must contact the police department and the state to report a missing person.
8. No medications permitted in any resident room without physician orders. In addition, the nursing staff to ensure that they are able to self-administer medications safely, timely and correct dosages must assess the resident. Any resident who has physician orders to keep medications in his or her room, must keep them locked in a bedside cabinet or table at all times. Failure to keep medications secured will result in the nursing staff removing the medications from the room as a matter of public and personal safety. The medications must be monitored by a nurse and logged in the resident's medication log each time the resident uses.
   Medications include but are not limited to: prescription drugs, over the counter medications like Tylenol, etc., cough syrups, cough drops, laxatives, ointments or liniments, suppositories, aspirin, vitamins, dietary supplements such as fish oil or flax seed oils or flax seeds, B-12, vitamin C, etc., Metamucil and the likes, eye drops such as Visine, etc., Chap Stick, etc.,
9. All clothing brought into the facility must be marked with the resident's initials using indelible ink or permanent marker. In addition, any changes in clothing must be noted on the resident's inventory each time an item of clothing is thrown away, removed or added to his or her collection. Please contact the charge nurse or Social Services Director with this information.
10. Meals are served at various times during the day. However, residents have the choice of when they wish to eat. Breakfast starts at 7:00 am, but residents can be served at times of his or her choosing if they decide they want to sleep in. Lunch is served at noon and dinner/supper is served at 5:00 pm. Nutritional snacks are available twenty-four hours a day and are located in the resident refrigerator and cupboards. Residents can help themselves to anything available (unless on a restricted diet by a physician). In addition to the

resident refrigerator, anytime between 6:00 am and 7:00 pm when the dietary staff is in the Facility, residents can get any other types of meals or food available besides just snack foods.

11. Residents can choose to have meals in their room, but are strongly encouraged to eat in the dining room as this provides much needed socialization and community interaction. In addition, it may not be possible to permit residents to eat in their rooms if he or she has the potential to choke or aspirate.
12. Residents can have their own little refrigerator in their room, if they choose. However, the staff must monitor and periodically clean out the refrigerators to ensure that there is no expired or spoiled food. If any is found, the staff will dispose of these items per regulatory requirement, and the Facility will not be responsible to replace any food items or medications in resident refrigerators.
13. Residents are permitted to decorate his or her room any way he or she likes. However, it is important to recognize and understand that should it become necessary to share rooms, all personal belongings from the resident who decorated the room, must not infringe on the space of the new resident. This means that there is a potential that personal belongings will need to be removed from walls, closets, bathrooms and sinks and maintained within half of the space to permit the other resident to decorate and keep his or her belongings in the room and closets as well. Any decorations located on the exterior door or wall must be made of fire retardant materials.
    The Facility is not responsible for lost or stolen items. Each resident is responsible for securing his or her own possessions at all times. Personal property such as chairs, beds, electric wheelchairs, etc. are not part of the facility's maintenance or replacement responsibility. Residents are responsible for all damages, repairs, maintenance and upkeep to his or her own property. Any item that is a potential hazard to any resident will be removed from the resident's room as a matter of public and personal safety.
14. Violence against staff, other residents, guests, visitors, etc. is NEVER permitted in this facility. This applies to anyone entering or in the Facility. In addition, violence against residents is NEVER permitted by anyone. ANY incident or allegation of violence, abuse or neglect MUST be reported to the charge nurse IMMEDIATELY and the charge nurse MUST contact local authorities, the Administrator and Director of Nursing IMMEDIATELY.
    A report must be filed with the state and a thorough investigation must ensue. Residents in NO WAY may be harassed, or further victimized by staff or other persons before, during or after an investigation. Residents have the right to make complaints directly to the state and to the Department of Health at any time. The Facility and/or its staff may NOT interfere in any complaints or investigations regarding complaints. Residents have rights, and this Facility will honor those rights at all times. (See Addendum F Resident Rights for More Details).
15. Because of the potential for abuse, preferential treatment or inappropriate contact or behavior, staff is never allowed to accept ANY personal gifts, favors or money from any resident or resident's family, guests, etc. without express permission from the Administrator.
16. It is important for residents and his or her family to understand that the relationship between staff and residents and their families is governed by the Policies of this Facility, Standards of Care, Licensing Rules and Laws of the Federal and State Governments.
    In addition, it is NEVER appropriate for employees to carry on personal relationships outside the Facility with residents. Employees must maintain a professional relationship at all times with residents. Therefore, personal or professional calls are not permitted to employees outside the Facility, nor are any personal favors, trips, purchases, etc. permitted.

