HEATHWOOD ASSISTED LIVING AND MEMORY CARE
AT PENFIELD

ASSISTED LIVING RESIDENCE
RESIDENCY AGREEMENT

RESIDENCY AGREEMENT

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RESIDENCY AGREEMENT

This Agreement is made between ***Heathwood Assisted Living at Penfield***, "Operator", _____(the "Resident" or "You"), _____, (the "Resident's Representative", if any); and _____(the "Resident's Legal Representative", if any).

RECITALS

A. The Operator is licensed by the New York State Department of Health to operate at ***100 Elderwood Court, Penfield, New York 14526*** as an Assisted Living Residence (The Residence) known as ***Heathwood Assisted Living at Penfield*** and as an Enriched Housing Program. The operator is also certified to operate an Enhanced Assisted Living Residence, a Special Needs Assisted Living Residence and an Assisted Living Program at this location.

B. You have requested to become a Resident at The Residence and The Operator has accepted your request.

AGREEMENTS

I. Housing Accommodations and Services

Beginning on _____ the "Operator" shall provide the following housing accommodations and services to You, subject to the other terms, limitations and conditions contained in this Agreement. This Agreement will remain in effect until amended or terminated by the parties in accordance with the provisions of this Agreement.

A. Housing Accommodations and Services

1. Your Apartment. You may occupy a ☐ ***Semi-Private*** ☐ ***Studio*** ☐ ***One-Bedroom*** ☐ ***Two-Bedroom Single/Double*** ☐ ***Companion Suite.***

Your Apartment number is_____ and subject to the terms as follows:

2. Common areas. You will be provided with the opportunity to use common areas at the Residence including: ***four (4) lounges, two (2) living rooms, main dining room, private dining room, community room, (2) wellness rooms, library, café, front porch, fenced in patio/back yard, gift shop and a theatre Room.***

3. Furnishings/Appliances Provided by the Operator. The following listing of an inventory of furnishings, appliances and other items supplied by the Operator in Your room. Each apartment has window blinds, bath/shower, closet, and hinged entry door. Additional furnishings such as bed with mattress, pillow, chair, nightstand table, dresser, lamp, sheets, pillowcase, blanket, and bedspread are made available if Your personal belongings are not brought to the facility.

4. Furnishings/Appliances Provided by You. The following listing of furnishings, appliances and other items supplied by you in your room.

☐ Television ☐ TV stand

☐ 1 power strip (only can have 4 items plugged into strip)

☐ 1 extension cord less than 6 feet long.

Other:_____.

Items (furnishings and appliances) not be permitted for safety reasons. Space heater, electric blanket, throw rugs, candles, electric air fresheners, electrical plug adaptors, extension cords greater than 6 feet in length.

B. Basic Services The following basic services will be provided to you, in accordance with your Individualized Services Plan.

1. Meals and Snacks. Three (3) nutritionally well-balanced meals per day, served at regularly scheduled times as well as one evening snack is included in Your Basic Rate. Diets available for residents include a Regular diet, a Low Concentrated Sweets, Modified Diet (Mechanical soft diet) and Finger food diet will be available to you if ordered by Your Physician and included on Your Individualized Service Plan.

2. Activities. The Operator will provide a program of planned activities, opportunities for community participation and services designed to meet your physical, social and spiritual needs, and will post a monthly schedule of activities in a readily visible common area of the Residence.

3. Weekly Housekeeping Services

4. Laundry of Your personal washable clothing and linens. The Operator will provide weekly laundry of your personal washable clothing and linens.

5. Supervision on a 24-hour basis. The "Operator" will provide appropriate staff on-site to provide supervision services in accordance with law. Supervision will include monitoring, responding to urgent or emergency needs or requests for assistance on a 24-hour a day, seven days a week basis as well as the other components of supervision as specified in law.

6. Case **Management.** The "Operator" will provide appropriate staff to provide case management services in accordance with law. Such case management services will include identification and assessment of Your needs and interests, information and referral, and coordination with available resources to best address Your identified needs and interests.

7. Personal Care. Will be provided based on needs identified by Your Physician and "Operator" staff as indicated on Your Individualized Service Plan and may include but is not limited to assistance with bathing, grooming, dressing, toileting, ambulation, transferring and medication administration. You agree the level of care provided by the Operator meets Your needs. As such, at any time You do not agree that the level of care is appropriate, You are responsible to notify the Operator.

8. Development of Individualized Service Plan (ISP). A plan will be developed in accordance with Your Physician and "Operator" staff. This ISP will be reviewed and revised every six months and whenever ordered by your physician or as frequently as necessary, to reflect the changing care needs of the resident.

C. Additional Services. Exhibit I.C., attached and made part of this Agreement describes in detail, any additional services or amenities available for an additional, supplemental or community fee from the Operator directly or through arrangements with the Operator. Such exhibit states who would provide such services or amenities, if other than the Operator.

D. Licensure/Certification Status. A listing of all providers offering home care or personal care services under an arrangement with the Operator, and a description of the licensure or certification status of each provider is set forth in Exhibit I.D. of this Agreement. Such exhibit will be updated as frequently as necessary.

II. Disclosure Statement

The Operator is disclosing information as required under Public Health Law Section 4658 (3). Such disclosures are contained in Exhibit II, which is attached to and made part of this Agreement.

III. Fees

A. Basic Rate

1. Flat Fee Arrangement

The Resident, Resident's Representative and/or Resident's Legal Representative agrees that the Resident (*or other specified party*) will pay, and the Operator agrees to

accept, the following payment in full satisfaction of the Basic Services described in Section I. B. of this Agreement. The Basic Rate as of the date of this agreement is:

Monthly Basic Service Rate: $ _____ per month

*Single occupancy in a two bedroom will incur an additional fee of $_____

2. Tiered Fee Arrangements

The Tiered fee arrangement, in which the amount of the Basic Rate Depends upon the types of services provided for some type of service and the fees for each tier of care, are set forth in detail in Exhibit III.A.2. and made part of this agreement.

B. A Supplemental or Additional fee is a fee for service, care or amenities that is in addition to those fees included in the Basic Rate. In some cases, the law permits the Operator to charge an Additional Fee without the express written approval of the Resident (*Refer to Section III.B of this agreement).*

A Community Fee is a one-time fee that the Operator may charge at the time of admission. The Operator must clearly inform the prospective Resident what additional services, supplies or amenities the Community Fee pays for and what the amount of the Community Fee will be, as well as any terms regarding refund of the Community Fee. The prospective Resident, once fully informed of the terms of the Community Fee, may choose whether to accept the Community Fee as a condition of residency in the Residence, or to reject the Community Fee and thereby reject residency at this Residence.
Any charges by the Operator, whether a part of the Basic Rate, Supplemental, Additional or Community Fees, shall be made only for services and supplies that are supplied to the Resident.

3. A Community fee is a one-time fee of $1,500 and is required to reserve Your room. This fee is refundable only if You terminate this Agreement in accordance with Section XIII of this agreement and vacate the room within ninety (90) days of the effective date of this Agreement.

Damages for Cleaning and Repairs

The parties agree that upon termination of the Agreement, the Room will be

returned to the Operator in good condition less normal wear and tear. Any cleaning or damages beyond normal wear and tear will be billed at cost of material plus labor.

4. Supplemental Services and/or Supplies will be itemized and attached to this Agreement as Exhibit I.C. – Additional Services, Supplies or Amenities.

Rate or Fee Schedule. Attached as Exhibits I.C and III.C. and made a part of this Agreement is a rate or fee schedule, covering both the Basic Rate and any Additional, Supplemental or Community fees, for services, supplies and amenities provided to You, with a detailed explanation of which services, supplies and amenities are covered by such rates, fees or charges.

C. Billing and Payment Terms

The payment of the Monthly Basic Service Rate and any authorized additional and agreed upon Supplemental or Additional Fees as detailed in this Agreement shall be payable monthly in advance by the first (1st) day of each calendar month to the facility Business Office or as deemed necessary by the Service Provider. A late charge of twenty-five dollars ($25) and one and one-half percent (1.5%) interest shall be assessed if the Monthly Basic Service Rate is not paid by the tenth (10th) day of the month. The interest shall be ***calculated as of the first (1st) day of the month until such amount is paid*** provided, however, that the Resident or Responsible Party, if any, shall have the right to contest that there has been late payment or that such sums are due under this Agreement, and that in the event of such a dispute, no late charges shall be imposed unless ordered by a court of competent jurisdiction, or unless otherwise agreed to by the parties.

