Cozy Nest Care Home

New Resident welcome Package

304534 Township Road 350, RM of Dundurn, SK, S7C 0E2

admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266 (306) 978 6425

WELCOME

Cozy Nest Care Home, nestled in the tranquil setting of the Rural Municipality of Dundurn, offers a compassionate and welcoming environment for elderly residents in need of care and support. Located just outside of Saskatoon, this care home combines the serenity of rural living with the conveniences of nearby urban amenities, creating an ideal atmosphere for individuals looking for a safe, nurturing place to call home. The home is operated in partnership with Saskatchewan Health Authority.

At Cozy Nest Care Home, the focus is on providing personalized care that emphasizes the dignity, comfort, and well-being of each resident. The facility offers a range of services designed to meet the unique needs of seniors, from basic assistance with daily activities to specialized care for those with mobility challenges or cognitive impairments such as dementia.

The home features private rooms that are thoughtfully designed to foster a homelike environment, equipped with all the comforts and safety features needed to ensure residents feel at ease. The decor is warm and inviting, with a focus on creating a space that promotes both independence and relaxation. The spacious common areas encourage socialization and engagement, with comfortable seating and spaces for activities like games, crafts, and entertainment.

Cozy Nest Care Home values the close relationships it builds with both residents and their families. Open communication, regular updates, and a collaborative approach to care ensure that families are always involved in the well-being of their loved ones. The team at Cozy Nest is dedicated to creating a safe and supportive environment where residents are treated with the utmost respect and kindness.

Cozy Nest Care Home is a place where seniors can feel truly at home, receiving the care they need in a setting that promotes comfort, independence, and well-being

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Communication Policy for Families

At Cozy Nest Care Home, we are committed to providing the highest standard of care for our residents while maintaining clear, consistent, and respectful communication with their families. To ensure the best outcomes for our residents and to avoid misunderstandings or conflicts, we have established the following communication policy:

- **Designated Point of Contact**

  To maintain clarity and consistency, we will communicate primarily with the individual who holds the **Power of Attorney (POA)** or the legally designated decision-maker for the residents. This person will be responsible for sharing information with other family members as they see fit.

  Name of Designated Contact Person: _____

- **Why This Policy?**
  - **Avoiding Conflicts:** Families often have multiple members with differing opinions. Communicating with one designated person helps prevent misunderstandings and ensures decisions are made in the best interest of the resident.
  - **Efficiency:** Streamlining communication allows our staff to focus on providing quality care rather than managing multiple conversations.
  - **Confidentiality:** We are committed to protecting the privacy and dignity of our residents. Sharing information only with the POA ensures compliance with privacy laws and ethical standards.

- **Family Meetings**

  Periodic family meetings can be arranged upon request, where the POA and other family members can discuss the resident's care plan with our team. These meetings will be scheduled in advance to ensure the availability of relevant staff members.

- **Emergency Situations**

  In the event of an emergency, we will immediately contact the POA. If the POA is unavailable, we will reach out to the secondary emergency contact provided in the resident's file.

- **Respecting Resident Wishes**

  If a resident is capable of making their own decisions and prefers to communicate directly with family members, we will respect their wishes while still adhering to legal and ethical guidelines.

We appreciate your understanding and cooperation with this policy. Our goal is to provide the highest standard of care for your loved one while maintaining clear and respectful communication with their family.

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Valuables Policy at Cozy Nest Care Home

At Cozy Nest Care Home, we are committed to providing a safe and comfortable environment for all of our residents. We understand that personal items and valuables are important to residents and their families. To ensure the protection of these items, we have established the following valuables policy:

1. **Personal Property:** Residents are encouraged to bring personal items such as clothing, small personal effects, and familiar objects that contribute to their comfort. However, we ask that families be mindful of the volume and size of items brought into the home, considering safety considerations and space limitations.

2. **Valuables:** For high-value items such as hearing aids, dentures, glasses, jewelry, or electronics, we strongly recommend that families arrange for tenant insurance to protect these items. Cozy Nest Care Home will not be responsible for covering any lost, damaged, or stolen items, either financially or otherwise. Insurance provides added peace of mind and ensures that valuable items are protected.

3. **Labeling of Valuables:** To assist in identifying and recovering lost or misplaced items, we ask that all personal valuables brought into the home be clearly labelled with the resident's name. This makes it easier for staff to locate items if they go missing and helps prevent confusion.

4. **No Responsibility for Lost Items:** Cozy Nest Care Home is not responsible for the loss, damage, or theft of personal items, including valuables. While we strive to maintain a secure and safe environment, it is essential that families take precautions, such as labelling items and securing valuables with personal insurance, to ensure their protection.

5. **Assistance from Staff:** Our staff is available to assist residents and families with organizing and keeping track of personal belongings. If a resident's items go missing, staff will make every effort to locate them, but we cannot guarantee that lost items will be recovered.

In summary, we recommend that families arrange for tenant insurance for high-value items, ensure that items are clearly labeled with the resident's name and understand that Cozy Nest Care Home will not be financially responsible for any lost or damaged valuables. By taking these steps, we can work together to provide a secure and comfortable living environment for all of our residents.

