North Carolina Department of Health and Human Services
Division of Health Service Regulation
Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, North Carolina 27699-2711
Telephone: (919) 855-4520 Fax: (919) 733-8274

For Official Use Only
License # _____
Beds: Nursing: ACH:
Computer FID:
Returned _____ Reviewed _____
MFF_____
License Fee:

Exhibit 12

2011
RENEWAL APPLICATION FOR LICENSE TO OPERATE A NURSING HOME

(Including Adult Care Home Beds in Combination Facilities)

Legal Identity of Applicant:
_____
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As (name(s) under which the facility or services are advertised or presented to the public):

PRIMARY: _____
Other: _____
Other: _____

Facility Mailing Address: Street/P.O. Box: _____
City: _____, State: _____ Zip:
_____

Facility Site Address: Street: _____
City: _____, State: _____ Zip: _____
County:
Telephone: (____) _____ Fax: (____) _____

E-mail Address of Administrator:
_____

1. Was this facility in operation throughout the entire 12-month reporting period ending September 30, 2010?
___ Yes ___ No

If No, for what period was the facility in operation? ____ / ____ / ____ through ____ / ____ / ____
month/day/year month/day/year

If No, for what reason was the facility not in full operation during this period? _____
_____
_____

2. Was there a change of ownership anytime between October 1, 2009 to September 30, 2010? ___ Yes ___ No

If Yes, what was the date of the change? ____ / ____ / ____

PART A **OWNERSHIP DISCLOSURE**
(Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner: _____
Street: _____
City: _____ *State:* _____ *Zip:* _____
Telephone: (____) _____ *Fax:* (____) _____
Email Address: _____
Senior Officer: _____

a. Legal entity is: ___ For Profit ___ Not For Profit

b. Legal entity is: ____ Corporation ___ LLC/LLP ___ Partnership
___ Proprietorship ___ Government Unit

c. Does the above entity (partnership, corporation, etc.) lease the building from which services are offered? ___ Yes ___ No

If Yes, name of building owner:
_____

2. Is the business operated under a management contract? ___Yes ___No

If Yes, name and address of the management company.

Name: _____
Street: _____
_____
City: _____ State: _____ Zip: _____
Telephone: (____) _____

3. If this business is a subsidiary of another entity, please identify the parent company below:

Name: NONE
Street: _____
Mailing _____
(*if different from Street*)
City: _____
State: _____ Zip:_____
Telephone: (____) _____ Fax:(____) _____) _____
Senior Officer: _____

PART B OPERATIONS

1. Facility Personnel

   a. Administration

   Name of the Administrator: _____

   Date Hired As Administrator: _____ N.C. License Number: _____

   b. Nursing

   Name of the Director: _____

   Date Hired As D.O.N.: _____ License Number: _____

   c. Medical Director:

   Name of Medical Director: _____

   Date Hired as Medical Director _____

   Office Address:

2. Environmental Enhancements Supporting Culture Change
   ("Enhancements" refer to practices and products that help create a homelike atmosphere within the nursing home. Some may be unique to one facility while others may be central to a particular model of culture change.) Listed below are the enhancement components reported on your renewal application last year. Please update these records, as they are used by the state for statistical purposes with respect to its enhancement grant program.

   Please check all the environmental enhancements implemented this year:

Please check Yes or No if the facility is:	Yes	No
a. Currently practicing a formalized culture change process/program?		
b. Currently implementing enhancements, but following no formalized culture change process?		

If Yes to 2a or 2b above, please check which components have been implemented:

☐	Cats	☐	Children	☐	Staff Empowerment	☐	Residential building design
☐	Dogs	☐	Plants	☐	Neighborhoods	☐	Residential dining enhancements
☐	Birds	☐	Gardens	☐	Other Animals	☐	Snoezelen
☐	Bathing	☐	Teams	☐	Aroma Therapy	☐	Other enhancements Please specify

_____

_____

If applicable, please indicate either the culture change philosophy being practiced (i.e.: Eden Alternative, Person Centered Care, Well Spring Model, etc.) or a philosophy unique to your home:

_____

PART C PATIENT SERVICES

(Please fill in any blanks and make changes where necessary. Check Yes or No.)