D. Adjustments to the Basic Rate or Additional or Supplemental Fees

1. You have the right to written notice of any proposed increase of the Basic Rate or any Additional or Supplemental fees not less than forty-five (45) days prior to the effective date of the increase, subject to the exceptions stated in paragraphs 3, 4 and 5 below.

2. Since a Community Fee is a one-time fee, there can be no subsequent increase in a Community Fee charged to You by the Operator, once You have been admitted.

3. If You, or Your Resident Representative or Legal Representative agree in writing to a

specific Rate or Fee increase, through an amendment of this Agreement, due to Your need for additional care, services or supplies, the Operator may increase such Rate or Fee upon less than forty-five (45) days written notice.

4. If the Operator provides additional care, services or supplies upon the express written order of Your primary physician, the Operator may, through an amendment to this Agreement, increase the Basic Rate or an Additional or Supplemental fee upon less than forty-five (45) days written Notice.

5. In the event of any emergency which affects You, the Operator may assess additional charges for Your benefit as are reasonable and necessary for services, material, equipment and food supplied during such emergency.

E. Bed Reservation

The Operator agrees to reserve a residential space as specified in Section I.A.1 above in the event of Your absence. You are responsible for payment of the Monthly Basic Service Rate of $_____for the time You are away from the facility. A provision to reserve a residential space does not supersede the requirements for termination as set forth in Section XIII of this Agreement. You may choose to terminate this Agreement rather than reserve such space, but must provide the Operator with any required notice as set forth in Section XIII of this Agreement.

IV. Refund/Return of Resident Monies and Property

Upon termination of this Agreement or at the time of Your discharge, but in no case more than three (3) business days after You leave the Residence, the Operator will provide to You, Your Representative or Legal Representative or any person designated by You with a final written statement of Your payment and personal allowance accounts at this Residence.

The Operator will return at the time of Your discharge, no more than three (3) business days any of Your personal allowance account or property which comes into the possession of the Operator after Your discharge.

a. **Refund room and board:** The Operator will refund on the basis or a per diem proration any advance payment(s) which You have made.

b. Death: In the event of Your death, the Operator will return Your property to the legally authorized representative of Your estate. In the event of Your death without a Will and the whereabouts of Your next-of-kin is unknown, the Operator shall contact the appropriate Surrogate's Court to arrange for transfer of Your property. Refer to section XIII of this agreement.

V. Transfer of Funds or Property to Operator

If You wish to voluntarily transfer money, property or items of value to the Operator upon admission or at any time, the Operator must enumerate the items given or promised to be given and attach to this agreement a listing of the items given to be transferred. Such listing is attached as Exhibit V and is made a part of this Agreement. Such listing shall include any agreements made by third parties for Your benefit.

VI. Property or items of value held in the Operator's custody for You.

If, upon admission or any other time, you wish to place property or things of value in the Operator's custody and the Operator agrees to accept the responsibility of such custody, the Operator must enumerate the items so placed and attach to this agreement a listing of such items. Such listing is attached as Exhibit VI of this Agreement.

VII. Fiduciary Responsibility

If the Operator assumes management responsibility over Your funds, the Operator shall maintain such funds in a fiduciary capacity to You. Any interest on money received and held for You by the Operator shall be Your property.

VIII. Tipping / Weapons / Pets

The Operator shall not accept, nor allow facility staff or agents to accept, any tip or gratuity in any form for any services provided or arranged for as specified by statute, regulation or agreement.

The Operator shall not allow weapons of any kind, including but not limited to mace/pepper spray, guns or knives of any kind.

The Operator shall not allow any animals/pets for permanent residency. Appropriate animals may be brought to the facility for visits, after providing written proof of current vaccinations, including rabies.

IX. Personal Allowance Accounts

The Operator agrees to offer to establish a personal allowance account for any Resident by executing a Statement of Offering (DOH-5195 – Addendum I) with You or Your Representative. You agree to inform the Operator if you receive or have applied for Supplemental Security Income (SSI) or Safety Net Assistance (SNA) funds. You must complete the following:

☐ I receive SSI funds ☐ I have applied for SSI funds
☐ I receive SNA funds ☐ I have applied for SNA funds
☐ I do not receive either SSI or SNA funds

If You have a signatory to this agreement besides Yourself and if that signatory does not choose to place Your personal allowance funds in a Residence maintained account, then that signatory hereby agree that he/she will comply with the Supplemental Security Income (SSI) or Safety Net Assistance (SNA) personal allowance requirements.

X. Admission and Retention Criteria for an Assisted Living Residence

1. Under the law which governs Assisted Living Residences (Public Health Law Article 46-b), the Operator shall not admit any Resident if the Operator is not able to meet the care needs of the Resident, within the scope of services authorized under such law, and within the scope of services determined necessary within the Resident's Individualized Services Plan. The Operator shall not admit any Resident in need of 24-hour skilled nursing care.
2. The Operator shall conduct an initial pre-admission evaluation of a prospective Resident to determine if the individual is appropriate for admission.
3. The Operator has conducted such evaluation of Yourself and has determined that You are appropriate for admission to this Residence, and that the Operator is able to meet Your care needs within the scope of services authorized under the law and within the scope of services determined necessary for You under Your Individualized Services Plan. You have agreed the Operator can meet your needs.
4. If You are being admitted to a Special Needs Assisted Living Residence, the

"Special Needs Assisted Living Residence Addendum" will apply.

5. If You are residing in a "Basic" Assisted Living Residence and Your care needs subsequently change in the future to the point that You require either Enhanced Assisted Living Care or 24-hour skilled nursing care, You will no longer be appropriate for residency in this Basic residence. If this occurs, the Operator will take the appropriate action to terminate this Agreement, pursuant to Section XIII of this Agreement.

XI. Rules of the Residence (if applicable)

Attached as Exhibit XI and made part of this Agreement are the Rules of the Residence. By signing this agreement, You and Your representatives agree to obey all reasonable Rules of the Residence.

XII. Responsibilities of Resident, Resident's Representative and Resident's Legal Representative

A. You, or Your Resident or Legal Representative to the extent specified in this Agreement, are responsible for the following:

1. Payment of the Basic Rate and any authorized Additional and agreed-to Supplemental or Community Fees as detailed in this Agreement.
2. Supply of Your personal clothing and effects.
3. Payment of all medical expenses including transportation for medical purposes, except when payment is available under Medicare, Medicaid or other third-party coverage.
4. At the time of admission and at least once every six (6) months, or more frequently if a change in condition warrants, providing the Operator with a dated and signed medical evaluation that conforms to regulations of the New York State Department of Health.
5. Informing the Operator promptly of any change in health status, change in physician, or change in medications.
6. Informing the Operator promptly of any change of name, address and/or phone number.

XIII. Termination and Discharge

This Residency Agreement and residency may be terminated as follows:

1. By mutual agreement between You and the Operator
2. Upon 30-day written notice from You or Your Representative to the Operator of Your intention to terminate the agreement and leave the facility.
3. Upon a 30-day written notice from the Operator to You, Your Representative, Your next of kin, the person designated in this agreement as the responsible party or any person designated by You. Involuntary termination of a Residency Agreement is permitted only for the reasons listed below, and then only if the Operator initiates a court proceeding and the court rules in favor of the Operator.

The grounds upon which involuntary termination may occur are:

1. You require continual medical or nursing care which the Residence is not permitted by law or regulation to provide;
2. Your behavior poses imminent risk of death or imminent risk of serious physical harm to You or anyone else;
3. You fail to make timely payment for all authorized charges, expenses and other assessments, if any, for services including use and occupancy of the premises, materials, equipment and food which You have agreed to pay under this Agreement. If Your failure to make timely payment resulted from an interruption in Your receipt of any public benefit to which You are entitled, no involuntary termination of this Agreement can take place unless the Operator, during the thirty-day period of notice of termination, assists You in obtaining such public benefits or other available supplemental public benefits. You agree that You will cooperate with such efforts by the Operator to obtain such benefits;
4. You repeatedly behave in a manner that directly impairs the well-being, care or safety of Yourself or any other Resident, or which substantially interferes with the orderly operation of the Residence;
5. The Operator has had his/her operating certificate limited, revoked, temporarily suspended or the Operator has voluntarily surrendered the operation of the facility;
6. A receiver has been appointed pursuant to Section 461-f of the New York State Social Services Law and is providing for the orderly transfer of all residents in the Residence to other residences or is making other provisions for the Residents' continued safety and care.