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After reading & reviewing the above, I/ we have decided to *(write initial on box):*

☐ Take the following item(s) with me for safe – keeping: (if listed on "Belongings List", indicate if taken)

☐ Clothes:_____☐ Jewelry:_____☐ Hearing Aid_____☐ Denture_____☐ Eyeglasses

☐ Other Items:_____

Leave the following item(s) for me/ my family/ friend to use knowing fully well that it might get lost or damaged & that I will take full responsibility for the loss. Further, that Cozy Nest will not be obligated to replace the lost or damaged item:

☐ Clothes:_____☐ Jewelry:_____☐ Hearing Aid_____☐ Denture_____☐ Eyeglasses

☐ Other Items:_____

Resident's Name	Resident's Signature	Date
POA/ SDM's Name	POA/ SDM's Signature	Date
On Behalf of Cozy Nest (Name)	Signature	Date

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Resident Belongings Record Move In

Quantity	Item (Clothes & Clothing Items)	Description (Color, etc.)	Taken (Person's Full Name)
Quantity	Item (Eyeglasses, Hearing Aid, Dentures etc.)	Description (Color, etc.)	Taken (Person's Full Name)
Quantity	Item (Radio, TV etc.)	Description (Color, Type, etc.)	Taken (Person's Full Name)
			Taken (Person's Full Name)

Above Items Received From (name/date): _ Received By (name/date): _

Sent to Laundry (name/date): _ Received from Laundry (name/date):

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Getting to Know You

At Cozy Nest Care Home, our recreation team is dedicated to creating engaging and enjoyable experiences for all our residents. To help us plan events, activities, and entertainment that suit your interests, please take a moment to share some information about yourself. Your input will ensure we can make your time here as enjoyable and fulfilling as possible!

Legal Name: _____

Preferred Name/Nickname: _____

Where I was born and raised: _____

If you enjoy chatting about your career, what did you do? _____

Activity Preferences

- Do you enjoy being part of group activities, or do you prefer quieter, individual activities?
  ☐ Group activities ☐ Individual activities ☐ Both
- What hobbies or activities have you enjoyed throughout your life? (e.g., gardening, reading, knitting, playing musical instruments, etc.) _
- Do you like arts and crafts, such as painting, drawing, or sculpture?
  ☐ Yes ☐ No
  If yes, what types of arts and crafts do you enjoy? _
- Do you enjoy music? What kind of music do you like to listen to? (Any favorite songs, artists, or genres?) ☐ Yes ☐ No
  If yes, please share your favorites: _
- Do you like playing games or cards? If so, which games do you enjoy?
  ☐ Yes ☐ No
  If yes, please specify: _
- Are there any specific religious, cultural, or spiritual practices that are important to you?
  _

Additional Information

Please use the space below to tell us anything else that will help us get to know you better. This could include important traditions, favorite holidays, or anything else you'd like to share.

_____

_____

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Consent for Physician Services

A Collaborative Approach to Your Health

At Cozy Nest Care Home, the health, safety, and well-being of our residents are our highest priorities. To ensure seamless, coordinated, and high-quality medical care, we partner with a dedicated attending physician who knows our home, our staff, and the unique needs of our residents.

Our Physician Care Policy

For all new residents, primary medical care will transition to our attending physician at Cozy Nest Care Home. Upon admission, our physician will assume responsibility for your loved one's day-to-day and urgent medical needs, including prescriptions and treatment orders.

We value and respect the important relationship you may have with your family physician. While primary care at Cozy Nest Care Home will be provided by our attending physician, your previous doctor is always welcome to collaborate with our team and share valuable insights about your loved one's care history and well-being.

Why This Policy is Essential for Quality Care:

- One Source of Care: Having a dedicated physician within our home prevents confusion, ensures consistency in treatment, and enhances safety especially in managing medications.
- Timely Access: Our physician visits on a biweekly or monthly basis and remains available to nursing staff for both urgent concerns and routine care.
- Seamless Teamwork: By working directly with our care team, the physician enables quick, clear communication about any changes in a resident's condition.

Your Acknowledgment and Consent (Indicate your choice)

☐ I/we acknowledge and understand that the Cozy Nest Care Home Physician will be the primary doctor responsible for medical care and consent to this arrangement to ensure the safest and most effective care for our loved one.

☐ I/We do not consent to this arrangement and accept responsibility for arranging a physician for myself/my loved one. (if you choose this option contact Resident Care Coordinator (RCC) for additional steps)

Resident/POA/SDM's Name:	.....	Witness Name:	.....
Resident/POA/SDM's Signature:	.....	POA/SDM's Signature:	.....
Date:	.....	Date:	.....

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TO BE FILLED BY RESIDNET FAMILY

COZY NEST CARE

Resident Diet Preference			
Resident's Name: _____		**Room Number: _____**	
Likes:		Dislikes:	
Preferred Meal Size:			
☐ Small	☐ Regular	☐ Large	
Preferred Food Temperature:			
☐ Hot	☐ Warm	☐ Cold	
Specific Snack Preferences:			
AM Snack: _____	PM Snack: _____	HS Snack (Before Bed): _____	
Beverage Preferences:			
☐ Hot Water	☐ Coffee	☐ Tea	☐ Cream/Milk
☐ Sugar	☐ Sweetener	☐ Milk %: _____	☐ Juice: _____
Cereal Preferences:			
	☐ Hot Cereal	☐ Cold Cereal	
Dietary Preferences:			
	☐ Non-Veg	☐ Vegetarian	☐ Other: _____
Allergy:			
Additional Information:	_____		
Signature:	_____	Printed Name & Title:	_____

NOTE: Please leave one copy for the Kitchen Team

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Important Documents for Admission

Cozy Nest Care Home – Intake Checklist:

Income Assessment *(gov.sk.ca) – Documents & Forms*

- Income-Tested Resident Charge CRA Consent Form ☐
- Seniors' Drug Pla N Application CRA Consent Form ☐
- Power of Attorney Document ☐
- Most Recent Tax Return or Notice of Assessment ☐

Consent & Authorization Forms

- Miscellaneous Consent Form ☐
- Pre-Authorized Debit (PAD) Form ☐
- Void Cheque for Payment Processing ☐
- Consent for Vaccine and/or an Influenza Antiviral Treatment ☐

