Name:_____

RESIDENCY AGREEMENT

The Waverly

The Company strongly believes in the importance of fully disclosing all services and fees to the best of our ability and in accordance with state law. As with any legally binding Agreement, it is our recommendation that you consult your legal counsel to ensure proper understanding of this Agreement before signing. Including Exhibits.

Room #_____

Table of Contents

RESIDENCY AGREEMENT

THIS RESIDENCY AGREEMENT ("Agreement") is made and entered into this _____ day Of _____, 20___ by and between the Parties to this Residency Agreement:

(i) The Company or The Waverly, Wellness Center of Trinity DBA The Waverly LLC.

(ii) Resident, _____

(iii) Resident's Representative, _____

(iv) Responsible Party: _____

(Resident and Resident's Representative are collectively referred to in this agreement as "you" or "Resident" unless the context requires otherwise.)

I. ADMISSION GUIUDELINES

A. Admission Policy:

Medical / psychological and personal information will be provided to The Waverly for consideration. A complete Medical Evaluation performed by a licensed physician or ARNP must be included upon application or if not available, will be agreed to by the applicant and arranged for. An approved *Health Form 1823* may be used for this purpose and must not be dated more than 60 days prior to admission or up to 30 days after admission. Information that must be included if available, with the application for admission is:

1. Recent (within the prior year) cognitive or intellectual evaluation
2. Measure of adaptive behavior or current Activities of Daily Living
3. Current communication assessment (strengths and weaknesses)
4. Evaluation of any sexual concerns
5. Any legal problems
6. Requirements of any behavior modification treatments
7. Current psychotropic medications or Dementia Medications
8. Any medical condition affecting present psychological or psychosocial functioning
9. Any impulse control problems
10. History of any explosive episodes, sexual acting out, or legal troubles

B. Residency Criteria:

In addition, the applicant must be ambulatory or need limited assistance, capable of administering his / her own medications under supervision, able to perform activities of daily living and capable and desirous of functioning within a family atmosphere. Also, will have a new evaluation at least once every year or upon a significant event, hospitalization or referral to hospice completed on Form 1823.

Upon determination of the Administrator or a licensed Physician, Advanced Registered Nurse Practitioner (ARNP), that the resident needs services beyond those that The Waverly is licensed to provide, the resident or responsible party will be notified in writing that the resident must make arrangements for immediate transfer to an appropriate care setting.

It is agreed that when a resident becomes or is physically or mentally ill so as to jeopardize the health or comfort of themselves or other residents, will be required to leave this Assisted Living Facility and the responsible party will be notified. In the event a resident has no person to represent him / her, The Waverly shall be responsible for making a referral to an appropriate social service agency for placement. If there is a disagreement regarding the appropriateness of placement the provisions of s.429, Florida Statute takes effect.

In case of temporary illness, not to exceed 7 days in a bed, temporary bedside care will be provided. The resident will be required to leave the facility if they become non-ambulatory or unable to self-administer medication. In case of a resident in a wheelchair, resident should be able to self-transfer and self-propel wheelchair.

Resident shall provide The Waverly with a 30-day notice of termination in writing, when they intend to leave The Waverly.

Residents who must have assistance with administering medication must have their *"Over the Counter"* medications centrally stored. Any OTCs that are brought in shall be labeled with the resident's name and will be put under lock and key, no requirement for a Dr's prescription is required.

Resident's Policies and Procedures shall be considered part of this contract. It will need to be signed and dated at the same time that the contract is executed. These rules are non-negotiable.

The Waverly agrees to hold a bed for a resident who is admitted to a nursing home or healthcare facility for a period not to exceed one month. The resident or responsible party shall notify The Waverly in writing of any changes in status that would prevent the resident from returning to The Waverly. Until such written notice is received, the agreed upon daily rate will be charged by the facility to hold the bed. Payment will be required to hold the bed.

The Waverly is not affiliated with any religious or governmental agency.

The Waverly is not a nursing home, nor does it provide Limited Nursing Services and therefore is not licensed to provide any nursing care. This can be handled by a third party, home health, Hospice and the like.

C. DNRO Policy

The Waverly will honor a DNRO as long as a legible copy has been presented and is on file, if any resident would like to execute a DNRO or advanced directive the facility will honor these and assist with obtaining the paperwork. No staff shall act as a witness to the document.

Elopement is considered to of happened when a resident leaves, without any knowledge of staff and has been gone for 8 hours, Staff are trained and drilled in elopement policy 2 times a year

II. SERVICES AND ACCOMMODATIONS

A. BASIC SERVICES

You will be entitled to the following Basic Services, which are included in the Basic Service Rate, subject to the terms and conditions of this Agreement:

- **Accommodations** – You are entitled to the use of the suite described in Exhibit A and to the use of the Company's personal property located in the suite. You are also entitled to use and enjoy with all other residents the common areas of the building (the "Community"). You may provide your own furnishings and personal property; however, the Company reserves the right to limit the number and type of furnishings if the Company determines that they present a safety hazard or potential safety hazard.

  Daily Meals - The Company will provide three meals daily. Snacks are available 24 hours a day. Meal Hours are: Breakfast 7:00 a.m., Lunch 12:00 noon, Dinner: 5:00p.m. We can accommodate a NCS diet as well as a regular diet.

- **Utility Service** - The Company will provide gas, electric and water service. Telephone charges are not included in the Basic Service Rate. Costs for basic cable television are described in Exhibit A.

- **Weekly Housekeeping Service** - The Company will deep clean your suite once a week. And on a **daily** basis make sure suite is presentable.

- **Weekly Laundry and Linen Service** - The Company will launder your personal items and your bed linens once a week. Personal laundry is available to be performed by resident

- **Life Enrichment Program** - The Company will provide planned social, educational and recreational programs totaling at least 12 hours per week and including 6 days a week

- **Staffing 24 hours a day** - The Company will have staff available 24 hours a day, seven days a week.

- **Medication Assistance-** The Company will aide with all medications

- **Assistance with Activities of Daily Living**—The company with assist with all ADL'S as applicable and wanted by resident.

The Company will provide thirty (30) days written notice of any change in Basic Services.

B. PERSONAL SERVICE PLAN By request only of Person or responsible party

The Company will make available, **at an additional cost**, a Personal Service Plan. The Personal Service Plan is designed to provide you greater personal services than those provided under the Basic Services. The Company will use a personal service assessment to determine the personal services you require prior to moving in and periodically throughout your residency. The results of the assessments and the cost of providing the additional personal services will be shared with you and your Responsible Party. In some circumstances, the provision of outside services may be required for your continued ability to safely remain at the Community. An outside agency or individual will be permitted to provide these services or any related personal services only if the Company has given prior approval.

C. AVAILABLE SELECT SERVICES

The Company may make Select Services available to you at your or your Responsible Party's request. If available, such additional services may include guest meals, transportation, transportation escort services, enhanced cable television, or special events. These additional choices are not included in the Basic Service Rate or the Personal Service Plan. A list of the available Select Services and a current fee schedule are available upon request.

D. SERVICES NOT COVERED BY RESIDENCY AGREEMENT

You and your Responsible Party are responsible for obtaining and paying for all services which are not included in the Basic Services (including, but not limited to, the services of a third-party health care and medical providers), These services may include, but are not limited to, pharmacy services, newspaper subscriptions, or beauty/barber services as well as transportation. Any fees for services provided by other service providers will be billed directly by the service provider. All third-party service providers (including, but not limited to, third party health care and medical providers) must receive the Company's prior authorization to provide services to you at the Community. All third-party providers who enter the Community must sign in with the front desk and fill out a visit form required by the state of Florida, and agree to comply with the Company's policies.

You may not contract with any of the Company's current employees to perform any services in the Community. You may contract with former employees to perform any services at the Community only with the Company's consent. The Company reserves the right to refuse entry to 1) former employees, 2) persons whose actions may be disruptive to the Community; 3) persons whose actions may threaten the safety of any resident or employee; or 4) persons whose presence may foreseeably result in liability to the Company.

III. RESIDENT RESPONSIBLITIES AND REPRESENTATIONS

A. CARE OF SUITE

You agree that the Community and the suite are in satisfactory, habitable condition. You also agree the Company has made no promise to decorate, alter, or improve the Community or suite, unless otherwise provided in writing by the Company and attached as part of this Agreement. You agree to maintain the suite and to surrender the suite upon termination of this Agreement in good condition, exclusive of normal wear and tear. You agree to pay all damages, beyond normal wear and tear, including any improvements made without the Company's consent, which you, your Family, and/or other Guests (including any agent, employee, contractor, or other invitee) cause to Community property. The family may assist in keeping the room clean and neat since deep cleaning is only weekly.

