BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson Residential Home

CONSENT UPON ADMISSIONTOTHOMPSON RESIDENTIAL HOME

I, _____, hereby consent to care at Thompson Residential Home encompassing nursing, routine diagnostic procedures, and routine medical treatment or rehabilitation ordered by my attending physician _____, his/her designee or, when necessary, by Carolyn Taylor-Olson, MD, Medical Director. Such care is to be provided by the nursing staff, consultants, or our rehabilitation team.

PHARMACY AGREEMENT

Thompson Residential Home has a contract with **Health Direct Pharmacy Services** to provide physician prescribed medications and supplies, medication administration sheets and a monthly visit by the consulting pharmacist.

You have the right to use your existing pharmacy whether local or mail away, but you must accept responsibility for ordering and obtaining your medications as well as notifying the nursing staff of any change in your medication regime.

The undersigned agrees to allow the current contracted pharmacy to review their medication lists to ensure all prescribed medications are being handled and administered within the requirements required in Thompson Residential Home.

DESIGNATION OF FINANCIAL REPRESENTATIVE

I,_____ wish to handle my own finances. I also authorize the following person to whom my bills should be sent and who will act for me, if needed in financial matters:

_____
Name of Individual/Relationship

DESIGNATION OF FAMILY REPRESENTATIVE

I_____designate_____
Resident Name of Individual/Relationship

to be my family representative. I give this person my authorization to participate in Resident Care Plan meetings, receive information concerning my total plan of care, and be the family representative to be called by staff concerning issues involving my care.

ADMISSION, Page Two.

This form has been fully explained to me and I acknowledge that I understand its contents.

_____ _____

Date Resident Signature

_____

Witness

Resident is unable to consent because:

_____

_____

_____ _____

Date Closest Relative or Guardian

_____

Witness

Note: Responsible party signs only when a resident is adjudicated incompetent by the State and there is proof of this or physician documents the resident is incapable of understanding his/her rights and responsibilities.

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

BED HOLD POLICY NOTIFICATION

RESIDENT _____

DATE _____

If you need to be discharged to the hospital for any reason your room will be held for you (provided you are up to date on your rent) until Thompson Residential Home receives written notice from you or your authorized representative of your intention not to return.

If you need to be discharged to Thompson House or any other short term rehabilitation facility due to change in medical status, unless we have received notice that you will not return, we expect that your rent will be kept up to date.

I have read and understand this policy.

_____

Resident/Representative

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

SERVICES/FEES

SERVICES INCLUDED IN THE DAILY RATE ARE:

- Room and Board
- Nursing Overview
- Activity Program
- Social Services
- Laundered Linen and Bedding
- Personal services required for the health, safety, good grooming, and well-being of the resident (See separate agreement)
- Housekeeping Services
- Maintenance Services
- Therapeutic diets under the direction of a Registered Dietitian
- Mail delivery Monday through Friday (except Holidays)
- Mail forwarding following discharge
- Personal funds management when requested in writing
- Transportation to meet medical needs of resident (See separate agreement)

ADDITIONAL SERVICES AVAILABLE BUT NOT INCLUDED IN THE DAILY RATE

- Daily newspaper - Brattleboro Reformer rates
- Beauty/Barber Salon - Rates are posted in the Salon
- Private telephone - Verizon Service fees
- Physical, Occupational and Speech Therapy
  - Initial evaluation $125, Additional treatment units at $25 per unit (15 minutes)
  - If Medicare reimbursement is appropriate charges will be billed to Medicare
- Dental Services - Rates will vary according to needs
- Laboratory Services - Brattleboro Memorial Hospital - BMH rates
- X-ray Services - Brattleboro Memorial Hospital - BMH rates

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

ADVANCE DIRECTIVES - PATIENT SELF-DETERMINATION ACT

INTRODUCTION

The State of Vermont and the Brattleboro Mutual Aid Association, Inc. (BMAA) recognize that a person, as a matter of right, may rationally make an election as to the extent of medical treatment s/he will receive in the event that his/her physical state reaches such a point of deterioration that s/he is in a terminal state and there is no reasonable expectation that life can be continued with dignity and without pain. A person has a fundamental right to determine whether or not life sustaining procedures which would cause prolongation of life beyond natural limits, should be used or withdrawn. To that extent the person may choose to execute an advance directive - any expression of a person's preferences for medical treatment in the event of future decisional incapacity. In Vermont two written forms are recognized by statutes - Terminal Care Document (often referred to as the Living Will) and Durable Power of Attorney for Health Care.

