BIRMINGHAM GREEN
RESIDENT ADMISSION AGREEMENT

This is the Admission Agreement (the "Agreement") between **Northern Virginia Health Center Commission d/b/a Birmingham Green d/b/a Northern Virginia Health Care Center** (the "Facility"), and _____ (the "Resident") and _____, the Resident Representative (the "Resident Representative"). This Agreement, effective as of _____, describes the services that Facility will provide to Resident, and the responsibilities of Facility, Resident, and Resident Representative.

1. SERVICES AND PAYMENT

A. Resident Representative.

i. **Definition:** The term Resident Representative includes and may refer to any of the following:

(1) An individual chosen by Resident to act on behalf of Resident for the purposes of supporting Resident in decision-making; having access to financial, medical, social or other personal information of Resident; managing Resident's financial matters; and/or receiving notifications to the extent authorized by Resident.

(2) A person authorized by state or federal law to act on behalf of Resident for purposes of supporting Resident in decision-making; having access to financial, medical, social or other personal information of Resident; managing financial matters; and/or receiving notifications to the extent authorized by Resident. This includes but is not limited to agents under power of attorney, representative payees, and other fiduciaries, acting within the scope of such legal authorization. A copy of the legal documentation providing such a person with authority must be on file with Facility and such person will only be granted those rights as specified in the legal documentation.

(3) Legal representatives, as that term is used in Section 712 of the Older Americans Act; or

(4) A court-appointed guardian and/or conservator of Resident acting within the scope of authority set forth in a court order. A copy of the order appointing a guardian or conservator and a certificate of qualification must be on file with Facility. The guardian or conservator will only be granted those rights as are contained in the court order.

ii. **Limitations on the Definition of Resident Representative:** Nothing in the definition of Resident Representative in this Agreement shall be intended or construed to expand the scope of authority of any Resident Representative beyond that authority specifically authorized by Resident, state or federal law, or a court of competent jurisdiction. A copy of any document (such as a Power of Attorney) or court order providing a Resident Representative with authority must be on file with Facility. Facility will only recognize the rights and authority provided by such document or court order. It is expressly agreed by Resident that Resident

Representative is authorized to receive communications from, and direct communications to, Facility and its agents (including its attorneys), regarding Resident's account and any unpaid balances associated with Resident's account.

iii. **Limitations on Obligations of Resident Representative:** Facility does not require a third party to guarantee payment as a condition of Resident's acceptance, admission, or of continued stay in Facility. Signing this Agreement as a Resident Representative does not financially obligate Resident Representative to pay Facility for Resident's care from Resident Representative's personal resources. The only situation in which Facility may assert a claim against Resident Representative is for breach of one or more of the "Obligations" identified in subparagraph iv, immediately below, or paragraph "G" concerning "Financial Responsibility" below.

iv. **Obligations of Resident Representative:** By signing this Agreement, Resident Representative agrees, both as the agent of Resident and personally, that Resident Representative will use Resident's available income and resources (in contrast to Resident Representative's own income and resources) to pay for Resident's care and services. Resident Representative acknowledges that he/she has legal access to Resident's income and other resources by a written agreement and accepts a duty to Resident and Facility to provide payment to Facility from Resident's income or other resources for any amounts owed by Resident to Facility. Resident Representative also agrees to apply for benefits to which Resident may be entitled, such as Medicaid benefits, and to provide any information and documentation necessary to the processing of Resident's application for benefits that is reasonably available. Resident Representative must execute the Resident Representative Verification and Agreement (**Attachment A**).

B. **Resident Physician.** Resident has chosen _____ as his/her attending physician. Facility may consult with Resident's physician and request that Resident's physician attend to Resident. Resident understands that Facility may require Resident to select an alternate physician if Resident's chosen physician is unable or unwilling to provide care to Resident at Facility and/or if Resident's chosen physician does not provide care in accordance with all federal and state requirements, including but not limited to scheduled visits, loss or limitation of his/her professional license, prohibition from participation in Medicare or Medicaid, or requests for services that are beyond those reasonably and customarily provided by and/or within Facility. Resident agrees that Facility may appoint an interim attending physician to Resident to avoid any interruption in physician services. If Facility selects an attending physician for Resident, Facility shall make all reasonable efforts, based on the information Resident has provided to Facility, to ensure that the services of the physician are covered by Resident's health insurance, if any, and Facility shall provide Resident with the physician's name, contact information, and specialty. If Resident's attending physician and/or his/her designee is unavailable within a reasonable amount of time when called upon by Facility, which reasonableness will depend on the circumstances necessitating the call, Facility may call upon Facility's Medical Director and/or designee to attend to Resident, at Facility's

discretion. Resident agrees to pay costs and expenses for physician services. Facility has no liability concerning the selection of Resident's attending physician.

C. **Hospital Information.** Resident authorizes any transferring hospital to provide Facility with a copy of Resident's medical record along with any other information about Resident, which the hospital may have upon Resident's discharge from the hospital and entrance and/or readmission to Facility.

D. **Services and Plan of Care.** Facility will provide Resident with room and board, residential services, medical services, and services related to Resident psychosocial well-being. These services will be provided in accordance with a "plan of care," which is developed with Resident and Resident Representative by Facility's interdisciplinary team, Resident's attending physician, and others according to Resident's needs and preference. Resident and Resident Representative have the right to attend Care Plan meetings, and an invitation to each Care Plan meeting will be extended to Resident and Resident Representative. Resident must notify the Facility if he/she does not agree to have Resident Representative receive an invitation to attend Resident's Care Plan meetings.

E. **Authorization for Electronic Transmission.** Nursing facilities are required by law to electronically submit individual assessment information to the Centers for Medicare and Medicaid Services (CMS). The information will be used for quality assurance and billing purposes. Other payer sources may require electronic submission of records for billing and assessment purposes. Resident hereby consents to such submissions.

F. **Acceptance.** It is the policy of Facility to admit and to treat all residents without regard to race, creed, color, national origin, sex, religion, disability, age, or other status protected by law. Facility will not admit any person whose condition or behavior requires medical management and counseling support that cannot reasonably be met by Facility. Each applicant will be reviewed on an individual basis to determine the appropriateness of his/her admission based on his/her healthcare needs and the services available at Facility.

G. **Financial Responsibility.**

i. **Fees.** Resident shall be liable for all fees for items and services provided and all costs and expenses incurred by Facility on Resident's behalf and shall be directly responsible to any providers of ancillary services used by Resident that are not provided by Facility, including expenses of discharge or transfer. Resident Representative shall be liable for any breach of his/her duty to protect and preserve Resident's income and resources, to make payment to Facility out of Resident's income and resources, and for any other breach of Resident Representative's obligations expressly stated in this Agreement. "Private pay" residents pay for Facility's services from their own income or resources or from their own private insurance at Facility's "Daily Room Rate" and at Facility's rates for other items and services. Residents covered under Medicare and/or Medicaid are responsible to pay Facility's copay, deductible, and other charges and fees from their own income or

resources to the extent that those charges and fees are not paid for by Medicare, Medicaid, and/or other third-party insurance and are properly payable by a Medicare or Medicaid resident. Facility's current rate sheet schedules for the Daily Room Rate and other items, services, and medical care have been provided to Resident as **Attachment B**. Facility may change these rate schedules from time to time upon sixty (60) days' written notice to Resident. This sixty (60) day advance notice requirement applies to systemic changes in Facility's published rate schedules. Such advance notice shall not apply in the event Resident requires additional services and/or a change in level of care due to a change in Resident's condition, in which event notice of change in individual fees and services will be provided to Resident and/or Resident Representative as soon as practicable under the circumstances.

ii. **Payment.** Facility charges and fees are due on or before the seventh day of each month. A service fee of twenty dollars ($20.00) will be charged for any returned checks. Any outstanding amounts not paid by the twentieth (20th) day of the month shall bear interest at the rate of eighteen percent (18%) annually (one- and one-half percent (1½%) per month). If Resident dies or is hospitalized or transferred and does not return to Facility, Facility will refund to Resident, Resident Representative, or Resident's estate, as appropriate, within thirty (30) days of Resident's death or discharge from Facility, any deposit or charges already paid, less Facility's per diem rate, for the days Resident actually resided or reserved or retained a bed in Facility, regardless of any minimum stay or discharge notice requirements.

iii. **Deposit.** "Private pay" residents who are not covered by Medicaid are required to pay one (1) month's scheduled charges as a deposit. In the event of Resident's death or discharge, the deposit will be applied to any final account balance, and the remainder returned to Resident or the administrator of Resident's estate.

iv. **Collection Costs and Legal Fees.** Should Facility determine to turn Resident's account over for collection to an attorney or collection agency, or should Facility seek to enforce any other provision of this Agreement after Resident or Resident Representative has failed to pay Facility's charges or Resident Representative has breached any of his/her obligations outlined in this Agreement, Facility is entitled to recover all its expenses of collection, including reasonable attorneys' fees and court costs.

v. **Change in Payor Status.** If Resident is eligible to change payor status to become a Medicaid resident, Facility may provide Resident and Resident Representative with information regarding an application for Medicaid eligibility. Resident and Resident Representative, however, have the ultimate duty and obligation to take all steps necessary, in a timely manner, to file for and obtain Medicaid eligibility and to pay all fees due from Resident to Facility. Resident or Resident Representative must notify Facility in writing as soon as possible of their intention to seek Medicaid eligibility and when the application for Medicaid is filed. Facility will attempt to place Resident in a Medicaid-certified bed, but Facility cannot guarantee the availability of a Medicaid-certified bed at any particular time.

vi. **Items, Services and Medical Care.** Facility offers a variety of items, services, and ancillary medical care that may not be covered by the Daily Room Rate and/or not reimbursable under insurance programs. In the event such items, service, and/or care is not covered by the Daily Room Rate nor reimbursable through insurance, Resident will be responsible to pay associated cost. These items and services could include, but are not limited to physician services, certain medications and supplies that are not reimbursable to Facility by another payer, podiatry services, physical therapy, dental services, special foods that are not ordered and/or required to achieve the goals as identified in Resident's plan of care, special nursing services, clothing, personal laundry, beauty and barber services, newspapers, radio, television, cable service, and other health, convenience, and comfort items and services. Resident will be provided with a current list of fees for which Resident may be responsible. Facility contracts with certain providers of pharmacy, therapy, podiatry, laboratory, and other ancillary services; however, Resident understands and agrees that he/she has a choice of service providers. If Resident chooses to utilize his/her own outside provider, Resident must notify Facility. Resident also hereby agrees to provide Facility with copies of Resident's records from such outside providers for inclusion in Resident's medical record and integration into Resident's plan of care. If Resident does not notify Facility of his/her choice of provider(s), Resident hereby consents to the use of Facility's choice of ancillary provider(s).

(a) **Pharmacy Services.** Facility has an agreement with Omnicare, (the "Primary Pharmacy") to provide medications, supplements, and supplies ordered for Facility residents. Resident has the right to choose to obtain such items from a different, available pharmacy. However, the following conditions may apply in the event Resident chooses to use a pharmacy other than Primary Pharmacy:

1. To ensure safe and uniform administration of Facility's medication program, all prescription and over-the-counter medications, supplements, and supplies must be specifically packaged in a manner consistent with Facility's medication administration system. Therefore, if Resident chooses to obtain medications, supplements, and/or other supplies from a pharmacy other than Primary Pharmacy, those items may need to be sent to Primary Pharmacy for repackaging. Resident understands and agrees that Resident will be responsible for payment of any repackaging charges incurred, which are currently $7.00 per 90-day supply.
2. In the event Resident's chosen pharmacy cannot provide a medication or other item as ordered and/or within a reasonable time, Facility may obtain the item from Primary Pharmacy. Resident understands and agrees that Facility will provide to Primary Pharmacy any payor information it has on Resident that may provide coverage for the item(s) ordered on Resident's behalf. However, Resident understands and agrees that Resident will ultimately be responsible for payment of any charges incurred.

3. All pharmacy services provided primarily to Facility to meet state and federal requirements and/or as part of Facility operations (e.g., maintaining and providing records such as Physician Order Sheets and Medication Administration Records, conducting Drug Regimen Reviews, and performing audits) will be provided by Primary Pharmacy.
4. Resident and Resident Representative understand and agree that Facility retains the right and ability to change pharmacies from Primary Pharmacy.

2. RESIDENT AND FACILITY RESPONSIBILITIES

A. **Consent to Care and Treatment.** By entering into this Agreement, Resident consents to receive the nursing facility care and services Facility has agreed to provide Resident. Resident consents to Facility's provision of routine care and treatment, as ordered by Resident's attending physician. Resident has the right to be fully informed about the care Facility provides to Resident, and Facility encourages Resident and Resident Representative to participate in planning and implementing Resident's care. Facility staff is available, in advance, to answer questions about the care and services Facility has agreed to provide to Resident. If Resident is incapable of making his/her own medical decisions or becomes so in the future, Facility will follow the direction of any Advance Directive and/or the direction of a legally authorized alternative healthcare decision-maker, such as a healthcare agent or guardian. Issues relating to Resident's health and expectations are discussed during this admission process and at regularly scheduled Care Plan meetings.

