MORRIS-PACE
416 Reading Ave.
West Reading, PA 19611
(Bus) 610-371-9590 (Fax) 610-374-0563

Thank you for your interest in **Morris-Pace Assisted Living/Personal Care Facility;**

The following documents are needed in order for **M-P** to consider your admittance.

1) **Admittance Application**
2) **MA-51 form**
3) **MA-51 Addendum**
4) **Dept. Of Public Welfare's Prescreening form**
5) **Summary of the purposed Resident (His/Her history)**
6) **Proof of Medical Insurance & Medication/Prescription coverage**
7) **30 day Prescription upon arrival**
8) **Violent history form**
9) **Medical information on INFECTIONS/Cancer**
10) **M-P can not meet the needs of a HOSPICE PATIENT/RESIDENT**
11) **When/If higher level of care is needed, homes Doctor will request change in housing due to M-P's inability to meet those needs.**

- **New residents may be asked to sign a 30 day notice upon entering the facility in order to protect both parties when/if this facility does not meet the needs of the New Resident. If Morris-Pace CAN meet the needs of this New Resident, the 30 day notice will be thrown out after the first 30 days. If a New Resident decides to leave due to not being satisfied with the performance of Morris-Pace, this 30 day notice protects said Resident from having to submit a 30 day notice after admission.**

- **NO FIREARMS OF ANY KIND WILL BE TOLERATED! This includes;**
- **Guns—(real or plastic), be-be, or pellet.**
- **Ammunition of any kind.**
- **Knives, straight-razors, or any sharp instruments.**
- **Sticks, bats, or branches.**

Please feel free to contact us for further information. Also, if there are any concerns, we appreciate that information as well.

Once **Morris-Pace** has all of the needed documents, we shall contact you directly in order to continue this process.

Thank you again in advance,

Nathaniel D. Pace

Morris-Pace

Admissions Application

Resident's Name________________________________ Birth Date________________

Sex M______ F______ Social Security No.____________________

Source of Income___________________ Amount____________ (SSI) Y____ N____

Medical Insurance Company______________________ Ins. Number______________

Prescription Insurance Y____ N____ Prescription Policy Number________________

Medicare Number_________________ Medicare Supplemental Ins. Y____ N____

Additional Medical Insurance Information____________________________________

Life Insurance Y____ N____ Funeral Director________________________________

Funeral Director's Phone Number___________________ Fax__________________

Designated Person/Emergency Contact______________________________________

Relationship to Resident__________________ Phone Number__________________

Address____

Power of Attorney________________________ Advance Directives Y_____ N_____

Address POA_________________________ Phone Number______________________

Referred By: Agency on Aging___ Newspaper___ Internet___ M/H M/R Center______

Hospital___ Relative___ Yellow Pages___ Advertisement___ Other________________

Needs/Expectations of New Resident:

____

____

____

MORRIS – PACE

Services & Benefits Provided

1. *Room and Board.*
2. *Administer Medications.*
3. *Physician on call and Home visits*
4. *Podiatrist that makes house visits.*
5. *Pharmacy that delivers.*
6. *3 square meals a day with snacks at night.*
7. *Laundry services.*
8. *Supply all sheets and towels and bath clothes.*
9. *Weekly activity schedule posted.*
10. *Menu's posted for 2 weeks.*
11. *Hair Grooming & Styling.*
12. *Assist with bathing, when needed.*
13. *Assist with SLIGHT incontinence, when needed.*
14. *Access to phone and fax machine.*
15. *Public transportation accessible and close to home.*
16. *Family oriented living among residents.*

Services NOT provided

1. *Transportation*
2. *Escort services*
3. *Morris-Pace DOES NOT administer Insulin nor finger sticks. Any resident that becomes a Diabetic and CAN NOT neither administer insulin nor check their blood sugar will receive a 30 day notice, and also CAN NOT live here. If you are hospitalized due to being a Diabetic, and you are unable to administer insulin or complete finger sticks YOU WILL NOT BE ALLOW TO RETURN UNITL YOU CAN COMPLETE THIS ISSUE. Morris-Pace cannot meet the needs of anyone who can't and must re-locate.*

Management of Admissions & Discharges

Upon admission a resident must have pre-admission screening done, an assessment completed, sign resident's contract with home as well as other documentation needed to provide necessary daily living requirements. There must be a current/new MA 51 form filled out, proof of insurance, proof of income, summary of who the resident is and where he/she lived and reason for placement, MH/MR involvement (if any), & medications and/or prescriptions.

