COUNTY OF DELAWARE

Board of Institutional Management
FAIR ACRES GERIATRIC CENTER
340 North Middletown Road
Media, Pennsylvania 19063

PHONE (610) 891-5739
FAX (610) 891-5916

COUNCIL
DR. MONICA TAYLOR
CHAIR
RICHARD R. WOMACK
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JAMES BONNER
MEDICAL DIRECTOR

Dear Family/Responsible Party,

Thank you for considering Fair Acres Geriatric Center. We have been providing quality care to the community for over 200 years. Selecting a Nursing Home is an important and difficult decision. The Admissions staff is available to assist you to facilitate and expedite the process. Enclosed are the materials and steps necessary for applying to Fair Acres Geriatric Center.

1. For Admission to Fair Acres
   - Complete the Application for Admission **Attachment A,** Pertinent Information **Attachment B,** and sign the Release of Records **Attachment C.** Please forward to Fair Acres, as soon as possible.
   - After receiving the above attachments, the Admissions Caseworker will contact you to review the information and schedule an appointment for an interview.
   - If possible, please photocopy all documents listed on **Attachment D,** to provide to the Admissions Caseworker at time of interview. **Please note that choosing to transmit personal Financial or Medical information via email is not secure and is done so at your own risk.**

2. For Medical Eligibility
   - Have your **Physician complete** and **sign** the enclosed (MA-51) Medical Evaluation Form.
   - Have **Applicant sign # 10** on the MA-51 Medical Evaluation Form. If applicant is unable to sign, responsible party must sign # 10 and document the reason on the MA-51 Medical Waiver Signature Form.

If you should have any questions, feel free to contact the Admissions Department at (610) 891-5739.

Sincerely,
Terri Furman
Admissions Director

Non-Discriminatory Statement

Fair Acres Geriatric Center complies with the provisions of the Federal Civil Rights Act of 1964 and the Pennsylvania Human Relations Act, (43 P.S. SS951-962.2), The Rehabilitations Act of 1973 (Section 504), the Age Discrimination Act of 1975, and all requirements imposed pursuant thereto, to the end that no person shall, on the grounds of race, color, national origin, ancestry, age, sex, religious creed, handicap or disability, be excluded from room participation, or be denied benefits of or otherwise be subject to discrimination in the provision of any care of service.

FAIR ACRES ADMISSION APPLICATION (A)
PHONE (610) 891-5739 FAX# (610) 891-5916

Name of Applicant: ______________________ (as it appears on Medicare card) Marital Status: ________

Applicant Address: ______________________ Years lived in Delco: ________

Current Location: ______________ Since: _______ Home Phone #: ______________

Veteran Branch: __________ Lifetime Occupation: __________ Ethnicity: __________ Religion: __________

Place of Birth: __________ U.S. Citizen: ☐ Y ☐ N Primary Language:__________ Interpreter Needed:☐ Y ☐ N

Has applicant ever been convicted of a Felony: ☐ Y ☐ N

Medicare #: ______________ DOB: __________ Social Security #: ______________

Other Medical Insurance: ______________________ HMO: ☐ Y ☐ N

Medicare Supplemental Insurance: ______________________ HMO: ☐ Y ☐ N

Long Term Care Insurance within 5 years: ☐ Y ☐ N Access Card (MA #): ______________

Medicare D Plan: ______________ Other Prescription Drug Plan: ______________

Primary Physician & Phone #: ______________ Living Will/Advance Directives: ☐ Y ☐ N

Total Monthly Income: __________ SS: __________ Pension: __________ Other: __________

Current Balance: Checking Acct.: __________ Savings Acct.: __________ # of Bank Accts: __________

CD's: __________ Stocks/Bonds/Annuities: __________ IRA(S): __________ Trust Account: __________

Own Real Estate: ☐ Y ☐ N Name(s) on Deed: ______________ Approx. Value: __________

Loans: ☐ Y ☐ N Amount: __________ Unpaid Nursing Home Balance: ☐ Y ☐ N Amount: __________

*****Fair Acres is not responsible for burial preparation and expenses. *****

Preferred Funeral Director and Phone #: ______________________

Restricted (Irrevocable) Burial or Prepaid Funeral: ☐ Y ☐ N Whom: ______________ Amt: __________

☐ Life Insurance Policies; include company, policy number, face and cash value: ______________

Have any assets or property been liquidated or transferred within the past **5** years: ☐ Y ☐ N

This includes any cash gifts, donations, transfers, withdrawals or transactions. If yes, please explain: __________

Elder Law Attorney: ☐ Y ☐ N Name & Phone #: ______________________

Primary Contact: ______________________ ☐Guardian ☐POA ☐Responsible Party ☐Medical ☐ Financial

Address: ______________________ E-mail: ______________

Home Phone #:______________ Business #: ______________ Cell #: ______________

I understand that the information supplied herein is correct and that fraudulent attempts to conceal or ignore material facts may result in possible legal proceedings by the Department of Human Services (DHS) (formerly Department of Public Welfare (DPW) and/or Fair Acres to recoup any assets inappropriately transferred.