Thompson Residential Home is an integral part of the Brattleboro Mutual Aid Association, Inc. It is the philosophy of BMAA to enhance the dignity of all individuals who reside in our community through a respect for the right of choice and self-determination as it pertains to the quality of life and health care treatment choices. We recognize the right of our residents to fully participate in planning care and treatment and this authority prevails over that of the family and is in accordance with the Federal Patient Self Determination Act of 1990. We respect the right of individuals to make health care decisions in advance through documents which reflect preferences regarding medical treatment, as well as the right to designate an individual to carry out intentions and to respect values and wishes regarding medical care. This includes the right to accept or refuse medical or surgical treatment and the right to complete an "advance directive", a written document made in advance of serious illness that states either a choice for health care or the designation of another person to make these decisions in the event of personal incapacity. In recognizing the right to self-determination, the BMAA does not discriminate against any individual regarding choices contained within an "advance directive" and does not have a religious or moral ideology which limits freedom of choice regarding health care. This includes the right of an individual to choose not to have an "advance directive".

PURPOSE

To ensure resident participation and involvement in decisions regarding life-sustaining treatment by ensuring that advance directives for health care are being offered as options to residents, if desired, and those residents who have not prepared such documents will be made aware of their legal right to choose to do so. This policy recognizes that some residents will elect not to complete an advance directive and will respect the resident's choice and wishes. It is the policy of BMAA to support all provisions of the Patient Self-Determination Act of 1990, as contained within the Omnibus Budget Reconciliation Act of 1987.

PROCEDURE

Upon admission residents will be informed of their rights, especially their right to refuse treatment, to privacy, to informed consent and to information about advance directives. Every resident will be given a copy of the Resident's Bill of Rights and a booklet on Advance Directives. Residents will sign a statement on admission stating that he/she has received a copy and explanation of both the Resident's Bill of Rights and advance directives.

Advance directives include the Terminal Care Document (often referred to as the Living Will), designed, when duly executed, to contain the express direction that no extraordinary measures be taken when the person executing the document is in a terminal state, without hope of recovery from such state and is unable to actively participate in the decision making process and the Durable Power of Attorney for Health Care, designed to enable persons to retain control over their own medical care during periods of incapacity through the prior designation of an individual to make health care decisions on their behalf. Residents will be asked if they have completed one or both of these documents

If the resident has one or both completed s/he will be asked to review and verify the directive(s) and provide a copy of either or both which will be placed in the resident's clinical chart and personal file. Residents who have not completed one or either will be provided with information and explanations as desired. Admission will not be based on the completion of either of these documents and no resident will be coerced to execute an advance directive.

A copy of the advance directive will accompany the resident should he/she require hospitalization or transfer to another facility.

As a demonstration of commitment to staff education efforts, as required by PSDA, the policy and procedure on Advance Directives will be given to present staff members, retained in the Policy and Procedure Manual and will be incorporated into the orientation for new employees

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

THE PEOPLE WHO SERVE YOU

While you are a resident of Thompson House, there will be many different staff members who will serve you in a number of different capacities. The listing furnished below will provide you with the names and telephone extensions of some of the staff who are here to serve you. You must first dial 254-4977 and ask the operator to connect you to the extension listed.

ADMINISTRATOR	Dane Rank	Extension 201
DIRECTOR OF NURSING SERVICES	Mark Malloy, RN	Extension 202
SOCIAL SERVICES	Michael Hudson	Extension 243
REHABILITATION	Lesley Clogston	Extension 244
ACTIVITIES	Shannon Bratcher, Director Danielle Covey, Assistant	Extension 242
BUSINESS OFFICE MANAGER	Kathleen Saunders	Extension 206
BOOKKEEPING	Susan Dematteis	Extension 205
MDS COORDINATOR	Chelsea Ogden	Extension 123
UNIT COORDINATOR	Stacy Malmberg Mary Jones	Extension 203
DINING/NUTRITIONAL SERVICES	Dana Ross	Extension 209
MAINTENANCE SERVICES	Todd Frost Jerome Spooner	Extension 245
HOUSEKEEPING	Heidi Lebron	Extension 121
STAFF DEVELOPMENT COORDINATOR	Sandy Merkle	Extension 122

Please feel free to contact any of the above with concerns you are unable to resolve.