If a resident or residents designee wants to move/leave/transfer, he/she is asked to submit a 30 day written notice of intent, if MORRIS – PACE asks that a resident move/leave/transfer, we will submit to 30 day written notice of intent to resident and their designee, as well as, the referring agency citing the reason for the move/leave/transfer. Reasons are included in the Residents Home Contract. Eviction will occur if, and only if , refusal to pay rent after repeated efforts and is documented , home closure(by Legal Entity or Dept., fundamental alterations to the home or site, a resident refuses to comply with home rules (documented proof) and/or is a harm to self or other residents, or home can no longer meet the needs of a resident.. We will do everything in our power to assist with any help to the resident before eviction/closure happens and make the necessary calls to get that person assistance. Any monies owed will be provided upon eviction/leaving/moving/closure. If home voluntary closes, DPW will be notified at least 60 days prior to the day of closure.

PART I: SCREENER INFORMATION

I-A: Title of Person Completing Screening: (Check ONE)

- ☐ Personal Care Home Administrator
- ☐ Designated Personal Care Home Staff Person
- ☐ Human Services Agency Staff (List Agency):

I-B: Printed Name of Person Completing Screening:

I-C: Signature of Person Completing Screening:

I-D: Name of Admitting Personal Care Home:

I-E: Date Screening Completed:

I-F: Screening Information Sources:

☐ Applicant ☐ Applicant's Informal Supports ☐ Medical records ☐ Other (specify):

PART II: APPLICANT INFORMATION

II-A: Name:

II-B: Date of Birth:

II-C: Primary Language Spoken / Means of communication:

II-D: Current Residence:

- ☐ Private home or apartment with…
  - ☐ …no formal or informal supports
  - ☐ …informal support (family/friends)
  - ☐ …formal support (home health, day services, etc)
  - ☐ …both formal and informal supports
- ☐ Other personal care home
- ☐ Nursing facility
- ☐ MH/ID Community setting
- ☐ Homeless
- ☐ Other (specify):

II-E: Length of Time at Current Residence:

- ☐ <3 months
- ☐ 3 months - 1year
- ☐ 1 - 5 years
- ☐ 5 or more years

II-F: Reason for Leaving Current Residence:

II-G: Level of Supervision Needed:

None	Minimal	Moderate	Extensive	Total
☐ Applicant requires no supervision either in the home or when in the community	☐ Applicant requires no supervision in the home or when in familiar surroundings, but needs attendance in unfamiliar places	☐ Applicant requires some supervision in the home and needs attendance when outside the home, and/or tends to wander	☐ Applicant requires regular supervision in the home and cannot leave home unattended; unaware of unsafe areas	☐ Applicant requires 24-hour direct supervision

II-H: Mobility Needs:

Independent	Minimal (Mobile)	Moderate (Immobile)	Total(Immobile)
☐ Applicant has **no** mobility needs and can evacuate independently in an emergency	☐ Applicant requires **limited** physical or oral assistance to evacuate in an emergency	☐ Applicant requires **moderate** physical or oral assistance to evacuate in an emergency	☐ Applicant requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons

II-I: Ability to Self-Administer Medications:

☐ **Applicant can self-administer without assistance**

☐ **Applicant can self-administer with (check all that apply)…**

- ☐ …assistance in remembering schedule
- ☐ …assistance in offering medications at prescribed times
- ☐ …assistance in opening container or locked storage area

☐ **Applicant cannot self-administer medications**

II-J: Personal Care and Medical Needs – Check all that Apply:

Activities of Daily Living (ADLs):	**Instrumental Activities of Daily Living (IADLs):**
☐ Eating	☐ Doing laundry
☐ Drinking	☐ Shopping
☐ Transferring in/out of bed/chair	☐ Securing and using transportation
☐ Toileting	☐ Managing finances
☐ Bladder Management	☐ Using the telephone
☐ Bowel Management	☐ Making and keeping appointments
☐ Ambulating	☐ Caring for personal possessions
☐ Personal Hygiene	☐ Written correspondence
☐ Managing Health Care	☐ Engaging in social and leisure activities
☐ Securing Health Care	☐ Using a prosthetic device
☐ Turning and positioning in bed/chair	☐ Obtaining clean, season clothing

Sensory Needs:

☐ Total hearing impairment

☐ Hears with device (specify):

☐ Total visual impairment

☐ Sees with device (specify):

Medical, Psychological, and Behavioral Diagnoses (list):

History of Problematic Behavior (Check all that apply):

☐ Suicide attempts ☐ Substance abuse

☐ Fire-starting ☐ Other (describe):

☐ Physical violence toward others

☐ Sexually abusive or inappropriate acts

This resident CAN SAFELY USE AND AVOID POISONOUS MATERIALS: ☐ YES ☐ NO

PART III: DETERMINATION

Based on this screening, I verify that the needs of this applicant can be met in this personal care home:

☐ YES ☐ NO

If "No" is checked, specify local assessment agency to which applicant was referred. Please be advised that this referral is required by § 2600.224(b):

PART IV: COGNITIVE SCREENING

Note: This section applies only if the applicant is seeking admission to a Secured Dementia Care Unit. This section must be completed by a physician or geriatric assessment team within 72 hours prior to admission to the Secured Dementia Care Unit.

Title of Person Completing Screening: (Check ONE)

☐ Physician

☐ Geriatric Assessment Team Representative

Printed Name of Person Completing Screening:

Signature of Person Completing Screening:

Diagnosis:

Date Screening Completed:

Behaviors Exhibited (Check all that Apply):

☐ Anxiety	☐ Disorientation	☐ Agitation	☐ Hostility	☐ Confusion	☐ Sadness
☐ Physically violent	☐ Delusional	☐ Lethargy	☐ Wandering	☐ Hallucinations	

Based on this screening, I verify that the needs of this applicant require secured care due to Alzheimer's Disease or other dementia: ☐ YES ☐ NO

Adult Residential Licensing - Documentation of Medical Evaluation (DME)

INSTRUCTIONS FOR USE

Applicable Regulations

§ 2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

§ 2600.141(a)(2) - The medical evaluation shall include the following:
(1) A general physical examination by a physician, physician's assistant or nurse practitioner.
(2) Medical diagnosis including physical or mental disabilities of the resident, if any.
(3) Medical information pertinent to diagnosis and treatment in case of an emergency.
(4) Special health or dietary needs of the resident.
(5) Allergies.
(6) Immunization history.
(7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
(8) Body positioning and movement stimulation for residents, if appropriate.
(9) Health status.
(10) Mobility assessment, updated annually or at the Department's request.

§ 2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

§ 2600.141(b)(2) - A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.

It's important to remember that the primary focus of these requirements is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner – **NOT that a form be completed**. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation.

Homes are PERMITTED to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

Homes are PROHIBITED from:

- Completing the "Medical Professional Information" section, unless the home employs a physician, physician's assistant or certified registered nurse practitioner.
- Completing all or a portion of the DME without an in-person evaluation by a medical professional.
- Completing all or a portion of the DME after an in-person evaluation that was performed outside of the timeframes specified by this regulation.
- Changing the content of a DME without the consent of the person who performed the evaluation. After obtaining consent, the DME must be changed by a registered nurse (RN) or licensed practical nurse (LPN).

It is strongly recommended that homes carefully review DME forms completed by a physician, physician's assistant or certified registered nurse practitioner to verify that all of the required information was recorded. Although the evaluations must be completed by medical professionals, homes are responsible for ensuring that the evaluations were complete and that the DMEs were filled out in their entirety.

Adult Residential Licensing - Documentation of Medical Evaluation (DME)

Resident Information	**Evaluation Information**		
Name:	Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date Resident Evaluated:	Date Form Completed:
Date of Birth:			

(1) - General Physical Examination	Height:	Weight:	Pulse Rate:
Blood Pressure:	Temperature:		

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable**
1.	
2.	
3.	