    Employees are strongly advised not to work outside this Facility in any capacity for any resident or resident's family or independent party outside this Facility using their license and training. If doing so he or she DOES NOT represent or work for this Facility in any way, while caring for any individual not residing in this Facility. If performing ANY outside work, he or she does so without Facility consent and without Facility endorsement, and without Facility Insurance Coverage of any kind.

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A SENIOR CARE FACILITY

Residents and families must understand that he or she places the employee and the person being cared for at risk for harm or liabilities that may not be within the scope of his or her license and could therefore jeopardize his or her license by offering or caring for someone not living in this Facility.

I _____ have received, read and understand the Rules and Regulations of the Facility and hereby accept the terms of the Agreements. I understand that failure to abide by one or more of the Rules and the Rental Agreement could result in termination of this Agreement and discharge or eviction from this Facility.

_____	_____
Signature of Resident	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Signature of Facility Representative	Date

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ADDENDUM F
RESIDENT RIGHTS

Under the State of Colorado and the Federal Government, residents of Nursing Facilities have been deemed to have certain rights. The following is the most current list of Resident Rights to which you are entitled, under 42 C.F.R. §483.10.

483.10(a) – Resident Rights - You have the right to:

- Be treated with dignity and respect, and to have the facility recognize you as an individual, in your choices, treatment and care.
- Receive care in a manner and environment that promotes enhancement of your quality of life.
- To receive quality care regardless of diagnosis, severity of condition, or payment source.

483.10(b) – Exercise of Rights - You have the right to:

- Exercise your rights as a resident (and/or resident's legal representative if resident is adjudge incompetent or incapacitated) of this facility and an American Citizen – free from interference, coercion, discrimination and reprisal from the facility – and be free from reprisals in exercising his/her rights.
- Designate a representative so that he/she can exercise the resident's rights if the resident is unable to make his or her own decisions, but only to the extent those rights are delegated to the representative, and only to the extent as permitted by State law. The resident can revoke a designation at any time, without representative permission.
- Know that the facility will not extend rights to the representative on behalf of the resident beyond the extent required by the courts and/or delegated by the resident. If a representative is making decisions that are not in the best interest of the resident, the facility 'shall' report such concerns when and in the manner required under state law.
- Participate in their care planning to the extent he/she is able.

483.10 (c) – Planning and Implementing – You have the right to:

- Be informed about what rights and responsibilities you have, to be informed of and participate in his/her person-centered treatment.
- Be fully informed in writing and orally, in a language that you can understand of your total health status/medical condition, your rights responsibilities, and the rules/regulations of the facility, and any changes in state or federal laws regarding your stay.
- Participate in the planning process, including identifying individuals or roles to be included in this process, the right to request meetings, the right to request revisions to the plan of care, the right to know risks and benefits of proposed care & treatment alternatives and options.
- Participate in establishing goals for yourself while in the facility including the expected outcomes of care, the type, amount, frequency, durations and any other factors related to the effectiveness of your care.
- Be informed in advance of any changes to the plan of care, and to refuse to start, change, and continue treatment. The right to refuse experimental treatment.
- Receive services/items agreed to in the care plan.
- See the care plan, including the right to sign after significant changes.
- Be informed by the facility - in writing when you become eligible for Medicaid, the items and services included in Medicaid coverage, and items that are not covered by Medicaid's per diem rate,

to which you may be legally charged by the facility and obligated to pay above your patient payment portion (if applicable), and further be notified when and if any of these charges change.

483.10(d) – Choice of Attending Physician - You have the right to:

- Choose your own physician and treatment – and the facility must honor that choice.