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson Residential Home

*******ADMISSION AGREEMENT*******

This is an agreement between _____ and Thompson Residential Home. The purpose of this agreement is to explain what services Thompson Residential Home provides, how they are paid for, and what the rights and responsibilities of each resident are.

I. SERVICES

Thompson Residential Home is licensed by the State of Vermont as a residential care home and as such may provide room, board, limited personal care, general supervision and medication management, but not full time nursing care. How much each of these services Thompson Residential Home provides is outlined below.

The State of Vermont regulates most of the services provided in a residential care home. The regulations contain much more detail about how care must be provided and you may ask the Administrator to see a copy of those regulations if you wish.

a. **Room** - Under this agreement, you will be provided with a private room. You may bring personal possessions with you to the home as space permits, unless the possessions create a fire or safety hazard. If you need to move to another room during your stay here, this agreement may have to be revised if the charge for that room is different. If Thompson Residential Home requests you move to another room, you will be given ample notice prior to the move.

We will hold your room for you according to the Bed Hold Policy in this packet.

We will do your personal laundry unless you prefer to make other arrangements. We will provide you with clean bed and bath linens and toiletry items including toilet tissue and facial tissue.

b. **Board** - You will be provided with three nutritionally balanced meals daily, in accordance with state regulations and dietary standards, and with consideration of your dietary needs. Some meals have menu choices available and you will have the option to select the meal you wish for those meals.

We offer morning, afternoon and evening snacks in Thompson Residential Home.

While most residents are on a Liberal Geriatric Diet, we offer a limited number of therapeutic diets if ordered by your physician.

c. **Personal Care** - At Thompson Residential Home the emphasis is on independence. We are committed to helping you maintain your independence in all aspects of your care.

d. **Transportation** - State regulations provide that you are entitled to up to four trips per month of up to twenty miles round trip, at no cost to you, for any activity, including medical appointments. After twenty miles for any trip, or after four trips per month, we will charge you $.45 per mile and $10.00 per trip.

e. **Nursing Care** - State regulations prohibit us from providing full time nursing care, except in limited situations. We offer the following types of services directly.

1. Availability of a nurse. We have a licensed nurse available 24 hours a day, to review assessments of each resident, administer medications and coordinate care with physicians. We will call on our nurse as necessary, if your condition warrants it, including if you become ill, need a change in your doctor's orders, or if your ability to care for yourself appears to be deteriorating.

2. If you become terminally ill and require more care, Hospice Care is permitted and available as per guidelines. There are, however, circumstances under which we may need to discharge you to a more appropriate level of care.

f. **Medication Management** - State regulations require that we determine if you are capable of self-administering your medications.

We offer both assistance with and administration of medications. As long as you are able to direct the administration of your medications in accordance with state regulations, we will provide you with necessary assistance such as reminding you of medication times or helping you take a medication. You must be willing and able to store all medications in a locked contained as per our policy. If you are not able, or when you are no longer able, to direct your administration of medications, we will administer them for you. We will do this by having our nurse administer them at no additional cost to you.

You are permitted to keep alcohol in your room but, like medications, they can be a danger to others so must also be kept in a locked container.

II. CHARGES AND FINANCES

You are being admitted to room _____. The charge for the Basic Level I service is _____. If you are assessed at Level II or Level III an additional fee will be added per day. You have been assessed at Level ___ and your Daily rate will be _____ due in advance. Assessments are done on admission and annually or as needed in the event of a significant change in status. Changes in the room rate will not:

a. Necessitate a change in this agreement. Thirty days written notice shall be given for a change in the daily room rate. However this may be waived on mutual agreement of TRH and resident/ representative.

b. Non-payment of charges will be cause for discharge in accordance with state regulations. For non-payment we may discharge you (an involuntary discharge) after thirty (30) days' notice, involuntary discharges have very specific guidelines which must be followed and you will receive a copy on request.

c. Payment for all Thompson Residential Home rooms is private pay or Long Term Care Insurance if applicable.

d. If you are required to leave this home, either because we discharge you involuntarily or because of a change in your condition which makes it impossible to remain here, we will provide you with a refund for payment made for days room was not occupied by you or your belongings. Such refund will be provided within thirty (30) days of discharge.