Third-Party Billing Authorization forms

- Pharmacy Provider: Cheetham's Pharmacy ☐
- Incontinence Products Supplier: Walking Stick Mobility ☐

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Government of Saskatchewan

SIDE A

Please return to:
Drug Plan & Extended Benefits Branch
Income Assessment - Operations Unit
3475 Albert Street
Regina, Saskatchewan S4S 6X6
Phone: 1-800-667-4884 or 306-787-5023
Fax: 306-787-8679
Website: www.saskatchewan.ca

Institutional Supportive Care - Income-Tested Resident Charge CRA Consent

- **Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 150 (for both Resident and Spouse).**
- **If you do not file income tax, complete Side B and provide required income documentation.**
- **Incomplete applications will result in delays in processing. Please ensure you have provided all information.**

RESIDENT INFORMATION (Please Print)		**SPOUSE INFORMATION (Please Print)**	
Resident's Surname	First	Spouse's Surname	First
Health Services Number	Date of Birth (YY/MM/DD)	Health Services Number	Date of Birth (YY/MM/DD)
Social Insurance Number		Social Insurance Number	
CONTACT INFORMATION (Please Print)			
Surname	First	Current Mailing Address	
Home Phone Number ( )	Work Phone Number ( )	City/Town/Village	Postal Code

DECLARATION AND CONSENT

Is the Power of Attorney (POA) signing on behalf of the resident? YES ☐ NO ☐

If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA, such as POA specific to or limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility and the general administration and enforcement of: the Income Tested Resident Charge pursuant to *The Housing and Special-care Homes Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks assessment under the Income-Tested Resident Charge requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

DATE

Signature of Resident, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if resident signs with an "X" or a mark.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.

DATE

Signature of Spouse, or if applicable, Guardian/Trustee/ Power of Attorney. A witness is necessary if spouse signs with an "X" or a mark.

PRINT NAME OF Guardian/Trustee/ Power of Attorney/Witness.

Seniors' Drug Plan Application

FORM A: CRA Consent

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax and Benefit Return showing Line 23600.
- If you do not file income tax, complete FORM B and provide all sources of income.
- Ensure you have provided all information. Incomplete applications will result in delays.
- Coverage is effective the date complete information is received, subject to approval.
- Please print the form and sign. Written signatures are required by CRA.

Please return to:
Drug Plan and Extended Benefits
3475 Albert Street
Regina, SK S4S 6X6
Phone: 306-787-3317
Fax: 306-787-8679
Email: PEB@health.gov.sk.ca

Applicant

Name:

Address: City

Postal Code: Phone Number:

Date of Birth (dd/mm/yyyy):

Health Services Number: Social Insurance Number:

DECLARATION and CONSENT

This consent authorizes Canada Revenue Agency (CRA) to provide Saskatchewan Ministry of Health with Line 23600 for this and future years, as long as you file income tax.

Is the Power of Attorney (POA) signing on behalf of the applicant? ☐ **Yes** ☐ **No**

If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant, a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable for CRA, such as a POA limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility and the general administration and enforcement of: the Seniors' Drug Plan pursuant to *The Prescription Drugs Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks coverage under Seniors' Drug Plan requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

Date:

Signature of APPLICANT (digital signatures not accepted)

Date:

If applicable, signature of **GUARDIAN / TRUSTEE / POWER OF ATTORNEY**.
A witness is necessary if Applicant signs with an "X" or a mark.

Print name if GUARDIAN / TRUSTEE / POWER OF ATTORNEY

Daytime contact number of GUARDIAN / TRUSTEE / POWER OF ATTORNEY

Government of Saskatchewan

Drug Plan & Extended Benefits

3475 Albert Street
Regina SK S4S 6X6

Phone 306-787-5023
or Toll-Free 1-800-667-4884
Fax 306-787-8679

LONG TERM CARE

OPTIONAL DESIGNATION FOR DETERMINING RESIDENT CHARGE

I, _____(name)

residing in _____(facility)

hereby wish to be designated as indicated below for purposes of calculating the income-tested resident charge. I understand that either designation does not automatically designate me in this way with other social safety net programs in the federal government (e.g. Guaranteed Income Supplement) and provincial government (e.g. Saskatchewan Assistance Plan and other Ministry of Health Programs).

Please check the designation applicable to your situation **(check only one box).** With this designation only the resident's income is considered in determining the resident charge.

☐ My spouse and I live in separate dwellings for reasons beyond our control. However, our marital status has not changed. *

☐ I am separated from my spouse pursuant to a separation agreement or a judicial separation. ** Effective Date _____

Signed this_____ day of_____ , 20_____ .

_____

Resident's Signature or Spouse's/Supporter's Signature **(POA)**

_____

Name of individual signing above (Please Print)

* Commonly called "involuntary separation"

** Sometimes called "legal separation"

H31-7797
2000/10

Pre-Authorized Debit (PAD) Plan agreement

I/we authorize Cozy Nest Care Home and the financial institution designated (or any other financial institution I/we authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one- time payments from time to time, for payment of all charges arising under my/our Cozy Nest Care Home account. Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the 28th day of each month. Cozy Nest Care Home will obtain my/our authorization for any other onetime or sporadic debits.

This authority is to remain in effect until Cozy Nest Care Home has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/we may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

Cozy Nest Care Homemay not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us.

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Please attach void cheque here.

Date:

Authorized Signature (s)

304534 Township Road 350, RM of Dundurn, SK, S7C 0E2

admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266 (306) 978 425

Miscellaneous Consent Form

Resident Name: _____

POA Name _____

POA Address: _____ City: _____

Postal Code: _____ Phone Number: _____

Emailed Statements

Cozy Nest Care Home offers emailed statements to save paper. Charges for hair care, transportation, cash withdrawals, incontinence products, or other miscellaneous expenses will be itemized on monthly statements.