483.10(e) – Respect and Dignity - You have the right to:

- Be treated with respect and dignity.
- Be free from any physical or chemical restraints imposed for the purpose of discipline or convenience, and when not required to treat a medical symptom or condition you have, consistent with 483.12(a)(2).
- Retain and use personal possessions, including furnishings and clothing as space permits, unless doing so would infringe upon the rights or health and safety of others.
- Share a room with your spouse when you live in the same facility as your spouse, and both spouses' consent.
- Share a room with the roommate of your choice when practicable, when both residents live in the same facility and both consents.
- Receive written notice including the reason for change before your room or roommate is changed.
- Refuse transfer to another room if the transfer is solely for the convenience of the staff. Transfer or refusal to transfer does not affect the resident's eligibility in Medicaid.

483.10(f) – Self-Determination - You have the right to:

- Choose activities, schedules (including sleep/waking times), health care and providers of health care services, consistent with your interests, assessments, and plan of care.
- Participate in other activities including social, religious and community activities that do not interfere with the rights of the other residents in the facility.
- Make choices about aspects in your life that are important and/or significant to you.
- Interact with members of the community and participate in community activities both inside and outside the facility.
- Receive visitors of your choosing at a time of your choosing, providing your visitors do not interfere with the rights of other residents/roommates. You may also deny visitation to anyone of your choosing.
- Immediate access to friends, family, representatives, etc. subject to your right to deny access or withdraw consent at any time, without restriction from the facility, subject to reasonable clinical and safety restrictions.
- Organize and participate in groups in the facility, in private if you choose, and to invite or deny access to a group or meeting to any representative or facility staff of your choosing.
- Receive response to all grievances resulting from a group, from the facility representative.
- Have family members or other representatives meet in the facility with families or resident representatives of other residents in the facility.
- Refuse to, or choose to, perform services at the facility.
- Manage your own financial affairs, including the right to know what charges a facility may impose against your personal needs account (if applicable). An accounting of residents' personal needs funds/expenses is provided quarterly and upon request.
- The facility may not require you to set up a personal needs account, and must accommodate you if you choose to have the facility manage your personal needs accounts. This facility maintains all personal needs funds in an interest-bearing account (separate from Operational Funds) and pays all balances greater than $50 interest each month, exceeding minimum regulatory requirements.

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483.10(g) - Information and Communication – you have the right to:

- Be informed of all your rights, all rules and regulations governing resident conduct and responsibilities during your stay at our facility.
- Access personal and medical information pertaining to yourself, upon written request, within 24 hours (excluding weekends and holidays), and receive a copy of personal records for self with two (2) working days in advance notice to the facility, in a manner and format and language the resident can read and understand. The facility has the right to charge for copies, based on the current hourly rate for the employee making the copies (whether hard copy or electronic), overtime rates apply if copying exceeds 8 hours, $0.25 per page black and white, $1.00 per page for color copies, postage at actual cost, if requesting the files be mailed. All charges are due up front at the time of copy completion and will not be billed.
- Receive notices in writing and in a language, you understand including: personal needs protection, procedures, eligibility for Medicaid, list of all pertinent local and state regulatory bodies governing nursing homes, advocacy groups, APS, complaint processes and when and where to file a grievance.
- Reasonable access to a telephone and privacy where calls can be made without being overheard, as well as stationery, postage and writing implements and the ability to send and receive mail, packages and other materials.
- Examine the most recent survey results and plan of correction, as well as receive information from state and regulatory agencies.
- Be provided with Advance Directives information and facility's policies regarding same.
- Be informed how to apply for Medicare/Medicaid benefits, and what benefits are included.
- Be notified of any changes when there has been an accident with injury and physician orders or treatment has changed or is needed, there is a significant change in resident condition, treatment changes are needed, a decision to transfer or discharge is needed or required.
- Change in room assignment, change in resident rights.

483.10(h) - Privacy and Confidentiality – You have the right to:

- Personal privacy and confidentiality of your personal medical information. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups, but does not require the facility provide a private room for each resident.
- Privacy in your oral, written and electronic communications, including the right to receive unopened mail and other letters and packages and materials.
- Secure and confidential personal or medical records.
- Refuse release of medical and personal records, except under legal or regulatory means

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483.10(i) – Safe Environment – you have the right to:

- A safe, clean, comfortable and homelike environment, allowing your personal belongings to the extent possible, ensuring that care can be provided safely and does not pose a safety or health risk.
- Housekeeping and maintenance services are necessary to maintain a sanitary, orderly, and comfortable interior including clean bed and linens in good condition, private closet space in each resident room, adequate and comfortable lighting levels. Comfortable and safe temperatures levels (71-81 degrees F), and safe and comfortable noise levels.