B. SUITE ACCESS

You agree to give the Company access to the suite in order to carry out the intent of this Agreement. Such entry includes, but is not limited to, performance of services provided as part of the Basic Services; response to emergency situations; and entry by authorized personnel with the reasonable belief that your safety or safety of others is in question or that the Company's policies and procedures are being violated.

The Company reserves the right to relocate you to a more appropriate suite within the Community as required for your health or safety, or because the residents of a companion suite are incompatible.

C. HEALTH ASSESSMENT

You agree that the Company may from time to time assess your health to determine if you are appropriate to stay in the Community. Not more than thirty (30) days prior to the date this Agreement is entered into, and at least every 3 years thereafter or upon the request of the Company, you agree to undergo an examination by your physician (or other licensed provider as allowed by law). An examination is also required if a significant change is observed. You agree that the Company may require you to undergo examination by a particular specialist, at your cost, as the Company determines is warranted by your current physical or mental status. You will request the examiner to provide the Company with recommendations, including a statement attesting to the appropriateness of the placement. Based upon the assessment(s) and the Company's judgment, the Company may determine your appropriateness to remain in the Community. You will request the examiner to perform any tests and complete any forms required by the Company or applicable law.

D. HEALTH CARE PROVIDER NOTIFICATION

You authorize the Company to contact responsible parties, health care providers, and/or other persons listed in your records:

(1) If the Company determines it is necessary to advise them of your situation;
(2) To arrange for health care services and other assistance required by you; or
(3) In case of an emergency. If you have a life-threatening emergency, the Company will contact an emergency rescue service.

If your designated health care providers are unavailable, you authorize the Company to arrange for the services of other health care providers.

During the term of this Agreement, you agree the Company may provide such persons with copies of your records, including, but not limited to, resident records to the extent they are needed to assist with treatment, advance directives, living will, and the names of persons empowered to make health care decisions, for the purpose of arranging for health care services.

E. OBLIGATORY INFORMATION

You will provide the Company with accurate, complete and current information about yourself, substitute decision-makers and health care providers, including but not limited to addresses and phone numbers, and your health care status and needs. You or your Responsible Party will provide the Company with complete copies of any health care power of attorney, power of attorney executed by you or of any court order, guardianship, or other legal action which may (1) affect your status or (2) designate or appoint another person to make health care or financial decisions or to bear financial responsibility on your behalf. You authorize the Company to rely on the instructions of such designees or appointees. You understand that you must immediately notify the Company of changes relating to any of the information stated above.

F. ADVANCE DIRECTIVES

Upon admission to the Company, it is strongly suggested that you have your advance directives in place in the event you become incapacitated. Advance directives include, but are not limited to, Living Wills, Powers of Attorney for Health Care, Guardianships and Do Not Resuscitate Orders. You will notify the Company and provide copies to the Company of such advance directives. If you do not have such advance directives in place, you understand that a court may name a guardian upon application of any interested party (including the Company), subject to all bond, accounting and other legal requirements. Neither the Company nor any of its employees or agents may be your guardian. If it is necessary for the Company to petition the court for appointment of a guardian, any costs associated therein shall be paid by you.

G. MOTORIZED VEHICLES

Motorized vehicles may be used by a resident, subject to the following:

1) You have a physician's order stating that such a vehicle is a medical necessity for you;
2) You have been assessed as being able to safely operate the vehicle and you continue to demonstrate that your operation of the vehicle does not pose a threat to the health and safety of yourself or others.
3 The vehicle is operated at a low setting; and

4 You agree to abide by the Company's safety guidelines for the use of motorized vehicles on the premises, which may be modified from time to time.

Reasonable accommodations will be made to the motorized vehicle rules, policies and practices (upon a showing of necessity) so long as the requested accommodation does not constitute a threat to the health or safety of yourself, the other residents, the residence staff or visitors.

You further understand and agree that the Company may, at its sole discretion, prohibit your further use of a motorized vehicle at any time if it becomes damaging to facility property or safety concern. Residents that use motorized vehicles that create damage to property, walls, etc. other than normal wear and tear may be responsible for fees to repair damage created by the resident and their device.

H. RESPONSIBILITIES UPON TERMINATION

You will vacate premises, removing all belongings on or before the effective date of termination. If you fail to remove your belongings by the effective date of termination, you understand and agree that the Company may continue to charge you for the Basic Service Rate of your suite. If the amount of belongings does not preclude renting the suite, the Company may clear the unit and charge you or your responsible party for moving and storing the items at a rate equal to the actual cost to the Company, not to exceed 20% of the regular rate for the unit, provided that fourteen (14) days' advance written notification is given. If the resident's possessions are not claimed within forty-five (45) days after notification, the Company may dispose of them. You will provide written notice of a forwarding address where you can be reached and receive mail.

Termination will not release you or the Company from any liability or obligation to the other party under the terms of this Agreement.

I. RULE AND REGULATION COMPLIANCE

You acknowledge that the Company is licensed by the State of Florida as a **Standard** Assisted Living Facility. You understand that the Company has shared common areas, and you agree to honor all rules of courtesy and respect for others.

You agree to abide by and conform to the rules, regulations, policies and procedures as they now exist and as amended from time-to-time for the operation and management of the Community.

J. GUESTS

You understand that as a resident, you have the right to associate with your friends and family ("guests") during reasonable hours. Because the Company is a licensed building, overnight guests are generally not permitted in a resident's room. Limited exceptions may be granted by the Executive Director based upon the resident's health status or other pertinent factors.

You acknowledge and understand that your guests are subject to the Company's Rules and Regulations, and if your guests become disruptive to the operations of the Community and/or are verbally or physically abusive to staff, residents or others, the Company may request that they leave the Community until their behavior is under control or may place limitations upon the location and time of their visitation. You understand that, where circumstances warrant, the Company may exclude such individuals from the Community.

IV. RATES

A. MOVE- IN FEE

1. **Fee** – You will pay the Company a one-time Move-In Fee to cover such items as administrative costs involved in the admission process, room preparation and maintenance in an amount indicated in Exhibit A at the time this Agreement is signed. These fees are non-refundable.

2. **Refund** – The Company will refund a prorated share of one-half of the Move-In Fee if this Agreement is terminated within ninety (90) days of the date this Agreement is signed and any one of the following circumstances occur:
   (a) The Company terminates this Agreement;
   (b) The Company determines you require care not offered by the Company.

X_____
(Please initial as having read and understood the above provision.)

B. MONTHLY SERVICE RATE

1. **Rate** – You agree to pay the Basic Service Rate and, if applicable, the charge for the Personal Service Plan as indicated in Exhibit A (together the "Monthly Service Rate").

2. **Refund** – The Company will refund a prorated share of the Monthly Service Rate based on the daily rate for any unused portion of payment if this Agreement is terminated before the end of a month:
   (a) following written notice in accordance with Section IV;
   (b) because you require relocation due to psychiatric hospitalization or medical reasons which necessitate care that is outside the scope of services the Company is licensed to provide.

Refunds will be prorated from the date of termination, regardless if you leave on or before such date. For terminations pursuant to subsection (b) the termination date shall be the date the suite is vacated and cleared of all personal belongings. For terminations due to discontinued operations, the Company will prorate all charges as of the date on which the Community discontinues operation, and if any payments have been made in advance, the payments for services not received will be refunded to the Resident or Responsible Party within ten (10) working days of closure of the Community whether or not such refund is requested by the Resident or Responsible Party. Unless prohibited by law, you agree the Company may offset such refunds by any amount due under the terms of this Agreement.

The Company will send an itemized list of any costs actually incurred and/or damages to the premises or suite, as well as any refunds due after deductions for such costs or damages, within forty-five (45) days to your last known address. You will respond in writing, within fourteen (14) calendar days of notification, to contest any of the damages included by the Company on the itemized list. In the event of closure of the facility, a prorated refund of advance payment for services not received will be made within 7 days of closure.

The refund policy is to apply when transfer of ownership, closing of the facility or move out of resident, reimbursement shall occur within 45 days of a written notice of termination. However, in no case shall it be required that the refund be made before the unit is vacated, except in case of death or discharge due to medical reasons, including mental health, the notice of termination is waived and a prorated refund will be given from the date of the vacation of the unit. If no written notice no proration of current month.

In case of death, refunds and /or property held in trust shall be returned to the guardian, spouse, and next of kin or held in trust for probate. If such person cannot be located, funds due to the resident shall be safeguarded until such time that the funds and property are disbursed. Such funds shall be kept separate from the funds and property of the other residents. In the event the funds of the deceased are not dispersed pursuant to the provisions of the Florida Probate Code within two years of the resident's death, the funds shall be deposited in the Aging and Adult Licensure Funds.

C. RESIDENT ABSENCE

If the Resident is absent from the Community for any reason, including, but not limited to, hospitalization, vacation, temporary nursing home care or rehabilitation, the Residency Agreement will remain effective and you will be charged the full Monthly Service Rate until such time that the Resident or Representative provides the Company with written notice of their intent to terminate the Agreement, pursuant to Section IV of the Agreement. Termination will be effective and charges will cease the later of the end of any applicable notice period or the removal of all of your personal belongings.