If the discharge is to a hospital or other placement, the effective date for this provision shall be the day we are notified you will not be returning.

If your intent is to move to another location we expect a thirty (30) day notice and it is expected that you will remove all personal possessions immediately. If personal possessions are not removed and prevent us from renting the room to someone else, the effective date of a refund shall be the date the possessions are removed.

III. RIGHTS AND RESPONSIBILITIES

a. Each resident retains all their civil rights while residing here. Furthermore, state regulations list specific rights of all residents of residential care homes, such as Thompson Residential Care Home. That list is attached to this agreement, and other copies are available on request. We will explain these rights before or at the time of admission.

b. If you are not satisfied with services or conditions in the home, we want you to tell us about it so we can try to resolve the concern. Our grievance procedure is attached.

c. As part of this agreement, we expect you to adhere to the reasonable guidelines established by us for the orderly management of a home. These guidelines are attached.

THOMPSON RESIDENTIAL HOME, Admission Agreement, Page Four.

IV. The undersigned agrees to abide by the terms of this agreement and in accordance with the regulations for residential care homes set forth by the State of Vermont.

You may terminate this agreement voluntarily with thirty (30) days written notice. If you discharge yourself voluntarily without providing thirty (30) days written notice to us, we are not obligated to provide you with any refund.

Signed _____ Date _____
Resident or Authorized Legal Representative

Signed _____ Date _____
Thompson Residential Home Designee

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

INVOLUNTARY DISCHARGE OR TRANSFER OF RESIDENTS

An involuntary discharge of a resident is the removal of the resident from a residential care home when the resident or the resident's legal representative has not requested or consented in advance to the removal. A transfer is the removal of the resident from the room the resident currently occupies to another room in the home or to another facility with an anticipated return to the home. An involuntary discharge or transfer may occur only when:

1. The resident's care needs exceed those which the home is licensed or approved through a variance to provide; or
2. The home is unable to meet the resident's assessed needs; or
3. The resident presents a threat to the resident's self or the welfare of other residents or staff; or
4. The discharge or transfer is ordered by a court; or
5. The resident has failed to pay monthly charges for room, board and care in accordance with the admission agreement.

In the case of an involuntary discharge or transfer, the Administrator shall:

1. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project.
2. Use the form prescribed by the licensing agency for giving written notice or discharge or transfer and includes a statement in large print that the resident has the right to appeal.
3. Include a statement in the written notice that the resident may remain in the room or home during the appeal.
4. Place a copy of the notice in the resident's clinical record.

A resident has the right to appeal the decision by the home to discharge or transfer. The process for appeal is as follows:

1. To appeal the decision to transfer or discharge, the resident must notify the administrator of the home or the director of the licensing agency. Upon receipt of an appeal, the administrator must immediately notify the director of the licensing agency.

Involuntary Discharge or Transfer of Residents, Page Two.

2. The request to appeal the decision may be oral or written and must be made within 10 business days of the receipt of the notice by the resident.
3. Both the home and resident shall provide all the materials deemed relevant to the decision to transfer or discharge to the director of the licensing agency as soon as the notice of appeal is filed. The resident may submit orally if unable to submit in writing. Copies of all materials submitted to the licensing agency will be available to the resident upon request.
4. The director of the licensing agency will render a decision within eight business days of receipt of the notice of appeal.
5. The notice of decision from the director will be sent to the resident and to the home, will state that the decision may be appealed to the Human Services Board, and will include information on how to do so.
6. The resident or the home will have 10 business days to file a request for an appeal with the Human Services Board by writing to the Board. The Human Services Board will conduct a *de novo*[from the beginning; anew] evidentiary hearing in accordance with 3 V.S.A. 3091.

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

ROOM RATES as of August 1, 2014
Thompson Residential Home
Level III

Residential Care Home with Nursing Overview, Basic Rate

Room Numbers
200, 203,
212,213. 214
215, 216, 221, 223

$113.00 daily

Room Numbers
201, 202, 217, 218
219, 220, 222, 224

$115.00 daily
All 17 rooms are private rooms

Level of Service *	Basic	Intermediate	High
Room Numbers: 200, 203, 212, 213, 214, 215, 216, 221, 223	113	126	146
Room Numbers: 201, 202, 217, 218, 219, 220, 222, 224	115	128	148

* Level of Service is defined as the level of the Functional Assessment.