483.10(j&k) – Grievances – you have the right to:

- Voice grievances to the facility or other agencies or entities that hear grievances without discrimination or reprisal. Such grievances include care, and treatment, behavior of staff and other residents and other concerns regarding long term care facility stay.
- Know how and where to file a grievance and see a copy of the policy.
- To report a grievance without interference from the facility. The facility may not prohibit in any way or discourage a resident from communicating with federal, state or local officials, or representatives of the state Ombudsman Program, or other advocacy representatives or agencies.

483.12 – The resident has the right to be free from abuse, neglect, misappropriation of resident property; and exploitation as defined in the subparts, free from corporal punishments, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.

482.12(a) – The Facility must:

- Not use verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion.
- Ensure that residents are free from physical or chemical restraints imposed for the purposes of discipline or convenience and that are not required to treat a resident's symptoms.
- Not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.
- Not employ anyone having a finding against him or her in the nurse aide registry concerning abuse, neglects, exploitation, mistreatment or resident or misappropriation of property.
- Prevent further abuse, etc. while investigation is in progress.
- Report results of investigation to Administrator and state.

483.15(b) – Equal Access to Quality Care – The facility:

- Must establish and maintain and implement identical policies and practices regarding transfer and discharge for all individuals regardless of source of payment.
- May charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law. In Colorado, the state requires private pay rates be at least equal to current Medicaid rates and may not be charged less than Medicaid daily per diem rates.

483.15(c) – Transfer and Discharge – Facility requirements include:

- Permitting each resident to remain in the facility, and not transfer or discharge from the facility unless: a) transfer or discharge is necessary for the resident's welfare and resident's needs cannot be met in the facility; b) transfer or discharge is appropriate because resident's health has improved sufficiently so does not need services any longer; c) safety of individuals in the facility is endangered due to the behavior or clinical status of the resident; d) health of residents in the facility would otherwise be endangered; e) resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; f) the facility ceases operations.

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- Documentation to reflect the reasons why transfer or discharge is required in your medical records, and proper 30 day notice before facility may transfer to resident and representatives with reason for transfer or discharge, effective date of transfer, location to which resident is transferred or discharged, proof of orientation for transfer or discharge.

483.15(d) – Notice of Bed Hold Policy and Return – Facility must:

- Before transfer to hospital or resident goes on therapeutic leave, provide written information to the resident or representative that specifies the duration of the state bed hold policy (if any) during which the resident is permitted to return and resume residence in the facility
- Provide policy regarding bed-hold periods, permitting returns to facility
- Provide bed hold notice upon transfer of resident to hospital or therapeutic leave which specifies the duration of the bed hold policy, and if there are any charges associated with holding a bed open for the resident during their leave of absence (private pay residents only or this facility).

483.15(e) – Permitting Residents to Return to facility (Bed Hold Policy) – Facility will:

- Establish a written policy on permitting residents back into the facility after hospitalization or therapeutic leave, including:
- A resident whose hospitalization or therapeutic leave exceeds the bed hold period under the State Plan, returns to the facility to their previous room if available, or immediately upon the first availability of a bed in a semi-private room (Medicare and Medicaid) if resident requires the services provided by the facility, is eligible for Medicaid, or is private pay.

I certify with my signature below that I have receive a copy of my resident rights.

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

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ADDENDUM G
MEDICATION ADMINISTRATION AND PHARMACY CHOICE

Occasionally a resident will have difficulty swallowing medications and other foods or liquids due to medical conditions, bitter taste associated with some medications, etc. where it may become necessary to crush medications and place them in foods such as applesauce or puddings. The Facility must have a resident's permission to do so. Therefore, the resident or his or her representative must choose one option below and sign this Addendum (Note: this decision can be revoked or changed at any time with a new signed Addendum):

I give permission to crush medications and place them in food, juice, puddings, etc. _____

I request to be consulted before any medication is crushed or added to food _____

I do not give permission to crush or place medications in food or juice _____

_____	_____
Signature of Resident	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Signature of Social Service Director	Date
_____	_____
Signature of Director of Nursing or Nursing Representative	Date

Residents have the right to choose his or her own Pharmacy. Please list the Pharmacy you wish the Facility to work with or choose **one or more below**.