B. **Resident's Refusal to Accept Care.** Resident (or their Resident Representative acting on the Resident's behalf within the scope of Resident Representative's legal authority) has the right to refuse any care, treatment, item, or service. Facility will not threaten or intimidate Resident into doing what Facility, the attending physician, and/or Resident Representative believes is best for Resident. Consistent with the exercise of Resident's right to refuse, Facility is released from any and all liability that may arise out of the lack of any care, treatment, item, or service so refused. Resident and Resident Representative are strongly encouraged to participate in the planning and implementing of Resident's care. Resident and Resident Representative understand and agree that if Facility believes Resident or Resident Representative's refusal of care for Resident poses a risk to Resident's or other individuals' health and/or safety, Resident may be discharged from Facility.

C. **Alcohol, Cannabis, and Controlled Substances.** Facility will not permit the use or possession of, without Facility's permission and a physician's order alcohol, cannabis or marijuana products, or any controlled substance (except as prescribed) in violation of any law. Any resident who, while on Facility premises, engages in the sale and/or unauthorized possession of alcohol, cannabis or marijuana products, or any controlled substance may be subject to discharge and may be referred to local law enforcement. Upon suspicion of possession of alcohol, cannabis, or marijuana products, or a controlled

substance violating this section and with consent of Resident, Facility may search the resident's room, personal locker, personal effects, and other personal spaces.

D. **Smoking and Vaping.** Facility is a non-smoking and non-vaping facility to protect the safety and health of Facility's residents, visitors, employees, and other providers of treatment and services. Resident agrees that he/she will not smoke while on Facility premises. Resident agrees to refrain from possessing or obtaining any smoking materials, including, but not limited to, cigarettes, e-cigarettes, pipes, cigars, vapes, lighters, lighter fluid, matches, tobacco, or vaping liquids. Resident also acknowledges that family members, visitors, and Facility staff are not permitted to assist Resident with smoking on Facility premises.

E. **Food & Beverages.** Although Resident has the right to have outside food and beverages (provided Resident complies with Facility's requirements for proper storage of any such items), Facility strongly encourages Resident to notify Facility prior to receiving/consuming outside food and/or beverages. This policy is for Resident's safety and well-being, as well as that of other residents of Facility.

F. **Firearms and Other Weapons.** Facility prohibits employees, residents, visitors, vendors, and others (except for law enforcement officials) from possessing firearms or other weapons designed to do bodily harm (e.g., knives with blades longer than four inches, brass knuckles, explosives, etc.) while in Facility and/or on Facility premises. Signage is posted throughout Facility setting forth these policies. Upon suspicion of possession of a firearm or other weapon or consent of Resident, Facility may search Resident's room, personal locker, personal effects, and other personal spaces.

G. **Emergency Medical Treatment.** Resident authorizes Facility to provide Resident with any emergency medical treatment that Facility and/or Resident's physician believes necessary and/or to arrange for Resident's transfer to a hospital or other facility for care beyond the scope of services of Facility.

H. **Authorization for Use of Image.** Resident hereby authorizes Facility to photograph Resident for identification purposes and to release Resident's photograph as reasonably necessary and appropriate should Facility and/or any law enforcement agency need to locate Resident. Resident also authorizes the use of photo, video, and/or other imaging technology as may be necessary for the assessment and treatment of certain health conditions (i.e., skin conditions) or during authorized telemedicine services.

I. **Resident's Personal Funds and Responsibility for Personal Items.** Resident is not required to deposit his/her personal funds with Facility. However, Facility will hold, safeguard, manage, and account for Resident's personal funds if requested by Resident based on the Resident Trust Fund and Valuables Agreement (**Attachment C**). Facility will not be responsible for any of Resident's valuables or personal effects stored in his/her room and/or kept on Resident's person beyond the exercise of reasonable care. Resident may bring small items for Resident's personal use, but Resident must label all items with Resident's full name. However, Facility strongly discourages Resident from keeping

valuable jewelry, papers, electronic equipment, large sums of money, or other valuable items at Facility. Facility strongly recommends that Resident keeps less than five (5) dollars in Resident's possession at any time.

J. **Liability for Personal Injuries, Illness, Disability, Death, or Other Harm.** Facility will not be liable for personal injuries, illness, disability, death, or other harm suffered by Resident while under Facility's care or while being transferred or discharged, except where personal injury, illness, disability, death, or other harm is caused by Facility's negligence or lack of reasonable care. Resident and Resident Representative agree to indemnify and hold Facility and its officers, employees, and agents harmless from and against any liability for personal injuries, illness, disability, death or other harm or property damage caused by Resident, Resident Representative, or Resident's other invitees to Facility.

K. **Electronic Monitoring.** Facility does not allow the use of electronic monitoring in resident rooms. "Electronic monitoring" means the use of an unmanned video recording system, with or without audio capability, installed in the room of a resident. In addition, staff are prohibited from covertly monitoring residents. Should Resident or their Resident Representative believe Resident to be the subject of covert monitoring please notify Facility. Please note that the Office of Licensure and Certification's complaint hotline number is (800) 955-1819.

L. **Residents' Rights.** Resident has received a written copy of the Residents' Rights and Responsibilities and shall sign the document in acknowledgement of these rights and responsibilities (**Attachment D**). Resident acknowledges that he/she has had the opportunity to review these rights and responsibilities and ask any questions Resident may have. Resident and Resident Representative further acknowledge that information regarding the Residents' Rights, including responses to questions, was provided in a manner reasonably understandable to Resident and/or Resident Representative. Resident and Resident Representative further acknowledge that Facility has the right to revise and amend its policies and procedures for implementing these rights from time to time, so that they are in compliance with applicable federal and state statutes, rules, and regulations. Facility shall provide Resident and Resident Representative with a copy of any revisions or amendments to the Residents' Rights and Responsibilities.

3. TERM, TRANSFER, DISCHARGE, AND TERMINATION

A. **Term & Termination.** This Agreement shall be effective as of the date first written above and will be effective for an initial term of one (1) month and shall renew automatically for successive (1) one-month term(s) until terminated. Resident may terminate this Agreement at any time by giving Facility written notice of termination at least five (5) days in advance of the proposed termination date and by leaving Facility on or before the termination date. Resident shall be responsible for the per diem rate and all other charges for goods and services provided by Facility through the termination date.

B. **Permission for Release of Information.** Facility reserves the right to release pertinent

information to appropriate community agencies for Resident's benefit and for continuity of care. By signing this Agreement, Resident and Resident Representative acknowledge receipt of Facility's Notice of Privacy Practices and gives permission to have appropriate information from his/her medical record released to community agencies for continuity of care and discharge from Facility. Facility may also release Resident's medical information to an individual Resident designates.

C. **Discharge Time.** Please be advised that Facility requires that each resident leave the Facility before 11:00 a.m. on the day of discharge. If check out by 11:00 a.m. on the day of discharge is not possible, prior arrangements must be made with the Social Services staff on the appropriate unit. Resident may be charged at the private daily room rate of the room from which Resident is being discharged for discharges occurring after 11:00 a.m. (a "Late Discharge"). Charges associated with a Late Discharge are NOT payable by insurance.

D. **Facility-Initiated Transfer and Discharge.**

i. **Transfer within the Facility.** Resident retains the right to refuse a transfer to another room within Facility if the purpose of the transfer is to relocate Resident from the distinct part of Facility that is a Skilled Nursing Facility to the distinct part of Facility that is a Nursing Facility or vice versa or if the transfer is solely for the convenience of staff. Facility may transfer Resident to another room within Facility contrary to Resident's wishes in situations including, but not limited to, where the transfer is necessary to meet Resident's health or safety needs which could not otherwise be met in Resident's current accommodation as documented in Resident's medical record. Resident may choose a roommate, and Facility will accommodate this choice when practicable and when both Resident and the proposed roommate agree to the arrangement. Resident has the right to refuse to move to a room in a different part of Facility if the purpose of that move is to obtain Medicare or Medicaid eligibility. However, refusing to consent to such a room change may nonetheless result in Medicare or Medicaid denial of coverage for Resident's continued stay. Resident's right to refuse such a room change does not relieve Resident from any financial obligation resulting from that refusal.

ii. **Discharge from the Facility.** Facility may transfer or discharge Resident from Facility only for one of the follow reasons:
   (a) The transfer or discharge is necessary for Resident's welfare and Resident's needs cannot be met in Facility.
   (b) Resident's health has improved sufficiently so that Resident no longer needs the services provided by Facility.
   (c) The safety of individuals in Facility is endangered due to the clinical or behavioral status of Resident.
   (d) The health of individuals in Facility would otherwise be endangered.
   (e) Resident fails, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) Resident's stay at Facility. Nonpayment applies if a Resident or Resident Representative fails to make payment for

a private pay Resident, Resident or Resident Representative does not submit the necessary paperwork for third-party payment, or after the third-party, including Medicare or Medicaid, denies the claim and Resident or Resident Representative refuses to pay for Resident's stay.

(f) Facility ceases to operate.

iii. **Notice of Facility-Initiated Discharge or Transfer.** Facility will give Resident at least thirty (30) days' prior written notice of a Facility-initiated transfer or discharge and an opportunity to appeal the transfer or discharge unless this is not practicable, such as in an emergency, or if a shorter notice period is permitted by law, such as when Resident's health improves sufficiently to allow a more immediate transfer or discharge, or the safety or health of individuals in Facility is endangered due to the clinical or behavioral status of Resident. While any appeal of a Facility-initiated transfer or discharge is pending, Facility may not transfer or discharge Resident unless the failure to discharge or transfer Resident would endanger the health or safety of Resident or other individuals in Facility. Except in an emergency, the Director of Nursing will ensure that written follow-up instructions are developed with the Resident and/or Resident Representative including information necessary to meet Resident's need for medical and nursing services and the name, address, and telephone number of the State Long-Term Care Ombudsman. A copy of these instructions will be provided to Resident and/or Resident Representative. A discharge summary will be developed and authorized by Resident's attending physician that includes Resident's medical condition at the time of transfer or discharge, Resident's medical and psychosocial history, the date of the transfer or discharge, and the location of Resident after discharge.

E. Resident-Initiated Discharge. Resident may arrange for Resident's discharge from Facility at any time and for any reason. If Resident does not, however, provide Facility with at least five (5) days' notice of Resident's departure, Resident will be charged for the (5) five-day notice period. Resident understands that failure to provide Facility such notice of Resident's intent to terminate this Agreement and leave Facility may impair and/or delay Facility's ability to make appropriate post-discharge arrangements for Resident. If Resident terminates this Agreement and leaves Facility without providing the required notice, Resident hereby releases Facility, its agents, and associates from all liability or responsibility for any potential claim arising out of any absence or delay in arrangements for post-discharge care, services, medications, and/or equipment. Resident agrees to pay all amounts owed by Resident to Facility prior to Resident's departure date.

4. READMISSION

A. Admission Documentation. If Resident is transferred to a hospital from Facility or for therapeutic leave and re-admission is anticipated, this Agreement and all other admissions documentation shall remain in full force and effect for a period of thirty (30) days from the date of discharge from Facility, unless a new admission agreement is executed by Facility and Resident and/or Resident Representative. A Resident requesting re-admission upon return may be asked to sign a new admission agreement.

B. **Bed Holds.** Facility will not hold a bed for Resident while Resident is hospitalized or on therapeutic leave unless Resident pays the Facility the Daily Room Rate during his/her hospitalization or therapeutic leave. Medicaid does not pay for bed holds while a resident is hospitalized. Medicaid residents who are discharged to the hospital will also have to pay the Daily Room Rate out-of-pocket to keep a bed; otherwise, Facility may move someone else into Resident's room. However, if Facility is not paid to hold Resident's bed, Resident may still have the ability to return as soon as an appropriate bed is available in a semi-private room in Facility and if Resident still needs the services provided by Facility (and, if Resident is on Medicaid, Resident is eligible for Medicaid nursing facility services). A Resident may not be permitted to return to Facility if one of the criteria for discharge discussed above is met and Facility provides written notice to Resident and/or Resident Representative. Following a transfer to the hospital, Facility shall provide timely notification of Facility's bed hold practices to Resident and/or Resident Representative.

C. **Storage of Belongings.** If Resident goes to the hospital and does not hold his/her bed, or if Resident expires, his/her belongings will be placed in storage at Facility. Arrangements must be made to have these items picked up as soon as possible. Any items not picked up within thirty (30) days will be donated to a charity of Facility's choosing.