Initial to email the monthly statement to reduce paper.

(Receipts will be available at Cozy Nest for up to 1 year from the statement date.)

Initial Here

Television Package (Bell)

Cozy Nest Care Home charges a mandatory $50 for cable, which cannot be waived. Approximately 50 channels.

Initial Here

Phone Package (SaskTel)

Resident/support is responsible for contacting SaskTel directly to obtain a phone connection. Resident is billed directly from SaskTel.

Initial Here

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admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266 (306) 978 425

PHOTO CONSENT FORM

At Cozy Nest Care Home, we cherish the moments we share with our residents and often capture these memories through photographs. To ensure we respect your loved one's privacy and preferences, we kindly request your consent to take and use photographs as outlined below. Photographs may be used for:

- Our website and social media pages.
- Newsletters, brochures, and other marketing materials.
- Internal use for documentation or celebrations (e.g., events, activities).

We are committed to maintaining the dignity and privacy of all our residents. Photos will only be used in a respectful and appropriate manner.

Consent to Share Photographs

I, the undersigned, grant Cozy Nest Care Home permission to share photographs that may include my loved one for the purposes listed above.

☐ Yes, I give my consent.

☐ No, I do not give my consent.

Contact Information

Name of Family Member/Supporter: _____

Relationship to Resident: _____

Acknowledgment and Signature

By signing below, I acknowledge that:

- I have the legal authority to provide consent for my loved one to be photographed.
- I understand the potential uses of these photographs as described above.

---------- ----------

Signature Date:

Thank you for your cooperation. We look forward to being part of your loved one's journey at Cozy Nest Care Home.

Sincerely,
The Management Team
Cozy Nest Care Home

304534 Township Road 350, RM of Dundurn, SK, S7C 0E2

admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266 (306) 978 425

CHEETHAM'S PHARMACY
514 Queen Street, Saskatoon, SK, S7K 0M5
P (306) 653-5112
F (306) 653-1661
Email: cheethamspharmacy@gmail.com

Payment Authorization form

I authorize Cheetham's Pharmacy Inc. and its associated financial institution to begin regular deductions from my/our financial institution or credit card for my/our associated charges related to pharmacy services received from Cheetham's Pharmacy. Payments of the charges associated with received pharmacy services will be deducted within the first 3 days of each month. The charges will be for the pharmacy services that resident(s) received in the previous month, for example charges for services received in January will be processed in February and so on. **You have waived the right to receive pre notification of the PAD and have agreed that you do not require advance notice of the amount of PAD/PAP prior to processing the charges.** Cheetham's Pharmacy Inc. will seek prior authorization for any charges that are sporadic or non-pharmacy related.

This authorization remains in effect until Cheetham's Pharmacy receives a written authorization of change or termination. Once the notice is received I/we agree that Cheetham's Pharmacy will process the final charges and once the final charges are processed, the payment agreement is terminated. The change or termination notice can be provided to the Pharmacy by email or mailing to the address provided below.

Cheetham's Pharmacy Inc. may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to us. I/we have certain recourse rights if any debit/charge does not comply with this agreement. For example, I/We have the right to receive reimbursement for any PAD/PAP that is not authorized or is not consistent with this PAD/PAP Agreement. In case of non-sufficient funds, there will be a $10 charge per instance. Please fill the information below.

Name of the resident: _____ SK Health Card #: _____

Power of Attorney Full Name: _____ (Please provide POA Document)

POA Correspondence Name: _____, Email: _____

Address: _____ City: _____ Prov: _____

Postal Code: _____ Ph # 1) _____ 2) _____

I, _____(resident or POA), authorize Cheetham's Pharmacy to transmit personal health information via email for the listed patient.

Authorized Signature: _____ Date: _____/_____/_____

CHEETHAM'S PHARMACY
514 Queen Street, Saskatoon, SK, S7K 0M5
P (306) 653-5112
F (306) 653-1661
Email: cheethamspharmacy@gmail.com

Payment Options:

Option 1:

Pre-authorized debit: Please provide a copy of Pre-authorized Debit form from the financial institution or a copy of a VOID cheque.

Option 2:

Credit Card Authorization (please be advised that there will be a 1.5% service charge applied to the payment when using the credit card for auto payment.)

Please fill in the information below and email, mail or fax to the pharmacy.

Credit Card (Visa/ MasterCard/ Amex # _____ (16 digit or 15 digits for AMEX)

Card Expiration Date: _____(MM) _____(YYYY) CVV: _____ (3 or 4 digits)

Authorized signature: _____ Date:_____

Medication Change and Medication Review Authorization

I am aware that medications may be modified and changed for the resident by the physician/prescriber from time to time.

I am aware that Cheetham's Pharmacy will conduct medication reviews from time to time and suggest possible changes to the medication to the physician in order to ensure the most appropriate medications are being used, drug interactions are prevented, and the resident'/ patient's health is at the forefront of therapies. These reviews may be conducted in collaboration with physicians, the home's care staff, and any other health care professional involved in the care of the resident/ patient.

I am aware and agree that Cheetham's Pharmacy can and will make changes to the medication regimen according to the physician's orders.

Please complete this authorization and return to the above-mentioned address or email address.

Authorized Signature: _____ Date: _____/_____/_____

Walking Stick Mobility
(By Marche Mates Mobility Inc.)

Unit # 40 – 510, Lauriston Street,
Saskatoon, SK S7K 0R5

Tel: (306) 242 – 7849
Fax: (306) 242 - 6849

Payment Authorization form - Incontinence Products

I / We authorize Marche Mates Mobility Inc. (DBA Walking Stick Mobility), hereinafter to be referred as 'The Company', to begin regular deductions from my/our financial institution or credit card for my/our associated charges related to Incontinence products received from the Company.