______________________ Relationship: ______________ Date: __________

Signature of: ☐Responsible Party ☐POA ☐Guardian

Pertinent Information (B)

Application Name: ______________________ **Prefers to be called:** ______________ # of Children ____

Are you receiving any home care in the community and/or enrolled in the waiver program? ☐ Y ☐ N

Living Situation/Support System: ______________________

Is the applicant aware of the pending nursing home placement? ☐ Y ☐ N ______________

Concerns with placement ☐ Y ☐ N **Concerns with Clutter/Hoarding** ☐ Y ☐ N **Dominant Hand** ☐ R ☐ L

Please indicate preferred Funeral Director and Phone # ______________________

****Fair Acres is not responsible for Burial preparation / expenses.**

Primary Physician & Phone# ______________________ **Last Appointment:** ____________

COVID 19 Vaccine ☐ Y ☐ N Manufacturer: ____________ Dates Given: 1st Dose ______ 2nd Dose ______

Flu Vaccine Given ☐ Y ☐ N Date: ____________ **Pneumovax (23) Given** ☐ Y ☐ N Date: ____________

Measles Vaccine <60 ☐ Y ☐ N Date: ____________ **Prevnar13 Given** ☐ Y ☐ N Date: ____________

Are there any outstanding appointments scheduled? ☐ Y ☐ N ______________

Any overt signs of infection (Respiratory, GI, ENT, jaundice, rash, wounds, fever, diarrhea, chills and /or cough) ☐ Y ☐ N

If seeking admission from home, please use the enclosed medication form, page 2. ☐

List Admission and D/C dates in Past (1) year from Hospitals and Nursing and Rehab Facilities: ______________

____

Additional Contact(s): (other than the Primary Contact noted on Application)

Name: ______________________ Relationship: ____________

Address: ______________________

Home Phone: __________ Business: __________ Cell: __________ Email: ____________

☐ POA: ☐ Medical ☐ Financial ☐ Guardian ☐ Responsible Party

Name: ______________________ Relationship: ____________

Address: ______________________

Home Phone: __________ Business: __________ Cell: __________ Email: ____________

☐ POA: ☐ Medical ☐ Financial ☐ Guardian ☐ Responsible Party

Has applicant ever been convicted of a Felony: ☐ Y ☐ N

Current use or history of: Drugs ☐ Y ☐ N Alcohol ☐ Y ☐ N Nicotine ☐ Y ☐ N If Yes, Last Cigarette Date: ________

Any signs of infestation (head lice, scabies/rash, bed bugs/bites) ☐ Y ☐ N

Current or history of: Wandering/Exit Seeking ☐ Y ☐ N Combative/Assaultive ☐ Y ☐ N 1:1 ☐ Other ☐

Comments: ______________________

***Per Pennsylvania Pre-Admission Screening Resident Review Regulations:**

***Does applicant have:** Any condition that caused intellectual disability, prior to the age of 18? ☐ Y ☐ N __________

*Circle **any diagnosis of** Dementia, Depression, Schizophrenia, Bipolar, Brain Injury, Huntington's Disease and/or PTSD.

***Seizures before** the age of **22?** ☐ Y ☐ N

***Any Mental Health Case Manager** (Intensive Case Manager (ICM), Blended or Targeted Case Manager, Resource Coordinator (RC), Community Treatment Team (CTT) or Assertive Community Treatment? (ACT) ☐ Y ☐ N

***In past 2 years, (Please Circle)** Admission to a **State Hospital,** Treatment in a **Psychiatric facility,** Treatment in a Partial Psychiatric Day Program, A Stay in a Long Term Structured Residence, Receive Electroconvulsive Treatment (ECT), Suicide Attempt or Ideation with a plan, Legal/Law intervention, 302 and/or Loss of Housing? **None of the above** ☐

List Admission and D/C dates in Past 2 yrs. for Psychiatric Facilities (If applicable):

____

____

____

______________________ ☐ Responsible Party ☐ Guardian Date ____________

Signature/Relationship ☐ POA: ☐ Medical ☐ Financial

COUNTY OF DELAWARE

(C)

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RELEASE OF RECORDS

I am requesting the release of the following medical records to Fair Acres Geriatric Center for the purpose of expediting the admission or obtaining past medical history for:

NAME	SS #	DOB

FOR DEPARTMENT USE ONLY:

❑ **Physician office records for the last year, including:**
☐ Current Medications, ☐ Diagnosis, ☐ CXR, ☐ Implanted Devices, and any history of vaccines (Pneumovax, Flu, PPD), MRSA, VRE, ESBL, and C-Diff, with dates

❑ **Outpatient Services:**
Psych Consult/Evaluation within the last year, 12 months Progress Notes, Current Medications

❑ **Target Review:**
Psychiatric Discharge Summaries within the last 2 years, History and Physical, Psychiatric Consult/Evaluation, Psychosocial Evaluation and CT Head/Neurology consults

❑ **Hospitals/Nursing Homes/Assisted Living:**
Face Sheet, H&P, Current Monthly Physician Order Sheets (MAR/TAR), MD Progress Notes, Nurses Notes _______days, Rehab Notes, Psych Consult/Evaluation (if applicable), Current Labs, Pertinent Consults or Test Results, and Immunization Record

I hereby authorize release of the following records to:

Fair Acres Geriatric Center
Admissions Department
340 N. Middletown Road P.O. Box 496
Lima, PA 19037-0496

Resident Name	Witness	Date
❑ Responsible Party ❑ POA ❑ Guardian	Relationship to Resident	Date

This consent is revocable at the written request of the person giving consent.

This release will remain in effect for
One year unless revoked by you.

FAIR ACRES ADMISSION DEPARTMENT

Phone # (610) 891-5739 Fax# (610) 891-5916

The Department of Human Services (DHS) at (610) 447-5500, (formerly the Department of Public Welfare), requires the supporting documents to complete the Medical Assistance (Medicaid/MA) Financial Eligibility Application for Long Term Care, (PA 600). Please bring copies when meeting with your Admission Caseworker at Fair Acres.

The local County Board of Assistance, 701 Crosby Street, Suite A, Chester, PA, determines eligibility for the nursing home grant once they have received/reviewed the PA 600 and copies of the following:

One Proof of Identification

☐ Birth Certificate ☐ Drivers/Non-Drivers License ☐ Passport ☐ Citizenship paper (if applicable)

Proof of Medical Insurance

☐ Medicare Card ☐ Other Medical Insurance Card ☐ Premium (Bill) for Medical Insurance

☐ Prescription Card ☐ Premium (Bill) for Prescription Plan

Other

☐Social Security Card ☐Pacemaker Card ☐Defibrillator Card ☐ Implant Card ☐ Marriage License

Verification of Current Income

☐ Social Security Statement
☐ Pension(s) Statement(s)
☐ Pension Address
☐ Long Term Care Insurance
☐ Railroad Statement
☐ Veterans Administration Award Letter
☐ Rental Income
☐ Civil Service Statement
☐ Annuity Statement
☐ Other

Verification of Financial Resources

DHS requires a 5-year lookback: Bank statements from the last 24 months and June and December statements of the prior 3 years. Include written explanation next to any transaction of $500.00 or more. Also, Include copies of checks. *If active Medicaid/MA in the Community, will only need the last 6 months of Bank Statements. *

Community spouse Y ☐ N ☐ Verification of their finances are also required.

☐Checking
☐CD's
☐401 Accounts
☐ Saving
☐Stocks/Bonds
☐IRA's
☐ Money Market
☐Trust Account
☐Annuities

☐ Verification of assets gifted/transferred in the last 5 years over $500.00 (when applicable).

☐ Copy of Deed (when applicable)

☐ Irrevocable pre-paid funeral or burial account (when applicable).

☐ Preferred Funeral Home Director and Phone#
*****Fair Acres is not responsible for burial preparation and expenses. *****

☐ Life insurance policies and current cash surrender value (when applicable).

☐ Long Term Care Insurance Policy (when applicable).

☐ Power of Attorney/Legal Guardian papers (when applicable).

☐ Advance Directive (Living Will or Durable Power of Attorney for Health Care).

☐ Humanity Gift Registry Card and/or Organ Donor Card, (when applicable).

☐ Medical Evaluation (MA 51) completed by the physician.

☐ MA 51 Attachment (when applicable). ____________

☐ PA 600 Given Received Sent Date_________

Please Note: The Medical Evaluation (MA 51) form # 1 thru 20C must be completed by the primary care physician except # 10, which is signed by the applicant in order to proceed with an assessment.

INSTRUCTIONS FOR COMPLETING
MA-51 MEDICAL EVALUATION

NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.

9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.

10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.

11. **Essential Vital Signs.** Self-explanatory.