Arkansas Valley Accumed _____ Kiowa Healthmart (Teddy B's) _____

____Other (Give name, full address, telephone # and fax# - if using web, provide all information):

_____
_____
_____
_____

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ADDENDUM H
CARE PLAN INFORMATION RELEASE AND CONSENT FORM

I _____ understand that the Facility is required by regulation to review my overall care plan on a quarterly basis and update it as needed with my input, and with the input of my representative (if applicable). In the course of this review, I understand that confidential health and financial matters may be discussed as well as treatments and other personal information.

I understand that I have the right to attend these conferences and to have input into the decisions regarding my care. My input may be in the form of suggestions, or comments agreeing or disagreeing with the plan presents. I may also decide if I want family members or others in attendance or not and which one(s) I want present if I so choose. I also understand that I have the right to restrict in writing any or all information that my family or others receives.

I have indicated below which family members or others who may be present at my care conferences and who may receive confidential health care information from the staff during my stay at the Facility. I understand that I may change this list at any time by completing a new Addendum H.

_____	_____
_____	_____
_____	_____
_____	_____

_____	_____
Signature of Resident	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Signature of Facility Representative	Date

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ADDENDUM I
ACCESS TO MEDICAL INFORMATION

Resident records are available to all residents and his or her legal representatives only. Family members not recognized by the courts as legal representative, guardian, POA or MDPOA, etc. are not permitted access to any medical or financial information without express written consent of the resident.

Access to review resident medical or financial information is granted Monday through Friday between the hours of 8:00 am and 4:00 pm after a written request has been made, not less than 24 hours in advance for viewing and 48 hours in advance if copies are needed.

There is no charge for viewing records. Copies of records are charged at a cost of $0.25 per page.

If any resident, his or her representative wishes to file a grievance regarding medical records, he or she may do so by contacting:

Medical Care Licensing Certification Division,
Colorado Department of Health
4300 Cherry Creek Drive South
Denver, CO 80222

Phone: (303) 692-2000

Nothing in this access policy will be construed to waive the responsibilities of the custodian of medical records in institutions to maintain confidentiality of those records in its possession.

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

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ADDENDUM J
CONSENT FOR TESTING AND IMMUNIZATIONS

I _____, hereby give my consent to the facility to have the listed resident's blood tested for HIV/AIDS/HBV and TB as needed due to the risk of occupational incident and potential for exposing the staff and other residents and guests of the facility to these contagious diseases.

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

I _____, hereby given my consent to receiving annual inoculations immunizing me against influenza and/or pneumonia if so indicated by my physician.

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

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ADDENDUM K
NOTICE FO PRIVACY PRACTICES

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561 West 1st North
Cheyenne Wells, CO 80810
719-767-5602
www.cheyennemanor.org

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

This notice applies to Cheyenne County Hospital District DBA Cheyenne Manor providing senior care in the Cheyenne County, Colorado area.

Resident	Date
MDPOA	Date
Facility Representative	Date

Janette Wollert, HIPAA Compliance Officer
jwollert@cheyennemanor.org

CHEYENNE MANOR
CARING & SHARING
A SENIOR CARE FACILITY

ADDENDUM L
COLORADO MOST FORM

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Legal Last Name		
Legal First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. *(See additional instructions on page 2.)*

A — Check one box only

CARDIOPULMONARY RESUSCITATION (CPR) ******Person has no pulse and is not breathing.******

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B — Check one box only

MEDICAL INTERVENTIONS ******Person has pulse and/or is breathing.******

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. **Do not intubate.** May use noninvasive positive airway pressure. Transfer to hospital if indicated. **Avoid intensive care.**

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

Additional Orders: _____

C — Check one box only

ARTIFICIALLY ADMINISTERED NUTRITION ***Always offer food & water by mouth if feasible.***

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D

DISCUSSED WITH (check all that apply):

☐ Patient
☐ Agent under Medical Durable Power of Attorney
☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))
☐ Legal guardian
☐ Other:_____

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature *(Mandatory)*	***Name*** *(Print)*	***Relationship/ Decision maker status*** *(Write "self" if patient)*	***Date Signed*** *(Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature *(Mandatory)*	***Print Physician / APN / PA Name, Address, and Phone Number***	***Date Signed*** *(Mandatory)*
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal Last Name	***Patient Legal First Name***	***Patient Middle Name (if any)***	***Patient Date of Birth***