5. NOTICE OF DEEMED CONSENT TO HIV AND HEPATITIS B AND C TESTING

A. **Deemed Consent to Testing.** Facility is legally authorized to require that Resident be tested for infection with human immunodeficiency virus (HIV) and for Hepatitis B or C viruses when a healthcare worker is exposed to bodily fluids from Resident in a way that may transmit HIV or Hepatitis B or C according to Centers for Disease Control and Prevention guidelines.

B. **Deemed Consent to Disclosure of Test Results.** In the circumstances described above, Virginia law deems Resident to have also consented to the release of the test results to the exposed health care worker. Resident will be provided with these test results as well. Test results, if positive, will be reported to the Virginia Department of Health.

6. MISCELLANEOUS

A. **Assignment & Delegation.** The provisions of this Agreement shall bind the respective parties hereto, their respective executors, administrators, heirs, legatees, devisees, beneficiaries, successors, and lawful assigns. The rights and obligations of Facility may be assigned by Facility at any time without limitation. The rights and obligations of Resident and/or Resident Representative hereunder shall not be assigned or delegated without the prior written consent of Facility.

B. **Merger, Modification, and Waiver.** This Agreement and its Exhibits, Addenda, and Attachments constitute the entire agreement between the parties hereto and may be amended or waived only by writing, signed by the parties to this Agreement or the waiving party. No waiver of any provision or default under this Agreement shall affect

the right of the parties thereafter to enforce any other provision or to exercise any right or remedy in the event of any other default.

C. **Severability.** Whenever possible, each provision of this Agreement will be interpreted in such a manner as to be effective under applicable law. If any provision or provisions of this Agreement shall be determined to be invalid or unenforceable, either in whole or in part, as contrary to the laws or public policies of the Commonwealth of Virginia or the United States, this Agreement shall be deemed amended to delete the offending provision or provisions and the validity or enforceability of the remaining provisions shall not be affected.

D. **Governing Law & Venue.** This Agreement shall be governed, construed, and performed in accordance with the laws of the Commonwealth of Virginia, without regard to conflict of law principles. If either party sues the other, such litigation shall be filed in the appropriate state or federal court for the County of Prince William. Each party agrees that all claims and matters may be heard and determined in any such court, and each party hereby waives any right to object to such filing on grounds of venue, *forum non-conveniens*, or other venue-related grounds. No provision of this Agreement may be construed to be a waiver by Facility of any immunities from suit or from liability that Facility may have by operation of law.

E. **Survival.** The terms of this Agreement shall survive the termination of this Agreement. The Agreement shall survive and not be revoked by the death of Resident or dissolution of Facility and such provisions shall additionally be binding upon the benefit of the Resident's estate, executors, personal representatives, heirs, beneficiaries, successors, and assigns, and shall be binding upon the benefit of Facility, its agents, employees, parent, subsidiary and affiliated companies, owners, managers, partners, officers, directors, successors, and assigns.

F. **Acknowledgement of Notices and Policies.** By signing this Agreement, Resident and Resident Representative acknowledge receipt and understanding of the following attachments, notices, policies, and consents, which are made part of this Agreement:

(a) Resident Representative Verification and Agreement (Attachment A)
(b) Schedule of Fees (Attachment B)
(c) Resident Trust and Valuables Agreement (Attachment C)
(d) Resident Rights and Responsibilities (Attachment D)
(e) Initial Assessment (Attachment E)
(f) Beauty and Barbershop Agreement (Attachment F)
(g) Insurance Authorization Form (Attachment G)
(h) Authorization for Release of Information (Attachment H)
(i) Virginia Sex Offender Registry Notice (Attachment I)
(j) Resident Property Loss/Damage Policy and Procedure (Attachment J)
(k) Advance Directives and Code Status Designation (Attachment K)
(l) Notice of Privacy Practices (Attachment L)
(m) Grievance Policies/Complaints Procedures (Attachment M)

(n) Photography Release and Consent (Attachment N)
(o) Authorization of Release of Body to Funeral Home (Attachment O)
(p) Consent for Influenza Vaccination (Attachment P)
(q) Consent for Pneumococcal Vaccination (Attachment Q)
(r) Laundry Agreement (Attachment R)
(s) Resident Telephone Agreement (Attachment S)
(t) Authorization to Receive and Open Mail (Attachment T)

7. UNDERSTANDING AND ACCEPTANCE OF AGREEMENT

A. <u>Consent & Acknowledgement</u>. By setting signature or mark below, Resident and/or Resident Representative represents and warrants that:

i. Resident and Resident Representative have read this Agreement or had this Agreement read to him/her.

ii. Resident and Resident Representative have had the opportunity to ask any questions pertaining to this Agreement, they have received responses to those questions, and those responses are acceptable as consistent with the terms of this Agreement.

iii. Resident and Resident Representative have not hastened into signing this Agreement, and Facility has advised Resident and Resident Representative have that they may have a trusted advisor or attorney review this Agreement on their behalf before signing.

(*Signatures on following page*)

By:
Northern Virginia Health Center Commission d/b/a Birmingham Green

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

Source of Authority (i.e., guardianship/conservatorship order, Power of Attorney, etc.):

_____

Resident Representative Address: _____

Resident Representative Phone: _____

ATTACHMENT A
Resident Representative Verification and Agreement

The undersigned Resident Representative has been appointed through legal means to act on behalf of Resident. The Resident Representative has been appointed to act on Resident's behalf by means of existing legal document(s) and a copy of any such document(s) has been provided to Facility. Resident Representative is authorized and agrees as follows:

1. To use the funds/assets of Resident to pay all costs and expenses incurred by Resident at Facility, and to arrange for the provision of personal clothing and care supplies as needed or desired by Resident and as required by Facility.

2. If Resident is a Medicaid Resident, to provide financial information with respect to monthly credits, increases, and decreases in Resident's financial account(s) and other assets to Facility to enable Facility to provide requested financial information to Medicaid representatives as they may request.

3. To use the funds of Resident to reimburse Facility for all damage (replacement costs) caused by Resident to furnishings, fixtures, and other property of Facility, its employees, or of other residents.

4. To use the funds of Resident to pay charges not covered by Medicaid, Medicare, or third-party insurance in a timely manner, and to notify the Administrator of any problem anticipated in paying such charges.

5. To give Facility twenty-four (24) hours advance notice of Resident's desire to make a home visit or otherwise leave Facility for personal reasons (a "Therapeutic Leave") and of the date on which Resident is expected to return to Facility. Facility will provide Resident with prescribed medication needed while on Therapeutic Leave, not to exceed dosages necessary for thirty (30) days. The undersigned further agrees to sign Resident out of Facility and promptly notify Facility if Resident will not be returning on the expected return date.

6. To indemnify and hold the Facility harmless from any claim, demands, costs, liabilities, losses, expenses, damages, etc., resulting from any injury or damage that Resident may incur or cause while on Therapeutic Leave.

7. To promptly advise the Administrator in writing of any change in contact information and/or of his/her status as Resident Representative.

8. Resident Representative acknowledges that he/she is aware of the complaint procedure to be used if there is a concern with the service of any department or employee of Facility.

Facility Representative Name	Printed Resident Name
Facility Representative Signature	Resident Signature
Date	Date
	Resident Representative Name
	Resident Representative Signature
	Date

ATTACHMENT B
Schedule of Fees

Level of Care	Rate	Room	Certified Coverage
Nursing Facility	$425 per day	Semi-Private	Medicare/Medicaid
Nursing Facility	$450 per day	Private	Medicare/Medicaid

Other Charges: Additional charges are made by Facility for oxygen and selected medical supplies. These charges are normally covered by Medicaid, Medicare, or another insurance.

Non-Facility Charges: The following is a non-exhaustive list of services provided by third-party contractors or private arrangements, the cost of which will be billed to Resident privately or to Medicaid, Medicare, or other insurance:

Physical Therapy	Physician Services	Pharmaceutical Services
Occupational Therapy	Podiatry Services	Laboratory Services
Speech Therapy	Emergency Dental Care	X-Rays

Personal Services: Resident will be personally responsible for the cost of personal services and sundry items including, but not limited to:

Cosmetics, Candy, Clothing, Gifts, Newspapers, Telephone Service in Room/Long Distance Charges.

Beautician/Barber Service: Beautician/barber service is available at Facility. If Resident maintains a Personal Funds Account with the Business Office, this service may be charged to Resident's account with Resident's consent.

Personal Funds: Medicaid eligibility offices determine the amount of personal income that will be required to be paid from Resident's own income or resources each month and the amount of any monthly allowance Resident will be permitted to keep for personal expenses.

Amenities: Free cable TV hookup is available in each room. A central dining room is available for independent residents. All resident rooms have their own toilet and washbowl; private rooms also have a shower. A variety of lounges are available for private and group visiting. The nursing facility has a special memory care unit of 60 beds for residents with .

ATTACHMENT C
Resident Trust Fund and Valuables Agreement

Resident is not required to deposit his/her personal funds with Facility. If Resident chooses to maintain such account with Facility, Resident hereby agrees as follows:

1. Facility shall furnish you a written receipt for all expenditures and deposits regarding any of your funds deposited with Facility.
2. A record of all transactions regarding your funds shall be maintained by Facility in accordance with generally accepted accounting principles.
3. You shall have access, at any time upon request, to the above record and shall receive an itemized quarterly statement of your account.
4. Facility has a surety bond to guarantee your funds.
5. All resident personal funds are kept in separate account(s) from Facility operating accounts.
6. Facility will not keep more than $50 in a non-interest bearing or petty cash fund for your account. Any sum more than $50 will be put in an interest-bearing account. On a monthly basis, the interest earned will be credited to your account.
7. You acknowledge that, upon discharge or death, the balance of your account, as well as a final accounting, will be promptly released within thirty (30) days to you or, in the case of death, the individual or probate jurisdiction administering your estate or as otherwise required by law.
8. You authorize Facility to distribute or return your money or property only to you or your Resident Representative upon written request, or to the individual administering you your estate upon death.
9. You acknowledge that you may authorize Facility to deposit your assets, including but not limited to Social Security and pension benefit payments, to your account, and pay your liabilities there from.
10. If you are deemed incompetent and no longer able to handle your valuables or money, Facility will look to Resident Representative to manage and handle your valuables and money within the scope of your Resident Representative's legal authority.
11. If you receive Medicaid benefits, Facility shall notify you when the amount in your account reaches $200 less than the Social Security Income ("SSI") resource limit for one person and that, if the amount in the account, in addition to the value of your other nonexempt resources, reaches the SSI resource limit for one person, you may lose eligibility for Medicaid or SSI.

_____ I DO wish to maintain a Resident Trust Fund with Facility in accordance with the above provisions.

_____I DO NOT wish to maintain a Resident Trust Fund with Facility.

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

Resident Fund Management Service
AUTHORIZATION AND AGREEMENT TO HANDLE RESIDENT FUNDS
• • PLEASE TYPE OR PRINT • •

ACCOUNT NUMBER

DIRECT DEPOSIT NUMBER

Resident Name _____ Taxpayer ID NO. _____

Facility Name BIRMINGHAM GREEN Facility Resident ID _____

Statement Address _____

CHECK ACCOUNT TYPE

1. RESIDENT FUND ACCOUNT

____NON-TRANSFERRING ACCOUNT (No automatic number of deposits to pay for care cost)

____TRANSFERRING ACCOUNT (Automatic transfer of care cost payments due Facility) with $_____ MONTHLY ALLOWANCE AMOUNT.

2. BURIAL ACCOUNT (Deposit only account - monies to be used for burial expenses only)

____Revocable (May be closed prior to death)

____Irrevocable (To be closed after death or if Resident transfers from Facility or if transferred to another burial account)

____Non-interest-bearing burial account (Interest will be paid if this item is NOT checked)

DIRECT DEPOSIT: Please enroll my indicated recurring benefit payments for direct deposit.

____Social Security ____Supplemental Security Income

____Veterans Administration ____Civil Service

____Railroad Retirement ____Miners Benefit/Black Lung

*** Note — Enter the direct deposit information in the RFMS software or complete the appropriate pension direct deposit form. If you are enrolling for any of the federal government agencies listed above and Resident has a representative payee, the representative payee MUST sign this form.

By my signature below, I hereby authorize Facility to establish and manage a FDIC insured interest bearing resident fund or burial account with the options as specified above. I understand I may have my recurring checks direct deposited to my resident fund account, I may make deposits to and withdrawals from my resident fund account at Facility, and I will receive a statement of any account I have at least quarterly.

If I elect to have a resident fund transferring account, I direct that the amount stipulated by me or required or permitted under federal, state, or local law from time to time in effect, be withheld monthly for my personal use and that the remainder be transferred to Facility for the payment of my care costs. I hereby authorize Facility Administrator and/or his/her designated staff, to from time to time adjust my personal allowance amount to comply with governing laws as they apply to me.