1. Continuing Care Retirement Communities (CCRC)
   a. Is the facility licensed by the Department of Insurance as a Continuing Care Retirement Community? ___Yes __No
   b. Does the CCRC own or operate a licensed home care agency? ___Yes ___No

2. Does the facility have an adult day care program? ___Yes ___No
   a. If Yes, indicate maximum number of clients that can be served on a daily basis. _____

3. Does the facility provide hospice care? ___Yes ___No

4. Does the facility have an adult respite program? ___Yes ___No

5. Does this facility provide outpatient rehabilitation therapy? ___Yes ___No

6. Was there a change to the licensed bed capacity between Oct 1, 2009 to Sept 30, 2010? ___Yes ___No
   a. If Yes, what was the effective date of the change? ___ /___ /___
   b. If Yes, indicate previous number of licensed beds (Nursing Fac, Adult Care). ____ NF____ACH

7. Is the facility a Combination Facility, thereby incorporating licensed ACH beds? ___Yes ___No

   a. If Yes, indicate which rules the facility chooses to apply to the operation of these ACH BEDS (NH rules, ACH rules or both NH & ACH)
   ☐ ***Nursing Home Licensure Rules***
   ☐ ***ACH Licensure Rules***

   If check both, complete checklist enclosed and submit with application.

8. Beds By Type (*Must complete Alzheimer's Special Care Unit data supplement sheet)
   a. Nursing Facility Beds (NF) (TOTAL)
      1. General Nursing Facility Beds
      2. *Alzheimer's Resident Special Care Unit Beds *
      3. HIV/AIDS Resident Beds
      4. Traumatic Brain Injury Resident Beds
      5. Ventilator Dependent Resident Beds
      6. Bariatric Beds _____
      7. Other (specify but do not include Medicare only unit):_____

   b. Adult Care Home Beds (ACH) (TOTAL)
      1. General Adult Care Home Beds
      2. * Alzheimer's Special Care Unit Beds *
      3. Bariatric Beds _____

   c. Total Licensed Beds

9. Bed Certification (based on form DHSR-4501, Breakdown of Room Numbers and Beds)

a. Number of beds certified for Medicare **only** (**Title 18 only**)	
b. Number of beds dually certified for both Medicare & Medicaid **(Title 18/19)**	
c. Number of beds certified for Medicaid **only** (**Title 19 only**)	

PART D PATIENT CENSUS

Important: Report patient census data for September 30, 2010 only.

1. Number of patients in facility on September 30, 2010

Nursing	Adult Care

2. Statistics on Nursing Home Patients

(a) Number of Nursing Level of Care patients on September 30, 2010 by age group	Male	Female
Under 35		
35 - 64 years old		
65 - 74 years old		
75 - 84 years old		
85 years old and older		
Totals		

(b) Nursing hours worked on this day for Nursing Patients by direct care RNs, LPNs and Nurse Aides.	

3. Statistics on Adult Care Home residents on September 30, 2010 by age groups

	Male	Female
Under 35		
35 - 64 years old		
65 - 74 years old		
75 - 84 years old		
85 years old and older		
Totals		

PART E PATIENT UTILIZATION DATA

Answer these questions for the reporting period of October 1, 2009 through September 30, 2010.

1. Beginning Census, Admissions, Discharges, and Deaths by Level of Care

- The "Beginning Census" refers to the number of patients/residents in your facility on October 1, 2009.
- "Admissions" refers to the number of persons admitted during the period from Oct 1, 2009 through Sept 30, 2010.
- "Discharges" and "Deaths" refer to all discharges and deaths from October 1, 2009 through September 30, 2010.

Tips:

- Your "Beginning Census" plus "Admissions" minus your total "Discharges" plus "Deaths" should be equal to, or less than, your facility's licensed capacity.
- Your totals for "Beginning Census" and for "Admissions" should agree with your totals on "Counties of Patient Origin" for Nursing Care and Adult Care, respectively.