D. SELECT SERVICES

In addition to the Monthly Service Rate, you agree to pay the Company the established charges for any Select Services provided to you by the Company.

E. PAYMENT

The Company will not issue a monthly statement the rate is constant and is expected to be paid per agreement, if any, charges incurred for Select Services provided during the prior month a bill will be provided. Payment for all charges shown on this statement is due on the tenth (10th) calendar day of each month. The first payment of the Monthly Service Rate is due prior to taking occupancy. If you move in after the first of the month, your

first Monthly Service Rate will be one thirtieth (1/30) of the usual rate times the number of days remaining in the month.

The Company will charge a $250.00 late fee if the Company has not received all fees when due. The Company will also charge a $25.00 returned payment fee for each check or automatic withdrawal that is returned by a financial institution for any reason, including but not limited to, insufficient funds or incompleteness. After two payments are returned by a financial institution to the Company, you will thereafter pay the Monthly Service Rate and any other amounts due by cashier's check. You also agree to pay interest on all amounts not paid by the due date. The interest rate will be the lesser of 1.5% per month or the highest rate permitted by law.

F. RATE CHANGES—COLA

The Company will provide at least thirty (30) days written notice of any change in the Basic Services Rate. The Company may offer or require a change in the Personal Service Plan when the Company determines additional services are requested or required. The new charge for the Personal Service Plan will be effective immediately upon the provision of written notice.

X_____
(Please initial as having read and understood the above provision.)

V. TERM AND TERMINATION

A. TERM

This Agreement will commence on the date set forth above and, if not terminated, will continue until terminated as provided below.

B. TERMINATION BY RESIDENT

You or your Responsible Party may terminate this Agreement upon thirty (30) days written notice to the Company. This Agreement terminates at the end of the notice period

X_____
(Please initial as having read and understood the above provision.)

C. TERMINATION BY THE COMPANY

The Company may terminate this Agreement, upon providing you or your Responsible Party forty-five (45) days written notice, for the following:

(1) You require care or services that the Company is unable to provide or which requires staff that are not available at the Company;

(2) You or your guests are disruptive, create unsafe conditions, are physically or verbally abusive to other residents, visitors or staff or otherwise impair the welfare of yourself or others in the Community;
(3) You or your Responsible Party fail to pay fees and charges when due, or you breach any representation, covenant, agreement or obligation under this Agreement.
(4) The Company discontinues operation of the Community.

X_____
(Please initial as having read and understood the above provision.)

The Company may, upon written notice to you or your Responsible Party, immediately terminate the Agreement, and transfer or discharge you for medical reasons, if you are certified by a physician to require emergency relocation to a facility requiring a more skilled level of care or you engage in a pattern of conduct that is harmful or offensive to other residents. If the emergency requires your immediate transfer, the Company will notify the Responsible Party at the earliest practicable hour.

The Company will provide a written explanation if the Company terminates this Agreement with less than forty-five (45) days notice. In the event you have no persons to represent you, the Community shall refer you to the social service agency for placement.

D. <u>TERMINATION BY EITHER PARTY</u>

You, your Responsible Party or the Company may terminate this agreement immediately upon written notice if a physician certifies, based upon an examination prior to moving out, that you must be relocated because of your health or notice in the event of death. A termination as described in this paragraph will be effective the day after you have vacated and all of your personal belongings are removed from the Community. If the amount of belongings does not preclude renting the suite, the Company may clear the unit and charge you or your responsible party for moving and storing the items at a rate equal to the actual cost to the Company, not to exceed 20% of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the Company may dispose of them

VI.

(A). <u>NON-DISCRIMINATION</u>

The Company does not discriminate on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment. The Company respects all religious faiths and does not have any specific religious affiliation.

(B). RISK AGREEMENT

You and your Responsible Party are responsible for your personal, financial and health care decisions. In addition, you are responsible for maintaining at all times your own health, personal property, liability, automobile (if applicable), and other insurance coverages in adequate amounts. You agree to obtain insurance with coverage for your personal property and your general liability in the amount of $100,000. You agree to provide proof of such coverage to the Company. You acknowledge that the Company is not an insurer of your person or property.

You understand and agree that:

1. The Company may encourage you to participate in community, leisure, and social activities and to maintain an appropriate level of independence in activities of daily living, as well as your personal and financial affairs;

2. Independent activities, responsibility for personal, financial, and health care decisions, and lifestyle and care preferences may involve risks of personal injury and/or property damage or loss;

3. The standard of services in an assisted living community **does not include** one-on-one care, assistance or supervision e.g., one resident assistant for each Resident, or immediate response to non-emergent needs. Consistent with your daily life activities, including but not limited to resting in your suite or common areas, watching television, listening to music, reading, and sleeping at night, there may be short and long periods of time in which you will be left alone, unsupervised;

4. The Company makes no representations or guarantees that the Company staff can prevent Residents from falling. Further, the Company does not represent or guarantee your health condition will not change or deteriorate throughout your Residency;

5. The services provided by the Company may not meet all of your personal, social, or health care needs and the Company will use its best efforts to assist you in arranging for services which you require and which are not included in this Agreement;

6. Many Residents of the Company suffer from memory impairment, including Alzheimer's disease and dementia. This condition can cause unexpected behavior including, but not limited to, wandering, forgetfulness, agitation towards others and confusion. The Company makes no representations or guarantees that it can predict the behavior of its Residents. Therefore, the Company also makes no representations or guarantees that it can always prevent a Resident from wandering or attempting to wander from the Community, entering into a private area, misplacing or losing items or engaging in physical contact with another Resident;

7. The Company makes no representations or guarantees that the Company is secure from theft or any other criminal act perpetrated by any other Resident or person; therefore, the Company recommends that valuables, including but not limited to,

jewelry and large amounts of money, not be brought into the Community. If you choose to bring in such valuables, you are doing so at your own risk and the Company will not be responsible for any theft or loss of these items;

8. Due to state regulations and fire code, the Company is not permitted to lock its exterior doors and, therefore, does not guarantee that its Residents will not wander out of the Community. In our memory care buildings, the exterior doors are alarmed with a delayed egress feature and our systems are designed to alert our staff to respond and assist a Resident to safety, should they wander from the building.

You understand and agree to assume the risks inherent in this Agreement.

The Company reserves the right to recover from you any loss caused by fire, vandalism or any other acts by you or your invitees or guests. The Company may assign such right to its insurance carrier.

C. RELIANCE

By entering into this Agreement, the Company is relying upon the truthfulness of the promises and representations made by you and your Responsible Party.

D. NO LIABILITY IF AWAY FROM COMMUNITY

In the event that you knowingly leave the Community or are temporarily away from the Community, any and all responsibility of the Company for your welfare shall terminate during your absence.

E. ASSIGNMENT

This Agreement is not assignable by you or your Responsible Party without prior written consent of the Company. The rights and obligations of the Company may be assigned to any person or entity, and such person or entity will be responsible to ensure the obligations of the Company under this Agreement are satisfied in full from and after the date that you are notified of such assignment. The Company may engage another person or entity to perform any or all of the services under this Agreement.

F. HEIRS AND SUCCESSORS

This Agreement is for the benefit of and binds the parties and their respective heirs, representatives, successors and assigns.

G. AMENDMENTS OR EXHIBITS

This Agreement and any written amendments constitute the entire agreement between the parties and supercede all prior and contemporaneous discussions, representations, correspondence, and agreements whether oral or written, pertaining to this Agreement. Except for the right of the Company to modify fees, rates and charges, amend services provided and establish reasonable operating procedures and rules for the general welfare and safety of the residents, this Agreement may be amended only in writing signed by both parties.

H. SEVERANCE

Any clause, term, phrase, provision, or part thereof contained in this Residency Agreement is severable, and in the event any of them shall to be found invalid, void, or unenforceable for any reason, this Residency Agreement shall be interpreted as if such invalid, void, or unenforceable clause, term, phrase, provision, or part thereof were not contained herein, and the remaining clauses, terms, phrases, provisions, or parts thereof, of this Residency Agreement shall not be affected by such determination and shall remain in full force and effect. No part of this Residency Agreement will be construed against any Party because the Party wrote the Residency Agreement

I. RESPONSIBLE PARTY

You have designated a Responsible Party, or are the responsible party who has agreed to the terms of the attached Responsible Party Agreement and whose signature appears below.
As such it is agreed that responsible party to pay the agreed rate and assist in the care of resident. Participating with the company staff in evaluating resident's needs. Help to maintain residents well being by following through with the obligations of the agreement. Relocating resident upon termination. Transferring resident to a hospital, nursing home or other facility in the event that the resident requires care beyond the scope the facility can provide Removing items from the suite when the resident leaves. Assisting with funeral arrangements and burial in the event of death.
You will make sure the facility is paid as responsible party and you agree to do this after getting a written notice of non-payment. You agree a copy of this agreement has been provided to you and that you have had time to ask questions that you as responsible party may have or the resident may have

K. SUBORDINATION

This Agreement and the parties' rights hereunder will be subordinate to any ground lease, mortgage or deed of trust now or hereafter placed upon the Community, but your right to remain in possession of your suite will not be disturbed so long as you comply with all of the provisions in this Agreement.