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

THE SALON
Peggy Howard, Stylist

Price List

Bangs	$5.00
Beard & Mustache	$5.00
Shampoo	$10.00
Cut	$18.00
Cut/Iron	$22.00
Shampoo/Blow Dry	$18.00
Shampoo/Blow Dry/Iron	$20.00
Set	$20.00
Shampoo/Cut	$22.00
Shampoo/Set	$22.00
Shampoo/Cut/Set	$30.00
Shampoo/Cut/Blow Dry	$28.00
Shampoo/Color/Blow Dry	$42.00
Shampoo/Color/Set	$42.00
Shampoo/Color/Cut/Blow/Iron	$52.00
Shampoo/Color/Cut/Set	$54.00
Permanent	$62.00

Payment for services is charged to the individual resident's account. Tipping for services is not permitted. Prices effective January 1, 2017.

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

SELF-ADMINISTRATION OF MEDICATIONS

_____ I wish to administer my own medications during my stay at Thompson Residential Home. I understand that it is my right to self-administer my medications subject to the professional staff's ongoing assessment of my ability to take my medications safely and accurately.

If I choose to exercise this right, the interdisciplinary team at Thompson Residential Home will assess my cognitive, physical and visual ability to carry out this responsibility. If the interdisciplinary team determines that I am able to self-administer my medications, I agree to abide by all established policies and procedures regarding this practice. I must be willing and able to keep all my medications in a locked contained for the safety of others. I further understand that I may be asked and must relinquish this right for my own benefit and protection if the interdisciplinary team decides I am no longer able to self-administer my medications safely.

_____ I choose not to administer my own medications and defer that responsibility to the Thompson Residential Home licensed staff.

_____

Resident's Signature

_____

Date

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.

Thompson Residential Home

RESIDENT RIGHTS

Every Thompson Residential Home resident shall be treated with consideration, respect, and full recognition of his or her dignity, individuality, and privacy. A community such as Thompson Residential Home may not ask a resident to waive his or her rights.

Each community shall establish and adhere to a written policy consistent with these regulations, regarding the rights and responsibilities of residents and which shall be explained to residents at the time of admission.

Residents may retain personal clothing and possessions as space permits, unless to do so would infringe on the rights of others or would create a fire or safety hazard.

A resident shall not be required to perform work for the community. If a resident chooses to perform specific tasks for the community the resident shall receive reasonable compensation which shall be specified in a written agreement with the resident.

Each resident shall be allowed to associate, communicate and meet privately with persons of his or her own choice. Thompson Residential Home has visiting hours from 8 a.m. to 8 p.m. Visiting hours are posted in the entry way of the Brattleboro Mutual Aid Association building.

Each resident may send and receive personal mail unopened.

Residents have the right to reasonable access to a telephone for private conversations. Residents shall have reasonable access to the community telephone except when restricted because of misuse. Restrictions as to telephone use shall be in writing. Any resident may, at his/her own expense, maintain a personal telephone in his/her own room.

A resident may complain or voice a grievance without interference, coercion or reprisal. Each community shall establish a grievance procedure which is explained to residents at the time of admission. The grievance procedure shall include at least time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the Office of the Long Term Care Ombudsman and the Vermont Protection and Advocacy system as an alternative or in addition to the community grievance mechanism.

A resident may manage his/her own personal finances. The community may manage a resident's finances only when requested in writing by the resident and then in accordance with the resident's wishes. The community shall keep a record of all transactions and make it available, upon request, to the resident, and shall provide the resident with an accounting of all transactions monthly.

Thompson Residential Home, RESIDENT RIGHTS, Page Two.

Resident funds will be kept separate from other accounts or funds of the community.

The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from, or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law including Title VII of the Older Americans' Act. The resident has the right

To review his or her medical or financial records.

Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints.

When a resident is adjudicated mentally disabled, such powers as have been delegated by the Probate Court to the resident's guardian shall devolve to the guardian pursuant to 14 VSA, Chapter 111.