If the Operator terminates the Residency Agreement for any of the reasons stated above, the Operator will give You a notice of termination and discharge, which must be at least thirty (30) days after delivery of notice, the reason for termination, a statement of Your right to object and a list of free legal advocacy resources approved by the State Department of Health.

You may object to the Operator about the proposed termination and may be represented by an attorney or advocate. If You challenge the termination, the Operator, in order to terminate, must institute a special proceeding in court. You will not be discharged against Your will unless the court rules in favor of the Operator.

While legal action is in progress, the Operator must not seek to amend the Residency Agreement in effect as of the date of the notice of termination, fail to provide any of the care and services required by Department regulations and the Residency Agreement, or engage in any action to intimidate or harass You.

Both You and the Operator are free to seek any other judicial relief that may be entitled.

The Operator must assist You if the Operator proposes to transfer or discharge You to the extent necessary to assure, whenever practicable, Your placement in a care setting which is adequate, appropriate and consistent with Your wishes.

This Agreement shall be terminated automatically in the event of Your death. Your estate will be billed for any unpaid charges. The Operator will charge, and is entitled to keep the full Monthly Basic Service Rate charged for the entire calendar month regardless of what portion of the month Your room is occupied.

XIV. Transfer

Notwithstanding the above, an Operator may seek appropriate evaluation and assistance and may arrange for Your transfer to an appropriate and safe location, prior to termination of a Residency Agreement and without a thirty (30) day notice or court review, for the following reasons:

1. If You develop a communicable disease, medical or mental condition, or sustain an injury such that continual skilled medical or nursing services are required;

2. If Your behavior poses an imminent risk of death or serious physical injury to yourself or

others; or

3. If a Receiver has been appointed under the provisions of New York State Social Services Law and is providing for the orderly transfer of all Residents in the residence to other residences or is making other provisions for the Residents' continued safety and care.

If you are transferred, in order to terminate Your Residency Agreement, the Operator must proceed with the termination requirements as set forth in Section XIII of this Agreement, except that the written notice of termination must be hand delivered to You at the location to which You have been transferred. If such hand delivery is not possible, then the notice must be given by any of the methods provided by law for personal service upon a natural person. If the basis for the transfer permitted under parts 1 and 2 above of this section no longer exists, You are deemed appropriate for placement in this Residence and if the Residency Agreement is still in effect, You must be readmitted.

Transferring to another Room: If You request a transfer from one room to another within the Residence, you agree to pay the Operator a non-refundable transfer fee of $750. This non-refundable transfer fee will include the cost of maintenance and cleaning of the room. The Operator may waive the transfer fee for reasons including, but not limited to:

- Your room preference was not available at the time of admission
- Your health care needs change thus requiring a different room
- Your financial needs change thus requiring a different room

XV. Resident Rights and Responsibilities

Attached as Exhibits XV and XVI (as applicable) and made a part of this Agreement is a Statement of Resident Rights and Responsibilities. This Statement will be posted in a readily visible common area within the Residence. The Operator agrees to treat You in accordance with such Statement of Resident Rights and Responsibilities.

XVI. Complaint Resolution

The Operator's procedures for receiving and responding to resident grievances and recommendations for change or improvement in the Residence's operations and programs are attached as Exhibit XVI and made a part of this Agreement. In addition, such procedures will

be posted in a readily visible common area of the Residence. You will have the right to voice grievances or recommendations about treatment or care. A Concern Log will be used to communicate Your concerns to facility staff. The Operator agrees to address any complaints or concerns in a timely manner.

The Operator agrees that the Residents of this residence may organize and maintain councils or such other self-governing body as the Residents may choose.

The Operator agrees to address any complaints, problems, issues or suggestions reported by the Residents' Organization and to provide a written report to the Residents' Organization that addresses the same.

Complaint handling is a direct service of the Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman is available to identify, investigate and resolve Your complaints in order to assist in the protection and exercise of Your rights.

XVII. Miscellaneous Provisions

1. This Agreement constitutes the entire Agreement of the parties.
2. This Agreement may be amended upon the written agreement of the parties; provided however, that any amendment or provision of this Agreement not consistent with the statute and regulation shall be null and void.
3. The parties agree that Assisted Living Residency Agreements and related documents executed by the parties shall be maintained by the Operator in files of the Residence from the date of execution until three (3) years after the Agreement is terminated. The parties further agree that such Agreements and related documents shall be made available for inspection by the New York State Department of Health upon request at any time.
4. Waiver by the parties of any provision in this Agreement which is required by statute or regulation shall be null and void.

XVIII. Agreement Authorization

We, the undersigned, have read this Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

_____	_____
Dated	(Signature of Resident)
_____	_____
Dated	(Signature of Resident's Representative)
_____	_____
Dated	(Signature of Resident's Legal Representative)
_____	_____
Dated	(Signature of Operator/Operator's Representative)

EXHIBIT I.C.

ADDITIONAL SERVICES, SUPPLIES OR AMENITIES

SERVICES	COST	ARRANGEMENTS
BEAUTICIAN / BARBER:	Cost per service provided	Please schedule an appointment with the beautician
LOCAL NEWS PAPER	Current Rates Apply	Resident's subscription order is placed by the resident or responsibility party.
SHOPPING	Per item at time of purchase	Per wellness calendar - Local grocery store weekly Facility Gift Shop
Dry Cleaning	Per item at time of service	Resident/Responsible Party
Phone Services	Current Rates Apply	Resident/Responsible Party
Transportation – Facility Van	No Charge within 5-mile radius (If available)	Resident/Responsible Party to make arrangements with facility staff
Basic Cable Television	Included	Operator
Community Fee	$1500.00	Resident/Responsible Party

EXHIBIT I.D.

LICENSURE/CERTIFICATION STATUS OF PROVIDERS

Your Right to Choose Providers

All Residents of this facility have the right to receive services from any provider, regardless of whether the Operator of this Facility has an arrangement with that provider. All Residents have the right to choose his/her health care providers.

1. Home Care Agency:

Home Care of Rochester (HCR)
85 Metro Park
Rochester, NY 14623
800-270-4904
585-272-1930

EXHIBIT II

DISCLOSURE STATEMENT

Heathwood Assisted Living at Penfield ("The Residence"), hereby discloses the following, as required by Public Health Law Section 4658 (3).

Referenced at www.health.ny.gov

1. The Consumer Information Guide developed by the Commissioner of Health is hereby available at: https://www.health.ny.gov/publications/1505.pdf

2. The Operator is licensed by the New York State Department of Health to operate 100 Elderwood Court, Penfield NY 14526, an Assisted Living Residence.

The Operator is also certified to operate at this location a Special Needs Assisted Living Residence, an Enhanced Assisted Living Residence and an Assisted Living Program. This additional certification may permit individuals who may develop conditions or needs that would otherwise make them no longer appropriate for continued residence in a basic Assisted Living Residence to be able to continue to reside in the Residence and to receive Special Needs Assisted Living services, Enhanced Assisted Living Residence, or Assisted Living Program as long as the other conditions of residency set forth in this Agreement continue to be met. The Operator is currently approved to provide:

- Special Needs Assisted Living services for up to a maximum of 24 persons.
- Enhanced Assisted Living services for up to a maximum of 25 persons.
- Assisted Living Program services for up to a maximum of 25 persons.

Optional Provision Begins

Below is a list of the needs/conditions that the Operator is able to serve and accommodate under its Special Needs Assisted Living Certification. ***Such individuals who may be eligible for the Special Needs Assisted Living Certificate or Enhanced Assisted Living Certificate includes those who:***

a. are medically stable; not in need of continual nursing care to preserve or maintain an otherwise unstable medical condition.
b. may require more intensive or additional/chronic assistance to perform Activities of Daily Living.
c. are capable of accepting direction and of self-preservation. Assistance with management of care and daily living needs will be provided through informal or formal surrogates.
d. chronically require physical assistance of another person to climb/descend stairs.

e. are Dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel.

f. Below is a list of needs/conditions that the Operator is not able to serve and accommodate under its Special Needs Assisted Living Certification, Enhanced Assisted Living Certification or Assisted Living Program.