L. NOTICES

Notices, absent those contained in section will be written and given by personal delivery or mailing by regular mail, postage pre-paid to the following or such other persons or places as the parties may notify each other. Notices shall be deemed given based upon the date personally delivered or upon the date postmarked.

Resident:_____

Mailing Address:_____

_____

_____

SCHEDULE OF SERVICES AND RATES

Resident _____

Community The Waverly ALF

Address 9309 Mercy Way

Trinity, Fl 34655

Suite # _____

Move-In Fee (Prior to Move-in) $_____

Basic Services

Basic Service Rate Includes: $_____

- **Accommodations** - You are entitled to the use of the suite described above and to the use of the Company's personal property located in the suite. You are also entitled to use and enjoy with all other residents the common areas of the Community. You may provide your own furnishings and personal property; however, the Company reserves the right to limit the number and type of furnishings if the Company determines that they present a safety hazard or potential safety hazard.

- **Daily Meals** - The Company will provide three meals daily. Snacks are available 24-hours a day.

- **Utility Service** - The Company will provide gas, electric and water service. Telephone charges are not included in the Basic Service Telephone is available. Rate. Basic cable television included in the Basic Service Rate.

- **Weekly Housekeeping Service** - The Company will clean your suite once a week.

- **Weekly Laundry and Linen Service** - The Company will launder your personal items and your bed linens once a week.

- **Life Enrichment Program** - The Company will provide planned social, educational and recreational programs.

- **Staffing 24 hours a day** - The Company will have staff on duty 24-hours a day, seven days a week.

- **Assistance with ADL's** as needed (PRN) and Medication Assistance is standard to all residents. Fall assistance is available when ambulating in building if required, as part of an order from physician, this may result in an extra charge.

- All Home Health services is coordinated by family as they choose provider and arrange for them to care for their loved ones. Resident may do this if capable.

The Company will provide thirty (30) days written notice of any change in Basic Services.

Personal Service Plan

Personal Service Plan Rate: This is upon request only by responsible party or resident

The Company will make available, at an additional cost, a Personal Service Plan. The Personal Service Plan is designed to provide you greater personal services than those provided under the Basic Services. The Company will use a personal service assessment to determine the personal services you require prior to moving in and periodically throughout your residency. The results of the assessments and the cost of providing the additional personal services will be shared with you and your Responsible Party. No outside agency or individual will be permitted to provide these services or any related personal services unless the Company has given prior approval.

To All NON-Medicaid Residents: The facility is not responsible for the purchase and payment for any incontinence supplies. This includes but is not limited to pull ups, briefs, wipes, etc. The facility does not supply personal hygiene items for any resident. Such items include but are also not limited to body wash, soap, razors, toothpaste deodorant, etc. The resident and or the responsible party should make necessary arrangements to obtain such items. The facility also is NOT responsible for the purchase of supplement type beverages such as Ensure, Boost, etc. These items can be purchased and delivered through our attending pharmacy for a cost that is payable by the resident and or responsible party.

MONTHLY SERVICE RATE $_____ Initial _____
(Add Basic Service Rate and Personal Service Plan)

Available Select Services

From time to time, the Company may make Select Services available to you at your request. When available, such additional services may include guest meals, transportation, transportation escort services, enhanced cable television, special events, or special programs. These additional choices are not included in the Basic Service Rate. Please contact your Executive Director for a current fee schedule.

I agree to the above Schedule of Services and Rates effective _____, and I understand and agree that the Company has a right to change these rates and/or change the services provided in accordance with the provisions of the Residency Agreement.

EACH OF THE UNDERSIGNED ACKNOWLEDGE THAT HE/SHE: (1) F HAS RECEIVED A COPY OF THE RESIDENCY AGREEMENT AND ALL EXHIBITS; (2) HAS READ OR HAD EXPLAINED TO HIM/HER THE RESIDENCY AGREEMENTAND ALL EXHIBITS; (3) HAS BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS AND CONSULT WITH FAMILY, FRIENDS, LEGAL COUNSEL., AND/OR HEALTH CARE PROVIDERS ABOUT THE RESIDENCY AGREEMENT AND ALL EXHIBITS; AND (4) UNDERSTANDSAND VOLUNTARILY CONSENTS TO THE TERMS AND CONDITIONS OF THE RESIDENCY AGREEMENT AND ALL EXHIBITS.

RESIDENT/
RESIDENT'S REPRESENTATIVE

_____

Date

_____

Printed Name

_____

Signature of Resident/ Resident Representative*

RESPONSIBLE PARTY

_____

Date

_____

Printed Name

_____

Signature of Responsible Party in his/her Individual Capacity

*****Resident's Representative understands and agrees that by signing this Agreement or exhibit He/she is signing in both a representative and Individual capacity.

COMPANY REPRESENTATIVE

_____

Printed Name

_____ _____

Signature of Company Representative ** Date

** This individual is authorized to sign this Agreement or exhibit on behalf of the Company and The Waverly

EXHIBITS INCLUDED:

A. **VOLUNTARY ARBITRATION AGREEMENT**

Items (B-H) below required by Florida statute to be provided to new residents

B. Informed Consent to Assistance with Medication by Unlicensed Personnel
C. Services that May be Performed by an ALF
D. Extended Congregate Care
E. Beneficiary Designation Form
F. Respite Care Addendum
G. Pharmacy Services Agreement
H. Rules of the ALF
I. Resident Bill of rights
J. Elopement policy
K. DNRO Policy,
L. Copy of SCHS-4-2006,
M. Grievance Policy,
N. Medication Policy,
O. Form DH-1896.

EXHIBIT A
VOLUNTARY ARBITRATION AGREEMENT

THIS ARBITRATION AGREEMENT CONTAINS A MODIFICATION OF LEGAL RIGHTS. PLEASE READ CAREFULLY.

SIGNING THIS ARBITRATION AGREEMENT IS VOLUNTARY AND IS NOT REQUIRED FOR ADMISSION TO THIS HEALTH CARE CENTER.

Where the context requires, the capitalized terms in this Arbitration Agreement have the meaning given to them pursuant to the Residency Agreement. The Resident, Resident's Representative, Responsible Party and the Company (hereinafter "the Parties") agree to the following Agreements to Arbitrate.

A. AGREEMENT TO ARBITRATE

Any and all claims or controversies arising out of or *in any way* relating to this Arbitration Agreement, the Residency Agreement, and/or any of the Resident's stay(s) at The Waverly, including disputes regarding the making, execution, validity, enforceability, voidability, unconscionability, severability, scope, arbitrability, interpretation, waiver, duress, preemption, or any other defense to enforceability of this Arbitration Agreement, whether arising out of State or Federal law, whether now existing or arising in the future, whether for statutory, compensatory or punitive damages and whether sounding in breach of contract, tort (i.e., negligence or wrongful death), or breach of statutory duties (including, without limitation, any claim based on Residents' Rights or a claim for unpaid Company (charges), irrespective of the basis for the duty or of the legal theories upon which the claim is asserted, shall be submitted to binding arbitration.

B. FLORIDA ARBITRATION CODE

The Parties hereby expressly agree that the Florida Arbitration Code found in Florida Statutes Chapter 682 shall apply to this Arbitration Agreement.

C. ARBITRATORS ARE SOLE DECISION MAKERS

A panel of Arbitrators will be chosen as described in **Section E.3.** of this Arbitration Agreement. The Arbitrators are empowered to, and shall, resolve **all** disputes, as it is the Parties' intent to completely avoid the court system.

D. WHAT IS ARBITRATION?

Arbitration is a cost effective and time saving method of resolving disputes without involving the courts. In arbitration proceedings, disputes are heard and decided by private

individuals called arbitrators. The Parties are not waiving the right to sue or obtain statutory and/or contractual remedies by agreeing to arbitrate disputes within the scope of this Arbitration Agreement. However, the Parties desire and expressly agree that any dispute between them be resolved *outside* of the court system. The essence of this Arbitration Agreement is that the Parties do not want a judge or jury to resolve their disputes.

1. Waiver of Trial by Judge or Jury. By entering into this Arbitration Agreement, the Parties are giving up and waiving their right to have any claim decided in a court of law before a judge and/or jury.