FOR ADDITIONAL DIAGNOSES, SEE "DIAGNOSES ADDENDUM" BELOW

(4) Special Health or Dietary Needs

☐ None
☐ This resident **CAN** safely use or avoid poisonous materials
☐ Secured Dementia Care (For SDCU admissions only)
☐ Other - SEE "NEEDS ADDENDUM" BELOW

(6) - Immunization History

Are immunizations current? ☐ Yes ☐ No ☐ Unknown

Td/Tdap Date:	Influenza Date:

Other Immunizations (List Date and Type):

(5) - Allergies

☐ None ☐ Unknown ☐ Listed Below:

(7) - Medications

☐ None

OR SEE "MEDICATION ADDENDUM" BELOW

Ability to Self-Administer Medications - Check all that apply:

☐ Can self-administer - no assistance from others
☐ Can self-administer - assistance to store medications in a secure place
☐ Can self-administer - assistance in remembering schedule
☐ Can self-administer - assistance in offering medications at prescribed times
☐ Can self-administer - assistance in opening container or locked storage area
☐ Can self-administer some medications but not others - See MED. ADDENDUM
OR
☐ Cannot self-administer medications

(8) Body Positioning / Movement

☐ None ☐ Listed Below:

(9) - Health Status		**Cognitive Functioning**	
☐ Excellent	☐ Poor	☐ Excellent	☐ Poor
☐ Good	☐ Actively Dying	☐ Good	☐ None
☐ Fair		☐ Fair	

(10) Mobility Needs Assessment	☐ Independent (Mobile) Resident has **no** mobility needs and can evacuate independently in an emergency	☐ Minimal (Mobile) Resident requires **limited** physical or oral assistance to evacuate in an emergency	☐ Moderate (Immobile) Resident requires **moderate** physical or oral assistance to evacuate in an emergency	☐ Total (Immobile) Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons

Medical Professional Information

By signing below, I certify that:

- I am a physician, physician's assistant or certified registered nurse practitioner whose license to practice is in good standing.
- The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation
- The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 Pa. Code Chapter 2600

Medical Professional Name:	**Medical Professional License #:**
Medical Professional Signature:	**Date Signed:**

Documentation of Medical Evaluation (DME) - Addendum Sheet

This sheet may be copied as needed if additional space is required

Resident Information	**Evaluation Information**	
Name:	Date Resident Examined:	Date Form Completed:

Diagnoses Addendum

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if Applicable**
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(4) Needs Addendum

☐ Special Diet - Check all that apply

☐ No Added Sodium
☐ Low cholesterol
☐ Mechanical Soft Foods
☐ Heart Healthy
☐ Pureed Foods
☐ No Concentrated Sweets

Other (describe):

☐ Special Health Needs - Include Description

(7) Medication Addendum

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

*** Residents may be able to self-administer some medications, but not others. The resident's ability to self-administer each medication should be assessed. If the resident can self-administer a medication, check "Yes." If a resident cannot self-administer a medication, check "No." If nothing is checked, the Department will assume that the resident cannot self-administer the medication.**

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/MR 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 MR 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 be 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 completed by the OPTIONS Unit in the Area Agency on Aging.

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/MR Care Services to be provided at home or in an Intermediate care facility for the mentally retarded
☐ 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.

21A. **MEDICALLY ELIGIBLE** ☐ Yes ☐ No ☐ Medically Appropriate for Waiver Services

21B. **Length of Stay** ☐ Within 180 days ☐ Over 180 days

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

MORRIS-PACE

June 10, 2010

(Effective 7/10/10)

I understand that, in the event that I need **DIABETIC** administration, I am responsibility for drawing my insulin, giving myself my shot and checking my blood sugar. **M-P has NEVER provided this service.** If I can be trained to do so, I can remain living here, **If not, I must re-locate to a facility that does DIABETIC ADMINISTRATION.**

______________________________ ______________________________

Resident Staff

Morris-Pace

416 Reading Ave.

W. Reading, PA 19611

Medical Information Sheet

Please answer the following questions:

1) Do you have any active infections? (i.e., MRSA, C-DIFF, HIV, Hepatitis A,B, or C, etc.)