Patients/Residents	Beginning Census	Admissions	Discharges (excluding deaths)	Deaths
(1) Nursing Patients				
(2) Adult Care Home Residents				

2. Inpatient Days of Care

Number of Days of Inpatient Care rendered during the reporting period.

a. Nursing Care (NC)

(1) NC Days Reimbursed by Medicare	
(2) NC Days Reimbursed by Medicaid	
(3) NC Days Reimbursed by Private Pay	
(4) NC Days Reimbursed by Other	
(**5**) Total { (1) + (2) + (3) + (4) }	

b. Adult Care Home (ACH)

(1) ACH Days reimbursed by Private Pay	
(2) ACH Days reimbursed by County Special Assistance	
(3) ACH Days reimbursed by Other	
(4) Total { (1) + (2) + (3) }	

3. Counties of Origin for Nursing Care Patients

- For the period of October 1, 2009 through September 30, 2010, list in Column A the counties where **Nursing Care patients** lived before coming to your facility.
- For each county in Column B1 give the number of nursing patients, from that county, who were living in the facility on October 1, 2009.
- For each county, in Column B2 give the total number of additional Nursing Care patients, from that county, who were admitted between October 1, 2009 and September 30, 2010.
- Report patients who were not NC residents as "Out-of-State" on lines 26 through 30. **Attach additional sheets if needed.**

For questions please call Medical Facilities Planning at (919) 855-3865

A	B		C	D
Permanent County of Residence for Individuals prior to Admission (if "out-of-state" indicate in last lines below)	Patient Census during reporting period:		TOTAL B1 plus B2	For each county indicate number of patients whose care was paid for, in whole or in part by Medicaid (Title XIX) program
	B1 In Facility at beginning	B2 Admitted during period		
EXAMPLE: 1. Wake	50	185	235	175
2. Yadkin	1	2	3	2
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
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20.				
21.				
22.				
23.				
24.				
25.				
26. Georgia				
27. South Carolina				
28. Virginia				
29. Tennessee				
30. Other Out-of-State				
31. TOTALS				

NOTE: Totals should correspond with the figures given in response to Question 1 under "Patient Utilization"

4. Counties of Origin for Adult Care Home Residents

- For the period of October 1, 2009 through September 30, 2010, list in Column A the counties where **Adult Care Home residents** lived before coming to your facility.
- For each county in Column B1 give the number of Adult Care Home residents, from that county, who were living in the facility on October 1, 2009.
- For each county, in Column B2 give the total number of additional Adult Care Home residents, from that county, who were admitted between October 1, 2009 and September 30, 2010.
- Report residents who were not NC residents as "Out-of-State" on lines 26 through 30. **Attach additional sheets if needed.**

For questions please call Adult Care Licensure at (919) 855-3765

A	B		C	D
Permanent County of Residence for Individuals prior to Admission (if "out-of-state" indicate in last lines below)	Patient Census during reporting period:		TOTAL B1 plus B2	For each county indicate number of patients whose care was paid for, in whole or in part by Medicaid (Title XIX) program
	B1 In Facility at beginning	B2 Admitted during period		
EXAMPLE: 1. Wake	50	185	235	175
2. Yadkin	1	2	3	2
1.				
2.				
3.				
4.				
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22.				
23.				
24.				
25.				
26. Georgia				
27. South Carolina				
28. Virginia				
29. Tennessee				
30. Other Out-of-State				
31. TOTALS				

NOTE: Totals should correspond with the figures given in response to Question 1 under "Patient Utilization"

PART F CURRENT OPERATING STATISTICS

1. Current Per Diem Reimbursement Rates/Charges.

Please state the CURRENT (as of the date the application is signed) basic daily charges/rates for residents or patients in your facility in the following categories of care.

For questions please call Certificate of Need at (919) 855-3873

Private Pay (Usual Customary Charge)	Private Room (1 bed/room)	Semi-Private (2 beds/room)	Ward
Nursing Care	$	$	$
Adult Care Home	$	$	$
Special Care Unit (specify)_____	$	$	$
Special Care Unit (specify)_____	$	$	$

Medicare	Code	Rate
Three most frequent RUGS codes and rates paid for them	1.	$
	2.	$
	3.	$

	Quarterly Rates			
Medicaid	Oct.-Dec.	Jan.-Mar.	Apr.-June	July-Sept.
Nursing Care	$	$	$	$

Medicaid Nursing Care	Rate
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

State/County Special Assistance	Rate
Adult Care Home	$
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