In the event of my death, I direct that any funds owed or advanced to me by Facility prior to my death are to be paid to Facility with any remaining balance in my resident fund account to become part of my estate.

By signing this form, I under penalties of perjury, certify that: (1) the number shown on this form is my correct taxpayer identification number, and (2) I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding.

* * RESIDENT'S ILLEGIBLE SIGNATURE OR MARK (X) REQUIRES TWO WITNESS SIGNATURES * *

Witness _____RESIDENT *_____

Witness_____ Date _____

* ANYONE SIGNING FOR RESIDENT MUST SIGN THE CERTIFICATION BELOW

I, the undersigned, certify that I am the legal representative as stated below for the above-named Resident and agree to all the terms stated above and I have provided valid legal supporting documentation of my legal capacity and authority.

_____
Facility Representative Name

_____
Facility Representative Signature

_____
Date

_____
Printed Resident Name

_____
Resident Signature

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

Source of Authority (i.e., guardianship/conservatorship order, Power of Attorney, etc.):

_____

Resident Representative Address: _____

Resident Representative Phone: _____

ATTACHMENT D
Resident Rights and Responsibilities

Facility must inform you of your rights and of all rules and regulations governing your conduct and responsibilities during your stay in Facility. This document provides an explanation of your rights as a resident of a nursing facility according to federal regulation, followed by a statement of your responsibilities with respect to Facility's rules and regulations and code of conduct.

YOUR RIGHTS

Equal Access

All residents have the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source.

Exercise of Rights

You have the right to exercise your rights as a resident of Facility and as a citizen of the United States, without fear of interference, coercion, discrimination, or reprisal. You also have the right to choose a Resident Representative to exercise your rights on your behalf. You retain the ability to exercise any rights that you do not delegate to a Resident Representative. Any Resident Representative appointed on your behalf through legal means may exercise the rights given to them in accordance with state and federal law, the legal instrument giving them authority, and/or court order.

You and/or your Resident Representative have the right to organize or participate in resident and/or family groups at Facility unless medically contraindicated in your medical record. You have the right to communication with and access to persons and services outside Facility.

Planning and Implementing Care

You and/or your Resident Representative have the right to be fully informed of your health status, including any significant changes, in a language you can understand. You have the right to be informed, in advance, by your physician and/or other practitioner or professional of proposed care and treatment, including the risks and benefits of such treatment and appropriate treatment alternatives to psychotropic medication or surgical procedures. You have the right to participate in the development and implementation of your plan of care, the right to accept, refuse, or discontinue treatments and services, including refusal to participate in experimental research, and the right to formulate an Advance Directive.

You have the right to choose your attending physician, if physician is willing and able to comply with all state and federal requirements for physician services within a nursing

facility, as well as the Facility's policies and procedures for implementing those requirements.

Respect, Dignity, and Self-Determination

You have the right to:

1. Be treated with respect and dignity.
2. Retain personal possessions, as space permits and unless doing so would infringe upon the rights, health, and/or safety of others and unless medical contraindicated as documented in your medical record.
3. Reasonable accommodation of your needs and preferences, except when doing so would endanger the health or safety of yourself or others.
4. Share a room with your spouse, including a same-sex spouse, when you both reside in Facility and consent to the arrangement.
5. Share a room with a roommate of your choice, when practicable, if you both reside in Facility and consent to the arrangement.
6. Receive written notice when practicable before a change in your room or roommate.
7. Refuse certain transfers to another room in Facility.
8. Choose activities, schedules (including sleeping and waking times), and healthcare services that are consistent with your interests, assessments, and plan of care.
9. Self-administer medications if your care team, including your attending physician, determines that it is clinically appropriate.
10. Be free from verbal, physical, sexual, and mental abuse or assault, from involuntary seclusion and corporal punishment, from physical restraint, from retaliation for submitting a complaint to state regulatory authorities or any other entity, from coercion, and from exploitation and misappropriation of your property by anyone.
11. Absent emergencies, be free from any chemical and physical restraints except as authorized by your physician to treat your medical symptoms.
12. Make choices about aspects of your life in Facility that are significant to you.
13. Absent emergencies, consent to or refuse treatment.
14. Interact with members of the community and participate in community activities both inside and outside Facility.
15. Receive visitors of your choosing at the time of your choosing, subject to your right to deny visitation, in a manner that does not impose upon the rights of another resident and subject to reasonable clinical and safety restrictions. You have a right to privacy for visits with your spouse or other individuals.
16. Immediate access to you by certain individuals, including your Resident Representative, any representative of the State, and your physician.
17. Choose or refuse to perform services for Facility.
18. Manage your own financial affairs, including the right to be informed, in advance, what charges Facility may impose against your personal funds. If you give responsibility to Facility to manage your funds, you have the right to access records of financial transactions made on your behalf and will be given a quarterly accounting of transactions.

Privacy and Confidentiality

You have the right to privacy in your spoken, written, and electronic communications, including the right to send and receive unopened mail and packages, unless medically contraindicated in your medical record. You have the right to personal privacy and confidentiality of your records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care such as bathing and toileting, visits, and meetings of resident and family groups. It does not include a right to be placed in a private room. You have the right to access your personal and medical records. You have the right to refuse the release of your medical records except as required by law and/or for other purposes as disclosed in Facility's Notice of Privacy Practices, including reasons related to your transfer or discharge.

Safe Environment

You have the right to a safe, clean, comfortable, and home-like environment that allows you to be as independent as possible.

Grievances

You have the right to voice grievances to the Facility Grievance Officer, other staff, or any other agency or entity that hears grievances without fear of discrimination or reprisal. Facility must make information on how to file a grievance or compliant available to you. You also have the right to prompt efforts by Facility to resolve grievances.

Admission, Transfer, and Discharge Rights

Facility must inform you in writing of the services available at Facility, the fees for such services, and any special characteristics of Facility.

Facility must permit you to remain in Facility and may not transfer or discharge you, unless:

1. The transfer or discharge is necessary for your welfare and your needs cannot be met by Facility.
2. Your health has improved sufficiently so that you no longer need the services provided by Facility.
3. Your clinical or behavioral status endangers the health or safety of others.
4. The health of individuals in Facility would otherwise be endangered.
5. You fail, after reasonable and appropriate notice, to pay for your stay at Facility.
6. Facility ceases to operate.

<u>The Facility will provide you with reasonable advance notice of discharge as required by law to help ensure an orderly transfer and discharge.</u>

Required Notices

You have been informed that if you become institutionalized or receive Home and Community-Based services for a continuous period, have a spouse in the community, and have not already become a Medicaid recipient, you may request a Resource Assessment from your local Department of Social Services. You have further been informed that the Resource Assessment will compile your total resources and your spouse's total resources to determine how much would be counted as available to each of you should you apply for Medicaid while you are at Facility. You understand that if you do not agree with the findings of the Resource Assessment, you may file an appeal in writing to the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219.

You have been informed of your right to examine, upon request, reports with respect to any survey conducted at Facility during the preceding three (3) years and any plan of correction in effect for Facility. The results of the most recent survey are posted in each resident dining room and in the reception area for your review. Results of the most recent survey are also available in summary form.

You have been informed of your right to file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, and misappropriation of resident property in Facility and non-compliance with requirements regarding advance directives and requests for information regarding returning to the community. You will not be subjected to retaliation for submitting a complaint.

Necessary contact numbers are listed below.

Your local Ombudsman, Rosemari Walker, can be contacted at 703-792-7662 (local) if you feel that your concerns are not being met through the facility grievance procedure. EMAIL address: pwaaa@pwcgov.org.

To contact Facility Grievance Official, Nicole Davis, Director of Social Services, please call 703-257-6215. EMAIL address: ndavis@birminghamgreen.org.

State Advocacy groups are as follows:

1. **ADULT PROTECTIVE SERVICES - PRINCE WILLIAM COUNTY DEPARTMENT OF SOCIAL SERVICES:** 7987 Ashton Avenue, Suite 200, Manassas, VA 20109. (703) 792-4200 (Local) and (888) 832-3858 (State Hot Line),
2. **OFFICE OF LICENSURE AND CERTIFICATION:** 9960 Mayland Drive, Suite 401, Henrico, VA 23233. (1-800) 955-1819 (Complaint Line)
3. **DISABILITY LAW CENTER OF VIRGINIA**: 1512 Willow Lawn Drive, Suite 100, Richmond, VA 23230, (800) 552-3962, info@dLCV.org.

4. **MEDICAID FRAUD CONTROL - UNIT OF THE OFFICE OF THE ATTORNEY GENERAL**: 202 North Ninth Street, Richmond, VA 23219. (800) 371-0824, MFCU_mail@oag.state.va.us
5. **THE PRINCE WILLIAM LONG TERM CARE OMBUDSMAN PROGRAM:** 5 County Complex, Suite 240, Woodbridge, VA 22192. (703) 792-7662, rwalker@pwcgov.org
6. **OFFICE OF THE STATE LONG TERM CARE OMBUDSMAN PROGRAM:** 8004 Franklin Farms Drive, Henrico, VA 23229. (1-800) 552-3402, ombudsman@dars.virginia.gov
7. **VIRGINIA ASSOCIATION OF AREA AGENCIES ON AGING:** 24 East Cary Street, Suite 100, Richmond, VA 23219. (804) 545-1644
8. **VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES:** 1610 Forest Avenue, Suite 100, Richmond, VA 23229. (804) 662-9333 (Local) (1-800) 552-3402 (Toll Free), dars@dars.virginia.gov
9. **PRINCE WILLIAM AREA AGENCY ON AGING:** 5 County Complex, S. 240, Woodbridge, VA 22192, (703) 792-6400, shenry@pwcgov.org

YOUR RESPONSIBILITIES

You understand that you and, when applicable, your Resident Representative have the following responsibilities during your stay at Facility:

1. To comply with all the terms of the Admission Agreement, along with Attachments, Addenda, and Exhibits.

2. To provide, to the best of your knowledge and understanding, accurate and complete information to Facility in all matters related to your health and well-being and matters that may affect your coverage for services and/or eligibility for benefits.

3. To inform Facility of any unexpected change you perceive or observe in Resident's health status.

4. To be considerate of other residents, visitors, and of Facility staff, including showing respect for others' property, space, culture, and conditions.

(*Signature on following page*)

By:
Northern Virginia Health Center Commission d/b/a Birmingham Green

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

ATTACHMENT E
Initial Assessment

Assessment: ___ Long-Term Care Admission ___ Skilled Medicare Admission

Social History:

Preferred Name: _____

Born: _____ Raised/Grew Up: _____

Highest Level of Education: _____ Profession: _____

Frequent Visitors ___ Yes __ No _____

Children: _____ Grandchildren: _____

_____

Family Issues/Conflicts ___ Yes ___ No

Explain: _____

Personal Interests: _____

Current Voter: ___ Yes ___ No Would You Like to Vote: ___ Yes ___ No

Spirituality/Cultural Beliefs: _____

Language(s) Spoken: _____

Smoking History: ___Yes ___No Current Smoker: __ Yes __No If Yes, How

Often? _____Alcohol Use: __ Yes __ No If Yes, Current Preference? _____

How Often? _____

History of Alcohol/Substance Abuse: ___ Yes ___No

If Yes, Which Substance? _____

Notes:

Prior Level of Functioning:

Living Arrangements: ___ Alone ___ Spouse ___ Family ___ ALF ___ NH

_____

Mobility Status: ___ Ambulates ___Ambulates with Assistive Device ___Wheelchair

Other Durable Medical Equipment Used: _____

Community Services Already in Home: ___Yes ___No

County Originally From: ___Prince William County ___Fairfax County ___Loudoun County__ Alexandria City __ Fauquier County __ Arlington County __ Manassas Park __ Manassas City ___ Other: _____

Referring County (if different): _____

Type of Services Already In Home: __ Private Pay In-Home Services __ Companion Services __ Subsidized Housing __ MPC Waiver Services __ Home Delivered Meals __ Food Stamps __ Protective Services __ Other: _____

Notes:

ATTACHMENT F
Beauty and Barber Shop Agreement

Resident's Name: _____

The purpose of this agreement is to provide ongoing hair care services for Resident. This quick reference will inform shop operators of your wishes for Resident's needs. Please specify colors (if known) for hair dying techniques, types of permanents requested, style of haircut and or other pertinent information that will be helpful to our staff. This agreement may be changed or cancelled upon request.