Such individuals who will not be eligible under the Special Needs Assisted Living, Enhanced Assisted Living or Assisted Living Program Certificate includes those who:

a. exhibit unmanageable assaultive or aggressive behavior;

b. are chronically intrusive, disruptive, or exhibit other behavioral characteristics to the extent that they interfere with the orderly operation of the facility;

c. chronically attempt to elope to the extent that they present a danger to themselves or interfere with the orderly operation of the facility;

d. are chronically uncooperative or resistive to the provision of personal care services, including any necessary toileting program and assistance with medications, as well as other such services, to the extent that such care cannot be maintained or managed.

Optional Provision Ends

The Operator will post prominently in the Residence, on a monthly basis, the current number of vacancies under its Special Needs Assisted Living and Enhanced Assisted Living programs. **It is important to note that The Operator is currently approved to accommodate within the Special Needs Assisted Living, Enhanced Assisted Living programs or Assisted Living program only up to the numbers of persons stated above.** If You become appropriate for Special Needs Assisted Living Services, Enhanced Assisted Living Services, or Assisted Living Program and one of those units is available, You will be eligible to be admitted into the Special Needs Assisted Living, Enhanced Assisted Living Program or Assisted Living Program. If however, such units are at capacity and there are no vacancies, the Operator will assist You and Your representatives to identify and obtain other appropriate living arrangements in accordance with New York State's regulatory requirements. If you become eligible for and choose to receive services in the Special Needs Assisted Living, Enhanced Assisted Living Residence program or Assisted Living Program within this Residence, it may be necessary for You to change your (room) within the Residence.

Heathwood Assisted Living at Penfield coordinates home care services with an approved home care agency. You may elect to use this home care provider or choose another provider.

1. The owner of the real property is **Robert M. Chur.** The address of such real property is 100

Elderwood Court, Penfield, NY 14526. The following individual is authorized to accept personal service on behalf of the property owner: **Administrator; President; Vice President of Operations Support; Designee.**

2. The Operator of the Residence is **Heathwood Assisted Living at Penfield**. The mailing address of the Operator is 100 Elderwood Court, Penfield, New York 14526. The following individual is authorized to accept personal service on behalf of the operator**: Administrator**; **President; Vice President of Operations Support; Designee.**

3. The Operator **has** ownership interest of **Heathwood Assisted Living at Penfield** in excess of 10% (whether legal or beneficial interest) on the part of any entity which provides care, material, equipment or other services to residents of The Residence.

4. All Residents of this facility have the right to receive services from any provider, regardless of whether the Operator of this Facility has an arrangement with that provider.

5. Residents shall have the right to choose their health care providers, notwithstanding any other agreement to the contrary.

6. Public funds for the payment of residential, supportive or home health services are available for eligible individuals. This facility does not accept Public Funds payments as payment in full. Therefore, if the facility rate exceeds the amount of Public Funds available to the resident and the resident is unable to pay (in full) the balance of the facility's basic daily rate, the facility will assist the resident in securing placement at another facility, pursuant to applicable laws and regulations.

7. The New York State Department of Health's toll-free telephone number for reporting of complaints regarding the services provided by The Assisted Living Operator is 1-866-893-6772.

8. The New York State Long Term Care Ombudsman Program (NYSLTCOP) provides a toll free number 1-855-582-6769 to request an Ombudsman to advocate for the resident. The local LTCOP telephone number is (585) 287-6414. The NYSLTCOP web site is www.ltcombudsman.ny.gov.

EXHIBIT III.A.2.

TIERED FEE ARRANGEMENTS FOR ENRICHED ASSISTED LIVING RESIDENCE (ALR) / ENHANCED ASSISTED LIVING RESIDENCE (EALR)

Monthly Rental Includes:

- ❖ 24-hour nursing staff on duty and 24-hour emergency response system
- ❖ Case Management Services
- ❖ Medication management for up to ten medications
- ❖ Three nutritious meals daily, plus evening snack
- ❖ Includes weekly housekeeping, laundry and linen service as well as daily trash removal
- ❖ Full-time recreation/activities program
- ❖ All utilities included except for a phone line
- ❖ Weekly shower assistance two times per week
- ❖ Weekly visits from the in-house MD and/or Nurse Practitioner and quarterly Podiatry visits
- ❖ Month-to-month rental (30-day Notice), no lease required

Level II – Enriched ALR Monthly Rent plus $525 additional per month

- ❖ Assistance with morning and/or evening care (dressing/undressing)
- ❖ Daily reminders for grooming needs (direction/setup – verbal cues)
- ❖ Able to self-manage oxygen but requires assistance with management less than daily.
- ❖ Medication reminders
- ❖ Toileting reminders once per day
- ❖ Requires two laundry days/week
- ❖ Requires repeated prompting (a.m. wake up, meal reminders, medication reminders)
- ❖ Requires occasional escorting to and from meals

Level II PLUS – Enriched ALR Monthly Rent plus $1,050 additional per month

Includes all Level II services + one or more of the following:

- ❖ Dressing – Requires clothing management system
- ❖ Assistance with daily grooming needs
- ❖ Escorts to and from meals daily
- ❖ Judgment – Requires daily re-direction and supervision of tasks
- ❖ Requires assistance by staff for additional showers per week
- ❖ Requires additional laundry and/or cleaning day per week

Level III – Enhanced Assisted Living (EALR) Monthly Rent plus $1,050 additional per month

Includes all Level II PLUS services and

- ❖ Requires a daily toileting schedule
- ❖ Assistance with daily oxygen management and/or other medical equipment.
- ❖ Assistance with daily diabetic needs (i.e. blood sugar monitoring, insulin management)

LEVEL IV – Enhanced Assisted Living (EALR) Monthly Rent plus $1,800 additional per month

Includes all Level III services + one or more of the following

- ❖ Requires assistance of one staff person (to transfer to/from bed or chair
- ❖ Requires daily assistance to manage incontinence
- ❖ Judgment – Requires constant re-direction and supervision
- ❖ Chronic Assistance of staff to manage ostomy care, catheter care

Special Needs Assisted Living Services (SNARL) – Special needs pricing per month, not a tiered service

Includes all Level IV services and requires a set area dedicated to dementia care with one or more of the following

- Requires assistance by staff for ADL's, daily, as needed and all scheduled showers.
- Judgement – May be unable to follow appropriate direction and requires constant re-direction with supervision and/or guidance.

EXHIBIT III.C.
2026 RATE/FEE SCHEDULE

APARTMENT STYLE	MONTHLY RENT	LEVEL II* (Add $525)	LEVEL II PLUS/ LEVEL III* Enhanced (Add $1,050)	LEVEL IV* Enhanced (Add $1,800)
Studio – 346 sq. ft.	$5150			
Studio D Wing – 346 sq. ft.	$5400			
Studio LG – 400 sq. ft	$5525			
One Bedroom – 514 sq. ft.	$6300			
One Bedroom Plus - 600 sq. ft. (Accommodates 2)	$6,500			
One Bedroom w/ Study - 638 sq. ft. (Apartment #'s 120 & 220 ONLY)	$6,600			
One Bed Deluxe - 700 sq. ft. (Apartment #'s 101 & 201 ONLY)	$6,650			
Two Bedroom - 840 sq. ft.	$6,800 Double $8,600 Single			
Second Person Fee (In designated apartments)	$1,800			
One Time Community Fee	$1,500			

MEMORY CARE	MONTHLY RENT
Companion Suite	$7,350
Studio Apartment	$7,750
One Bedroom Apartment	$7,950
One Time Community Fee	$1,500

MEDICATION MANAGEMENT	MONTHLY COST
1-10 MEDICATIONS	**NO ADDITIONAL FEE**
11-20 MEDICATIONS	$125
21-29 MEDICATIONS	$225
30+ MEDICATIONS	$325

EXHIBIT V.

TRANSFER OF FUNDS OR PROPERTY TO OPERATOR

The following money, property or things of value have been voluntarily transferred to the Operator, by You.
Heathwood Assisted Living is not responsible for any damage or loss of any listed money, property, or items of value.

_____

_____

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_____

Resident/Representative Signature _____ Date _____

Operator Signature _____ Date _____

EXHIBIT VI.