Please complete only if applicable:

Alzheimer's/Dementia Special Care Unit	Rate
Additional cost or fee to resident	$

(Use reverse side or separate sheet if needed)

2. Total Current Staff for Existing Facility

Do not include the following: courtesy or attending staff, private duty nurses, volunteer workers or the same employee in more than one category. These employees were on the payroll as of _____.
month/day/year

For questions please call Certificate of Need at (919) 855-3873

	Average Annual Salary	Hourly Consulting Fee	Total Facility FTE's	Total Facility Annual Consul. Hrs.
Routine Services				
Registered Nurses				
Licensed Practical Nurses (LPNs)				
Certified Nurse Aides				
Medical Director				
Director of Nurses				
Assistant Director of Nurses				
Staff Development Coordinator				
Ward Secretary				
Medical Records				
Pharmacy Consultant				
Administration and General				
Administrator				
Assistant Administrator				
Other Office Personnel				
Dietary				
Licensed Dietitian				
Food Service Supervisor				
Cooks				
Dietary Aides				
Social Work Services				
Social Services Director				
Social Services Assistant(s)				
Activity Services				
Activity Director				
Activity Assistant(s)				
Housekeeping/Laundry				
Housekeeping Supervisor				
Laundry Supervisor				
Housekeeping Aides				
Laundry Aides				
Maintenance				
Maintenance Supervisor				
Janitors				
Ancillary Services				
Physical Therapist				
Rehabilitation Aide				
Respiratory Therapist				
Occupational Therapist				
Speech/Hearing Therapist				
Total Positions / Total Consultant Hours				

ADULT CARE HOME (ACH) SUPPLEMENT

For questions please call Adult Care Licensure at (919) 855-3765

1. Please give the number (1, 2, 3, etc.) of Adult Care residents currently in facility with a physician's diagnosis of the following: a) **Mental Illness** (**MI**) which includes a psychiatric illness but does not include mental retardation, developmental disabilities or Alzheimer's/Dementia; b) **Mental Retardation/Developmentally Disabled** (**MR/DD**) such as Downs syndrome, autism, cerebral palsy, or epilepsy; or c) **Alzheimer's Disease** or related dementia which may include multi-infarct dementia, Parkinson's Disease, Huntington's Disease, Creutzfeldt-Jakob Disease or Picks Disease. If a resident is dually diagnosed, only count the resident once, based on the primary diagnosis.

Resident Age - years	MI	MR/DD	Alzheimer's/Related Dementia
Under 35			
35 - 64			
65 - 74			
75 - 84			
85 or older			
TOTAL			

2. On September 30, 2010, number of Adult Care residents receiving Medicaid reimbursed Basic Adult Care Home Personal Care (not Enhanced): _____

3. On September 30, 2010, number of Adult Care residents receiving Medicaid reimbursed Enhanced Adult Care Home Personal Care: _____

4. On September 30, 2010, number of Adult Care residents on State/County Special Assistance (SA): _____

5. On September 30, 2010, number of private pay Adult Care residents: _____

6. Current total monthly private pay charge (average base plus add-ons if more than one price) for:

	Rate
Private Room (1 bedroom)	$
Semi-Private (2 beds/room)	$
3 or more beds/room	$

7. Check any that apply:

		Number of Beds
❒	Alzheimer's Special Care Unit in facility [Rules 13F .1300 apply]	

This application must be completed and submitted with <u>ONE COPY</u> and a license fee to the Nursing Home Licensure and Certification Section, Division of Health Service Regulation prior to the issuance of a 2011 nursing home license.

The undersigned submits this application for licensure for the year 2011 (subject to the provision of the Nursing Home Licensure Act, Article 6, Chapter 131E of the General Statutes of North Carolina and to the rules adopted thereunder by the North Carolina Medical Care Commission) and certifies the accuracy of this information.

_____ _____
Name of Chief Administrative Officer Title

Signature: _____ Date: _____
(Chief Administrative Officer or Representative)

Please identify the contact person for questions regarding this application:

Name: _____ Telephone: (_____) _____
(Contact Person)

This information will not be filed as part of your renewal application.

