Village Ridge Negotiated Service Agreement

Resident Information: Room No. _____

Name _____ Prefers to be called _____

Date of Birth _____ Place of Birth _____

Social Security No. _____ Date of Admission _____

Admitted from _____

Diagnoses _____

_____

Allergies _____

Health Care Providers:

Primary Care Doctor _____ Phone _____ Fax _____

Doctor _____ Phone _____ Fax _____

Dentist _____ Phone _____ Fax _____

Pharmacy _____ Phone _____ Fax _____

Hospital _____ Nursing Facility _____

Funeral Home _____ Phone _____

Emergency Notification:

The resident requests that the following person(s) be notified in case of an emergency:

Name _____ Relationship to resident _____

Phone (home) _____ Work _____ Cell _____ Email: _____

Name _____ Relationship to resident _____

Phone (home) _____ Work _____ Cell _____ Email: _____

The resident has a: □POA □DPOA

The status of the POA or DPOA is: □Active (Must have a physicians' statement)

□ Inactive

Resident Name _____

Activities of Daily Living (ADLs):

Please mark the appropriate box that indicates the residents' actual ability at the present time.

0: Independent: the resident can perform without any assistance

1: Supervision/Reminders/Cueing: the resident requires someone to be in attendance

2: Physical assistance needed: the resident needs actual hands on assist with at least a portion of the task to be completed.

3: Unable to perform: the resident cannot perform the task and requires total assist.

1. **Bathing**:	**Specify who will assist, type of assistance**	**Frequency**
Date:	☐Tub/Whirlpool ☐Shower	_____
____ ☐	_____ _____	
2. **Shampoo:**	Specify (family, beauty shop, staff etc.)	
____ ☐	_____	_____
3. **Oral Care:**	Specify (denture care, set up, cue, assist, etc.)	
____ ☐	_____	_____
4. **Hygiene:**	Specify (AM/PM cares: washing face, combing hair, shaving, etc.)	
____ ☐	_____ _____	_____
5. **Miscellaneous:**	Specify (help w/hearing aids, eyeglasses, nail care, makeup, etc.)	
____ ☐	_____ _____	_____

Resident Name _____

	Specify who will assist, type of assistance	**Frequency**
6. **Toileting:**	Specify (Cue, walk to BR, scheduled plan, incontinent products)	
____	_____	_____
☐	_____	
	_____	
7. **Perineal Care:**	Specify (assist w/cleansing after toileting, etc.)	
____	_____	_____
☐	_____	
8. **Dressing**	Specify (upper body, lower, body, shoes/socks, bra only, etc.)	
____	_____	_____
☐	_____	
9. **Transfers**	Specify (assist w/all transfers, bed to stand, chair to stand, etc.)	
____	_____	_____
☐	_____	
10. **Mobility**	Specify (stand by assist, walker, wheelchair, assist to meals, etc.)	
____	_____	_____
☐	_____	

DIET ***This facility does not provide special diets other than no concentrated sugar and no added salt.

☐ Regular ☐ No concentrated sugar ☐ No added salt

11. **Meal Preparation**	Specify (eats all meals in DR, assist w/microwave, checking food in refrigerator, etc.)	
____	_____	_____
☐	_____	

Resident Name _____

	Specify who will assist, type of assistance	**Frequency**
12. **Eating**	Specify (assist w/cutting food, special utensils, etc.)	
____	_____	_____
☐	_____	

13. **Special Monitoring:** Indicate all that apply by marking appropriate box.

	Staff Interventions	**Frequency**
☐ **Fall Risk**	_____	_____
	_____	_____

☐ **Therapy** (Include name of Provider and how often the resident is seen)

Date	Provider	Frequency of Visits	Date Discontinued
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ **Cognitive** (Long or short term memory deficit, poor decision making, etc.)

☐ Resident needs reminders to attend meals, activities, etc.

Other needs or interventions: _____

_____

_____

☐ **Other** (smoking precautions, motorized wheelchair, etc) _____

Staff Interventions	**Frequency**
_____	_____
_____	_____

14. **Health Maintenance Activities:**

A. Blood Pressure: Staff will do unless stated otherwise

☐ Daily ☐ Weekly ☐ Monthly ☐ Per MD order

Resident Name_____

B. Blood Glucose (Resident must supply strips and lancets)

☐ Resident will do independently ☐ Staff will perform

☐ Daily ☐ 2xDay ☐ 3xDay ☐ 4xDay ☐ Per MD order

C. Weight: Staff will do unless stated otherwise

☐ Daily ☐ Weekly ☐ Monthly

D. Treatments: (As ordered by MD) Check all that apply

☐ **Oxygen** ☐ Staff assist ☐ Independent

☐ Concentrator ☐ Portable tanks Provider: _____

☐ **Breathing Treatments** ☐ Staff assist ☐ Independent

☐ Daily ☐ 2xDay ☐ 3xDay ☐ 4xDay ☐ PRN

☐ **Compression Stockings** ☐ Staff assist ☐ Independent

☐ On in AM ☐ Off in PM

☐ **Skin Care** ☐ Staff assist ☐ Outside Provider ☐ Independent

Write in the details of the skin care: _____

_____

☐ **Other** _____ ☐ Staff assist ☐ Independent

If staff assistance is needed please write in any pertinent details: _____

_____

15. **Medication Management: *Any medication kept in resident apartment must be either locked in a cabinet or box or apartment must be locked when resident is not there.**

☐ Staff will provide physician ordered medications

☐ Resident will self administer ☐ All medications ☐ Some medications**:** _____

☐ Staff will set up resident medications in ☐ weekly ☐ monthly planners

Medications will be stored by ☐ Resident ☐ Facility ☐ Other _____

_____ will be responsible for making sure the medications are available for set up by facility staff.

Resident Name_____

16. **Instrumental Activities of Daily Living** **Frequency**

Transportation

☐ Independent ☐ Family Provided ☐ Facility Provided _____

Use of Telephone ☐ Phone in apartment ☐ Facility Phone

☐ Independent ☐ Staff assist _____

Personal Laundry

☐ Independent ☐ Family will do ☐ Staff will do _____

Housekeeping: Staff will provide 1x/week unless stated otherwise _____

☐ Resident must be present at housekeeping time

☐ May be done when resident is not in apartment

Use of Medical Alert System

☐ Resident is able to use independently ☐ Resident needs reminders to use

☐ Resident needs special equipment to activate_____

17. **Psycho/Social**

☐ Specify (i.e. interventions for dementia, depression, etc.)

_____

_____

_____

☐ Individualized Activity Plan (Staff will remind and assist resident to activities and offer meaningful activities to enhance quality of life.) List activities that the resident might enjoy below.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Resident Name_____

Signing below indicates that the services provided to the resident shall be provided as outlined in this agreement. Amendments shall be added when the services and/or needs and preferences change.

_____ _____

Resident Date

_____ _____

Resident's legal representative Date

_____ _____

Administrator/Operator Date

_____ _____

Licensed Nurse Date

Outside Resources: The facility cannot provide skilled services. An outside home health agency, hospice agency, etc. must provide any skilled services. Outside resources may include therapy service, oxygen provision, home health, hospice, etc. All outside providers must provide the facility with a Plan of Care for the resident's medical record to be maintained by the facility.

Services to be provided by outside resources:

1. _____ provided by _____

Address of Provider _____ Phone _____

Payment source for outside provider _____

2. _____ provided by _____

Address of Provider _____ Phone _____

Payment source for outside provider _____

3._____ provided by _____

Address of Provider _____ Phone _____

Payment source for outside provider _____