HAIR CARE	PRICE	WEEKLY	SEMI-MONTHLY	MONTHLY	AS NEEDED
Shampoo & Blow Dry	$28.00	□	□	□	□
Shampoo & Roller Set	$34.00	□	□	□	□
Shampoo curling or Flat Iron	$40.00	□	□	□	□
Women's Haircut Only	$28.00	□	□	□	□
Permanent Color	$50.00	□	□	□	□
Relaxer/Perm	$70.00	□	□	□	□
Men's Haircut	$20.00	□	□	□	□
Men Clipper Cut	$18.00	□	□	□	□
Shampoo Only	$10.00	□	□	□	□
Add Conditioner to other services	$5.00	□	□	□	□
Add Hot Oil Treatment to other services	$12.00	□	□	□	□
Shampoo Press & Curl	$45.00	□	□	□	□
Add a cut to other services	$15.00	□	□	□	□
Shampoo/Hair Straightening Relaxer	$70.00	□	□	□	□
Highlights Full/Partial	$65.00/90.00	□	□	□	□
Braids	1-4 @$8.00 each 5 or more @ $5.00 each	□	□	□	□
Braid Removal	$12.00	□	□	□	□
Women's Hair removal-Brow, Chin, Lip	$8.00 each or all 3 for $20.00	□	□	□	□
Men's Facial Grooming/Shave	$8.00	□	□	□	□

(*Signature on following page*)

I agree to the following service for the above-named Resident.

Facility Representative Name	Printed Resident Name
Facility Representative Signature	Resident Signature
Date	Date
	Resident Representative Name
	Resident Representative Signature
	Date

Attachment F
Insurance Authorization Form

Resident Name: SSN: Date of Birth:

Home Address:

Facility Name: Sex:

Resident Representative: Phone Number:

Relationship to Resident: Address:

Primary Insurance Coverage

Medicare#: _____

(OR)

Insurance Company Name: _____ Phone Number:_____

Address:

Insurance ID: _____ Group: _____ Expiration Date: _____

Is this an HMO? Yes No Is this a managed care contract? Yes No

Case Manager's Name: Phone Number:

Secondary Insurance Coverage

Medicaid #: _____ State: _____

(OR)

Insurance Company Name: _____ Phone Number:_____

Address:

Insurance ID: _____ Group: _____ Expiration Date: _____

Is this an HMO? Yes No Is this a managed care contract? Yes No

Case Manager's Name: Phone Number:

I request that payment of authorized Medicare or other insurance benefits be made to _____ for any services billed to me by that provider/supplier.

I authorize the holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for related services.

_____ _____

Facility Representative Name Printed Resident Name

_____ _____

Facility Representative Signature Resident Signature

_____ _____

Date Date

_____

Resident Representative Name

_____

Resident Representative Signature

_____

Date

ATTACHMENT H
Authorization for Release of Information

Resident: _____ Medical Record Number: _____

This is to certify that I give my permission for the release of all necessary information (history, physical, discharge summary, psychological evaluations, psychiatric evaluations, and others), regarding the above-named person to **Northern Virginia Health Center Commission d/b/a Birmingham Green d/b/a Northern Virginia Health Care Center.**
_____.

Reason for Requested Information:

_____

_____
Facility Representative Name

_____
Facility Representative Signature

_____
Date

_____
Printed Resident Name

_____
Resident Signature

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

ATTACHMENT I
Virginia Sex Offender Registry Notice

Facility is required by law to determine if a potential resident is a registered sex offender if the resident is anticipated to stay longer than three days or does in fact stay longer than three days. By your signature below, you acknowledge that you have been advised of the following: registered sex offenders who may be living and/or working in or about the area of Facility may be identified through access to the Virginia Sex Offender Registry. The Registry is available at:

http://sex-offender.vsp.virginia.gov/sor/

Information regarding sex offenders may be obtained electronically. You understand that you should exercise whatever due diligence you feel is necessary with respect to information on sexual offenders who appear on the Registry. Specific questions, concerns, or requests for assistance with access to the Registry should be directed to the Facility's Social Worker. Upon request, Facility staff will assist you in accessing this information and will provide you with printed copies of requested information.

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

ATTACHMENT J
Resident Property Loss/Damage Policy and Procedure

The Facility Administrator is responsible for the provision and maintenance of an organized program by which residents and/or their resident representatives may report property that has been lost or damaged. Residents, resident representatives, families, and staff are encouraged to report any item that has been lost or damaged as soon as possible to the Manager in charge of Resident's unit.

PROCEDURE FOR LOST ITEMS

1. Residents and/or Resident Representatives will be given a copy of the "Policies and Procedures for Receiving and Acting on Resident Complaints and Recommendations" at the time of admission. Verbal explanation of this policy and procedure will be provided if needed. *Please note, the Admissions Agreement makes clear that Facility will not be held liable for property damage, except where such damage is caused by Facility's negligence or lack of reasonable care.
2. The nurse who receives the report of a lost item will initiate a Property Loss/Damage Report as soon as possible. Resident's personal belongings inventory list will be reviewed. **If the item is on the inventory list**, Resident's room will be checked (with their permission) and Resident and/or Resident Representative has the right to be present if they wish. The loss will also be passed along in all the nursing reports to the on-coming shifts.
3. The laundry, housekeeping, and dietary staff will be notified concurrently so they can search their respective areas.
4. If this initial search does not produce the missing item, the unit Case Manager will follow-up. If this is a monetary loss or an object of value, then Resident and/or Resident Representative will be given the option of filing a police report.
5. Staff will make several attempts to locate the item for ten days as outlined above.
6. If after ten days, the item has still not been located, the Case Manager will get direct feedback from Resident and/or Resident Representative on how to resolve the incident.
7. The Facility Administrator and Involved Department Heads will be given a copy of the "Property Loss/Damage Report" when completed.

PROCEDURE FOR DAMAGED PROPERTY

1. Residents and/or their Resident Representatives will be given a copy of the "Policies and Procedures for Receiving and Acting on a Resident Complaint and Recommendations" at the time of admission. Verbal explanations will be given if needed.
2. Any staff member who finds damaged property will turn it over to the unit's Manager who will then notify Resident's Case Manager. The Case Manager will coordinate the repair of the item and assist with finding financial sources to pay for the repair if

needed. For example, broken glasses will be taken to a local optician for repair by the Case Manager. The vendor will provide the Case Manager with the bill and the Case Manager will assess whether a DMAS 122 can be submitted so Resident's patient pay portion can be adjusted. Alternative financial assistance will be explored for residents not having a patient pay portion. Ultimately, Resident will be responsible for repairing personal items if all other resources are exhausted.

3. For those items that will not be reimbursable, a "Property Loss/Damage Report" will be completed and distributed as outlined above.

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

ATTACHMENT K
Advance Directives and Code Status Designation

Facility recognizes Resident's right to formulate an Advance Directive. An Advance Directive is a decision about life sustaining or life prolonging measures in cases where Resident is acutely and terminally ill and not conscious or otherwise competent to make decisions. Facility will not withhold or withdraw life sustaining or life prolonging measures from Resident without an Advance Directive and a physician order to that effect. Resident is not required to execute an Advance Directive.

Interpretation and Implementation:

1. An Advance Directive is a written instruction such as a living will or durable power of attorney for health care.
2. During the admission process, the Admission Coordinator or Social Services Director will be responsible for educating and providing written materials for Resident and all other relevant parties regarding Advance Directives.
3. If there is an Advance Directive, it must be presented to Facility.
4. Advance Directives are never a condition of admission.
5. Facility staff is responsible for providing information and handling the finalized document but should not participate in the decision-making process or act as a witness.

You ____ **HAVE, or** ____ **HAVE NOT** executed an Advance Directive. If yes, you must furnish Facility with a copy. I understand that Facility may be unable to honor the terms of any previously executed Advance Directive unless and until I provide Facility with a copy.

You _____**WOULD, or** _____**WOULD NOT** like to execute an Advance Directive.

_____
Facility Representative Name

_____
Facility Representative Signature

_____
Date

_____
Printed Resident Name

_____
Resident Signature

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

CODE STATUS DESIGNATION

RESIDENT'S NAME: _____

Cardiopulmonary Resuscitation (CPR) was developed to try to restart the heart if it stops abruptly causing sudden death (e.g., as from a heart attack). A study by the American Heart Association of 300 elderly people in nursing homes who had CPR performed shows a survival rate of just two percent (2%). Residents who are elderly or have other multiple medical problems are also at risk to experience severe bruising and/or broken bones that can cause internal damage (such as punctured lungs or livers.) Residents who did survive with CPR frequently functioned at a lower level than they did before CPR.

As part of nursing home resident rights, each resident or his or her resident representative (if the resident is unable to make an informed decision) needs to decide about whether he or she would like CPR initiated in cases of sudden death. You do have the right to change your mind on your code status at will by notifying your physician, nursing staff, or social worker.

When a "Full Code" status is requested, that means that if our staff find you not breathing with your heart not beating, we will start CPR and call 911. We will continue to do CPR until the emergency squad comes or unless a physician happens to be on site and declares you deceased. The emergency squad will take over CPR and transport you to the hospital. It is up to a physician to determine whether CPR was not successful and can be stopped. Be aware you could end up on a ventilator for artificial breathing once you are in the hospital. We will send the hospital a copy of any advance directives you may have, and they will make every attempt to reach your Resident Representative and carry out your stated wishes.

A "Do Not Resuscitate" status means that if staff find you not breathing or your heart not beating, we will keep you comfortable until you have either started breathing on your own or you pass away naturally. Your physician must write the order in your chart and on a special yellow "Durable Do Not Resuscitate" form (DDNR) provided by Virginia Department of Emergency Services (which we will give you).

Staff understands the importance of this decision and will be available to answer questions. Staff can also decide you should talk directly with the physician if you have further questions.

I wish to have a "Full Code" order placed on my chart and have CPR started in case of sudden death. I understand I am at risk for death, injuries, and the possibility of being placed on life support even with CPR.

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

*****OR*****

I wish to have a "Do Not Resuscitate" order placed on my chart (please speak to your physician).

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

ATTACHMENT L
Notice of Privacy Practices

Our Facility has a longstanding commitment to protecting the privacy of individually identifiable health information, also referred to as Protected Health Information ("PHI"). A part of this commitment involves compliance with the privacy standards contained in the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and regulations promulgated thereunder (collectively referred to as "HIPAA"). This statement generally describes the requirements of HIPAA.

Our Facility is required by law to provide you with this notice so that you will understand how Facility may use or share your medical information. Facility is required to adhere to the terms outlined in this notice. If you have any questions about this notice, please contact the Facility Administrator. You may request a copy of this notice at any time.

HIPAA establishes a federal floor of safeguards to protect the confidentiality of medical information. State laws may provide stronger privacy protections and apply over and above federal privacy standards. HIPAA gives patients more control over their PHI. It sets boundaries on the use and release of health records. It establishes safeguards that health care providers must achieve to protect the privacy of PHI. It holds violators accountable, with civil and criminal penalties that can be imposed if a facility violates patients' privacy rights. It enables patients to find out how their information may be used and what disclosures of their information have been made. It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure. It gives patients the right to examine and obtain a copy of their own health records and request corrections.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in Facility. The notice will specify the effective date on the first page in the top right-hand corner. In addition, if material changes are made to this notice, the notice will contain an effective date for the revisions and copies can be obtained by contacting the Facility Administrator.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by mailing a letter to Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, by emailing ocrcomplaint@hhs.gov, or by visiting www.hhs.gov/hipaa/filing-a-complaint/index.html. To file a complaint Facility, contact our Privacy Officer at (703) 257-0935. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. We will notify you promptly if any breach occurs that may have compromised the privacy or security of your PHI.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you visit our Facility, a record of your visit is made. Typically, this record contains information about your condition and the treatment that we provide. We use and/or disclose this information to:

- Plan our care and treatment
- Communicate with other health professionals involved in your care
- Document the care you receive
- Educate health professionals
- Provide information for medical research
- Provide information to public health officials
- Evaluate and improve the care we provide

Understanding what is in your record and how your health information is used helps you to:

- Ensure the information is accurate
- Better understand who may access your health information
- Make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe the way we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall into one of the categories.

For Treatment: We may use medical information about you to provide you with medical treatment. We may disclose medical information about you to doctors, nurses, therapists, or other facility personnel who are involved in taking care of you at our Facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. Different departments of our Facility also may share medical information about you to coordinate your care and provide you medication, lab work, and X-rays. We may also disclose medical information to people outside Facility who may be involved in your medical care after you leave Facility. This may also include family members or visiting nurses who provide care in your home.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at Facility may be billed to you, an insurance company, or a third party. For example, to be paid, we may need to share information with your health plan about services we

provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you for health care operations. This is necessary to ensure that all our residents receive quality care. For example, we may use medical information to review our services and to evaluate the performance of our staff. We may also combine medical information about many residents to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, therapists, and other facility personnel for review and learning purposes. We may remove information that identifies you so others may use it to study health care and health care delivery without learning the identities of residents.

For State Licensure Surveys: As a licensed, skilled nursing facility, we are subject to monitoring by the state licensing agency and/or Center for Medicare & Medicaid Services in the form of surveys which are conducted at least every 15 months, and perhaps sooner if complaints are made. Your medical records may be accessed by the state licensing agency and the Centers for Medicare & Medicaid Services during this survey process.