Primary Contact Person for the Patient	*Relationship and/or MDPOA, Proxy, Guardian*	*Phone Number/email/Other contact information*

Healthcare Professional Preparing Form	*Preparer Title*	*Phone Number/Email*	*Date Prepared*

Patient Primary Diagnosis	*Hospice Program (if applicable) /Address*	*Hospice Phone Number*

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please refer to the "Getting the MOST Out of the Medical Orders for Scope of Treatment: Guidelines for Healthcare Professionals," www.ColoradoMOST.com

Completing the MOST form:

- MOST form master may be downloaded from www.ColoradoMOST.com and photocopied onto **Astrobrights® "Vulcan Green"** or **"Terra Green"** 60lb paper. This special paper is strongly encouraged but not required. Visit www.ColoradoMOST.com for a link to paper suppliers.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing the Medical Orders:

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;
  - at any substantial change in the person's health status or treatment preferences; and
  - when legal decision maker or contact information changes.
- If substantive changes are made, please complete a new form and void the replaced one.
- **To void the form, draw a line across Sections A through C and write "VOID" in large letters. Sign and date.**

REVIEW OF THIS COLORADO MOST FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed
			☐ No Change ☐ New Form Completed

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

CHEYENNE MANOR
CARING & SHARING
A SENIOR CARE FACILITY

ADDENDUM M

STATEMENT OF UNDERSTANDING

THERE ARE NO PRIVATE ROOMS IN THIS FACILITY

Cheyenne Manor is a Medicaid supported facility. This means that 100% of the rooms must be available for Medicaid covered residents or Private Pay residents. It also means that any potential Medicaid resident must take precedent for placement over any Private Paying residents. Additionally, Medicaid does not pay for private rooms, therefore **NONE** of the rooms within this facility can be private occupancy or private rooms. Therefore, everyone entering this facility, or placing a friend, family member or resident **must** understand that ALL rooms are semi-private rooms and therefore are subject to placement of up to two residents per room at any time, without notice and without approval. The facility Interdisciplinary Team, in its sole discretion, has the right to place residents together in rooms to provide care for up to 38 residents, the total number of licensed beds by the State of Colorado, without the consent of the resident and/or family member, POA, MDPOA, guardian, etc.

_____	_____
Signature of Resident	Date
_____	_____
Signature of Legal Representative	Date
_____	_____
Signature of Facility Representative	Date

CHEYENNE MANOR
CARING & SHARING
A SENIOR CARE FACILITY

DIETARY QUESTIONNAIRE

We realize that everyone has different dietary preferences and different dietary needs. In order to meet each residents needs it helps to know their individual dietary history. Please answer the following questions to the best of your knowledge.

Resident name: _____ Attending: _____ ID# _____

Are you on any special dietary restrictions Yes ☐ No ☐

Please choose or describe the current type of diet you are ***prescribed*** or are currently following?

☐ Regular (no restrictions) ☐ Diabetic ☐ Renal ☐ Low Fat ☐ No Added Salt ☐ Liquid
☐ High Calorie (#_____/day) ☐ Low Calorie (#_____/day) ☐ Pureed ☐ Mechanical Soft
☐ Other please describe _____

Recent weight loss/gain in the past 30 days _____ last 120 days _____
What do you consider your "normal" weight? _____
Please list any known reason(s) for weight change_____
Please list any recent changes in eating pattern_____

Food Allergies? ☐ Yes ☐ No Please list below any food allergies you have including strong negative reactions:
_____

_____

DRINK/BEVERAGE Preferences: (please check all that apply)

For Breakfast, I like to drink: ☐ coffee ☐ tea ☐ hot chocolate ☐ orange juice ☐ cranberry juice
☐ Prune juice ☐ apple juice ☐ grapefruit juice ☐ V8 ☐ tomato juice
☐ Cran-apple ☐ Cran-Grape ☐ grape juice ☐ whole milk ☐ 2% milk
☐ Other _____

For Lunch (noon meal), I like to drink: (Please check all that apply)
☐ Coffee ☐ tea ☐ hot chocolate ☐ soda: _____
☐ Flavored drink _____ ☐ iced tea ☐ Other _____

For Dinner (5PM meal), I like to drink: (Please check all that apply)
☐ Coffee ☐ tea ☐ hot chocolate ☐ soda: _____
☐ Flavored drink _____ ☐ iced tea ☐ Other _____

What snack foods do you tend to like best?