2. Final with Limited Rights to Review (Appeal). The Arbitrators' decision binds the Parties, and the Parties have a limited right of review for only the express reasons allowed by the Florida Arbitration Code found in Florida Statutes Chapter 682.

3. Binding on Parties and Others. It is the intention of the Parties that this Arbitration Agreement shall inure to the direct benefit of and bind the Company, its parent, affiliates, subsidiary companies, management companies, landlords, joint venture partners, sister companies, consulting companies, consultants, contract service providers, administrators, executive directors, owners, officers, partners, members, incorporators, shareholders, representatives, other stakeholders, directors, medical directors, employers, employees, managers, successors, assigns, agents, attorneys and insurers and any entity or person that provided any services, supplies, or equipment related to the Resident's stay(s) at Walton Place; and shall inure to the direct benefit of and bind the Resident, his/her successors, spouses, children, next of kin, guardians, administrators, legal representatives, responsible parties, assigns, agents, attorneys, health care proxies, health care surrogates, attorneys-infact, designees, beneficiaries, distributees, insurers, heirs, trustees and representatives, including the personal representative or executor of his/her estate, any person whose claim is derived through or on behalf of the Resident, and any person who executed this Agreement or the Residency Agreement. The Parties agree that all aspects of a controversy, including claims, cross-claims, and counterclaims, made by or against any person or entity bound by this Agreement shall be included and exclusively adjudicated through Binding Arbitration, except as otherwise stated herein.

4. Non-Jury/Bench Trial. If this Arbitration Agreement is found to be void, invalid or unenforceable for any reason, then the Parties hereby agree that they waive their right to a jury trial and agree to have their disputes resolved by a judge via a bench trial.

5. Survival Clause. Except as noted below in **Section I** ("Right to Change your Mind") of this Arbitration Agreement, the terms and conditions recited herein shall survive and remain in full force and effect notwithstanding the death of the Resident, the discontinuation of operations at the Company or The Waverly, or the termination, cancellation or natural expiration of the Residency Agreement or any other contract between the Parties.

6. Integration Clause. This Arbitration Agreement represents the Parties' entire agreement regarding disputes, and it can only be changed in a writing signed by all Parties.

E. ARBITRATION PROCESS

1. Demand for Arbitration shall be made by the claimant ("Claimant") in writing and submitted to the other Party ("Respondent") to this Arbitration Agreement via certified mail, return receipt requested.

2. The Arbitration Hearing. Unless the Parties mutually agree otherwise, the Arbitration Hearing shall take place in Pinellas County.

3. Arbitration Panel. The arbitration panel shall be composed of three (3) arbitrators ("Arbitrators"). Within 30 days after the Demand for Arbitration, Claimant and Respondent shall each select an arbitrator, and these two arbitrators shall mutually agree on a third "Neutral" arbitrator to be the remaining arbitrator on the panel. Each Arbitrator has a quarterly obligation to disclose, in writing, any current or previous relationship, including but not limited to financial or personal, the Arbitrator has or had with the Parties, their attorneys or law firms, a witness, or another Arbitrator.

4. Rules: Procedural Rules and Substantive Law. Except as otherwise stated herein, the Arbitrators shall apply the Florida Rules of Evidence and Florida Rules of Civil Procedure. The Arbitrators shall apply, and the arbitration award shall be consistent with, the State substantive law of Florida, except as otherwise stated in this Arbitration Agreement or the Parties' underlying Residency Agreement. A claim that is not served and filed within the statute of limitations period that would apply to the same claim in a court of law in Florida shall be waived and forever barred.

5. Award. The arbitration award shall be delivered to the Parties no later than five (5) working days following the conclusion of the arbitration hearing. The award shall set forth in detail the Arbitrators' findings of fact and conclusions of law.

6. Fees and Costs. The Neutral Arbitrator's fees and costs associated with the arbitration shall be divided equally among the Parties to this Arbitration Agreement. Claimant and Respondent shall each be responsible for the fees and costs of the arbitrator that each selected. The Parties shall bear their own attorneys' fees and costs in relation to preparation for and attendance at the arbitration hearing unless otherwise provided by law.

7. Refusal to Arbitrate. To the extent permitted by applicable law, any Party to this Arbitration Agreement who refuses to go forward with arbitration hereby acknowledges that the Arbitrators will go forward with the arbitration hearing and render a binding decision without the participation of the Party opposing arbitration or despite his/her/its absence at the arbitration hearing.

8. Confidentiality. To the extent provided by law, the arbitration proceeding shall remain confidential in all respects, including all settlements, arbitration filings, deposition transcripts, documents produced or obtained in discovery, or other materials provided by and exchanged between the Parties, and the Arbitrators' findings of fact, conclusions of law, and award.

9. Waiver of Claim. Any claim shall be waived and forever barred if it arose prior to the date upon which the demand for arbitration is mailed and is not presented in the arbitration hearing.

10. Waiver of this Arbitration Agreement. Any Claimant may file his/her/its dispute in a court of competent jurisdiction subject to the Respondent's approval, which approval shall be established by Respondent's filing a response to the Complaint without simultaneously moving to enforce this Arbitration Agreement. However, a waiver of this Arbitration Agreement for one dispute shall not constitute a waiver of this Arbitration Agreement for any other dispute. Should one of the Parties to this Arbitration Agreement breach its terms by initiating a lawsuit in the judicial forum, the Parties expressly agree that participation in cooperative general discovery while a motion to compel arbitration is pending shall not constitute evidence of a waiver of the right to arbitrate.

F. SEVERABILITY PROVISION

Any clause, term, phrase, provision or part thereof contained in this Arbitration Agreement is severable, and in the event any of them shall be found to be invalid, void, or unenforceable for any reason, this Arbitration Agreement shall be interpreted as if such invalid, void, or unenforceable clause, term, phrase, provision or part thereof were not contained herein, and the remaining clauses, terms, phrases, provisions or parts thereof, of this Arbitration Agreement shall not be affected by such,determination and shall remain in full force and effect. No part of this Arbitration Agreement will be construed against any Party because that Party wrote the Arbitration Agreement.

G. BEFORE ACCEPTING THIS ARBITRATION AGREEMENT

1. Right to Consult with Attorney. Please read this Arbitration Agreement very carefully and ask any questions that you may have. You should also feel free to consult with an attorney of your choice before agreeing to the terms and conditions of the Residency Agreement, including but not limited to the terms and conditions of this Arbitration Agreement (which are expressly incorporated into the body of the Residency Agreement as if set forth fully therein).

2. Opportunity to Read. The Parties understand and agree that each has received a copy of this Arbitration Agreement and has had an opportunity to read and ask questions about this Arbitration Agreement.

H. MANNER OF ACCEPTANCE

Acceptance of this Arbitration Agreement can be accomplished by signing below or by any other manner of acceptance recognized by contract law or equity.

I. RIGHT TO CHANGE YOUR MIND

This Arbitration Agreement may be rescinded (i.e., canceled) by written notice, sent certified mail, by any Party to any Party within thirty (30) days from the date of the Resident's admission to The Waverly. If alleged acts underlying a dispute governed by the Arbitration Agreement are committed prior to the rescission date, this Arbitration Agreement shall be binding with respect to said alleged acts.

EACH OF THE UNDERSIGNED ACKNOWLEDGE THAT HE/SHE: (1) HAS READ AND FULLY UNDERSTANDS ALL FIVE (5) PAGES OF THIS ARBITRATION AGREEMENT; (2) UNDERSTANDS THAT BY ACCEPTING THIS ARBITRATION AGREEMENT, EACH HAS WAIVED HIS/HER OR ITS RIGHTS TO A TRIAL BEFORE A JUDGE AND/OR A JURY; (3) VOLUNTARILY CONSENTS TO ALL OF THE TERMS AND CONDITIONS OF THIS ARBITRATION AGREEMENT; (4) HAS RECEIVED A COPY OF THIS ARBITRATION AGREEMENT; AND (5) CERTIFIES THAT HE/SHE IS THE RESIDENT OR A PERSON AUTHORIZED BY THE RESIDENT OR OTHERWISE AUTHORIZED TO EXECUTE THIS ARBITRATION AGREEMENT

RESIDENT/ RESIDENT'S REPRESENTATIVE	**RESPONSIBLE PARTY**
_____	_____
Date	**Date**
_____	_____
Printed Name	**Printed Name**
_____	_____
Signature of Resident/ Resident Representative*	Signature of Responsible Party in his/her Individual Capacity

*****Resident's Representative understands and agrees that by signing this Agreement or exhibit He/she is signing in both a representative and Individual capacity.

COMPANY REPRESENTATIVE

_____	_____
Signature of Company Representative **	Date

** This individual is authorized to sign this Agreement or exhibit on behalf of the Company and The Waverly.

EXHIBIT B

INFORMED CONSENT TO ASSISTANCE WITH MEDICATION BY UNLICENSED PERSONNEL

Assisted living facility (ALF) law permits the Company to administer medications to residents if the Company has a licensed nurse on staff, or to assist residents with self-administered medication (§ 429 F.S.).