2) Incontinence issues, bowel or bladder?

3) M/H or M/R consumer?

4) Addictions? (Drugs, legal and Illegal, or Alcohol) Pain Meds?

5) Any open wounds or sores?

6) Any CANCER?

Resident Signature ______________________ Print ______________________

Referring agency ______________________ Agency staff ______________________

MORRIS-PACE HOME RULES

1) All medications prescribed by a Doctor must be taken.
2) NO SMOKING INSIDE OF THE BUILDING, smoking outside in designated areas only. Extinguish cigarettes and cigars in appropriate containers.
3) ALL RESIDENTS MUST PARTICIPATE IN FIRE, EMERGENCY PREPAREDNESS, AND SHELTER IN PLACE DRILLS!
4) NO FIGHTING OF ANY KIND ON THE PROPERTY.
5) NO ALCOHOL or ILLEGAL DRUGS permitted on the premises. Residents can not be under the influence of ANY ILLEGAL DRUG or ALCOHOL while on the premises.
6) NO destruction of facility property or any residents property will be tolerated, whomever is responsible will be held accountable to replace/repair damaged goods.
7) Master key, **for M-P staff only,** will be used to gain entrance for work purposes/emergencies. Residents will not be receiving keys to any rooms.
8) NO STEALING of any kind! If you are caught, or another resident complains that you have taken/STOLEN anything that is not yours, a 30 day notice will be given immediately, **as long as there is proof/evidence** to substantiate this claim.
9) All Residents must bathe at least twice a week.
10) While eating, Residents MUST be fully dressed! (i.e. pants, skirt, shirt, blouse, & socks/stockings & shoes.
11) Residents must keep their room, night stand, and sleeping areas clean of debris.

12) All clothes must be put in there proper place at all times, their names/initials MUST be inside of their clothes to ensure that all clothing is returned properly.

13) Bath mats MUST NOT be taken up or removed at anytime from tubs or showers!

14) NO ADDITIONAL PETS OF ANY KIND ALLOWED, **M-P** has 3 cats in our facility.

FIRE EXITS MUST NEVER BE BLOCKED!

15) TV's and Radio's in residents rooms must be turned off after 11pm, or, the use of an ear plug/head phones must be used.

16) Visiting hours start at 9am, ending at 9pm, DAILY. Guest are not permitted to roam freely through-out the Facility. Guest must be accompanied by the Resident with whom they came to see.

17) Smoking is only permitted near RED bench's in (3) outside locations: (1) At bottom of entrance ramp next to the potted plant, (2) at the bottom steps next to potted plants, & (3) in the middle of yard near flag pole using fire retardant devices to extinguish you cigarette/cigar/smoking device.

18) ONLY STAFF MAY SMOKE OUTSIDE KITCHEN EXIT NEAR DUMPSTERS using a fire retardant device to extinguish cigarettes. (add 3/5/09)

19) FIRE EXIT/SECOND MEANS OF EGRESS are not to be used as a smoking exit. THIS IS AN EMERGENCY EXIT ONLY AND MUST STAY LOCKED FOR SAFTY!!

20) Resident's may not be deprived of his/her rights.

21) Resident's rights may not be used as a reward or sanction.

22) Administrator will, in plain language, explain to the resident and the resident's designee, on the Home Rules, Residents Rights, and Complaint Procedures and have them sign by the resident & their designee. This ensures that the Regulation 2600.42a thru 42y are fully understood as required by the Dept. of Public Welfare.

23) **NO FIREARMS OF ANY KIND WILL BE TOLERATED IN/ON THIS PROPERTY!** This includes; Guns of any kind (real, plastic, be-be, or pellet), Ammunition of any kind, knives, straight-razors, any sharp instruments, and/or sticks, bats, or branches.

24) Banking Business hours are as follows: Open every day 9am to 3pm!