12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**

13. **Vacating of building.** How much assistance does the patient require to vacate the building?

14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?

15. **Diagnostic Codes and Diagnoses.** ICD diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary. There is room for any other pertinent diagnoses.

16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.

17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.

18. **Prognosis.** Indicate patient's prognosis based on current medical condition.

19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/ID Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to ID individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. **The physician must sign and date the MA-51. A licensed physician must sign the MA-51.** It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT]).

Questions 21 and 22 are completed by Aging Well or the appropriate Department of Human Services program office. These questions are used by the Department to certify the Individual's medical eligibility for services.

MEDICAL EVALUATION ☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE

5. AGE	6. SEX	7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code) ☐

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) ____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction. I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT ____ DATE ____

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING
☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

	PRIMARY (Principal)
	SECONDARY
	TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) ____

17. PHYSICIAN ORDERS

Medications ____

Treatment ____

Rehabilitative and Restorative Services ____

Therapies ____

Diet ____

Activities ____

Social Services ____

Special Procedures for Health and Safety or to Meet Objectives ____

18. PROGNOSIS - CHECK ✓ ONLY ONE
☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE
☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A **PHYSICIAN'S RECOMMENDATION** To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/ID Care Services to be provided at home or in an intermediate care facility for the intellectually disabled
☐ ICF/ORC Care Services to be provided at home or in an intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) ____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**

ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) ____ TELEPHONE ____ PHYSICIAN SIGNATURE ____ DATE ____

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21 **MEDICALLY ELIGIBLE** ☐ Yes ☐ No

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE ____ DATE ____

ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE

FAIR ACRES

340 N. MIDDLETOWN ROAD
MEDIA, PA 19063

MA-51 ATTACHMENT

FA AD 105.1 Feb 2020

MA-51 MEDICAL WAIVER SIGNATURE FORM

THIS FORM IS TO BE USED WHEN THE APPLICANT IS PHYSICALLY AND/OR MENTALLY INCAPACITATED TO THE EXTENT THAT SIGNING HIS/HER NAME IS NOT POSSIBLE.

______________________________ IS UNABLE TO SIGN THE MA-51 (#10) BECAUSE OF THE FOLLOWING REASON(S):

____

____

______________________________________ (SIGNATURE/RELATIONSHIP TO APPLICANT)

____ / ____ / ____ (DATE)

Only complete if being admitted from home

Medication List

NAME______________________ DATE:__________

ALLERGIES

Do you have any medication allergies? ☐ Y ☐ N **If yes, please list the allergies and the reaction(s):**

____

____

Check if an allergy or reaction to: ☐latex ☐ contrast dye ☐adhesive tape ☐iodine ☐other

____

MEDICATION LIST

(Please include as needed and over the counter medications, vitamins and dietary/herbal supplements)

Medication Start Date (If Known)	Medication ** Note: Please document dosage information as indicated on the medication container, must match **	Dose	Frequency (How often)	Stop Date (If Known)

Person Completing Form & Relationship: ______________________________

This section below is **ONLY** to be completed by Doctor, Nurse Practitioner, Physician Assistant or designee who has authority to complete this form. Please update the above list to reflect medication additions or deletions as needed.

____

Date _______ Time _______ Changes made to medication list ☐ Y ☐N Signature ______________

09/2015

Guidelines

Personalizing Residents' Rooms

Fair Acres' rooms are furnished with a bed, over bed table, nightstand, wardrobe closet and a 3-drawer chest. We also provide washers and dryers in each building, and microwaves and refrigerators on every unit.
We encourage personalizing residents' rooms by bringing in some familiar items that will help create a homelike atmosphere. The following information will assist you in your planning.

Items to bring:

- A two-week supply of clothing to be exchanged seasonally, including a seasonal coat. Please refer to Clothing/Laundry Policy found in this packet.
- Please provide a television if this is something that is important to your family member. Television must be a flat screen TV, **no larger than 32",** with a size appropriate stand. No other type of television is permitted. Smart televisions, Fire, Roku, Apple, and any other streaming devices are not permitted on the Fair Acres guest network. If streaming is desired, Resident will be responsible for providing their own individual Internet service.

  Please note: Flat screen TVs are not permitted to be hung on the wall.
- Small inexpensive items such as radios, headphones, clocks, cellphones, etc.