Residents subject to discharge from the community, under Section 4.15.c of these regulations shall:

(1) be allowed to participate in the decision-making process of the agency concerning the selection of an alternative placement;
(2) receive adequate notice of a pending transfer; and
(3) be allowed to contest their transfer by filing a request for a fair hearing before the Human Services Board in accordance with the procedures in 3 VSA, Section 3091.

Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the community. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a 30 day notice of discharge in accordance with section 5.3.a of these regulations.

Residents have the right to formulate advance directives as provided by state law and to have the home follow the resident's wishes.

The enumeration of resident rights shall not be construed to limit, modify, abridge, or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, in easily readable print, be given to residents on admission, and posted conspicuously in public places in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Advocacy Network.

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

******* FIRE INSTRUCTIONS *******

1. Upon admission, find two exits nearest your room. Count doors between your room and the exits, so you can find your way out in case of smoke.

2. When you hear a fire alarm, ACT, don't investigate.

3. NEVER use elevator during a fire.

4. IF FIRE IS IN YOUR ROOM - follow these instructions.

    A. Exit room and close door.
    B. Pull fire alarm.
    C. Exit building through fire exits.

5. IF FIRE IS NOT IN YOUR ROOM - follow these instructions.

    A. If door is closed, check to see if it is cool. If door is cool, open slowly and proceed to the nearest exit.
    B. Crawl in smoke - fresh air will be near the floor.
    C. Take your room key so that you may return if the exits can be used.

6. IF YOUR ROOM DOOR IS HOT - DON'T OPEN IT. YOUR ROOM MAY BE THE SAFEST PLACE TO BE.

    A. Seal all cracks with wet towels.
    B. Shut off any fans.
    C. Signal for help at your window.

IN ALL INSTANCES, STAY CALM. HELP IS ON THE WAY.

The Brattleboro Mutual Aid Association, Inc. has made extensive renovations to the building to ensure that the utmost fire safety precautions have been met. In addition, the staff conducts quite regularly and often "fire drills" to remind residents and staff of the procedures to follow in the event of a fire.

STATE OF VERMONT ADVOCACY GROUPS

Area Long Term Care Ombudsman
Katrina Boemig
Vermont Legal Aid – Long-term Care Ombudsman Project
56 Main Street, Suite 301
Springfield, VT 05156
Telephone: 800-889-2047
Email: kboemig@vtlegalaid.org

Adult Protective Services
Division of Licensing and Protection
Department of Aging and Independent Living
103 South Main Street, Ladd Hall
Waterbury, Vermont 05676
Telephone: 800-564-1612

Vermont Division of Licensing and Protection
Department of Disabilities, Aging and Independent Living
HC 2 South
280 State Drive
Waterbury, Vermont 05671-2060
Email (preferred method): ahs.dailscintake@vermont.gov
Telephone: 1-888-700-5330
FAX: 1-802-241-0383

VT Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
Phone: (802) 241-0090
FAX: (802) 241-0100

VT Department of Disabilities. Aging & Independent Living (DAIL)
103 South Main Street, Weeks Building
Waterbury, Vermont 05676
Senior Help Line: 800-642-5119

DAIL – Adult Services Division (Choices for Care/VT Long Term Medicaid)
Economic Services 802-769-2525
Clinical Services 802-251-2118

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

CPR CONSENT/DECISION

_____
RESIDENT NAME

_____
PHYSICIAN

I, the above named resident, have discussed the risks and benefits of CPR with my attending physician and have been provided with the information to make the following decision.

_____ I have made the informed choice NOT TO HAVE CPR administered.

_____ I have made the informed to HAVE CPR initiated by Thompson House/Thompson Residential Home staff and to be transported by qualified personnel to Brattleboro Memorial Hospital.

****

_____ is unable to make the above decision because _____
I have been appointed by him/her to be the DPOA-HC and have furnished Thompson House/Thompson Residential Home with the appropriate documentation to support this. I have discussed the risks and benefits of CPR with his/her attending physician and have been provided with the information to make the above decision.

_____ _____
Guardian/DPOA-HC Date

_____
Resident's Signature Date

_____
Representative of Thompson House/Thompson Residential Home Date

_____
Physician Signature Date

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

AUTHORIZATIONS

I hereby authorize Thompson Residential Home to:

- Take a photograph of me necessary for identification: YES _____ NO ____
- Put my name on the door to my room: YES ____ NO ____
- Do my personal laundry: YES ____ NO ____

I understand it is my responsibility to have all my personal belongs marked with my name if ThompsonHouse is to do my laundry. Otherwise I will provide a laundry basket or bag to hold my dirty laundryfor pickup.