PROPERTY/ITEMS HELD BY OPERATOR FOR YOU

The following property/items are being held by the Operator for you as you requested.
Heathwood Assisted Living is not responsible for any damage or loss of any listed property, or items of value.

_____

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_____

_____

Resident/Representative Signature _____ Date ____/____/____

Operator Signature _____ Date ____/____/____

EXHIBIT XI

RESOURCES

NYS Department of Health Adult Home Complaint Hotline 1-866-893-6772

The Department's toll free number is for the reporting of complaints regarding home care services and the services provided by the assisted living operator.

Local Ombudsmen - American Red Cross (585) 287-6414

A Long-Term Care Ombudsman is a trained and certified advocate who is available to resolve issues on behalf of the residents and their families. Their mission is to protect the health, safety, welfare, human and civil rights of persons living in assisted living and other facilities. They serve as a link between residents and government resources that can be used to resolve issues.

New York State Directory (Effective 1/17)

County	Name	Phone	Email
ALLEGANY	Taryn Roloson	607-962-8225 ext. 112	troloson@aimcil.com
CATTARAUGUS	Lisa Newman	716-817-9222 844-527-5509	lnewman@people-inc.org
CHAUTAUQUA	Lisa Newman	716-817-9222 844-527-5509	lnewman@people-inc.org
CHEMUNG	Suzanne Motheral	607-274-5498	smotheral@tompkins-co.org
ERIE	Lisa Newman	716-817-9222 844-527-5509	lnewman@people-inc.org
FULTON	Kathryn Horan	518-372-5667	khoran@cathcharschdy.org
GENESEE	Dianna Leach	585-287-6461	dleach@lifespanrochester.org
MONROE	Dianna Leach	585-287-6461	dleach@lifespanrochester.org
NIAGARA	Lisa Newman	716-817-9222 844-527-5509	lnewman@people-inc.org
ONEIDA	Krystal Wheatley	315-272-1872	kwheatley@rcil.com
ONONDAGA	Jeff Parker	315-671-5108	jparker@ariseinc.org
ONTARIO	Dianna Leach	585-287-6461	dleach@lifespanrochester.org
OSWEGO	Jeff Parker	315-671-5108	jparker@ariseinc.org

EXHIBIT XV

RIGHTS AND RESPONSIBILITIES OF RESIDENTS IN AN ASSISTED LIVING RESIDENCES

RESIDENT'S RIGHTS AND RESPONSIBILITIES SHALL INCLUDE, BUT NOT BE LIMITED TO THE FOLLOWING:

(A) Every resident's participation in assisted living shall be voluntary, and prospective Residents shall be provided with sufficient information regarding the residence to make an informed choice regarding participation and acceptance of services;

(B) Every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed;

(C) Every resident shall have the right to have private communications and consultation with his or her physician, attorney, and any other person;

(D) Every resident, resident's representative and resident's legal representative, if any, shall have the right to present grievances on behalf of himself or herself or others, to the residence's staff, administrator or assisted living operator, to governmental officials, to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or individuals within or outside of the residence to work for improvements in resident care;

(E) Every resident shall have the right to manage his or her own financial affairs;

(F) Every resident shall have the right to have privacy in treatment and in caring for personal needs;

(G) Every resident shall have the right to confidentiality in the treatment of personal, social, financial and medical records, and security in storing personal possessions;

(H) Every resident shall have the right to receive courteous, fair and respectful care and treatment and a written statement of the services provided by the residence, including those required to be offered on an as-needed basis;

(I) Every resident shall have the right to receive or to send personal mail or any other correspondence without interception or interference by the operator or any person affiliated with the operator;

(J) Every resident shall have the right not to be coerced or required to perform work of staff members or contractual work;

(K) Every resident shall have the right to have security for any personal possessions if stored by the operator;

(L) Every resident shall have the right to receive adequate and appropriate assistance with activities of daily living, to be fully informed of their medical condition and proposed treatment, unless medically contraindicated, and to refuse medication, treatment or services after being

fully informed of the consequences of such actions, provided that an operator shall not be held liable or penalized for complying with the refusal of such medication, treatment or services by a resident who has been fully informed of the consequences of such refusal;

(M) Every resident and visitor shall have the responsibility to obey all reasonable regulations of the residence and to respect the personal rights and private property of the other residents;

(N) Every resident shall have the right to include their signed and witnessed version of the events leading to an accident or incident involving such resident in any report of such accident or incident;

(O) Every resident shall have the right to receive visits from family members and other adults of the resident's choosing without interference from the assisted living residence; and

(P) Every resident shall have the right to written notice of any fee increase not less than forty-five (45) days prior to the proposed effective date of the fee increase; provided, however, that if a resident, resident representative or legal representative agrees in writing to a specific rate or fee increase through an amendment of the residency agreement due to the resident's need for additional care, services or supplies, the operator may increase such rate or fee upon less than forty-five (45) days written notice.

(Q) Every resident of an assisted living residence that is also certified to provide enhanced assisted living and/or special needs assisted living shall have a right to be informed by the operator, by a conspicuous posting in the residence, on at least a monthly basis, of the then-current vacancies available, if any, under the operator's enhanced and/or special needs assisted living programs.

Waiver of any of these resident rights shall be void. A resident cannot lawfully sign away the above-stated rights and responsibilities through a waiver or any other means.

IF YOU FEEL THAT ANY OF THE RIGHTS IDENTIFIED HAVE BEEN OR ARE BEING VIOLATED, YOU MAY CONTACT:

To report complaints regarding home care services and the services provided by this facility, contact the New York State Department of Health toll free at (866) 893-6772 www.nyhealth.gov

NYS Department of Health Regional Offices:

Western Regional Office
Triangle Building
335 East Main Street
Rochester, NY 14604-2127
(585) 423-8100

The Long Term Care Ombudsman Program
Lifespan
1900 South Clinton Avenue, Suite 13
Rochester, NY 14618
(585) 287-6414
(800) 454-5030

EXHIBIT XVI

RESIDENT RIGHTS AND RESPONSIBILITIES
ASSISTED LIVING PROGRAM
(If Applicable)

The Social Services Law and the Public Health Law give you certain rights as a resident. AT A MINIMUM, A RESIDENT HAS THE RIGHT:

1. To receive courteous, fair and respectful care and treatment, and not be physically, mentally or emotionally abused or neglected in any manner;

2. To exercise his or her civil rights and religious liberties, and to make personal decisions, including the choice of physician, and to have the assistance and encouragement of the operator in exercising these rights and liberties;

3. To have private written and verbal communications or visits with anyone of his or her choice, or to deny or end such communications or visits;

4. To send and receive mail or any correspondence unopened and without interception or interference;

5. To present grievances and complaints including those related to care and services and recommend changes in policies and services on his/her behalf, or the behalf of other residents, to the administrator, facility staff, the Department of Health, other government officials or any other parties without fear of interference, coercion, discrimination or reprisal. This extends to the resident's designee, as well. If not satisfied with the results of the complaint investigation, the resident or his/her designee shall have the right to appeal the outcome to the Department of Health or other government agency, as appropriate.

6. To join other residents or individuals inside or outside the facility to work for improvement in resident care;

7. To confidential treatment of personal, social, financial and health records;

8. To have privacy in treatment and in caring for personal needs;

9. To receive a written statement (admission agreement) of the services regularly provided by the facility operator, those additional services which will be provided if the resident needs or asks for them and the charges (if any) for these additional services;

10. To manage his or her own financial affairs;

11. To not be coerced or required to perform the work of staff members or contractual work; and if the resident works, to receive fair compensation from the operator of the facility;

12. To have security for any personal possessions if stored by the operator;

13. To have recorded on the facility's accident or incident report the resident's version of the events leading up to the accident or incident;
14. To object if the operator terminates the admission agreement against the resident's will; and

15. To refuse treatment after being fully informed of and understanding the consequences of such actions, unless such refusal causes, or is likely to cause, in the judgment of a physician, life threatening danger to the resident or others.