Under ALF law, "assistance with self-administered medication" means that trained, unlicensed staff can help a person to self-administer their medications by performing such tasks as bringing the resident's medication to the resident; reading a prescription label and removing a prescribed amount of medication from the container; placing the medication in the resident's hand or in another container and helping the resident to lift it to their mouth; applying topical medications; returning the medication to storage; and keeping a record of medications that the resident has self-administered.

"Assistance with self-administration" does not include calculating medication dosages; putting the medications in a resident's mouth; preparing or administering injections; applying rectal, urethral, or vaginal preparations; administering medications by way of a tube inserted in a body cavity; administering parenteral preparations; conducting irrigations or using debriding agents for treating skin conditions; administering medications through intermittent positive pressure breathing machines or nebulizers; or performing any medication task which requires judgment or discretion. The unlicensed individual who will be providing "assistance" must have completed a 4-hour training course and has demonstrated their ability to assist you.

At the Company, staff assisting residents with self-administration: o **will** or, XXX **will not** be overseen by either a registered nurse, R.N., or licensed practical nurse, L.P.N.

I, _____, have been informed of this policy and agree to have trained, unlicensed Community staff provide me with assistance in self-administering my medications.

Resident Date

Responsible Party Date

(State of Florida form for consent)

EXHIBIT C
SERVICES THAT MAY BE PERFORMED BY AN ALF

With a STANDARD ALF License: The Waverly Holds this License

1. Provide assistance with, or supervision of, activities of daily living, including ambulation, bathing, eating, grooming, toileting, and transferring.

   "Assistance" means direct physical assistance with ADLs rather than actually performing the task for the resident; however, facility staff may feed residents who are unable to feed themselves. This is the only exception.

   Supervision of ADLs includes reminding residents to engage in specific activities and, when necessary, observing or providing verbal queuing to assist residents while they perform them, as is often the case with residents who have Alzheimer's disease or other forms of advanced dementia.

2. Assistance with self-administered medication by reminding residents to take the medication, opening bottle caps for residents, opening pre-packaged medications for residents, reading the medication labels to residents, observing resident while they take medication, checking self-administered dosage against the label on the container, reassuring residents that they have obtained and are taking the dosages prescribed keeping daily records of when residents receive supervision, and reporting noticeable changes in the condition of the resident. Check Glucose, Vital Signs, compression hose, assist with prefilled insulin pens.

3. Employ an RN or LPN to administer medication, including injections; blood glucose testing; take vital signs; give pre-packaged enemas when ordered by physician, observe residents, and report observation to a physician.

4. Effective May 2018 may delegate responsibility for taking resident vital signs to a certified nursing assistant and Direct care staff who have been trained.

With a LIMITED NURSING LICENSE: The Waverly does not hold this license

1. May perform all functions authorized by a standard ALF.

2. Employ or contract with a registered nurse, license practical nurse, or advanced registered nurse practitioner to perform any of the following acts: Conduct passive range of motion exercises; apply ice caps or collars; apply heat, including dry heat, hot water bottles, heating pad, aquathermia, moist heat, hot compresses, sitz bath and hot soaks; cut the toenails of diabetic residents or residents with a documented circulatory problem if the written approval of the resident's health care provider has been obtained; performing ear and eye irrigations; conducting a urine dipstick test; replacement of an established self-maintained indwelling urinary catheter, or performance of an intermittent urinary catheterizations; perform digital stool removal therapies; apply and change routine dressings that do not require packing or irrigation, but are for abrasions, skin tears and closed surgical wounds; care for stage 2 pressure sores (care for stage 3 or 4 pressure

sores are not permitted under this rule); care for casts, braces and splints (care for head braces, such as a halo is not permitted under this rule); conduct nursing assessments if conducted by a registered nurse or under the direct supervision of a registered nurse; for hospice patients, providing any nursing service permitted within the scope of the nurse's license including 24-hour nursing supervision.

NOTE: All nursing services must be ordered by a physician, except administration of medication.

With an EXTENDED CONGREGATE CARE License: The Waverly does not hold this license

1. May provide all of the services permissible in a standard ALF and an ALF licensed to provide limited nursing.

2. Licensed nursing staff in an ECC program may provide any nursing service permitted within the scope of their license consistent with residency requirements and the Community's written policies and procedures, and the nursing services are:

   A. Authorized by a health care provider's order and pursuant to a plan of care;
   B. Medically necessary and appropriate for treatment of the resident's condition;
   C. In accordance with the prevailing standard of practice in the nursing community;
   D. A service that can be safely, effectively, and efficiently provided in the facility;
   E. Recorded in nursing progress notes; and
   F. In accordance with the resident's service plan.

GUIDELINES FOR ESTABLISHING FACILITY SPECIFIC CRITERIA FOR CONTINUED RESIDENCY IN AN EXTENDED CONGREGATE CARE FACILITY

An individual must meet the following minimum criteria in order to be admitted to an extended congregate care program.

Be at least 18 years of age.

Be free from signs and symptoms of a communicable disease, which is likely to be transmitted to other residents or staff; however, a person who has human immunodeficiency virus (HIV) infection may be admitted provided that he would otherwise be eligible for admission.

Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted.

Not be of danger to self or others as determined by a health care provider.

Not be bedridden.

Not have any stage 3 or 4 pressure sores.

Not require any of the following nursing services:

oral or nasopharyngeal suctioning;

assistance with nasogastric tube feeding;

monitoring of blood gases;

intermittent positive pressure breathing therapy;

skilled rehabilitation services for treatment of consequences of stroke or fracture;

treatment of a surgical incision, unless the surgical incision and the condition which caused it have been stabilized and a plan of care developed;

any service or treatment requiring 24-hour nursing supervision.

Criteria for continued residency in an ECC program shall be the same as the criteria for admission, except as follows:

Resident may be bedridden for up to 14 consecutive days.

A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the Community if the following conditions are met:

Resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;

Continued residency is agreeable to the resident and the Community;

An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the Community. Community staff may provide any nursing service with the scope of their license including 24-hour nursing supervision, and total help with the activities of daily living.

This is provided for informational purposes only.

EXHIBIT E

BENEFICIARY DESIGNATION FORM

Under Florida law, in the event of the death of a resident, the Company must return all refunds, funds, and property to be held in trust to a resident's personal representative, if one has been appointed at the time the Company disburses such funds. If no personal representative has been appointed, the Company is to return all refunds, funds, and property to a resident's spouse or adult next of kin named in this Beneficiary Designation Form, which the Company is required to provide to you by § 400.427(7) of the Florida Statutes.

I, _____, hereby

designate _____, to be
(Name and Relationship of Designee)
my beneficiary in the event I die and no personal representative has been appointed. I understand and authorize the Company to return all refunds, funds, and property to the beneficiary named in this document if no personal representative has been appointed.

RESIDENT/ RESIDENT'S REPRESENTATIVE	**RESPONSIBLE PARTY**
_____	_____
Date	**Date**
_____	_____
Printed Name	**Printed Name**
_____	_____
Signature of Resident/ Resident Representative*	Signature of Responsible Party in his/her Individual Capacity

*****Resident's Representative <u>understands</u> and <u>agrees</u> that by signing this Agreement or exhibit He/she is signing in both a <u>representative and Individual capacity.</u>

COMPANY REPRESENTATIVE

_____	_____
Signature of Company Representative **	Date

** This individual is authorized to sign this Agreement or exhibit on behalf of the Company

EXHIBIT F

RESPITE CARE ADDENDUM

I. SERVICES

The Company will provide the personal care services that are listed in Section I of the Residency Agreement. You agree to occupy unit_____ for a period of _____ days commencing on _____. If your Respite Stay extends beyond that period, you agree to sign a new Respite Care Addendum or the standard the Company Residency Agreement, depending upon your length of stay.

II. FINANCIAL ARRANGEMENTS

In addition to the established Monthly Service Rate, you will pay the Respite Care Fee ("Respite Fee") of $_____ per day. The Respite Fee is payable in advance on a monthly basis and is due on the first calendar day of each month, except for the first payment which is due at the time this Addendum is executed. If this Addendum becomes effective after the Company has prepared the itemized statement for the following month, the first payment will also include the charges for the following month.

III. TERM AND TERMINATION

This Addendum will be in effect for the period stated above unless either party terminates this Addendum for any reason by giving three (3) days prior written notice to the other party. The Company will credit your account for unearned charges in the month following termination, but You will pay a minimum Respite Fee of three (3) days' charges during the term of the Addendum. In the event You choose to remain a permanent Resident at the Community, two-thirds (2/3) of the Respite Fee paid will be applied to the move-in fee due for the unit in which You reside and will follow the guidelines set forth in the Residency Agreement. In the event You pay a Respite Fee and the total amount paid is greater than the move-in fee for the unit in which You reside, no refund will be given.