Please complete the following information for the most recent, completed payroll **year** (do not include contracted labor figures). **Please make sure totals are for a year, not just one month.**

Amount of total Nurse Aide wages paid $ _____ (round to nearest dollar) *****

If total wages paid includes paid time off (e.g. sick leave, vacation time) and you are able to translate paid time off wages into hours worked, please include those wages in the total reported above and also include those hours in the total hours worked that you report below.

If you are not able to equate paid time off wages into hours worked please do not include those corresponding wages into the total wages paid above. Likewise, you will not include those paid time off hours in the hours worked below. This will provide consistency between the total wages reported with the total number of hours worked.

Total number of Nurse Aide hours worked _____ (do not include contracted labor figures)

Remember only include hours worked that are associated with the total wages reported above.

Computed Average Hourly Wage $ _____ (divide amount of total NA wages paid by total hours worked – round to two decimal points (e.g. $9.02)

Payroll Year referenced _____ (mo./yr – mo./yr)

*** Please do not include wages/hours of nurse aides who work exclusively as medication aides**

Once completed, please include this form with your license renewal application. This form will be forwarded to the DHHS Office of Long Term Services and Supports. It will not be retained as part of your license renewal application.

For questions, please call Jan Moxley at 919-855-4429.

Thank you.

Staff Turnover Rate Information for Nursing Homes - Questions about this form: Call Jan Moxley (919) 855-4429

Please complete the following information regarding aide (e.g., nurse aides, personal care aides and/or home management aides) turnover rates and return with your application. This information is requested to enable the Division of Health Service Regulation and the Department of Health and Human Services to track turnover rates in nursing homes, adult care homes and home care agencies. The information you provide by answering questions below will be compiled and aggregated with other responses by type (i.e., nursing homes, adult care homes, home care agencies). Collection and analysis of data on an annual basis helps measure the size and stability of this workforce over time. **This information is not filed as a part of your renewal application.**

1. Licensed as: ___ACH ___Nursing Home ___Combination facility ___Home Care Agency
2. Licensed bed capacity: _____/Beds
3. Are you an NC NOVA (New Organizational Vision Award) Special License recipient? _____Yes _____No
For information about NC NOVA go to: www.ncnova.org

For the period October 1, 2009 through September 30, 2010:

(IF NONE WRITE "0")	Full Time	Part Time
3. How many aides at your facility **QUIT** their jobs?		
4. How many aides at your facility were **FIRED** or terminated?		
5. How many **NEW** aides were hired?		
6. How many aide positions are currently budgeted?		
7. How many aides were on your payroll on ***September 30, 2010?***		

8. Do you feel that you have an *Aide Turnover Problem?*

_____No problem _____Yes, it's a mild problem _____Yes, it's a substantial problem

Circle one response for each question below:	Almost Impossible	Very Difficult	Slightly Difficult	Not Difficult
9. How difficult has it been to find enough aides to fill vacant positions?	1	2	3	4
10. How difficult has it been for your facility to retain aides?	1	2	3	4

About your leadership positions…

11	In what **MONTH** and **YEAR** did your current ***ADMINISTRATOR*** begin working in that position?	**MONTH**	**YEAR**
12	Is your current ***ADMINISTRATOR*** working on a regular basis, or "filling in" on a temporary or interim basis? ***(CIRCLE ONE NUMBER)***	**1**: REGULAR / PERMANENT	**2:** INTERIM / TEMPORARY
13	*If your current **ADMINISTRATOR** started within the last year*, please circle how many ***DIFFERENT OTHER*** persons have served in that position since October 1, 2009? (DO NOT include "temporary" or "acting" administrators) ***(CIRCLE ONE NUMBER)***	**0 1 2 3**	**4 OR MORE**
14	In what **MONTH** and **YEAR** did your current ***DIRECTOR OF NURSING*** begin working in that position?	**MONTH**	**YEAR**
15	Is your current ***DIRECTOR OF NURSING*** working on a regular/ permanent basis, or "filling in" on a temporary or interim basis? ***(CIRCLE ONE NUMBER)***	**1**: REGULAR / PERMANENT	**2:** INTERIM / TEMPORARY
16	*If your current **DIRECTOR OF NURSING** started within the last year*, then please circle how many ***DIFFERENT OTHER*** persons have served in that position since October 1, 2009? (DO NOT include "temporary" or "acting" DONs) ***(CIRCLE ONE NUMBER)***	**0 1 2 3**	**4 OR MORE**

See next page for statewide turnover survey results from previous years

This page is for your information only. It is not necessary to return it.