I further understand that Thompson Residential Home is not responsible for lost items. I have beeninformed not to have money or valuables in my room.

We offer, as a courtesy, a safe in the Business Office to keep your valuables and any cash inexcess of $5.oo. Please contact Gail Brown at ext. 205 for use of the safe. Please allow us to keepyour valuables safe or have your family take them home. If you choose you may also purchase a lockbox for your room.

You will be given a key to your room upon request.

_____

Signature of Resident/Responsible Party Date

_____

Thompson Residential Home Representative Date

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

RELEASE FROM LIABILITY

I, _____ currently a resident of Thompson Residential Home, 80 Maple Street, Brattleboro, Vermont, request that I be permitted to have fresh eggs prepared to my wishes and specifications.

I recognize the concern of Thompson Residential Home to provide the safest and best possible meals, including its decision, as a way to protect myself from potential risk of food poisoning, to serve only pasteurized eggs.

While I do recognize these risks, I have made my decision and hereby release Thompson Residential Home from all responsibility and liability that may occur from my eating fresh eggs prepared for me.

Signed: _____

Date: _____

Witness: _____

BRATTLEBORO MUTUAL AID ASSOCIATION, INC.
Thompson House

STATEMENT OF ACKNOWLEDGMENT

I, _____, acknowledge that the staff person listed below has reviewed the following information with me on this date:

Resident Rights
Resident Responsibilities
Guidelines governing Resident Conduct
Services Available/Related Fees
Charges for Services not covered
under the basic per diem rate of Thompson Residential Home
Advance Directives

I further acknowledge that I have been encouraged to ask questions, that I fully understand the above information, and have been given a copy for my future reference.

_____	_____
Date	Signature of Resident/Responsible Party
_____	_____
Date	Signature Thompson Residential Home Representative

In the even that documented proof exists that a resident has been adjudicated incompetent by the State of Vermont or his/her physician has documented that the resident is incapable of understanding his/her rights and responsibilities, this document may be signed on behalf of the resident by his/her responsible party.

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I understand that as part of my health care, the nursing community and the physician(s) who care for me originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, to arrange for the billing and payment of my care, and to carry out routine health care operations, such as assessing quality.

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the nursing community reserves the right to change its notice and practices, and that prior to implementation of those changes will mail a copy of the revised notice to me. I have been informed that if I refuse to sign this consent for the use and disclosure of my health information, the nursing community may refuse to admit me or treat me in any manner.

I understand that I have the right to:

* Object to the use of my health information for directory purposes.
* Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that the nursing community is not required to agree to the restrictions requested. If the nursing community agrees to any restrictions, then it is bound by those restrictions.
* Revoke this consent in writing, except to the extent that the nursing community has already taken action in reliance thereon. I understand that if I revoke my consent, then the nursing community will no longer be able to treat me, and that I will need to be discharged from the nursing community.

I consent to the use and disclosure by the nursing community and its agents or representatives, and the physicians who care for me, of all my health information for treatment, payment and health care operations (as more fully articulated in the Notice of Information Practices).

I have read and understood this consent form. I have had the opportunity to ask questions, and have had all of my questions answered to my full satisfaction.

_____ _____

Signature Date

_____

Print Name

NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOU HEALTH RECORD/INFORMATION

Each time you visit a nursing community, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the many health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- A tool in educating health professionals;
- A source of information for public health officials who oversee the delivery of health care in the United States;
- A source of data for facility planning and marketing;
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

OUR RESPONSIBILITIES

Our nursing community is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practice change, we will mail you a revised notice.

NOTICE OF INFORMATION PRACTICES, Page Two.