BY THEIR SIGNATURES, the parties executed the Addendum to be effective _____, 20___.

For the Company	Title	Date
Resident		Date
Responsible Party		Date

EXHIBIT G
PHARMACY SERVICES AGREEMENT

The Company works closely with pharmacy providers to make certain that the needs of our residents are met. Preferred pharmacy providers are chosen based upon their ability to provide services to our residents to enhance their health and wellness. Important services include:

- Screening for possible negative drug interactions
- Assessments for potential allergic reactions of medications
- Recommending therapeutic substitutions when appropriate
- Providing competitive pricing for comparable packaging and offering generic substitutions when appropriate
- Alerting staff and physicians when there is a duplication of prescriptions
- Individual wellness recommendations
- Regular scheduled review and monitoring of medications
- Routine or emergency delivery 24-hours a day, 365 days a year
- Medication packaging that meets the Community's standards for safety

Our "preferred provider" for pharmacy services at the Community is First Choice LTC Pharmacy. Our staff works closely with this pharmacy to meet the needs of our residents. They will review all current medications before your move-in and the consultant pharmacist will be in the Community on a regular schedule to meet with you individually, if needed.

If you decide to use another pharmacy provider other than the Company's "preferred provider", they will be required to meet the Company's standards regarding medication management.

Please review and sign the following statement acknowledging you understand the Company's expectations and requirements regarding the provision of medications.

I understand that if I choose not to use the Company's preferred provider, I may be charged a fee, which is set forth on Exhibit X, the Select Services List.

I understand that I will be required to provide medications that are packaged in a unit of use packaging system, unless I have been granted an exemption to the packaging requirement by the Chief Operating Officer.

I understand there is a service fee of $_____ a month associated with a packaging exemption due to the additional administrative oversight required.

If at any time I am not able or no longer willing to provide this type of packaging system and I do not have an exemption, I understand that I need to find alternative housing.

X_____
(Please initial as having read and understood the above provision.)

If I do not use the Company's preferred provider, I also understand that I will have the responsibility for reordering medications but in the event the medications are not delivered **within two days prior to the depletion** of my medication stock, the Company will reorder my

medications with the 'Preferred Pharmacy' to ensure no disruption takes place. **I agree to pay for the medications and any associated service charges.**

The fees associated with reordering medications from the "Preferred Pharmacy" are determined by the "Preferred Pharmacy", and are in addition to the service fee described above.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE TERMS OF THIS PHARMACY SERVICES AGREEMENT.

Resident Signature	Date
Legal Representative Signature	Date

(Pharmacy form)

Exhibit: H

The Waverly

Rules of the residence

1) No consumer can be admitted with a communicable disease in a transmittable stage
2) Memory Care Clients may NOT keep or maintain a phone or cell phone on their person or in their room at any time. The Facility provides a land line for all personal calls that is available at any time.
3) Height and weight must be recorded on admission. Weight will continue to be obtained and recorded every six months thereafter.
4) The facility does furnish television sets. There is no charge for basic cable hook-up.
5) There are private telephones in the rooms. This is for local calls only
6) When the Resident is discharged, the responsible party is to contact the office and make arrangements for settlement of the account at least 30 days prior to discharge.
7) Activity programs will be available to all residents to participate in if desired. These are not compulsory and the resident has the choice to participate
8) Each resident has limited storage space; therefore, their possessions cannot be stored at the facility. Only Items that will actually be used may be brought to facility.
9) All foods brought into the facility for the residents are to be individually wrapped and placed in a sealed container, (Plastic with a air tight lid is suggested), to help the facility maintain pest control. Must be stored in Kitchen. Or room if they have a refrigerator in room
10) Facility is not responsible for valuables in a residents room and or possession. This includes but is not limited to jewelry, clothing, dentures, hearing aides, adaptive devices, money, cell phones, etc. It is strongly recommended that all valuables either be kept secure in the facility safe or taken home with a loved one and or responsible party.
11) Bed linens will be changed weekly unless necessary to have it done sooner, Residents are responsible for making their beds other then on linen change day. If this is possible
12) Staff members will clean rooms thoroughly weekly. Residents are responsible for keeping them tidy day to day. Hoarding and storing of excess belongings that impair navigation through the room or items that pose a safety threat must be removed.
13) All meals will be consumed at the dining room table. One exception would be if you are ill and are not able to get out of bed, for no more than 7 days. Staff will directly assist with this.
14) This facility or employees will discard of any personal items not picked up within 30 days of discharge. Residents will continue to be charged until such items are retrieved and removed from the facility.
15) The administrator cannot act as a guardian or trustee for any resident or his property.
16) All drug or food allergies must be documented.
17) In the event of flu epidemic or any communicable disease, this facility may use judgment in not allowing the public to visit the facility or resident, which is left to the discretion of the administrator.

18) The Waverly is a non-smoking residence. There is absolutely no smoking allowed inside the building. A smoking area is provided. Anyone that is found smoking in any room in the house will be asked to find other accommodations. The only designated smoking area is the courtyard by the main dining room. NO SMOKING on the front of property at any time.
19) The outer doors have been secured for the night, they must be left this way for security reasons. The doors are locked at 10 p.m. on Sunday thru Thursday and 11p.m. on Friday and Saturday night.
20) The kitchen is not to be used at will. If you require something from the kitchen you must ask a staff member. The kitchen stays under lock and key. There will be beverages available 24/7
21) All common areas are videotaped 24 hours 7 days a week.
22) The individual has the choice of who is there doctor and they seek treatment from.
23) You may not store fruits such as bananas, apples, oranges, etc. in your room that are not consumed immediately. This results in fruit fly infestations.
24) We require that you have complete compliance with all prescribed medications by a licensed physician.
25) No using of illegal substances, no illegal substances may be kept in your room or on the company property at any time. Failure to comply will result in a 45-Day Letter of discharge.
26) No verbal or physical aggression towards another client or staff.
27) You are also required to sign in and out so that staff are always aware of your whereabouts.
28) You must participate on an ongoing basis with your plan of care. Plan of care includes but is not limited to bathing as scheduled, accepting care of staff when needed to maintain your cleanliness, taking medications as prescribed, following doctor's orders, etc. Failure to do so may result in a 45-Day letter of discharge as directed by the Administrator.
29) If at any time you are to strike another resident or a staff member for any reason whatsoever, you will receive an immediate discharge from the facility. There is zero tolerance for any act of violence toward anyone in the facility. Abusive Language will also not be tolerated.
30) There is absolutely no alcohol permitted on company property. This includes resident rooms, as well as any other location in the facility. There is absolutely no provision for the abuse of alcoholic beverages on the property. Non-compliance will result in an immediate 45-Day notice of discharge.
31) At no time may any resident take any glassware out of the dining room and into any other area of the facility. This includes coffee cups, goblets, plates, and silverware. All items of the dining area are to remain in the dining area. Please do not take them out of the dining room for any reason. All residents are required to maintain their living space. All areas shall remain clean, tidy,
and free of offensive odors. Resident who fails to assist in maintaining their person space or if a resident's room becomes inundated with extreme odor the Administrator will meet with you to rectify the situation. If an agreeable compromise cannot be made you may receive a 45-Day letter of discharge from the facility.

Exhibit I

400.428 Residents Bill of Rights.

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 400.427.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right.

This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. This notice shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, when applicable, the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council, where complaints may be lodged. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council.
(3) (a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal.
(a) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.
(b) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.
(c) The agency may conduct periodic follow up inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.
(d) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.
(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.
(5) No facility or employee of a facility may serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:
(a) Exercises any right set forth in this section.
(b) Appears as a witness in any hearing, inside or outside the facility.
(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.
(6) Any facility which terminates the residency of an individual who participated in activities specified in subsection (5) shall show good cause in a court of competent jurisdiction.
(7) Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefore, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party

Exhibit J
Elopement Policy

The policy as defined for our Facility of Elopement is that a resident has left the property and did not inform staff of where he or she was going and 8 hours has passed without any one seeing the resident. Unless the resident has been defined by management as a high-risk resident, then it would be if no one has seen the resident in 3 hours. Law enforcement would be called if this criterion is met

High Risk Resident: One who has no ability to communicate where he or she lives.
Or one who has been determined by their physician to need a higher level of monitoring.

All residents shall have their photo taken at time of admission. All high risk shall be accounted for daily.

However, if someone has been found to be missing:

Step 1: Senior staff on duty will conduct a thorough search identifying which staff will search and who will remain available for the care of other residents with a periodic recheck of the areas on property where the resident would usually be.