FOOD PREFERENCES: Indicate preferences of the following food items:

CHEYENNE MANOR
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A SENIOR CARE FACILITY

For Breakfast, I like: ☐ eggs - cooked how?: _____
☐ Bacon crisp ☐ bacon chewy ☐ ham ☐ sausage patty ☐ sausage link
☐ Pancakes ☐ waffles ☐ biscuits and gravy ☐ biscuits and jelly ☐ donuts
☐ Pastries ☐ White Toast ☐ Wheat Toast ☐ Raisin Toast ☐ Rye toast
☐ Sour Dough Toast ☐ Oatmeal ☐ Flavored Oatmeal ☐ Malt-O-Meal
☐ Cream of Wheat ☐ Cream of Rice ☐ Other _____
☐ Omelet made with:_____

For Lunch (noon meal) I like: ☐ sandwich _____
☐ Soup (kind): _____ ☐ Salad Plate ☐ Hot meal ☐ Pasta ☐ Beef
☐ Chicken ☐ Pork ☐ Fish ☐ I am a Vegan ☐ I am Vegetarian

Please list two or three of your favorite meals to eat:

_____ _____

_____ _____

For Dinner (5PM meal) I like: ☐ sandwich _____
☐ Soup (kind): _____ ☐ Salad Plate ☐ Hot meal ☐ Pasta ☐ Beef
☐ Chicken ☐ Pork ☐ Fish ☐ I am a Vegan ☐ I am Vegetarian

Please list two or three of your favorite meals to eat:

_____ _____

_____ _____

Food dislikes: Please list all food that you dislike, won't eat or have a strong negative reaction to if eaten:

_____ _____
_____ _____

Are you able to eat and drink without assistance? ☐ Yes ☐ No
Do you have any difficulty chewing or swallowing food or drinks? ☐ Yes ☐ No
Do you have dentures or partial? ☐ Yes ☐ No
Are they loose or is it difficult to chew with them? ☐ Yes ☐ No - Last time they were checked? _____
What snack foods do you tend to like best? _____

Would you like to meet with the dietitian to discuss your diet or diet options? ☐ Yes ☐ No

Please let us know how we can make your dining experience better! Thank you!
Dietary Services Department

CHEYENNE MANOR
CARING & SHARING
A SENIOR CARE FACILITY

561 West 1st North
PO Box 938
Cheyenne Wells, CO 80810
719-767-5602

Initial Identification & Summary Sheet

Resident Name:	Previous Address:				City:	State:	Zip Code:	Phone:
Nick Name:	DOB:	Age:	Sex:	SSN:	Medicare #:			Medicaid #
					VA #:			

Emergency Contact #1	Address:	City:	State:	Zip Code:	Cell:
Relationship:					
Emergency Contact #2:	Address:	City:	State:	Zip Code	Cell:
Relationship:					
Emergency Contact #3:	Address:	City:	State:	Zip Code:	Cell:
Relationship:					

Dentist:	Last Seen:	Address:	City:	State:	Zip Code:	Phone:
Optician:	Last Seen:	Address:	City:	State:	Zip Code:	Phone:
Audiological:	Last Seen:	Address:	City:	State:	Zip Code:	Phone:
Funeral Home:		Address:	City:	State:	Zip Code:	Phone:

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Mail Delivery Authorization

Please indicate below, the manner in which you wish to have your personal mail delivered.

_____ Deliver my mail to me personally.

_____ Deliver only personal mail to me. (Letters, cards, magazines, newspapers.)

Forward business mail, (bills, checks, etc.,) to the person named below:

_____

_____

_____

_____ Forward all mail, unopened, regardless of the type to the person named below:

_____

_____

_____

I hereby acknowledge that I understand and agree with all of the above information.

_____ _____
Signature of Resident Date

_____ _____
Signature of Legal Representative Date

_____ _____
Signature of Facility Representative Date

CHEYENNE MANOR
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A SENIOR CARE FACILITY