Payments for charges associated with Incontinence products received will be deducted within seven days of receipt.

By signing the Payment Authorization form, I / We agree to waive our right to receive pre-notification for the debit amount and confirm that I / we do not require advance notice of the amount of the Pre-Authorization debit prior to processing the charges.

The company shall invoice incontinence products at the stated unit rates, which we understand are subject to change without prior notice.

This authorization remains in effect until the Company receives written notice of change or termination, and until all previous dues have been cleared. I / we may provide the change or termination notice to the Company via email or by mailing to the address provided.

The Company may assign this authorization, fully or partially, by operation of law, change of control or otherwise, by providing at least 10 days prior written notice. I/we have certain recourse rights if any debit/charge do not comply with this agreement. Further the Company may impose a $10 charge per instance, in case of non-sufficient funds.

Amount to be debited: CAD…… (Subject to variation based on supplies made during the period.)

Frequency of payments: **Monthly**

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/We have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/We may contact my/our financial institution or visit www.payments.ca

Name of the resident: _____ SK Health Card #: _____

Power of Attorney Full Name: _____

Email: _____

Address: _____ City: _____ Prov: _____

Postal Code: _____ Ph # 1) _____ 2) _____

I, _____ (resident or Power of Attorney), authorize Marche Mates Mobility Inc. to transmit personal / health information via email for the listed patient.

Note: Please attach a copy of the Power of attorney, where a POA has been assigned

Walking Stick Mobility
(By Marche Mates Mobility Inc.)

Unit # 40 – 510, Lauriston Street,
Saskatoon, SK S7K 0R5

Tel: (306) 242 – 7849
Fax: (306) 242 - 6849

Payment Options

Option 1:

Pre-authorized debit: Please provide a copy of Pre-Authorized Debit form, from the financial institution or a copy of a VOID cheque.

Option 2:

Credit Card Authorization (please be advised that there will be a 1.5% service charge applied to the payment when using the credit card for auto payment.)

Please fill in the information below and email, mail or fax to the pharmacy.

Credit Card (Visa/ MasterCard/ Amex # _____ (16 digit or 15 digits for AMEX)

Card Expiration Date: _____(MM) _____(YYYY) CVV: _____ (3 or 4 digits)

Authorized signature: _____ Date:_____

Authorized Signature: _____ Date: _____/_____/_____

Saskatchewan Health Authority

COVID-19/ Seasonal Influenza/ Pneumococcal/Tetanus Vaccine Immunization Consent Substitute Decision Maker

INITIAL APPLICABLE BOXES

This form is to be used only for persons 18 years and older who:

- **DO NOT HAVE capacity to sign for their own medical services, AND**
- **DO HAVE a legal substitute decision-maker designated.**

Section 1: Client Information OR See addressograph/label above		
Last Name	First Name	Gender M F
Health Services Number	Birthdate (YY/MM/DD)	Long Term Care or Personal Care Home (if applicable)

Section 2: Vaccine Screening Questions: (Substitute Decision-Maker or Practitioner to complete)

General Screening:

1. Is this person sick or have a fever today? ☐ No ☐ Yes - describe: _____
2. Does this person have severe allergies? ☐ No ☐ Yes - describe: _____
3. Has this person reacted to previous vaccines? ☐ No ☐ Yes - describe: _____
4. Is this person immunocompromised? ☐ No ☐ Yes _____
5. Does this person have any medical conditions? ☐ No ☐ Yes – describe: _____

   _____
6. Is this person on any medication? ☐ No ☐ Yes - list _____

   _____
7. Does this person have any bleeding disorders? ☐ No ☐ Yes - describe: _____

COVID-19 Vaccine Screening:

☐ COVID-19 Screening Questions completed with substitute decision-maker or practitioner. Refer to and provide COVID-19 Vaccine Fact Sheet. Refer to ***saskatchewan.ca/COVID19*** for more information.

Influenza Vaccine Screening:

☐ CS-A-0001 Influenza Vaccine Screening Questions Algorithm completed with substitute decision-maker or practitioner. Refer to and provide Influenza Vaccine Fact Sheet. Refer to ***www.4flu.ca*** for more information.

Pneumococcal Conjugate 20 (Pneu-C-20) Vaccine Screening:

For eligibility refer to Chapter 10, Pneu-C-20 Product Pages of the Saskatchewan Immunization Manual (SIM).

☐ Pneumococcal Conjugate 20 Vaccine Screening completed with substitute decision-maker or practitioner. Refer to and provide Pneumococcal Conjugate 20 Vaccine Fact Sheet.

Tetanus Diphtheria Pertussis (Tdap) Vaccine Screening:

For eligibility refer to Chapter 10, Tdap Biological Product Pages and Chapter 5, Tetanus Prophylaxis in Wound Management of the Saskatchewan Immunization Manual (SIM).

☐ Tetanus Diphtheria Pertussis (Tdap) Vaccine Screening completed with substitute decision-maker or practitioner. Refer to and provide Tetanus Diphtheria Pertussis (Tdap) Vaccine Fact Sheet.

Saskatchewan Health Authority

COVID-19/ Seasonal Influenza/ Pneumococcal/Tetanus Vaccine Immunization Consent Substitute Decision Maker

INITIAL APPLICABLE BOXES

Section 3: Consent for Vaccine and/or an Influenza Antiviral (Substitute Decision-Maker to complete)

I have read the information in the fact sheet(s). I understand the information provided and have had the opportunity to ask questions. I am aware that the Saskatchewan Health Authority may access immunization records from the provincial electronic immunization registry (Panorama) to determine the need for immunization. I am aware that immunizations and health related information will be documented in Panorama and may be shared with healthcare professionals to provide public health services, assist with diagnosis and treatment, and to control the spread of vaccine preventable diseases.