Step 2: Senior staff on duty will initiate protocol

Step3: Senior staff will be responsible for calling Law enforcement and making report and filling out incident report.

Senior staff is defined through length of employment or job title

We shall review this procedure twice a year, and new hires within 30 days.

Procedure

1) If we determine a resident is missing, we shall immediately search all property and decide of last known time seen.
2) Call administrator or manager to help with a determination of the elopement and should the call to law enforcement be advanced ahead of the policy time limit.
3) Call family members or guardian
4) Call case manager if applicable.
5) Call Law enforcement and fill out report.
6) If found make all calls to parties who were called when missing.
7) Never neglect other residents in our care.

Exhibit K

A. DNRO Policy

The Waverly will not require the execution of a DNRO for any reason and will not discriminate on residency whether there is one or not. The resident will be provided information on Form SCHS-4-2006 and DH Form 1896 a copy provided if requested.

If the resident has A DNRO already executed it must be presented on admission to facility, and if not, it shall be documented that it was requested in the file. At any time during residency that a resident would like to execute a DNRO the facility will aid in the acquisition of the form for the resident for them to take to their physician to sign.

A copy must be kept in Resident's file. All staff will honor a DNRO. If resident is receiving Hospice services, then they will be contacted immediately. All staff shall receive training in this policy and understanding DNRO's.

The original yellow paperwork will be required a copy will not be sufficient.

Legal requirement is FS 429.255, FAC 58A-0186

Exhibit L
Copy of SCHS-4-2006,

Health Care Advance Directives
The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.
When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.
By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive? It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.
Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will? It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation? It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best? Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law? No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive? Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

 If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.

 Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.

 Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.

 Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

 If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information on Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

 As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney, be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

 If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

 If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread

the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

 If you would like to read more about organ and tissue donation to persons in need you can view the Agency for Health Care Administration's website http://ahca.MyFlorida.com (Click on "Site Map" then scroll down to "Organ Donors") or the federal government site www.OrganDonor.gov. If you have further questions you may want to talk with your health care provider.

 Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity www.AgingWithDignity.org
(888) 594-7437
Other resources include:
American Association of Retired Persons (AARP)
www.aarp.org
(Type "advance directives" in the website's search engine)
Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.
Brochure: End of Life Issues
www.FloridaHealthFinder.gov
(888) 419-3456

Living Will

Declaration made this _____ day of _____, 2____, I, _____,
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,
and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.
It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.
In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:
Name _____
Street Address _____
City _____ State _____ Phone _____
I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____
(Signed) _____

Witness _____ Witness _____
Street Address _____ Street Address _____
City _____ State _____ City _____ State _____
Phone _____ Phone _____
At least one witness must not be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:
“End-stage condition” means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.
“Persistent vegetative state” means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.
“Terminal condition” means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.
These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____

Street Address _____

City _____ State _____ Phone _____

Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____

Street Address _____

City _____ State _____ Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

_____

_____

_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Name _____

Signed _____

Date _____

Witnesses 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:
I give:
(a) _____ any needed organs or parts
(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:
_____
_____
_____
(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:
_____
_____
_____
Signed by the donor and the following witnesses in the presence of each other:
Donor's Signature _____ Donor's Date of Birth _____
Date Signed _____ City and State _____
Witness _____ Witness _____
Street Address _____ Street Address _____
City _____ State _____ City _____ State _____
You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place. **Health Care Advance Directives**

I, _____
have created the following Advance Directives:
___ Living Will
___ Health Care Surrogate Designation
___ Anatomical Donation
___ Other (specify) _____
---------- FOLD ----------
Contact:
Name _____
Address _____
_____
_____
Phone _____
Signature _____ Date _____

Exhibit M

Grievance Policy

STANDARD:
All residents or their representatives have the right to pursue a grievance with regards to their participation in the assisted living facility. The "The Waverly" assisted living facility will hear and attempt to resolve all grievances in a fair and timely manner. It is the purpose of this process to work for the betterment of the resident.

PROCEDURES:

1. The aggrieved person, or person acting on his/her behalf will meet with the person against whom the complaint is directed, or with the person who is most involved in the conditions resulting in the complaint. This meeting will be informal and designed to provide a solution that will not require further discussion. Cases of verbal or physical abuse shall be reported directly to the Administrator/Owner.

2. If a solution cannot be reached, the aggrieved (or representative) may ask the Supervisor for an appointment, this must be done in writing it can be a short note or email it must be signed and dated The meeting must be held within five (5) days of receipt of the grievance. The aggrieved (and/or representative) and the Supervisor will discuss the problem, and will attempt to reach a solution satisfactory to all parties.

3. If a solution cannot be reached, an appointment may be scheduled with the Administrator/Owner, this request will be in writing as well. The request for the meeting with the Administrator/Owner must be made within five (5) days of the meeting with the Supervisor. The Administrator/Owner will be supplied with notes from the previous meeting and will discuss the situation with the aggrieved (and/or representative) privately, and will attempt to reach a solution satisfactory to all parties. The Administrator/Owner shall remain the last and final avenue for the hearing of resident grievances.

4. A written summary of the formal grievance heard by the Administrator/Owner will be recorded, which includes the nature of the grievance and a remediation/correction plan. Residents will be informed of their right to complain to the Ombudsman and or AHCA

5. A log will be maintained of each complaint filed

Exhibit N

MEDICATION POLICY

All staff will receive training on the medication as prescribed by the licensing agency for the facility, which would include training on 58A-50185 by a registered Nurse or Pharmacist this training will be updated annually. Each staff person will be responsible to follow that training and not deviate from it. Staff will be required to report and discrepancies to their immediate supervisor for them to follow up on.

- You cannot make changes on a prescription label. Only a pharmacist can change a prescription label.
- Record medication each time it is offered on MOR. (***Medication Observation Record)***
- You must be prepared to demonstrate that you can read and understand a prescription label.
- You may place any unused medication back into the bottle as long as it hasn't been contaminated. (If pills or other solid medication are dropped onto a clean surface, they are probably not contaminated.)
- Observe the resident's response to the medication and report redness, draining, pain, or itching, swelling, or other discomforts or visual disturbances or consumer's complaints. Know where to learn about side effects and what to look for. And do not be afraid to report any problems out of the ordinary to management or ownership.
- Reorder medications from the pharmacy 3 days prior to running out.
- Medications are to be kept in the medication cabinet at all times and locked.
- Keep up the MOR.
- The order written on the MOR must match the prescription label exactly.
- MOR's must be signed and initialed on the back to identify the initials of all who assist and supervise medications intake. "Emar" may be used in place of handwritten MOR'S
- Be prepared to demonstrate a medication pass at moment's
- notice for a RN or their designee.

- All meds to be returned to pharmacy for disposal per agreement with pharmacy.

- We will not require a prescription for over-the-counter medications but will require they be centrally stored.

- PRN (as needed) medications we cannot assist if the label does not give the reason, it is being taken by the resident. (Ex for right knee Pain)

- If there is any doubt, please make it the best practice to ask for clarification (Better safe than sorry)

- Clients may use their own pharmacy, and we will do our best to work with that pharmacy but if we find resident is at risk, we will have to make arrangements with the resident or family member to correct ASAP if this is not done, we will need to handle in a manner that we see fit to make sure no interruption happens in the resident's medications.

- No staff may enter a medication cart until they have been properly trained, there is no exceptions to this.

- There will be a properly trained staff person on duty at all times, most medications will be handled by Med techs and not nurses, however and medications that require a nurse will be handled by a licensed nurse

Medication is one of the most serious things we aid clients with, all aspects of this must be addressed with the resident's health and safety in mind. Please take pride in this aspect of your work.

Exhibit O REQUIRED TO BE GIVEN BY STATUTE

SAMPLE FORM

State of Florida **MUST BE ON YELLOW PAPER**

DO NOT RESUSCITATE ORDER

(Please use ink)

Patient's Full Legal Name: _____Date: _____

(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn. (If not signed by patient, check applicable box):

❑ Surrogate ❑ Proxy (both as defined in Chapter 765, F.S.)

❑ Court appointed guardian ❑ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____

(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (Artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____

(Signature of Physician) (Date) Telephone Number (Emergency)

_____

(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2002

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____

(Signature of Physician) (Date) Telephone Number (Emergency)

_____

(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2002

State of Florida

DO NOT RESUSCITATE ORDER

_____

Patient's Full Legal Name (Print or Type) (Date)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, h e r e by direct that CPR be withheld or withdrawn. (If not signed by patient, check applicable box):

❑ Surrogate

❑ Proxy (both as defined in Chapter 765, F.S.)

❑ Court appointed guardian

❑ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____

(Applicable Signature) (Print or Type Name)

Important!

In order to be legally valid this form MUST be printed on yellow paper prior to being completed. EMS and medical personnel

are only required to honor the form if it is printed on yellow paper.
This box will not show up when the form is print.