We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE WILL USE OR DISCLOSE YOUR HEALTH INFORMATION

1. TREATMENT. We will use your health information for treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from our nursing community.
2. PAYMENT. We will use your health information for payment. For example, a bill may be sent to you or a third-party payer, including Medicare or Medicaid. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis,procedures, and supplies used.
3. HEALTH CARE OPERATIONS. We will use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care services we provide.
4. BUSINESS ASSOCIATES. There are some services provided in our organization through contracts with business associates. Examples include our accountants, consultants, and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.
5. DIRECTORY. Unless you notify us that you object, we may use your name, location in the nursing community, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy, and except for religious affiliation, to other people who ask for you by name. We may also use your name on a name plate next to or on your door in order to identify your room, unless you notify us that you object.
6. NOTIFICATION. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition. If we are unable to reach your family member or personal

representative, then we may leave a message for them at the phone number that they have provided us, e.g., on an answering machine.

NOTICE OF INFORMATION PRACTICES, Page Three

7. COMMUNICATION WITH FAMILY. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
8. FUNERAL DIRECTORS. We may disclose health information to funeral directors and coroners to carry out their duties consistent with applicable law.
9. ORGAN PROCUREMENT ORGANIZATIONS. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
10. MARKETING. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
11. FUND RAISING. We may contact you as part of a fund-raising effort.
12. FOOD AND DRUG ADMINISTRATION (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
13. WORKERS COMPENSATION. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
14. PUBLIC HEALTH. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
15. CORRECTIONAL INSTITUTION. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for yourhealth and the health and safety of other individuals.
16. LAW ENFORCEMENT. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
17. REPORTS. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more residents, workers, or the public.

NOTICE OF INFORMATION PRACTICES, Page Four.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the nursing community, the information in your health record belongs to you. You have the following rights:

You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the communities general health care operations, and/or to a particular family member, other relative, or close personal friend. We ask that such requests be made in writing on a form provided by this nursing community. Although we will consider your requests with regard to the use of your health information, please be aware that we are under no obligation to accept it or to abide by it. We will abide by your requests with regard to disclosure of your clinical and personal records to anyone outside of the nursing community, except in an emergency, if you are being transferred to another health care institution, or the disclosure is required by law. 45 Code of Federal Regulations (C.F.R.) 483.10(e) provides that a nursing community must abide by a resident's right to refuse the release of his/her personal or clinical records to any individual outside of the nursing community, unless the release is necessary because the resident is being transferred to another health care institution, or it is required by law.

If you are dissatisfied with the manner in which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the ADMINISTRATOR. We will attempt to accommodate all reasonable requests. For more information about this right, see 45 C.F.R. 164.522.

You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. You may make such requests orally or in writing; however, in order to better respond to you request we ask that you make such requests in writing on this nursing community's standard form. If you request to have copies made, we will charge you a reasonable fee. For more information about this right, see 45 C.F.R. 164.524.

If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by our nursing community to make such requests. For a request form, please contact the ADMINISTRATOR. For more information about this right, see 45 C.F.R. 164.526

You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years). We ask that such requests be made in **NOTICE OF INFORMATION PRACTICES, Page Five.**

writing on a form provided by our nursing community. Please note that an accounting will not apply to any of the following types of disclosures; disclosures made for reasons of treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes. You will not be charged for your first accounting request in any 12 month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee. For more information about this right see 45 C.F.R. 164.528

You have the right to obtain a paper copy of our Notice of Information Practices upon request.

You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our nursing community's Privacy Officer, who is the Administrator.

If you believe that your privacy rights have been violated, you file a complaint with us. These complaints must be in writing on a form provided by us. The complaint form may be obtained from the Administrator, and when completed should be returned to him. You may also file a complaint with the secretary of the federal Department of Health and Human Services. There will be no retaliation for filing a complaint.

Effective date: April 10, 2003

THOMPSON RESIDENTIAL HOME

PERSONAL FUNDS AUTHORIZATION FORM

RESIDENT _____

RESIDENT NUMBER _____

DATE _____

The purpose of this form is to request and authorize the Brattleboro Mutual Aid Association, Inc. (BMAA) to hold and dispense my personal funds as I request.

BMAA will keep complete records of all deposits and disbursements of my funds and will provide me or my designated financial representative (or both) a monthly report of the transactions within my account.

I understand that all funds will be deposited in an interest bearing account with Brattleboro Savings and Loan Association and that there is no limit* on the amount of funds I may keep in my personal needs account.

I further understand that I will be requested to sign a receipt when money is either deposited or withdrawn from my account and that this personal funds authorization can be withdrawn at any time by me or my designated financial representative upon written notification to BMAA.

_____
Signature of Resident

_____
Signature of Witness