Items not permitted due to safety risk:

- Cloth covered chairs
- Refrigerators
- Hot plates and heating devices of any kind
- Sharp objects and weapons of any kind
- Household items such as laundry detergent, cleaning solutions, air fresheners, perfume/cologne and aerosol sprays of any kind may not be stored in residents' rooms.
- Extension cords are not permitted. (UL approved surge protectors with circuit breakers are permitted and sold in the Gift Shop and Social Services Department for your convenience.)
- Video or audio recording devices (i.e.: digital recorders, Amazon Echo devices, Google Home devices)

Important points:

- Resident rooms are equipped with phone jacks and are cable ready. Cable choices are Fair Acres Cable TV, which is free of charge, or Comcast. If you wish to contract with Comcast for cable tv services, the responsible party will contact Comcast directly to set up service and billing. For information regarding a private phone line, please speak with your Social Worker.
- All residents have the right to accept food brought into the facility by any visitor(s) for any reason. Food brought into the facility is permitted, provided care is taken to ensure food is handled properly for safe and sanitary storage and consumption. Residents and their

representatives will be informed upon admission about the policies related to food being brought into the facility. Please refer to Addendum **(O)** in your Admissions Day Packet.

- Snacks are welcome, if diet permits, however please provide a covered container to store them in. Please **do not bring** in microwaves and/or refrigerators. They are available on each unit.
- Storage is not permitted under a residents' bed, on over-head light fixtures, or on heating/cooling vents.
- All items must be at least 18" from the ceiling.
- Furniture items, including chairs, are not permitted into the facility without the approval of Fire & Safety Management due to safety and space requirements. **Furniture that is brought into the facility cannot exceed 4ft tall and/or 3ft wide.** Please use the yellow *Furniture Authorization Form* when seeking approval of a furniture item. This form can be obtained from the Admissions Office or Social Services Department.
- All items, large and small, must be labeled.
- **DO NOT** bring any medications unless you are seeking a respite stay. All medication will be provided by the Fair Acres In-house Pharmacy.
- **For Respite Admissions Only:** original medication vials/bottles should be sent to the admitting unit with your family member. *Please note* that the dosage on the medication bottle must match the current dosage of medication that is being given. If a medication dosage has been changed, the correct prescription must be on the medication bottle/vial. If new medications are ordered for your family member during their respite stay, you may incur additional charges.
- Please keep all valuables at home. Fair Acres is not responsible for valuables.

Thank you for your cooperation. We invite you to call upon staff should you need assistance.

Please note that due to CoVid 19, visitation is permitted, however, we ask that you refer to current facility guidelines for information regarding visitation. For more information regarding Covid-19 as it relates to our facility, please visit our website at www.fairacres.org

Visiting Hours

Visiting hours at Fair Acres are flexible and dependent upon the consent of the resident.
Fair Acres recognizes and respects the residents' right to deny or withdraw consent at any time for any reason, regarding access for visitation.

The Administration of Fair Acres reserves the right to withhold or restrict visitor privileges on a temporary or permanent basis, if, in the opinion of the Administrator the visitations violate an individual resident or group of residents' individual rights.

Clothing/Laundry Policy

- Families will bring a two-week supply of clothing to be exchanged seasonally, including a seasonal coat. This includes 14 complete changes of clothing, and appropriate undergarments, especially if incontinent.

- **On the day of admission** families will bring clothing in a heavy-duty plastic bag, with name attached, directly to the Laundry Department Shed located outside of Building #2. Clothing can be placed in the tan shed located in front of Building #2. The Laundry Department staff will pick up the residents' clothing from the Laundry shed, inventory, label, and deliver the clothing to the new residents' room.

    - In addition, please send a two-day supply of clothing to the designated unit, with your family member, including pajamas, which you have labeled with residents' name, unit and room number using a permanent marker. These are the clothes the resident will be using until all his/her clothing has been labeled and returned from the Laundry Department.

- Please provide shoes and slippers for the resident, which also need to be labeled. If you have any questions regarding appropriate footwear, please contact Fair Acres Rehab Department at 610-891-5856.

- You may provide additional clothing as needed according to available space. All clothing must be labeled by our Laundry Department. Please refer to procedure above.

- Please select clothing that is wash and wear. The Laundry Department is not equipped to iron or press clothing, or handle clothing with special laundering requirements, such as dry clean only, wash in cold water, hand wash, gentle cycle, etc.

- When a **respite** admission arrives at Fair Acres, a sign will be placed on the residents' wardrobe closet indicating that the residents' family will do the laundry. Clothing should be placed in the bottom of the closet in the laundry bag provided by the Admissions Department. Clothing is not to be sent to the Laundry Department. If a resident is here on an extended Respite stay, and they do not have any remaining clean clothing, clothing may be sent to the Laundry Department as long as the clothing has been labeled by our Laundry Department or by the family, with a permanent marker.

Please remember that every item of resident clothing must be labeled, <u>even if the resident or family plan to do the laundry.</u>