IF YOU FEEL THAT ANY OF THESE RIGHTS HAVE BEEN OR ARE BEING VIOLATED, YOU MAY CONTACT:

NYS Department of Health, Office of Housing & Adult Services Regional Office:

Western Regional Office (Rochester)
335 East Main Street 1st Floor
Rochester, NY 14604
(585) 423-8185

The Long-Term Care Ombudsman Program
The NYS Office for Aging
Two Empire State Plaza
Albany, NY 12223-1251
Toll Free (855) 582-6769
Local Chapter (585) 287-6414

OR

NYS Department of Health, Office of Health Systems Management Area Office:

Home Care Program
Rochester Area Office
Triangle Building
335 East Main Street
Rochester, NY 14604-2127
(585) 423-8121

EXHIBIT XVII

Heathwood Assisted Living
Resident and Family Compliments/Concerns

Instructions: Residents, Family Members, Resident Representatives/Advocates may file a compliment or concern. Concerns may be filed without fear of threat or reprisal. The top portion of this report will be completed by a Staff Member and submitted to the Case Manager. The Case Manager will provide a prompt response to the Resident/Family Member and Staff Member.

Resident _____ Room # _____ Date ___/___/___

Name of person filing compliment/concern _____
Phone # _____ Relationship to Resident _____

Date incident occurred ___/___/____ Time _____ am/pm Location _____

Describe the nature of the compliment/concern _____
_____
_____
_____
_____
_____
_____

Initial Response/Action Taken (complete for concerns)
_____
_____
_____
_____

Staff Member Signature _____ Date ___/___/___

Immediately Forward to Case Manager

****

Resolution (complete for concerns)
_____
_____
_____
_____
_____

Case Manager Signature _____ Date ___/___/___

cc: Administrator

ADDENDUM A
(If Applicable)

ADDENDUM A
(If Applicable)

SPECIAL NEEDS ASSISTED LIVING RESIDENCE
ADDENDUM TO RESIDENCY AGREEMENT

This is an addendum to a Residency Agreement made between Heathwood Assisted Living at Penfield (the "Operator"), _____, (the "Resident" or "You"), _____ the "Resident's Representative"), and/or _____(the "Resident's Legal Representative"). Such Residency Agreement is dated ____/____/____.

This addendum adds new sections and amends, if any, only the sections specified in this addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Agreement. This addendum must be attached to the Residency Agreement between the parties.

I. Special Needs Assisted Living Certification

The Operator is currently certified by the New York State Department of Health to provide Special Needs Assisted Living at Heathwood Assisted Living at Penfield located at 100 Elderwood Court, Penfield, New York 14526.

II. Request for and Acceptance of Admission

You or Your Resident Representative or Legal Representative have requested that You become a Resident at this Special Needs Assisted Living Residence (the "Residence") and the Operator has accepted such request.

III. Specialized Programs, Staff Qualifications and Environmental Modifications

- Specialized services to be provided in the Special Needs Residence; a secure specially designed memory care.
- The memory care unit is staffed with direct care staff at a ratio of 1:8 for days and evenings and 1:15 for the overnight hours.
- All staff working on the memory care unit are provided additional training in dementia care by appropriately trained educators. In addition, care staff are provided at least 12 hours of work related training annually. The facility has a

partnership with the local Alzheimer's Association to provide staff and family programs.

- Memory care offers a secure environment with a delayed egress exit, alarmed secure exit doors with a keypad to enter and exit the area to protect the health, safety and welfare of Residents.

IV. Financial Arrangements

The following supersedes the Financial Arrangements section III. A. 1 and 2 of the admission agreement:

The resident and the resident's representative, if any, agree to pay, and the operator agrees to accept, the following payment in full satisfaction of the basic rate for services, material, equipment, and food as specified in the Admission Agreement and in Section II of this addendum which the operator must provide according to law and regulation: Monthly Room/Board Rate $_____.

V. <u>Addendum Agreement Authorization</u>

We, the undersigned, have read this Addendum Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

____/____/_____
Date (Signature of Resident)

____/____/_____
Date (Signature of Resident's Representative)

____/____/_____
Date (Signature of Resident's Legal Representative)

____/____/_____
Date (Signature of Operator or Operator's Representative)

ADDENDUM B
(If Applicable)

ENHANCED ASSISTED LIVING RESIDENCE
ADDENDUM TO RESIDENCY AGREEMENT

This is an addendum to a Residency Agreement made between Heathwood Assisted Living at Penfield (the "Operator"), _____, (the "Resident" or "You"), _____ the "Resident's Representative"), _____(the "Resident's Legal Representative"). Such Residency Agreement is dated_____.

This addendum adds new sections and amends, if any, only the sections specified in this addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Agreement. This addendum must be attached to the Residency Agreement between the parties.

I. Enhanced Assisted Living Certification

The Operator is currently certified by the New York State Department of Health to provide Enhanced Assisted Living at Heathwood Assisted Living at Penfield located at 100 Elderwood Court, Penfield, New York 14526.

II. Request for and Acceptance of Admission

You or Your Resident Representative or Legal Representative have requested that You become a Resident at this Enhanced Assisted Living Residence (the "Residence") and the Operator has accepted such request.

III. Specialized Programs, Staff Qualifications and Environmental Modifications

- Specialized services to be provided in the Enhanced Residence include assistance with; transfers, unmanaged incontinence, catheter/ostomy care, medical equipment and feeding assistance approved by this licensure.
- Direct care staff are scheduled 24 hours/day, 7 days/week. Additional staff include environmental, wellness, dining, a case manager, RN nurse manager, and Administrator. Staffing is available for review.
- Staff are provided at least 12 hours of work related education and training annually, in addition to dementia training. Direct care staff are certified through New York State and a background check in completed;

- The building is secure with alarmed doors and after-hours entry requires a key pad code to enter or exit the building. A Wanderguard system is in place at the front entrance for those residents at risk for wandering and a pull cord system connected to the facility radio is located in each apartment to protect the health, safety and welfare of Residents.

IV. Financial Arrangements

The following supersedes the Financial Arrangements section III. A. 1 and 2 of the admission agreement:

The resident and the resident's representative, if any, agree to pay, and the operator agrees to accept, the following payment in full satisfaction of the basic rate for services, material, equipment, and food as specified in the Admission Agreement and in Section II of this addendum which the operator must provide according to law and regulation: Monthly Room/Board Rate $_____. An Individualized Service Plan (ISP) has been completed and determined the Enhanced Care Level is:

☐ Level III or ☐ Level IV. Your Level of Care rate is $_____.

The resident agrees to apply for and maintain all applicable income entitlements and public benefits necessary to pay for services provided by the operator.

IV. Addendum Agreement Authorization.

We, the undersigned, have read this Addendum Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

_____

Dated (Signature of Resident)

_____

Dated (Signature of Resident's Representative)

_____

Dated (Signature of Resident's Legal Representative)

_____

Dated (Signature of Operator or Operator's Representative)

ADDENDUM C
(If Applicable)

ASSISTED LIVING PROGRAM RESIDENCE
ADDENDUM TO RESIDENCY AGREEMENT

I. General Provisions

This is an addendum to a Residency Agreement made between Heathwood Assisted Living at Penfield (the "Operator"), _____, (the "Resident" or "You"), _____ the "Resident's Representative"), _____(the "Resident's Legal Representative"). Such Residency Agreement is dated_____.

II. Assisted Living Program Certification

The Operator is currently certified by the New York State Department of Health to provide Assisted Living Program services at Heathwood Assisted Living at Penfield located at 100 Elderwood Court, Penfield, New York 14526.

III. Request for and Acceptance of Admission

You or Your Resident Representative or Legal Representative have requested that You become a Resident at this Assisted Living Program Residence (the "Residence") and the Operator has accepted such request.

This addendum adds new sections and amends, if any, only the sections specified in this addendum. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Agreement.

The parties to this addendum understand that this program is an Assisted Living Program (ALP) providing long term residential care and providing or arranging for home care services to the resident in accordance with New York State Social Services Law and Public Health Law and the regulations of the New York State Department of Health.

IV. Assisted Living Program Services

The ALP operator must be responsible for providing an organized, 24-hour-a-day program of supervision, care and services including:

1) The services listed in the Admission Agreement; and

2) The provision of, or arrangement for, the following home care services:

Personal care services which are reimbursable under Title XIX of the federal Social Security Act; Home health aide services; Personal emergency response services; Nursing services; Physical therapy; Occupational therapy; Speech therapy; Medical supplies and equipment not requiring prior approval; and Adult day health care in a program approved by the Commissioner of Health.