Name of Substitute Decision-Maker

Relationship to Client	Daytime Phone Number

I consent for the person named above to receive the **COVID-19 Vaccine(s):** ★
☐ Telephone Consent See Section 4

Signature: Date (YY/MM/DD):

I consent for the person named above to receive the **Influenza Vaccine:** ★
☐ Telephone Consent See Section 4

Signature: Date (YY/MM/DD):

I consent for the person named above to receive the **Pneumococcal Conjugate 20 (Pneu-C-20) Vaccine**:
☐ Telephone Consent See Section 4

Signature: Date (YY/MM/DD):

I consent for the person named above to receive the **Tetanus Diphtheria Pertussis (Tdap) Vaccine**:
☐ Telephone Consent See Section 4

Signature: Date (YY/MM/DD):

I consent for the person named above to receive an **influenza antiviral** (Oseltamivir) for prophylaxis and treatment when an influenza outbreak is declared by the Medical Health Officer / Population and Public Health Services.
☐ Telephone Consent See Section 4

Signature: Date (YY/MM/DD):

Section 4: Telephone Consent (Healthcare Provider to complete)

☐ **COVID-19 Vaccine(s)**
☐ **Influenza Vaccine**
☐ **Pneu-C-20 Vaccine**
☐ **Tdap Vaccine**
☐ **Influenza Antiviral (Oseltamivir)**

Healthcare Provider to obtain consent per **Chapter 3 of the Saskatchewan Immunization Manual (SIM),** including as it relates to Panorama under Section 3 above. **Complete section 3 first for all applicable vaccines – signature below of person obtaining a telephone consent from substitute decision maker identified in section 3.**

Name of Healthcare Provider (Print)	Healthcare Provider Signature	Date (MM/DD/YY)

Saskatchewan Health Authority

Long Term Care Moving –In Agreement

Every long term care (LTC) home in Saskatchewan Health Authority (SHA) strives to create a sense of home, a community, where individuals with varied preferences, needs and abilities live together. Open communication, mutual respect and flexibility are some of the foundational principles that enhance life in LTC. These principles also contribute to healthy workplace environments for care team members. It is through mutual commitment to these principles that community is created.

This agreement is between SHA and:

Name of Resident

Name of Personal Guardian and Relationship (As applicable)

Name of Proxy

Name of Substitute Decision Maker and Relationship (As applicable)

Name of Two Treatment Providers
(In the absence of a Personal Guardian, Proxy and/or Substitute Decision Maker)

The LTC Moving in Agreement is considered a medical agreement. If a person requires long term care but lacks the capacity to make a health care decision, the Personal Guardian, appointed by court; Proxy, identified in the Health Care Directive; Substitute Decision Maker, determined by nearest relative list; or two Treatment Providers, in that order of priority, may sign on the Resident's behalf (The Health Care Directives and Substitute Health Care Decision Makers Act, 2015).
If the Personal Guardian or proxy sign this agreement on behalf of the Resident, as the Responsible Party, they agree to enter this agreement on behalf of the Resident.

THE RESIDENT AND/OR RESPONSIBLE PARTY acknowledge and agree to abide by our provincial SHA applicable policies as well as protocols and procedures in place at the LTC Home both now and in the future, including but not limited to the following:

GENERAL CARE

1. Medications
    - No pharmaceuticals/medications or other non-prescription treatments are to be kept in the Resident's possession or supplied by relatives or friends without the knowledge and consent of the Manager or designate.
    - Medications are to be dispensed and packaged by the pharmacy under contract with the SHA or LTC Home.

2. If the Resident needs new clothing, money or effects, the Resident/Responsible Party will be responsible to supply these. Staff at the LTC Home will not alter clothing without the consent of the Resident or the Responsible Party.
3. Damage or Loss of Property
   - Reasonable effort is made for the Resident's protection, but the SHA or LTC Home does not accept responsibility for damage or loss to the Resident's property.
   - The Resident/Responsible Party is encouraged to consider obtaining contents insurance (i.e. tenant's pack) for the Resident's belongings, which may include personal or valuable items such as dentures, hearing aids, jewelry, etc. Labelling of personal belongings is also encouraged.
4. Authorization for personal electrical appliances (example: fans, humidifiers, coffee makers, electric blankets, etc.) must be obtained before use.
5. Structural alterations or additions to the premises are not allowed.
6. The Resident is aware that the LTC Home may have registered pets that either visit or reside in the home. If the Resident does not want a pet to come into his/her room, the Resident will notify the care team and the care team will indicate this in the Resident's care plan.
7. Resident Room
   - The Resident is required to bring clothing and is encouraged to bring small personal items to personalize his or her room.
   - The Resident understands that after discussion with the Resident/Responsible Party, for sanitary or other safety reasons, the home has the right to request removal and/or disposal of any article by the Resident/Responsible Party.
   - Each home has a regular process for staff to review the environment of the home including resident rooms for infection control, safety and security reasons.
8. The SHA or LTC Home will take the Resident's picture for the purpose of identification by staff, medication administration and for resident safety purposes. See SHA-05-002 Informed Consent to Care Policy and SHA-08-009 Patient Identification Verification Policy.
9. Personal health information will be shared with:
   - Care team members, including but not limited to, therapies, social work, pastors, acute care staff, etc.
   - Elections Canada, Statistics Canada, Canada Census and Saskatchewan Provincial Elections, unless the Resident/Responsible party indicate otherwise.
10. Concern handling processes will follow SHA-02-013 Concern and Complaint Management Policy.
11. The SHA has zero tolerance for verbal, physical, emotional and psychological abuse of residents, staff, patient and family partners, physicians, etc. Situations of potential or actual abuse will be address by the SHA accordingly.