OTHER ALLOWABLE USES OF YOUR MEDICAL INFORMATION

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include medical directors, outside attorneys, copy services when making copies of your health records, and registered dietitians. When these services are contracted, we may disclose your health information to these business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Providers. Many services provided to you as part of your care at our Facility are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers, such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical Therapist, Occupational Therapist, Speech Therapist), portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, licensed clinical social workers, and suppliers (e.g., Prosthetic, Orthotics).

Treatment Alternatives. We may use and disclose medical information to tell you about possible treatment options or alternatives that may be of interest.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest.

Facility Directory. We may include information about you in the Facility directory while you are a resident. This information may include your name, location in Facility, your general condition (e.g., fair, stable, etc.) and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the

clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends, and clergy members can visit you in Facility and generally know how you are doing.

Individuals Involved in Your Care or Payment for Care. We may disclose medical information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in our Facility. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

Restrictions. We will never sell your information, share it for marketing purposes, or share psychotherapy notes without your written permission. We may contact you for fundraising efforts, but you can tell us not to contact you again.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
Although your health record is the property of Facility, the information belongs to you. You have the following rights regarding your medical information:

Right to Request Record. You can ask to see or get an electronic or paper copy of your medical record and other health information about you. We will provide this information within 30 days of your request. If we need additional time to provide this information, we will send you a notice informing you of this and extending the time we have to provide the record for up to 30 days.

Right to Amend. If you feel that medical information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right to amend as long as the information is kept by or for Facility. You must submit your request in writing to the Facility Administrator. In addition, you must provide a reason for your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information:

- That was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- That is not part of the medical information kept by or for Facility; or
- To something that is not accurate and/or complete.

If we deny your request to amend your record, we will tell you why within 60 days.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your medical information, other than those made for purposes such as treatment, payment, or health care operations. You must

submit your request in writing to the Facility Administrator. Your request must state a time period which may not be longer than six (6) years from the date the request is submitted. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you may request that we limit the medical information we disclose to someone who is involved in your care or the payment of your care. We are not required to agree to your request and may say "no" if we feel it may impact your care. You must submit your request in writing to the Facility Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

If you pay for an item or service out-of-pocket in full, you may ask us not to share information about that item or service for the purpose of payment or our operations with your health insurer. We will agree to this request unless a law requires us to share that information.

Right to Request Confidential Communications. You may ask us to contact you in a specific way or to send mail to a specific address. We will agree to all such reasonable requests.

Choose Someone to Act for You. If you have given medical power of attorney to someone 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 they instruct us to take.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with residents' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project so long as the medical information they review does not leave Facility.

Workers' Compensation. We may disclose medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health purposes, including:

- Prevention or control of disease, injury, or disability.

- Reporting births and deaths.
- Reporting reactions to medications or problems with products.
- Notifying people of recalls of products.
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.
- Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- With organ procurement organizations.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose medical information when requested by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About you, the victim of a crime if, under limited circumstances, we are unable to obtain your agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at our Facility.
- In emergency circumstances to report a crime, the location of the crime or victims, the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

(*Signature on page following*)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: _____

Medical Record Number: _____

Facility Name: _____

I have received a copy of Facility's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Facility has the right to change this notice at any time. I may obtain a current copy by contacting the Facility Administrator.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES:

_____

Signature of Resident or Resident Representative Date

_____

Print name

FOR FACILITY USE ONLY: COMPLETE THIS SECTION IF YOU ARE UNABLE TO OBTAIN A SIGNATURE.

1. If Resident or Resident Representative is unable or unwilling to sign this Acknowledgement or the Acknowledgement is not signed for any other reason, state the reason.

_____
_____
_____

2. Describe the steps taken to obtain Resident's (or Resident Representative's) signature on the Acknowledgement.

_____
_____
_____

Completed by:

_____

Signature of facility representative Date

** Place signed or completed acknowledgement in Resident's medical record. **

ATTACHMENT M
Grievance Policies/Complaints Procedures

1. Concerns may be communicated by telephone, mail, office visit, or in person to appropriate staff. No resident will be subjected to reprisal by staff for submitting a complaint.

2. Hopefully, nursing concerns will be addressed and resolved through informal and frequent contact with the nurse. If satisfaction is not forthcoming, contact the Director of Nursing, then the Facility Administrator.

3. Non-nursing concerns can be similarly addressed and resolved through informal and frequent contact with the staff of social work, activities, dietary, housekeeping and laundry. Again, if satisfaction is not achieved, contact the Facility Administrator.

4. Staff members exchange information with each other daily; therefore, complaints or recommendations made to any staff member can and should be relayed to the appropriate department. Additionally, the Facility Administrator invites residents and families to contact him at any time.

5. The resident council is also a forum in which complaints and recommendations may be made. Issues are to be noted by staff, acted upon in a timely manner, and resolutions reported to the resident council.

6. If concerns are not satisfactorily resolved after communication with appropriate staff members and the Facility Administrator, residents and families may contact the person in the community who acts as liaison between nursing homes and the community, through the Prince William Long Term Care Ombudsman Program. Phone numbers and names of persons to be contacted are listed on the bulletin board in the main lobby of the facility.

7. A copy of these policies and procedures shall be furnished to each resident upon admission and posted on the main bulletin board.

Local Ombudsman (703) 792-7662

(*Signature on following page*)

Facility Representative Name	Printed Resident Name
Facility Representative Signature	Resident Signature
Date	Date
	Resident Representative Name
	Resident Representative Signature
	Date

ATTACHMENT N
Photography Release and Consent

PLEASE COMPLETE EACH SECTION AS APPROPRIATE

Resident Name: _____

A. I, _____, understand that Facility will take photographs for purposes of resident photo identification.

_____ _____
INITIAL DATE

B. I, _____, hereby grant permission to Facility to **photograph the forenamed Resident for such private uses as facility scrapbooks, poster displays of events, activities and/or celebrations.**

_____ _____
INITIAL DATE

C. I, _____, hereby grant permission to Facility to **photograph the forenamed Resident for the purpose of reporting/recording and publishing press releases to local newspapers concerning thank you notes of volunteer and donor organizations.**

_____ _____
INITIAL DATE

Resident and/or Resident Representative acknowledge that Facility uses video surveillance in common areas of the campus as part of its quality assurance and improvement activities and health care operations as defined by 45 C.F.R 164.501 and 164.506.

(*Signature on following page*)

_____	_____
Facility Representative Name	Printed Resident Name
_____	_____
Facility Representative Signature	Resident Signature
_____	_____
Date	Date
	_____
	Resident Representative Name
	_____
	Resident Representative Signature
	_____
	Date

ATTACHMENT O
Authorization of Release of Body to Funeral Home

RESIDENT NAME: _____
DATE: _____

I HEREBY AUTHORIZE FACILITY TO RELEASE THE REMAINS OF_____
(NAME OF DECEDENT)

TO THE

_____
(NAME, ADDRESS, & TELEPHONE OF FUNERAL HOME)

SIGNATURE

_____

DATE/TIME _____

IF I HAVE CHOSEN NOT TO DESIGNATE A FUNERAL HOME AT THIS TIME, I ACKNOWLEDGE AND CONCUR WITH THE POLICY OF FACILITY TO RELEASE THE BODY FOR HOLDING TO A LOCAL FUNERAL HOME OF THE HEALTHCARE CENTER'S CHOICE, SHOULD IT NOT BE POSSIBLE TO OBTAIN A DECISION FROM FAMILY MEMBERS WITHIN FOUR HOURS OF THE DEATH OF RESIDENT. I AGREE TO BE RESPONSIBLE FOR TRANSPORTATION AND TEMPORARY HOLDING COSTS.

_____ _____
Family Member/Resident Representative Date

RELEASED BY: _____
(SIGNATURE)

DATE/TIME: _____

RELEASED TO: _____
(NAME OF FUNERAL HOME)

SIGNATURE: _____ DATE: _____

ATTACHMENT P
Consent for Influenza Vaccination

To help us maintain a healthy environment for the residents and staff of Facility, we begin administering the flu vaccine when it becomes available annually.

A Vaccine Information Statement (VIS) – *Influenza (Flu) Vaccine: What You Need to Know* — has been prepared by the Centers for Disease Control and Prevention. It contains important information regarding influenza and the influenza vaccine. It is included in this information packet. Please review it carefully before completing this consent. If you have questions or would like further information, contact our Director of Nursing at 703-257-6220.

Please indicate your selections below:

_____Please administer the flu vaccine to below-named Resident. To my knowledge, Resident does not have an allergy to eggs, chicken, chicken feathers, chicken dander; a history of previous reaction to the flu vaccine; or a history of Guillain-Barré Syndrome.

_____DO NOT administer the flu vaccine to below-named Resident.

_____Resident is allergic to eggs.
_____Resident is allergic to chicken, chicken feathers, or chicken dander.
_____Resident has a history of a previous reaction to the flu vaccine.
_____Resident has a history of Guillain-Barré Syndrome.
_____Other reason_____

_____
Facility Representative Name

_____
Facility Representative Signature

_____
Date

_____
Printed Resident Name

_____
Resident Signature

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

ATTACHMENT Q
Consent for Pneumococcal Vaccination

I hereby give Facility permission to administer a pneumococcal vaccination to me. I understand that this immunization is to be given only one (1) time. To the best of my knowledge, I have not received a pneumococcal vaccination. Because of different regional outbreaks, a second vaccination may be suggested by a physician if it has been five (5) years since the first vaccination.

I understand that because of this vaccination, I may experience some side effects such as:

Slight discomfort
Redness of the arm
Soreness of the arm
Muscle aches (occasionally)
Slight fever (occasionally)
Joint aches (rarely)
Rash (rarely)

I have had all my questions answered and understand the risks and benefits of the vaccine.

Signature – Resident: _____ Date: _____

Signature/Title – Witness: _____ Date: _____

I, _____, Resident Representative for _____, hereby give permission for Facility to administer a one (1) time pneumococcal vaccination.

To the best of my knowledge, _____has not received a pneumococcal vaccination.

Date: _____
Signature – Resident Representative

Date: _____
Signature – Title / Witness

☐ Refused
Reason:_____
_____

DATE ADMINISTERED: _____

A signed and completed copy of this consent must be placed in Resident's medical record.

ATTACHMENT R
Laundry Agreement

I, _____, hereby authorize Facility to maintain personal laundry for:

_____.

All personal laundry will be laundered by Facility. This fee is covered by Medicaid and Medicare or by the private daily rate.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

_____**OR**_____

I, _____**,** do not authorize Facility to maintain personal laundry

for: _____.

I understand and agree that if the family or Resident Representative chooses to do laundry, it will be picked up and cleaned at least twice per week. I also agree to supply a clothes hamper that is totally closed with no holes in which Resident will keep his or her laundry. If the laundry has not been cleaned in a timely manner, Facility retains the right to clean Resident's laundry.

All laundry must be labeled in permanent marker with Resident's name to ensure laundry is returned to the appropriate resident. Facility's policy requires Resident's clothing to be labeled even if the family or Resident Representative is responsible for Resident's laundry.

_____
Facility Representative Name

_____
Facility Representative Signature

_____
Date

_____
Printed Resident Name

_____
Resident Signature

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

ATTACHMENT S
Resident Telephone Agreement

Policy:

It is the policy of Facility to allow residents to obtain a private telephone for their use. Resident and/or their family can do this through Verizon Telephone Company.

Facility will not be responsible for payment of the phone, maintenance, and/or any related charges. Facility will only be responsible for the service of the line from the main panel to Resident's room.

Procedure:

Obtaining a Private Telephone

1. At the time of admission, the procedure for contacting Verizon will be discussed and the appropriate documentation completed.

2. Resident and/or family member must contact Verizon at 1-800-483-4300 to arrange for a private line to be brought to Facility and payment. If you can show Verizon a Medicaid card and inform them that Resident is going into a nursing home, a reduced rate may be available.

3. Resident and/or family should notify Verizon that the service must be connected between the hours of 8AM and 3PM (Monday through Friday). Verizon will only have access to the equipment room and appropriate staff during those hours.

4. Usually within 24 hours, Facility will be able to connect the telephone line to Resident's room, but in some cases, if there is a problem with the internal system, we may have to contact our private telephone company which could take up to five working days.

5. Resident and/or family must furnish the telephone.

6. Facility asks that Resident and/or family contact the Admissions Coordinator after they contact Verizon so that we may make the necessary arrangements with our staff for the internal connections and to inform the Business Office of Resident's phone information.

Reporting Maintenance and Repairs of Resident Telephone Service Problems

1. Resident and/or family should promptly notify Facility first of any problems with a telephone so that staff can determine if the problem is internal or external.

2. If the problem is likely external, Resident and/or family member will be notified to contact Verizon directly for repairs of Resident's telephone. Services requiring Verizon technicians

to come to Facility must be scheduled between the hours of 8AM and 3PM (Monday through Friday).