V. Furnishings/Appliances Provided by the Operator. The following listing of an inventory of furnishings, appliances and other items supplied by the Operator in Your room. Each apartment has window blinds, bath/shower, closet, and hinged entry door. Additional furnishings include a bed with mattress, pillow, chair, nightstand table with lockable drawer, dresser, lamp, sheets, pillowcase, blanket, and bedspread are made available if Your personal belongings are not brought to the facility.

VI. Financial Arrangements

The following supersedes the Financial Arrangements section III. A. 1 and 2 of the admission agreement:

The resident and the resident's representative, if any, agree to pay, and the operator agrees to accept, the following payment in full satisfaction of the basic rate for services, material, equipment, and food as specified in the Admission Agreement and in Section II of this addendum which the operator must provide according to law and regulation: Monthly Rate $_____.

The resident agrees to apply for and maintain all applicable income entitlements and public benefits necessary to pay for services provided by the operator.

The resident agrees to responsibility and pay for all personal clothing, health care services including, without limitation, hospital, skilled nursing facility, physicians; rehabilitation therapists, nursing services, private duty personnel, medications and vitamins not covered by individual insurance, eye, ear, and dental examination and services, laboratory testing, x-rays, telephone, cable, beauty/barber services.

VII. Resident Rights and Responsibilities

Attached as Exhibit XVI and made a part of this Agreement is a Statement of Resident Rights and Responsibilities for Assisted Living Program. This Statement will be posted in a readily visible common area within the Residence. The Operator

agrees to treat You in accordance with such Statement of Resident Rights and Responsibilities.

VIII. Specialized Programs, Staff Qualifications and Environmental Modifications

- Specialized services to be provided in the Assisted Living Program Residence include assistance with; dressing, grooming, bathing, medication management and other activities of daily living, approved by this licensure.
- Direct care staff are scheduled 24 hours/day, 7 days/week. Additional staff include environmental, wellness, dining, a case manager, RN nurse manager, and Administrator. Staffing is available for review.
- Staff are provided at least 12 hours of work related education and training annually. Direct care staff are certified through New York State and a background check in completed;
- The building is secure with alarmed doors and after-hours entry requires a key pad code to enter or exit the building. A Wanderguard system is in place at the front entrance for those residents at risk for wandering and a pull cord system connected to the facility radio is located in each apartment to protect the health, safety and welfare of Residents.

IX. Addendum Agreement Authorization.

We, the undersigned, have read this Addendum Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

_____

Dated (Signature of Resident)

_____

Dated (Signature of Resident's Representative)

_____

Dated (Signature of Resident's Legal Representative)

_____

Dated (Signature of Operator or Operator's Representative)

ADDENDUM D

Financial responsibility with 30-day Notice

The undersigned acknowledges that a thirty (30) day written notice to voluntarily or involuntarily terminate the Admission Agreement is required.

The undersigned also acknowledges that he/she is required to pay the Monthly Basic Service Rate for the entire thirty (30) day notice period.

The resident's obligation to pay the Monthly Basic services rate will terminate as of the latter of the thirty (30) day written notice period or the date the apartment/unit/room has been vacated and all the residents' property has been removed from the apartment/unit/room.

_____ ____/____/____
Resident Signature or Authorized Representative/Power of Attorney Date

_____ ____/____/____
Facility Representative Signature Date

ADDENDUM E

Personal Guarantee of Payment
(If Applicable)

_____ personally, guarantees payment of
(Guarantor(s))

charges for _____ basic rate and any
(Resident)

services, materials, or equipment necessary while residing at this facility not covered

by the basic rate.

_____ _____
Guarantor's Signature Date

_____
Guarantor's Name (Print)

ADDENDUM F

Guarantor of Payment of Public Funds

(If Applicable)

If You have a signatory to this Agreement aside from Yourself and that signatory controls all or a portion of your public funds (SSI, Safety Net, Social Security, other), and if that signatory does not choose to have such public funds delivered directly to the Operator, then the signatory hereby agrees that he/she will personally guarantee continuity of payment of the Basic Rate and any agreed upon charges above and beyond the Basic Rate form either your Personal Funds (other than your personal net allowance) or SSI, Safety Net, Social Security or other public benefits, to meet your obligations under this Agreement.

_____ _____

Guarantor's Signature Date

_____

Guarantor's Name (Print)

Availability of Public Funds - All residents should be aware that public funds for the payment of residential, supportive or home health services are available for eligible individuals. Residents should also be aware that the facility does not accept public funds payments as payment in full. Therefore, if the facility rate exceeds the amount of public funds available to the resident and the resident is unable to pay (in full) the balance of the facility's basic daily rate, the facility will assist the resident in securing placement at another facility, pursuant to applicable law and regulation.

ADDENDUM G
ASSISTED LIVING PROGRAM

RELEASE OF RESIDENT MEDICAID INFORMATION TO FACILITY

I, _____, hereby authorize the

_____ County Department of Health

("the Department") to release information about _____'s Medicaid case to:

Heathwood Assisted Living at Penfield
100 Elderwood Court
Penfield, New York 14526

This information may be used by the facility to assist the Resident to obtain Medicaid eligibility and annual Medicaid re-certification. This information may include, but is not restricted to, income and resource information related to my Medical Assistance case. The Department is authorized to release all information except for the following:

_____
(indicate information you do not wish released)

_____

This authorization will continue without expiration unless indicated otherwise here:

_____.
(Authorization Expiration Date)

I retain the right to rescind this authorization at any time with written notice.

_____ _____
Date Resident Signature

_____ _____
Date Responsible Party/Sponsor

Check Appropriate Agency: □ Power of Attorney □ Resident's Agent
□ Legally Designated Representative
□ Next-of-Kin □ Guardian
□ Other _____

ADDENDUM H
ASSISTED LIVING PROGRAM

AUTHORIZATION FOR FACILITY TO
REPRESENT THE RESIDENT IN THE MEDICAID PROCESS

Date _____

I, _____, hereby authorize

_____ to act on behalf of

_____ in the Medicaid application and re-certification process. This authorization includes representation in the appeal of a denial of Medicaid eligibility or benefits should such representation become necessary because the Resident and/or the Responsible Party is unable to make such appeal provided the operator deems such appeal advisable.

The Operator shall be authorized, **but not obligated,** to file on its own initiative a Medicaid application or Medicaid re-certification application on behalf of the Resident if the Resident or his/her representatives are unable to do so. I understand that by signing this Authorization, **the Operator does not undertake any obligation to file any such application or appeal of Medicaid benefits on behalf of the Resident** unless the Operator deems its action is necessary and prudent.

This authorization will continue without expiration unless indicated otherwise here:

_____.
(expiration of authorization date)

I retain the right to rescind this authorization at any time with written notice.

_____ _____
Date Resident Signature

_____ _____
Date Responsible Party or Sponsor

Check Appropriate Agency:
□ Power of Attorney
□ Resident's Agent
□ Legally Designated Representative
□ Next-of-Kin
□ Guardian

ADDENDUM I

Adult Care Facility Statement Offering Personal Allowance Account

Heathwood Assisted Living at Penfield **Operating Certificate: 370-S-852**

For Supplemental Security Income (SSI) and Home Relief (HR Recipients)

I understand that New York State Department of Health (NYS DOH) Regulations provides me, as an SSI or SNA recipient, with a personal allowance which may be used as I wish for clothing, personal hygiene items, and other supplies, services, entertainment, or transportation for my personal use.

I understand that the operator cannot accept my personal allowance to pay for supplies and services that the operator is required to provide by law, regulation, or admission agreement. In addition, my personal allowance may not be used to pay the operator for any services for which payment is available under Medicare, Medicaid, or third-party coverage.

I understand that the operator must offer me or my representative a facility maintained personal allowance account to safeguard my personal allowance funds.

I understand that if I or my representative choose a facility maintained personal allowance account, the NYS DOH Regulations require the operator to: make these funds available to me for my own use; tell me the business hours when I may deposit or withdraw my funds or review my personal allowance records; pay me interest (if my funds are in an interest bearing account); show or give me upon request, or at least every three months, a summary of my account which includes my current balance; tell me of any other important facts about my account.

I understand that I do not have to put my funds in a facility-maintained account.

I understand that I may close my facility-maintained account at any time and have my funds returned to me.

I understand there are legal protections for my funds and account.