MEDICAL CARE

12. Health Care Directives
    - If the Resident has a Health Care Directive, a copy is provided to the home.
    - The Health Care Directive or Saskatchewan Medical Order for Scope of Treatment (SMOST) (CS-OS-0993) will inform the care team of the Resident's health care choices in the event of a serious illness, sudden collapse and/or cardiac arrest.

- The Resident will be invited to meet with the care team to review an existing Health Care Directive, or discuss and complete one.
    - If the resident does not have capacity to create a health care directive, their substitute decision maker will have an opportunity to engage in shared decision making with the resident's practitioner, to create a SMOST. (Physician or Nurse Practitioner).
    - If there is no Health Care Directive or SMOST at the time a decision is needed, the Substitute Decision Maker will be contact to make the decision.
- The care team will offer support and provide information to make informed health care decisions.

13. Resuscitative Services
    - In accordance with the Saskatchewan Ministry of Health Program Guidelines for Special Care Homes, staff at the LTC Home will provide resuscitative service to Residents indicating their wish to receive it in the event of a cardiac arrest.
    - Staff not certified in CPR will perform Hands Only CPR as directed by 911 dispatchers. Staff certified in CPR shall proceed as trained. Automated External Defibrillators (AEDs), where available, may also be used.
    - In the event the Health Care Directive or SMOST indicates a resident wishes further treatment, they may be transferred by staff to an acute care facility for further treatment.

14. The LTC Home will coordinate the purchase of medications, etc. with the community pharmacy contracted by the LTC Home (sharing of Personal Health Information with community pharmacies for this purpose will occur).

15. Medical treatment, nursing care, medication administration, immunization, and therapeutic services for the Resident will be supported by the home where indicated and appropriate consents reviewed.

TRANSFER/RELOCATION/END OF SERVICE PROTOCOL/DEATH

16. The SHA or LTC Home reserves the right to transfer/relocate a Resident to a different room or LTC Home. The SHA or LTC Home will discuss transfer/relocation with the Resident and/or Responsible Party. If the situation is urgent, contact with the Responsible Party will be made as soon as possible once the Resident's care needs are met and explanations will be provided. Under these conditions, the SHA or LTC Home accepts responsibility to move the Resident's personal belongings to the Resident's new location and the associated costs.

17. If it is determined by the SHA or LTC Home that relocation or end of service is appropriate because the Resident's health has improved sufficiently so that the Resident no longer needs the services of the LTC Home, the Resident's care will be assessed, coordinated, and planned in collaboration with the Resident and/or the Responsible Party and an SHA Assessor Coordinator.

18. The Resident's personal health information will be shared with the receiving home when resident is transferred from one LTC to another LTC Home, acute care facility, medical clinic, etc. including the return from acute care.
19. The Resident/Responsible Party may request a transfer to another room within the home. The SHA or LTC Home will strive to accommodate such requests taking into consideration space availability, appropriateness of the transfer, the care needs of the Resident and other residents and the capacity of the home.
20. The Resident/Responsible Party will collaborate with the SHA or LTC Home to arrange timely relocation of the Resident's belongings.
21. The Resident/Responsible Party may request a transfer to another home that is able to support the care needs of the resident and providing there is no balance owing on the account.
22. In accordance with the SHA Finance policy and the Resident's financial agreement, the Resident/Responsible Party must ensure all payments are made and up to date at the end of service. The SHA will take the steps required to address any overdue funds at end of service, per the Saskatchewan Ministry of Health Program Guidelines for Special Care Homes, the SHA Finance policy and the Resident's financial agreement.

23. End of Service/Discharge/Death

- The circumstances surrounding Resident discharge/ end of service can be a sensitive and uncomfortable time for the Responsible party; ensuring end of service plans are arranged for removal of personal belongings can increase the Responsible party's ability to navigate the end of service with ease.
- The Resident/ Responsible party will ensure a plan is in place to remove the Resident's personal belongings within 48 hours of the end of service, unless otherwise discussed and agreed upon by the Responsible party and the LTC Home Manager/Director.
- If the Responsible Party does not reside within the same geographic area of the Resident, or if the Responsible Party encounters barriers to removing the Resident's personal belongings, the Responsible Party should discuss these barriers and review options with the LTC Home Manager/Director to have additional time to remove the Resident's personal belongings.

24. If the Resident and/or the Responsible Party fails to comply with this agreement

- A meeting between the Resident/Responsible Party and the administrator/Manager will be scheduled to discuss the areas of concern.
- Notice of end of service (exit from long term care services as a final option) may also be given by the LTC Home.

LTC HOME CONTACT INFORMATION

Open and honest communication, full disclosure and mutual respect are cornerstones of establishing and maintaining relationships between care providers and recipients of care. SHA and its affiliates support a culture of openness and willingness to learn from issues and concerns and are committed to working with
you to seek resolution. In the event that questions or concerns arise, they may be directed to:

_____ _____

Name/Title Phone Number

AGREEMENT SCOPE

I, the undersigned Resident and/or Responsible Party, upon the Resident's move to a LTC Home within Saskatchewan Health Authority agree to the items outlined, as discussed, and I recognize that this agreement will remain in effect in the event of a subsequent move to another LTC Home.

DATED at _____ , Saskatchewan, this _____day of _____, 20_____.

_____

Signature of Resident, Responsible Party and/or PROXY

_____

Printed Name of Resident, Responsible Party and/or Proxy

FUNERAL HOME PREFERENCE

To ensure the Resident's wishes are honored, the Resident or Responsible Party may designate a preferred funeral home for future arrangements. Providing this information helps streamline the process when needed.