3. Resident and/or family should inform Verizon that their technician must check in with the receptionist, who will contact an appropriate staff member to accompany the technician to Resident's room and/or the equipment room.

ACKNOWLEDGMENT OF RESIDENT TELEPHONE AT FACILITY

Resident's Name: _____

Resident's Room Number: _____

Telephone Number: _____

Date of Anticipated Installation: _____

I, the undersigned, acknowledge connection of such service internally by Facility's private phone company could take five or more business days after Verizon has confirmed they have completed their installation.

Person Responsible for Payment of Phone Bill:

Name: _____

Address: _____

Telephone: _____

(*Further information on page following*)

I have been informed of the phone policy and procedure.

I DO____ wish to obtain a phone through Facility.

I DO NOT____ wish to obtain a phone through Facility. I may reconsider at a future time.

_____
Facility Representative Name

_____
Facility Representative Signature

_____
Date

_____
Printed Resident Name

_____
Resident Signature

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

ATTACHMENT T
Authorization to Receive and Open Mail

Each resident has a right to receive unopened mail and packages. A resident may, however, permit Facility to open mail on the resident's behalf using this form. Any mail that appears to be personal correspondence will not be opened.

Please select which option below is your preference:

_____ I authorize Facility to assist with managing my financial correspondence. If I choose to open a resident trust account, I authorize Facility to make any deposits into my resident trust account as appropriate and then forward all correspondence to me and/or my Resident Representative as appropriate. In addition, any information relevant to medical billing (such as a copy of my Medicare card or other correspondence) will be included in my files. To assist me in managing my financial correspondence, I authorize Facility staff to open mail that appears to be from the following entities:

Social Security Administration, The Centers for Medicare and Medicaid Services, The Commonwealth of Virginia (including the Department of Medical Assistance Services), Medicare Advantage plans, Insurance/managed care entities, Banks and other financial institutions, Local governments (including Prince William, Alexandria, Arlington, Fauquier, Fairfax, and Loudoun counties), Pension/retirement plans, Department of Health and Human Services, The Veteran's Administration, and Private insurance companies.

_____ I do not authorize any mail to be opened.

_____
Facility Representative Name

_____
Printed Resident Name

_____
Facility Representative Signature

_____
Resident Signature

_____
Date

_____
Date

_____
Resident Representative Name

_____
Resident Representative Signature

_____
Date

Birmingham Green
Where Life Flourishes

Northern Virginia Health Center Commission and Birmingham Green Adult Care Residence
Phone: (703) 257-0935 | Fax: (703) 257-6242
birminghamgreen.org
8605 Centreville Road
Manassas, VA 20110-8426

ATTACHMENT U

Birmingham Green/NVHCC Consent to Release Information to Charities for Cards or Gifts

Dear Residents, Families and Friends of Birmingham Green,

Northern Virginia Health Center Commission and Birmingham Green Adult Care Residence (NVHCC/Birmingham Green) regularly partners with charities and organizations that wish to send cards or gifts to our residents as part of their outreach and community engagement efforts. To participate in these wonderful opportunities, we would need your consent to share your name with these charities. Please review the details below and indicate your preference.

By signing this form, you authorize NVHCC/Birmingham Green to share your name with charitable organizations that may wish to send cards or gifts. No other personal or medical information will be shared, and this consent is entirely voluntary.

If you agree to allow us to release your name for this purpose, please fill out the form below.

Resident's Name: _____

Consent to Release Information:

I, [Resident's Name/Family Member's Name], hereby give consent for NVHCC/Birmingham Green to release my (or my loved one's) name to charitable organizations that wish to send cards, gifts, or similar tokens of kindness. I understand that no other personal or medical information will be shared with these organizations.

- I understand that this consent is voluntary and that I may revoke it at any time by providing written notice to NVHCC/Birmingham Green.
- I understand that once the information is disclosed, it may no longer be protected by HIPAA or other privacy regulations.
- I understand that this consent will remain in effect unless I choose to revoke it.

Resident or Legal Representative Signature: _____

Printed Name: _____

Date: _____

If you have any questions or concerns, please contact us at iwilliams@birminghamgreen.org.

Sincerely,

Isla Williams
HIPAA Compliance Officer
8605 Centreville Road
Manassas, VA 20110-8426
iwilliams@birminghamgreen.org
703-257-6234

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Policy #400-001A

Directory Opt-Out and Status Change Request for BG Campus Wide

Opt-Out

☐ *I hereby request that my name, building, neighborhood, and room number* ***not be included*** *on the Directory.*

Print Resident's Name: _____ **Date:** _____

Signature: _____ **Date of Birth** _____
Resident or Personal Representative

Change Request

☐ ***I hereby request that my name, building, neighborhood, and room number be placed in the Directory. I no longer wish to "opt out," as previously indicated.***

Print Resident's Name: _____ **Date:** _____

Signature: _____ **Date of Birth** _____
Resident or Personal Representative

Facility Use Only:
Form to be forwarded to medicalrecords@birminghamgreen.org

Status change request processed by: _____

To be filed in permanent medical record.

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Policy #400-000

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct Birmingham Green/NVHCC to release my protected health information described below to **OR**

I, _____, healthcare agent or power of attorney for healthcare

of _____, direct Birmingham Green/NVHCC to disclose and release protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above -- (Check A or B):

☐ A. **Disclose** my complete health record (this includes but not limited to care planning, hospital transport, incidents, diagnoses, lab tests, prognosis, treatment, and billing, for all conditions.)
OR

☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
☐Mental health records
☐Communicable diseases (including HIV and AIDS)
☐Alcohol/drug abuse treatment
☐Other (please specify) _____

Form of Disclosure:
An electronic record or access through an online portal (Check one)☐Hard copy or☐ Verbally
This form shall be effective (Check one):

☐All past, present, and future periods, OR
☐Date or event: _____ unless I revoke it.
(NOTE: You may revoke this form in writing at any time by notifying Birmingham Green.)

_____ _____
Name of the Individual Giving this Authorization Resident's date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Birmingham Green

Resident Handbook

Birmingham Green

Where Life Flourishes

Welcome to Birmingham Green. This handbook is designed to make your transition into your new lifestyle as smooth as possible.

It will answer many of your immediate questions and will serve as a reference in the future.

We promote an environment that nurtures and encourages innovation and creativity in the pursuit of excellence. We are a community that is professionally recognized as a leader in the field of long-term care.

We are a trusting and enthusiastic partnership of elected officials, board members, staff leaders, employees, and community.

Birmingham Green Nursing Home Key Staff

Chief Executive Office	Denise Chadwick Wright
Chief Operating Officer	Joan Thomas
Chief Financial Officer	Perry Mason
Director of Human Resources & Compliance	Alice Decker
Administrator	Aaron Rebuck
Assistant Administrator	Patricia McDowney
Medical Director	Jeffry Waldman
Director of Nursing	Abonge Ngembus-Nihngeh
Business Office Manager	Diane DeShazo
Director of Social Services	Nicole Davis
Life Enrichment Director	Alicia Boykin
Director of Food Services	Charles Healey
Dietitian	Isobel Rowland
Rehabilitation Director	Maithili Patibandla
Director of Volunteer and Support Services	Andre Porter
MDS Coordinator	Sam Dua
MDS Coordinator	Manpreet Walia
Director of Building Services	Hani Ghannam
Environmental Services Supervisor	Rosemarie Kayes

Birmingham Green residents have the right to choose their Attending Physician while residing within our Facility.

Listed below are physicians currently with privileges at Birmingham Green:

Medical Director Jeffery Waldman, M.D. 6201 Centreville Road, Suite 100 Centreville, VA 20121 703-263-9600	Vohra Wound Physicians Steven Hawkins, M.D. 3601 SW 160th Ave Miramar, FL 33027 305-866-7123
Arun Gupta, M.D. Shimla Medical Center 9306 Forest Point Circle Manassas, VA 20110 703-330-3322	Prita Bhardwaj M.D. 106 Elden Street, Suite 18B Herndon, VA 20170 703-723-9100
Umar Rahman, M.D. Psychogeriatric Services, LLC 12073 Tech Road, Suite B Silver Spring, MD 20904 Cell: 703-869-8016 Office: 301-593-1315	Yong and Joon Coe, D.D.S. (Dentist) 19490 Sandbridge Way Leesburg, VA 20176 703-283-3325
Robert Breiner, M.D. (Podiatrist) 5105 Backlick Road, Ste S Annandale, VA 22003 703-941-7770	

Administration:

The Facility Administrator in collaboration with the Chief Executive Officer and the Board of Directors establishes the policies and procedures for health care management. Birmingham Green maintains close communication with the medical staff, Residents, and Resident Representatives to ensure that the needs of all residents are met.

Admissions:

The day of admission is full of activities and introductions. Specific information concerning the services available is provided so that you and your Resident Representative will be familiar with life at Birmingham Green. Please be sure to provide us with copies of your Power of Attorney, Guardianship, Living Will, social security card, and other insurance cards if applicable.

Alcohol:

Residents who desire alcoholic beverages are asked to speak to their doctor. It is Birmingham Green's policy to require a physician's order for the consumption of alcoholic beverages on our premises. The alcohol must be securely stored and dispensed by licensed nursing staff in the same manner as all medications. Birmingham Green is not responsible for the provision and cost of alcoholic beverages.

Banking Hours:

Resident funds are available 24 hours per day, 7 days a week. The Business Office is open Monday through Friday 9am to 5pm. Contact the Nursing Supervisor after hours, weekends and holidays by calling 571-221-2929.

Withdrawal amounts are dependent on the balance in your account. Please contact a Business Office team member with any questions.

Beauty Shop:

A full-service Beauty Shop is available to meet your needs. Current hours are posted outside the beauty shop located by the Aviary area. Services from wash and set to permanents and colorings are available. A price list is available upon request and payment can be transferred directly from your resident fund account. To schedule an appointment, you or a family member should speak to the nurse on your neighborhood or call the receptionist at 703-257-0935.

Bed Rails:

It is the policy of Birmingham Green to identify and reduce the safety risks and hazards associated with bed rail use. Bed rails will be used only after individual bed rail assessment indicates that bed rail use is safe and appropriate. When bed rail use is medically indicated, the risks and benefits of bed rails will be reviewed with the Resident or Resident Representative and informed consent will be obtained prior to installation.

Business Office:

The Business Office is available from 8:00am to 5:00pm Monday through Friday to answer any questions regarding billing and finance.

Each resident can open a resident fund account. Residents have access to their funds seven days a week during posted resident bank hours. Same-day cash withdrawals are limited to $100.00 ($50.00 for Medicaid residents) . Requests for $100.00 ($50.00 for Medicaid Residents) will be honored within three banking days.Please be aware that the resident bank can cash personal checks for resident use Monday through Friday only. Residents are discouraged from carrying cash in excess of Five Dollars ($5.00) to avoid loss. Upon request, Birmingham Green may provide you a lockbox for safe keeping of your valuables; however, should you use a lockbox provided by Birmingham Green, Birmingham Green disclaims all responsibility for your safekeeping of valuables in such a lockbox aside from the exercise of reasonable care.

Dietary and Dining Services:

The dining service at Birmingham Green consists of three nutritious meals with snacks available throughout the day and night. You are encouraged to have meals in the main dining room or the neighborhood dining room areas. Beverages, such as juices, are available and offered between meals on a regular basis. Lunch is the heavier meal of the day, while dinner consists of lighter fare. Weekly menus are posted in each neighborhood.

A full-time registered dietician is available to provide nutritional assessments. The menus run on a five-week basis and cycle seasonally three times throughout the year to provide variety. Special dietary needs such as therapeutic diets and mechanically altered textures are ordered by the primary physician. Alternate meal items may be selected from the planned menu if preferred. To update food preferences or inquire regarding special nutritional needs, please contact our dietician (ext. 6229). Families are asked to check with staff nurses before bringing in food items.

Emergency Preparedness

Birmingham Green will comply with all applicable Federal, State, and local emergency preparedness requirements. Birmingham Green establishes and maintains an emergency preparedness program that meets all requirements for Long-Term Care (LTC) Facilities.

Residents will be educated on facility specific risks and emergency preparedness strategies. Residents are asked to participate in emergency drills as needed.

Facility Services Department:

The Facility Services Department will connect personal televisions to the cable ready service available. If your television is “cable ready” it will be connected to the local cable service basic level.

All electrical equipment brought in by our residents must be inspected for electrical safety and tagged by Facility Services staff prior to being used. For your convenience, this service is available Monday through Friday. For residents’ safety, use of extension cords, power strips, coffee pots, microwave ovens, warming plates and other similar appliances are prohibited in resident rooms.

The Facility Services Department is not responsible for repairing residents’ personal items or for replacing batteries in these items.