I understand that I may ask the NYS DOH or legal/advocacy agencies to help me if I do not receive my personal allowance or have access to money in my personal allowance account.

Check one of the following boxes:

□ I authorize the operator to establish a facility maintained personal allowance account.

□ I do not authorize the operator to establish a facility maintained personal allowance account.

□ As representative for _____, I agree to comply with the personal allowance requirements set forth above. □ **I do** / □ **I do not** authorize the operator to establish a facility maintained personal allowance account.

□ I am not an SSI or SNA recipient. However, the operator has offered to maintain a personal fund account for me. I hereby authorize such an account.

_____ _____/_____/_____
Signature of Resident Date

_____ _____/_____/_____
Signature of Legally Designated Representative/Responsible Party Date

_____ _____/_____/_____
Signature of Operator or Designee Date

DOH-5195 (former DSS-2853) (Rev. 7/85, 6/14, 10/15, 12/15)

ADDENDUM J

CONSUMER INFORMATION GUIDE:

ASSISTED LIVING RESIDENCE

ADDENDUM K

CHANGE IN LEVEL OF CARE

This is an addendum to a Residency Agreement made between Heathwood Assisted Living at Penfield (the "Operator"), _____, (the "Resident" or "You"), _____ the "Resident's Representative"), and/or _____(the "Resident's Legal Representative"). Such Residency Agreement is dated ____/____/____.

This addendum updates sections of the initial Agreement as dated above. Only the sections specified in this addendum are affected. All other provisions of the Residency Agreement shall remain in effect, unless otherwise amended in accordance with this Agreement. This addendum must be attached to the Residency Agreement between the parties.

I. Financial Arrangements

The following supersedes *Fees Section III. A. 1 and 2* of the admission agreement: The resident and the resident's representative, if any, agree to pay, and the operator agrees to accept, the following payment in full satisfaction of the basic rate for services, material, equipment, and food as specified in the Admission Agreement and in Section II of this addendum which the operator must provide according to law and regulation: Monthly Room/Board Rate $_____. An Individualized Service Plan (ISP) has been completed and determined the Assisted Living Residence Care Level is:

☐ Level I / ☐ Level II or ☐ Level II Plus and Your Level of Care rate is $_____.

The resident agrees to apply for and maintain all applicable income entitlements and public benefits necessary to pay for services provided by the operator.

II. Addendum Agreement Authorization

We, the undersigned, have read this Addendum Agreement, have received a duplicate copy thereof, and agree to abide by the terms and conditions therein.

_____

Dated (Signature of Resident)

_____

Dated (Signature of Resident's Representative)

_____

Dated (Signature of Resident's Legal Representative)

_____

Dated (Signature of Operator or Operator's Representative)

ADDENDUM L
(if Applicable)

RESPITE STAY
ADDENDUM TO RESIDENCY AGREEMENT

_____ ("You" or "Resident") have requested to stay in Heathwood Assisted Living at Penfield ("Community") until _____ {date} (the "Respite Stay"). This Respite Stay is limited to up to one-hundred twenty days (120) in any twelve- month period. In connection with the Respite Stay, you and the Community have entered into the Community's Adult Care Facility Residency Agreement, a copy of which is attached to this addendum. The Community holds the Enriched Housing Program, Assisted Living Residence, Special Needs Assisted Living Residence and Enhanced Assisted Living Residence licenses and certifications:
The purpose of this Addendum is to amend certain provisions of the Residency Agreement to reflect your Respite Stay.

1. During your Respite Stay, the rate you will be charged for each day of the Respite Stay will be $ _____ ("Daily Rate"), inclusive of all services that the Community may provide you.

2. During your Respite Stay, you may terminate your Respite Stay, this Addendum, and the Residency Agreement early by delivering to the Community notice of termination at least three days prior to the date you intend to vacate your Apartment/Room. If you paid for the Respite Stay in advance and you elect under this Section to shorten the Respite Stay, the Community will refund to you an amount equal to the amount you prepaid minus the product of the number of days you actually stayed multiplied by your Daily Rate.

3. The Community may also terminate your Respite Stay upon three days' written notice on the grounds set forth in the Termination procedure provided in the Residency Agreement.

4. After your Respite Stay expires, this Addendum shall expire and be of no further force and effect. If you have not terminated this addendum, pursuant to Paragraph 3, you will continue to be bound by the terms of the Residency Agreement, including any payments that need to be made by the terms of that Agreement and which have not been made during the term of your Respite Stay.

5. Within 30 days prior to admission, you must provide a dated signed medical examination report which conforms to Department Regulations (DOH-3122 or an approved substitute). Thereafter, you must have a physical examination at least once every six (6) months (or more frequently if a change in condition warrants) and additional examinations considered necessary by your physician.

6. During the Term of your Respite Stay, the provision of this Addendum supersedes any provisions of the Residency Agreement that are inconsistent with this Addendum. All other terms in your Agreement remain in full force and effect.

7. All Residents admitted under this Temporary Residential Care Addendum to the Residency Agreement shall receive the same emergency evacuation training as all other Residents.

8. Only Residents appropriate for the level of care for which the Community is licensed by the Department of Health to provide will be admitted to the Temporary Residential Care Program.

9. In the event that you wish to become a permanent resident at the Community upon expiration of your Respite Stay, you must notify the Community at least one week prior to the expiration of your Respite Stay, and you will continue to be bound by the terms of the Residency Agreement, including any payments that need to be made by the terms of that Agreement and which have not been made during the term of your Respite Stay.

Having read this Addendum, the undersigned acknowledge that they understand the rights and obligations created by this Addendum and the Original Agreement, and by signing below agree to all the terms and conditions contained therein. The Responsible Person(s) signs this Addendum to undertake to guarantee the obligations of Resident, including the payment of all fees that the Resident may owe the Community under this Addendum and the Original Agreement.

_____	_____
Signature of Community Representative / Title	Date
_____	_____
Signature of Resident	Date
_____	_____
Signature of Responsible Person	Date

Addendum M
Fall Risk Information and Acknowledgement

Resident: _____ **Date:** _____

Individuals who reside in our facility are often elderly, frail, and unable to independently care for themselves. Many of our residents also suffer from confusion and are unable to make safe decisions. All of these conditions increase the likelihood of falls.

Falls are unavoidable in any facility that provides services to the elderly. We feel it is important for our residents and their representatives to understand that we make efforts to reduce falls. Even with safety precautions, nearly half of individuals in a long-term care setting, fall yearly. The majority of those with one incidence of a fall in the previous year will fall again despite safety measures.

We welcome input and involvement of the family and loved ones in the common goal of protecting the resident from the injuries that can result from falls.

Some of the specific reasons that falls occur in the elderly include:

- Physical disability resulting from a medical condition
- Confusion and inability to communicate needs
- Slower reflexes
- Unstable gait, deceased balance, or mobility deficit (e.g., poor sitting balance)
- Sensory deficits (vision, somatosensory [touch], or vestibular [balance relating to inner ear] changes)
- Failing eyesight and hearing
- Cognitive impairment
- General weakness
- Joint pain
- Incontinence
- Some medications
- Depression

In order to assist us to provide a safe environment, please help us by following the plan of care designed for you. For instance, if you require a walker or cane, please use this every time you stand up, keep it close to where you are. Utilize the pull cords if you need assistance in your room or bathroom.
Safety and fall prevention requires cooperation of all involved including the resident, your family, and the facility.

One of the most important considerations is having the resident's representative(s) remain active in the care of their loved one. Participating in resident care conferences, making suggestions to staff, and pointing out any situation that is of concern can accomplish this. Staff members are always available to listen to suggestions, complaints, concerns, and even compliments!

Additionally, although nursing staff (licensed nurses and home health aides/personal care asides) work in the facility seven days a week, 24 hours a day, ***nursing services are not one-on-one*** in this level if care.

Thank you for taking the time to understand the unique fall risks you or your loved one will experience due to his/her physical and/or mental condition. Signing below is simply an acknowledgement that you have read the above information and understand that the facility is not able to prevent all falls.

Resident or Residents' Representative(s)

_____ _____ _____

Resident or Representative Printed Name | Resident or Representative Signature | Date

_____ _____ _____

Resident Representative Printed Name | Resident Representative Signature | Date

Facility's Representative

_____

Facility Representative Printed Name

_____ _____

Facility Representative Signature | Date