☐ We have a preferred funeral home

- Name: _____
- Contact: _____ *(Phone/Address)*
- Special Instructions (if any):_____

ADDITIONAL INFORMATION

Thank You

Dear Resident's Family,

Thank you for choosing Cozy Nest Care Home for your loved one's care. We are committed to providing a safe and supportive environment for all our residents.

If there is any additional information about your loved one that you would like us to know, please share it below. This will help us provide the best possible care.

Additional Information About: _

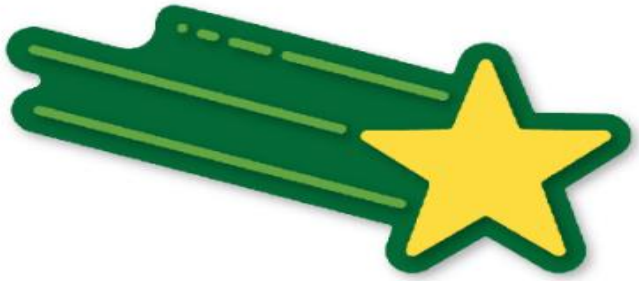
If you have any questions or would like to discuss this further, please feel free to contact us.
Thank you for trusting us with your loved ones' care.

Sincerely,
The Management Team
Cozy Nest Care Home

304534 Township Road 350, RM of Dundurn, SK, S7C 0E2

admin@cozynestcare.ca www.cozynestcare.ca (306) 978 6266 (306) 978 425

Saskatchewan Health Authority



Preventing Falls and Injuries

Staying Safe in Your New Home

CS-PIER-0083
FEBRUARY 2024

saskhealthauthority.ca

Facts about Falls

What is a fall?

The Saskatchewan Health Authority defines a fall as any unintentional change in position where the person ends up on the floor, ground, or other lower level, with or without an injury. This includes falls that occur while being assisted by others.

What is a near fall?

A near fall is a sudden loss of balance that does not result in a fall. This can include a person who slips, stumbles, or trips but is able to regain control prior to falling.

Why should I be concerned about falls?

Falls are the leading cause of injury in older adults. One in three older adults fall each year. Fifty percent of residents living in long term care homes may experience a fall this year. Falls may lead to injuries, confusion, depression, immobility, loss of independence, and fear of falling again. Injuries from falls can lead to hospitalization and rapid decline in functioning and health, often leading to death. Near falls can be a sign of an increased risk of future falls, but there are things that can be done to help prevent falls.

The most common areas for falls are resident rooms and bathrooms.

Together we will reduce the risk of falls and fall-related injuries!

CS-PIER-0083

Care Team Support

- Your care team will frequently check your risk of falling while you live here.
- Your care team will provide information about falls, fall-related injuries, equipment, and make referrals to help you move safely.
- At scheduled care conferences, you and your care team will work together to make a plan to reduce your risk of falls and fall-related injuries.
- Consult your care team to discuss your Vitamin D and Calcium needs.

Vitamin D plays a role in reducing falls amongst the elderly in long term care by increasing muscle strength, bone strength and improving balance. Calcium helps to keep bones strong which reduces the risk of injury following a fall, especially for those residents with osteoporosis.

If you see a falling star…

The falling star symbol identifies that a resident is at high risk for falling. If you notice them struggling with their balance, please notify the care team immediately.

If you see a night icon…

The night icon identifies residents that are up often during the night and are at a higher risk of falling. Staff will check on these residents more frequently during the night to ensure they are safe.

There may be posters displayed in the home that explain the meaning of the above icons.

CS-PIER-0083

How Residents and their Support Persons can Help

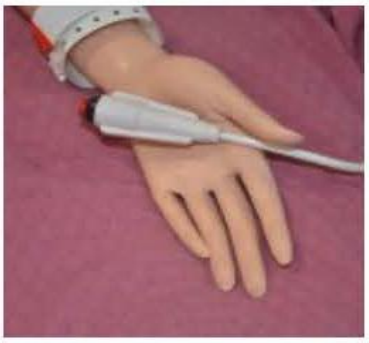
- Keep bedrooms, bathrooms, and floors uncluttered.
- Wear well-fitting footwear when you are not in bed. The best shoes are flat with enclosed heels and rubber soles.
- Non-slip socks are safer than regular socks and bare feet. Ask your care team for more information.
- Keep your most personal items within easy reach.
- Use recommended mobility aids. Do not use furniture to support yourself.
- Eat healthy and nutritious meals and drink plenty of fluids.
- Ensure your pain is under control. If it is not, ask your care team for help.
- Participate in strengthening or balance exercises if you are capable. If you can, try to walk every day.
- Ensure eyewear and hearing aids are well maintained and the correct prescription.
- Support the use of falls prevention and injury reduction items such as hip protectors, non-slip socks, alarms, fall mats, etc.
- Be open to medication reviews and changes aimed at reducing fall risk.

For more information about fall prevention and resident safety, please speak with your Healthcare Provider

CS-PIER-0083

Care Team Support

Call, don't fall!



Please use your call bell for assistance!

- Please ring for your care team if you need help to move. We may be a moment, but we **will** be there to help you.
- Call your care team if your room is not safe to walk in, for example if there are spills or objects in your path.
- If it is dark, turn on a light or use a night light.
- Sit up in bed for a minute before you stand up. Standing up too quickly can make you dizzy.
- Ensure you have your balance before you start to walk.
- If you have a walking aid or wheelchair, make sure to use it at all times. Ensure that it is within reach and that the brakes are on when moving to and from your bed.
- Use the bathroom handrails and grab bars.