Family Night:

Birmingham Green encourages families to attend the Family Nights hosted by our Social Work Department. A speaker may be invited to present information on topics relevant to our residents' needs. Previous topics have included medication and the elderly, depression, and coping with stress. This is also a time for family members to discuss ideas, suggestions, questions, and common concerns regarding staff or services available at Birmingham Green.

Grievances:

We are dedicated to creating an atmosphere in which residents and families feel comfortable approaching the appropriate person with concerns. We welcome your suggestions and ideas. Residents and their families have the right to voice opinions and to make suggestions regarding the quality of care and the environment of the home. The following may be contacted for assistance.

Grievance Officer: Nicole Davis
Social Worker (703) 257-6215 ndavis@birminghamgreen.org

Other staff members:
Nurse Managers, staff social workers, Director of Nursing, Administrator, CEO

Prince William Long Term Care Ombudsman
(703) 792-7662

Hospice Services:

Hospice care is available as a benefit under Medicare and Medicaid. The Hospice benefit is designed to meet the unique needs of people who have a life-limiting illness, providing them and their families with special support and services. If you are interested in Hospice Services or would like more information about this benefit, please see your social worker.

Housekeeping and Laundry:

The housekeeping department will clean, dust, sanitize, and remove trash from all resident rooms and bathrooms daily.

The Laundry Department processes residents' laundry. To reduce the risk of lost or misplaced items, all clothing and washables must be labeled clearly. Staff will assist in labelling clothing with the resident's name. Clothing such as "dry clean only" and "hand wash" should not be placed in the hamper for the laundry to clean. Due to the required use of hot water and temperatures, delicate clothing is not recommended.

Life Enrichment:

The Life Enrichment Department provides programs to fulfill your social, cultural, spiritual, educational, recreational, musical, and cognitive needs. Activities routinely offered include church services, field trips, entertainment, socials, bingo, gardening, exercise, and crafts.

Our Life Enrichment staff visit residents shortly after admission to discuss specific interests and hobbies. Families are encouraged to participate in events occurring during visits. Birmingham

Green also maintains a wheelchair van. Life Enrichment staff offer outings to residents throughout the year.

Our memory care neighborhood provides therapeutic recreation services including group and individual programming.

Medical Director:

In addition to the attending physicians, Birmingham Green consults with a medical director who oversees physician services and participates in quality assurance and performance improvement activities.

Medical Director
Jeffry Waldman, M.D.
6201 Centreville Road, Suite 100
Centreville, VA 20121 (703) 263-9600

Nursing:

Our nursing team provides quality, person-centered care for our residents. The Director of Nursing, Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants are selected based on their high professional standards and sensitivity to residents. Ongoing educational programs are provided for the nursing team to meet the changing needs of residents.

Pharmacy Services:

Birmingham Green currently contracts with an outside pharmacy to meet the pharmaceutical needs of our residents. Residents have the option to select a preferred pharmacy but might incur repackaging expenses as set forth in the Admissions Agreement. All residents' medications require a physician's order, which is filled through the contract pharmacy.

In general, residents' medications are dispensed by our pharmacy and administered by our nursing staff. Residents who are assessed as capable of self-administration of medications may be able to self-administer medications and keep their medications in their rooms with some medication safety measures.

Family members are asked to assist by not bringing in any medications, including over-the-counter medications. We closely monitor our residents' medication's side effects. Drug to drug interactions may put our residents at risk.

Personal Belongings:

We encourage you to bring personal items that will create an atmosphere that is cheerful and familiar to you. Furnishings such as a lounge chair and pictures are encouraged as space allows. Small appliances such as radios and televisions are permitted as space allows and deemed safe. When personal items are brought in or returned home after admission, be sure to inform the nurse so your personal inventory sheet can be updated. Family members are encouraged to label personal items for easy identification.

Physician:

Each resident must be seen at least once every thirty days for the first ninety days after admission and every sixty days thereafter as mandated by Federal regulation.

Several local physicians serve on the Birmingham Green medical staff. The choice of physician is the decision of the Resident and Resident Representative. All physicians must be credentialed prior to practicing at Birmingham Green.

Rehabilitative Therapy:

Birmingham Green offers rehabilitative therapies through a contracted service with Select Rehab. This department designs each resident's rehabilitative program to conform to the needs of the resident and the orders of their physician. Speech, occupational, and physical therapy are offered to each resident as ordered by the attending physician. The goal of rehabilitative therapy is to assist the resident in maintaining the highest level of independence possible.

Religious Services:

Your minster, priest, imam, monk, rabbi, or spiritual leader is welcome at Birmingham Green. Regularly scheduled services are provided. If your church, temple, mosque, or synagogue would like to provide additional services, please contact our activities department.

Resident's Rights:

Assuring that each resident's rights are protected is the responsibility of every employee at Birmingham Green. We provide staff training upon hire and several times a year. Resident's Rights are reviewed with each resident and resident representative at the time of admission and at least annually thereafter. It is important that you understand these rights. Any time you have questions or concerns, please bring them to the attention of a staff member. A complete list of your rights is included with your admission package.

Restraint Free Environment:

Birmingham Green believes that all residents have the right to be free from any physical or chemical restraint unless required and authorized by the resident's physician to treat the resident's medical symptoms.

Safety:

Residents may use the grounds as they choose during daylight hours, unless restricted by their physician. For safety reasons, residents are asked to use the sidewalks and pathways provided and are discouraged from wandering around the grounds after dark. Residents who wish to leave the grounds are requested to inform the appropriate staff of their destination and approximate time of return.

Residents are expected to assist in keeping the grounds neat by placing trash in designated receptacles. No resident is permitted to willfully damage or destroy Birmingham Green property.

The use of illegal drugs is strictly prohibited on the grounds of Birmingham Green. Possession and/or use of illegal substances violates Birmingham Green's Code of Behavior and the laws of the Commonwealth of Virginia. Such behavior may subject the residents to notice of intent to discharge and/or involvement with law enforcement agencies.

Smoking and Vaping:

As of January 1, 2015, Birmingham Green became a non-smoking facility. This includes use of cigarette's pipes, e-cigarettes, vape pens, vape pens, etc. This policy has been implemented to protect the safety and health of Birmingham Green's residents, visitors, employees and other providers of treatment and services. Residents admitted after January 1, 2015, will be informed prior to and upon admission of this policy and will be required to review and sign a "No Smoking Policy Notice" at the time of admission.

In keeping with Medicare and Medicaid rules regarding resident rights, Birmingham Green will also continue to allow the privilege of supervised smoking for current nursing home residents who were admitted to Birmingham Green prior to January 1, 2015, while maintaining a safe environment for all who live and work here.

All smoking rules outlined in Policy 110-323-1 and 1A remain in effect for residents admitted to Birmingham Green prior to January 1, 2015. The designated nursing home smoking area for residents, staff, and visitors is the gazebo area outside of door #12. Smoking is strictly prohibited inside of Birmingham Green, front porch, courtyards, or any other outdoor areas. Smoking cessation information and support is available for any resident who wishes to stop smoking at any time.

Social Work:

A comprehensive social work program is considered integral to providing quality care to our residents. Our social workers serve as the liaison between staff, residents, and resident representatives in the transition from home to nursing home and other times of emotional, psychological, or social adjustments. As part of the interdisciplinary team, the social workers work closely with all departments in a team approach to person centered psychosocial care. Our social workers provide a wide variety of services including help with coping skills, managing finances, discharge planning, making referrals, or contacting other needed resources. Social workers are often called upon to act as advocates for our residents. If you need a service or have a question or concern, our social workers will work to help you obtain a solution.

Telephone:

A telephone is available in each neighborhood for resident use only without extra charge, but you may opt to have a private phone in your room by setting that up through Verizon. Financial arrangements, installation, and disconnection service arrangements are entirely the responsibility of Resident.
Installation must be coordinated through our Facility Service Department for a connection from Verizon to Resident's room. A telephone information sheet is provided on admission and is available from the receptionist.

Valuables:

It is suggested that residents do not bring expensive jewelry or other valuable keepsakes into Birmingham Green. You may ask your social worker about a lock box if you have valuables in need of safekeeping.

Visitors:

Birmingham Green encourages families and friends to visit residents in their homes. In order to ensure the safety of residents and visitors, the visitors will be asked to register at the front desk and wear the name badge provided.

It is very important that staff be notified whenever you leave the property with your visitor. Please sign out with front desk staff whenever you leave Birmingham Green.

Volunteer Services:

Volunteer programs include friendly visitors (non-English speaking included), adopt a grandparent, reading, mending, and helping with programs. Please let the volunteer coordinator, social worker, nurse, or admissions coordinator know of any specific needs that you may have. Please alert the volunteer coordinator if you wish to become a volunteer as well.

Weapons:

No resident is permitted to keep possession of any weapons that could be used to injure any other person. The use and or possession of any guns and/or weapons by a resident will not be tolerated while residing at Birmingham Green.

SIGNATURE PAGE FOR NURSING HOME RESIDENT HANDBOOK

I acknowledge that I have reviewed the Birmingham Green Handbook.
My signature below indicates my understanding and agreement with the information therein.

Choice of Attending Physician:_____

Attending Physician Contact Information: _____

Resident Printed Name: _____ Date: _____

Resident Signature: _____ Date: _____

Resident Representative: _____ Date: _____

Staff Witness: _____ Date: _____

Birmingham Green
Television Channel Lineup

2 MessageNOW
3 CW 50
4 NBC 4
5 FOX 5
6 MNT 20
7 ABC 7
8 PBS 26
9 CBS 9
10 PBS 22
11 CNN
12 FOX NEWS
13 CNBC
14 MSNBC
15 C-SPAN
16 C-SPAN2
17 OAN NEWS
18 CMT
19 NBC SPORTS
20 ESPN
21 ESPN2

22 ESPNU
23 ESPN NEWS
24 FOX SPORTS 1
25 BIG 10 NETWORK
26 FETV
27 ION
28 BBC AMERICA
29 BRAVO
30 A&E
31 FREEFORM
32 DISCOVERY
33 ANIMAL PLANET
34 NATIONAL GEOGRAPHIC
35 LIFETIME
36 LIFETIME MOVIES
37 TBS
38 TNT
39 USA
40 TV LAND
41 TCM
42 HALLMARK
43 HALLMARK MOVIES

44 AMC
45 RFDTV
46 INSPIRATION
47 GSN
48 REELZ MOVIES
49 FX
50 HGTV
51 HISTORY
52 WEATHER
53 OVATION
54 TRAVEL
55 UP
56 DISNEY
57 QVC
58 TRINITY
59 EWTN
60 DAYSTAR
61 TLC
62 COMEDY CENTRAL
63 ID
64 DISNEY
65 NICK-AT-NITE
66 FXX

Birmingham Green

Memorandum of Understanding

Name: _____Date:_____

My signature below indicates my understanding and agreement to the following expectations upon admission to Birmingham Green.

- I will not smoke while on the campus of Birmingham Green.
- I will not have any smoking materials (lighter, cigarettes, etc.) on my person while a resident at Birmingham Green.
- I will follow medical doctors' orders on how to manage the smoking cessation process- this may include taking a prescription medication and or wearing a patch.

I will follow the recommendations of my medical treatment team.

I have read and understood the facility's expectations and will comply with their recommendations.

I understand that if I decline, it may result in a discharge from the facility.

Resident Signature: _____ Date:

Witness: _____ Date:

Responsible Party/Advocate: _____Date:

BIRMINGHAM GREEN
SPECIAL CARE UNIT

_____ for _____

(Resident/Guardian/Responsible Party) (Resident)

I. SPECIAL CARE UNIT OVERVIEW

The Special Care Unit is a safe, secure environment for residents with serious cognitive impairments due to dementia or a psychiatric diagnosis that impacts the residents' ability to recognize danger or protect their own safety. Our Special Care Unit includes a key-code entry and cameras to monitor residents inside and out of the courtyard.

II. CRITERIA FOR ADMISSION TO SPECIAL CARE UNIT

A. The resident meets all the requirements of general nursing home placement

B. The resident is at risk of elopement from the nursing facility.

C. Residents on this unit may be demonstrating behaviors such as memory dysfunction (immediate, recent and remote); poor judgment, disorientation to time, place and person; decreased attention span; mood fluctuations; agenda behavior such as exit seeking.

D. The resident does not require a level of nursing care that cannot be safely managed within the unit secondary to the needs and behaviors of the residents that reside in the unit.

E. The resident does not exhibit behavior that may result in injury to self or others.

F. The resident can transfer with limited assistance.

III. ONGOING RESIDENT EVALUATIONS

The Responsible Party understands that when the resident no longer meets the criteria for admission to the secured unit, based on ongoing evaluations, the resident will be moved to a room outside of the secured unit as appropriate. The Responsible Party will be given prior notification of the transfer from the Secured "Special Care Unit".

Responsible Party Signature: _____ Date: _____

My signature indicates my understanding and agreement as written above.