25) If anyone is caught using ILLEGAL DRUGS or ALCOHOL on the premises, this includes filling a prescription at another Pharmacy and hiding it from M-P, a 30 Day Notice will be given immediately! There will not be a RETRACTION. No warning will be given. M-P MUST be aware of all medications ordered for you, NO EXCEPTIONS!

26) Medication must be given INSIDE OF MED ROOM ONLY! Exceptions are allowed by Administrative Staff ONLY!

27) Administration, Staff, & Residents shall be treated with **DIGNITY & RESPECT!** This includes and not limited to:

A. No profanity directed towards anyone.

B. Hand & Arm gestures.

C. Threats towards Staff & Residents.

28. Meal times are as follows; Breakfast starts at 6:30am first seating, 7am second seating, Lunch starts at 11:30a & 12p, Dinner starts at 4:45p & 5:15p. If you are late/miss these times, a nutritionally balanced meal will be given as required by DPW/Regulation 2600.
29. Medication times are as follows; Starting at 7a-9a, 11p-1p, 4p-6p, & 7p-9p. All residents are required to come to Med room at these times, NO EXCEPTIONS!!
30. ANY resident that interferes with **M-P** handling ANY medical issues with another resident shall receive a 30 day notice. MEDICAL EMERGENCIES must be handled by **M-P staff only!!** (9/9/10)

______________________________ (Resident)

______________________________ (Staff)

MORRIS-PACE

Morris-Pace has requested information from Resident & Referring Agency that the following behaviors are not present, and have NEVER OCCURERD with said Resident:

1) **Arson**
2) **Aggravated Assault**
3) **Robbery**
4) **Sexual Assault/RAPE**
5) **Suicide Attempt**
6) **Weapons Offensives**

______________________________	____________
Resident	**Date**
______________________________	____________
Referring Agency	**Date**
______________________________	____________
Administrator	**Date**

MORRIS – PACE
416 Reading Ave.
West Reading, PA 19611
610-371-9590 (BUS)
610-374-0563 (FAX)

4/26/13

Attention: ALL PRESCRIBING PHYSICIANS

Good Day;

It has been brought to my attention by DPW that you might not be aware of the times we are administering the medications you order for our residents. The medication start times are as follows; 7a (Breakfast), 11a (Lunch), 4p (Dinner), &7p (Bedtime). In order to be in compliance with our regulations, please take some time to address this concern and notify Morris-Pace of your findings. Please sign one of the following:

1. Medication times ARE consistent with the times I want the medications administered.

____
Physician signature

2. Medication times ARE NOT consistent with the times I want the medication administered.

____

Please attach or list ANY/ALL medications that DO NOT meet your Dr.'s order.

Nathaniel D. Pace, Admin.

MORRIS-PACE

416 Reading Ave.

West Reading, PA 19611

(Bus) 610-371-9590 (Fax) 610-374-0563

30 DAY NOTICE FOR NEW ADMITTACE

This 30 day notice is designed to protect Morris-Pace & ANY NEW RESIDENT! It is important that **M-P** meet the needs of every resident, especially **new residents** moving into this facility.

I, ______________________________ willingly have signed this 30 day notice in the event that I am unhappy/unsatisfied with my needs not being met by **M-P.** I will move out 30 days after moving into this facility. **M-P** shall assist me with re-location possibilities as stipulated in the Dept. Of Public Welfare's Regulation, (2600-42n). **Morris-Pace and /or Resident,** before the 30 days are up, will decide it this facility meets the needs of the resident. If ________________________ needs **are** being met, the 30 day notice is thrown out, if the needs of ________________________ **can not** be met, ______________ ______________ shall move out once we have found adequate housing that meets the need of the resident.

______________________________	______________________________
Resident **Date**	**Administrative Staff** **Date**

MORRIS – PACE'S RATE INFORMATION FOR 2021

SSI-----------------------------$770.10

SSI W/Supplement----------$1,233.30

SS & Supplement-----------$1,253.30

State Supplement-----------$439.30

Private Pay------------------$1,750.00 (Room) thru $4,800.00 (Apartment)

ALL RESIDENTS WILL RECEIVE AT LEAST **$85.00** PER MONTH FOR THEIR PERSONAL EXPENSE'S.