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
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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

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

Name of Applicant: _____ Marital Status: _____ Mother's Maiden Name: _____
(as it appears on Medicare card)

Applicant Address: _____ Years lived in Delco: _____
Current Location: _____ Since: _____ Home Phone #: _____
Gender: _____ Ethnicity: _____ Religion: _____
Veteran Branch/years of service: _____ Lifetime Occupation: _____
Place of Birth: _____ U.S. Citizen: ☐ Y ☐ N Primary Language: _____ Interpreter Needed ☐ Y ☐ N
Has applicant ever been convicted of a Felony: ☐ Y ☐ N
Does applicant have any possible pending criminal charges: ☐ Y ☐ N

Medicare #: _____ DOB: _____ Social Security #: _____
Other Medical Insurance: _____ HMO: ☐ Y ☐ N
Medicare Supplement Insurance: _____ HMO: ☐ Y ☐ N
Long Term Care Insurance within 5 years: ☐ Y ☐ N Access Card (MA #): _____
Medicare Part D Plan: _____ Other Prescription Drug Plan: _____
Primary Physician & Phone #: _____ Living Will/Advanced Directive: ☐ Y ☐ N

Total Monthly Income: _____ SS: _____ Pension: _____ Other: _____
Current Balance: Checking: _____ Savings: _____ # of Bank Accts: _____
CD's: _____ Stocks/Bonds/Annuities: _____ IRA(s): _____ Trust: _____
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 & 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: _____ ☐ POA: ☐ Medical ☐ Financial ☐ Responsible Party ☐ Guardian
Address: _____ Email: _____
Primary #: _____ Secondary #: _____ Work #: _____

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

(B)

Pertinent Information

Applicant 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 & Phone #: _____

****Fair Acres is not responsible for burial preparation/expenses****

Primary Physicians & Phone #: _____ **Last Appointment:** _____

COVID 19 Vaccine ☐ Y ☐ N Manufacturer: _____ Dates: 1st Dose _____ 2nd Dose _____

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

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

Does applicant have 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 ☐

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

_____

Additional Contact(s): other than Primary Contact listed on Attachment A

Name: _____ Relationship: _____

Address: _____

Primary #: _____ Secondary #: _____ Work #: _____ Email: _____

Name: _____ Relationship: _____

Address: _____

Primary #: _____ Secondary #: _____ Work #: _____ Email: _____

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

Does applicant have any possible pending criminal charges: ☐ Y ☐ N

Current use of 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 ☐ Y ☐ N Other ☐ Y ☐ N

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, received Electroconvulsive Treatment, 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 years for Psychiatric Facilities (if applicable): _____

_____

_____ Relationship: _____ Date: _____

Signature of: ☐ Responsible Party ☐POA ☐ Guardian

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(C)

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.
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, the appropriate Department of Human Services program office, or the Department's designee. 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 _____

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. Please note, no additional furniture items are permitted to be brought into the facility. 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.
- If being admitted to a unit that does not have a TV mounted on the wall, 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".** A TV stand with dimensions not exceeding 36" wide and 24" high can be brought into the facility. Prior approval for the TV stand must be obtained by contacting the Facility Fire and Safety Manager at 610-891-5932. 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:

- 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 cable ready. The cable provider is Fair Acres Cable TV, which is free of charge. Please note on units 8^{10}, 8^{11} & 8^{12} Fair Acres Cable services and TV are provided. Outside cable services are not permitted. 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. There are no exceptions.
- 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 go to 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 Shed located outside of Building #2. Clothing can be placed in the tan shed located in front of Bldg. 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 the 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>**