Results of Direct Care Worker Turnover Data Collected in Prior Years

Turnover Rates	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Nursing Facilities	103%	103%	95%	105%	107%	117%	111%	110%	107%	85%
Adult Care Homes	119%	113%	115%	109%	107%	111%	117%	109%	118%	93%
Home Care Agencies	53%	50%	37%	49%	41%	46%	50%	48%	52%	36%

Results of Administrator and Clinical Manager Turnover Data Collected

Administrator Turnover Rates	2005			2006			2007			2008			2009		
	None	Low	High	None	Low	High	None	Low	High	None	Low	High	None	Low	High
Nursing Facilities	71%	19%	10%	73%	21%	7%	68%	26%	6%	72%	20%	9%	78%	18%	4%
Adult Care Homes	77%	21%	3%	81%	12%	6%	83%	12%	5%	77%	18%	5%	77%	17%	6%
Home Care Agencies	81%	18%	1%	87%	12%	1%	90%	9%	1%	89%	9%	2%	88%	11%	1%

Clinical Manager Turnover Rates	2005			2006			2007			2008			2009		
	None	Low	High	None	Low	High	None	Low	High	None	Low	High	None	Low	High
Nursing Facilities	61%	27%	12%	58%	27%	15%	66%	24%	10%	64%	23%	13%	69%	23%	8%
Adult Care Homes	67%	25%	8%	70%	21%	9%	73%	19%	9%	66%	26%	8%	70%	22%	8%
Home Care Agencies	69%	26%	5%	73%	19%	8%	74%	19%	7%	58%	30%	12%	74%	20%	6%

No turnover = Only one individual in the management position during the last year

Low turnover = Two individuals in the management position during the last year

High turnover = Three or more individuals in the management position during the last year.

Administrators = administrators of nursing homes and administrators or executive directors of adult care homes and home care agencies.
Clinical managers = directors of nursing in nursing homes, resident care directors in adult care homes, and clinical managers or nurse supervisors in home care.

If you have an interest, just for your own information, in calculating the turnover rate of your facility/agency go to:
http://winastepup.org/calculators/index.html. Click on the turnover calculation link for your setting (nursing home, adult care home, home care).

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION
NURSING HOME LICENSURE AND CERTIFICATION SECTION
2711 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-2711
TELEPHONE: (919) 855-4520

FOR OFFICIAL USE ONLY
Computer Number
License Number
Initial _____
Effective Date _____

ALZHEIMER'S SPECIAL CARE UNIT REQUIRED DISCLOSURES DATA SUPPLEMENT

2011 APPLICATION FOR LICENSE TO OPERATE A NURSING HOME

(Including Adult Care Home Beds in Combination Facilities)

(Applicable only to facilities that advertise, market or otherwise promote themselves as providing a special care unit for persons with Alzheimer's disease or other dementias. A Special Care Unit means a wing or hallway within a nursing home or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities.)

LEGAL IDENTITY OF APPLICANT:

_____

_____

{Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.}

DOING BUSINESS AS (d/b/a) - names under which the facility or services are advertised or presented to the public:

PRIMARY
Other:
Other:

FORMAT FOR SPECIAL CARE UNIT DISCLOSURE STATEMENT

The special care unit disclosure statement must address the items in order as listed below. It is to be submitted with the License Application.

(1) The philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to the following;

Safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medication;

A structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities;

Individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and

Methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance;

(2) The process and criteria for admission to and discharge from the unit;

(3) A description of the special care services offered in the unit;

(4) Resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition;

(5) Safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior or other behavior management problems;

(6) Staffing in the unit;

(7) Staff training based on the special care needs of the residents;

(8) Physical environment and design features that address the needs of the residents;

(9) Activity plans based on personal preferences and needs of the residents;

(10) Opportunity for involvement of families in resident care and the availability of family support programs and,

(11) Additional costs and fees for the special care provided.