



ELM CREST MANOR

100 Elm Ave.

NEW SALEM, NORTH DAKOTA 58563

(701) 843-7526 FAX # (701) 843-8376

Providing Quality Skilled Care Since 1969

2026

Dear Prospective Resident &/or Family Member:

Thank you for your interest in Elm Crest Manor. I have enclosed the **Entrance Application and Social History**, which we ask that you complete and return these 4 pages to be placed on the waiting list. When we have an opening we will be contacting you with more information and after we received the **application** for our file. I have also enclosed several other sheets for your information. Included is information about how our daily rates are figured. An evaluation will be done, within the first few days after admission and/or a hospital return and then quarterly thereafter, to determine the daily rate. The other document is several pages of information and what can be brought to a Resident's room. **PLEASE READ THIS CAREFULLY.** Applications will be held for only one (1) year unless the family or responsible person notifies us otherwise.

After approval of the Application, other paperwork that will be needed is listed below:

- A PHYSICAL no more than 5 days prior to admission with a Doctor's Order that a Skilled Nursing Home is required. We will provide the doctor's orders to your physician when we offer the bed. **Please bring all home medications with you on the day of admission.**
- **We will need to photocopy the front and back** of their Social Security Card, Medicare and Medicare Part D card, Medicaid card, and all insurance cards (Health and Nursing Home); also a Driver's License or Picture I.D. card is helpful. Please also bring your nursing home insurance policy to review.
- Please bring copies of all legal paperwork (Power of Attorney for health, financial, a Living Will, Guardianship, Conservatorship, etc.)
- Anyone using a Powered Wheelchair will need to be assessed prior to its use in our facility by our Occupational Therapist. (We do not allow scooters.)

We prefer to admit in the AM or by 1:00 p.m. (CT) Monday through Friday, but will admit for emergency purposes only, at any time. The admission process will take about 3 hours.

Please feel free to call to make an APPOINTMENT TO VIEW FACILITY and/or FOR AN APPLICATION REVIEW or should you have any further questions.

Yours truly,

Rita Schulz, LBSW

The completed 4 page application can be emailed back to me at [lswelmcrest@westriv.com](mailto:lswelmcrest@westriv.com)



**ELM CREST MANOR**  
*100 Elm Ave.*  
**NEW SALEM, NORTH DAKOTA 58568**  
**(701) 843-7526 FAX # (701) 843-8376**  
*Providing Quality Skilled Care Since 1969*

**ELM CREST MANOR  
 NURSING HOME APPLICATION**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ PHONE#: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ CURRENT MARITAL STATUS: \_\_\_\_\_

EDUCATION: \_\_\_\_\_ OCCUPATION & EMPLOYMENT HISTORY: \_\_\_\_\_

SOCIAL SECURITY# \_\_\_\_-\_\_\_\_-\_\_\_\_ MEDICARE # \_\_\_\_\_

MEDICARE PART **D** (Drug) Plan Name: \_\_\_\_\_ # \_\_\_\_\_

MEDICAID # \_\_\_\_\_ Effective date: \_\_\_\_\_ Applying soon? Yes/ No

SUPPLEMENTAL INSURANCE (NAME AND PHONE#) \_\_\_\_\_  
 POLICY # \_\_\_\_\_

NURSING HOME INSURANCE (NAME AND PHONE#) \_\_\_\_\_  
 POLICY # \_\_\_\_\_

FULL NAME OF SPOUSE: \_\_\_\_\_ LIVING: Yes / No  
 RESPONSIBLE PARTY: \_\_\_\_\_

**LEGAL PAPERWORK \*** Durable Power of Attorney \_\_\_\_\_ Guardianship \_\_\_\_\_  
 Conservatorship \_\_\_\_\_ Other: \_\_\_\_\_

ADVANCE DIRECTIVE: Durable Power of Attorney/Healthcare \_\_\_\_\_ Living Will \_\_\_\_\_  
 Durable Power of Attorney/Financial \_\_\_\_\_ Other: \_\_\_\_\_

CODE STATUS: **I II III** (Circle)

|                     |                     |                              |                  |
|---------------------|---------------------|------------------------------|------------------|
| <b>NEXT OF KIN:</b> | <b>RELATIONSHIP</b> | <b>FULL MAILING ADDRESS:</b> | <b>PHONE #'s</b> |
|---------------------|---------------------|------------------------------|------------------|

(LIST 3 & IN ORDER TO BE CALLED OR ON LEGAL PAPERWORK LISTED ABOVE (\*))

|  |  |              |
|--|--|--------------|
|  |  | (H) _____    |
|  |  | (W) _____    |
|  |  | (Cell) _____ |
|  |  | (H) _____    |
|  |  | (W) _____    |
|  |  | (Cell) _____ |
|  |  | (H) _____    |
|  |  | (W) _____    |
|  |  | (Cell) _____ |

DIAGNOSIS: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

DOCTOR'S Name/address/phone#: \_\_\_\_\_

Last Seen: \_\_\_\_\_ **(continued-over)**

Page 2. RESIDENT NAME: \_\_\_\_\_

DENTIST'S name/address/phone#: \_\_\_\_\_

Last Seen: \_\_\_\_\_

EYE DOCTOR'S name/address/phone#: \_\_\_\_\_

Last Seen: \_\_\_\_\_

CLINIC: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

LAST Flu Shot: \_\_\_\_\_ Tetanus Shot: \_\_\_\_\_ Pneumonia Shot: \_\_\_\_\_ Shingles Shot: \_\_\_\_\_  
(Date) (Date) (Date) (Date)

RELIGION/Name of current Church & City: \_\_\_\_\_

(Which Synod) \_\_\_\_\_ Pastor's Name: \_\_\_\_\_

FUNERAL HOME/MORTICIAN: name/address/phone #: \_\_\_\_\_

Pre-paid Burial: Yes / No

**PAYMENT SOURCE FOR CHARGES TO RESIDENT/APPLICANT:** (check all that apply)

Self \_\_\_\_\_ Medicaid \_\_\_\_\_ (Applying soon for Medicaid \_\_\_\_\_) Insurance \_\_\_\_\_ Other: \_\_\_\_\_

\*\*\*PLEASE COMPLETE AS OF THE DATE OF APPLICATION: (& check all that apply)\*\*\*

**IS APPLICANT:** Ambulatory \_\_\_\_\_ Bedfast \_\_\_\_\_ Ambulates with Assistance \_\_\_\_\_

AND USES A: Cane \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair \_\_\_\_\_

Motorized W/C \_\_\_\_\_  
Standby Assistance \_\_\_\_\_ OTHER: \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
CONTINENT \_\_\_\_\_ INCONTINENT \_\_\_\_\_ (Bladder \_\_\_\_\_ Bowel \_\_\_\_\_)

Wears Incontinence Product \_\_\_\_\_ (Type) \_\_\_\_\_

COMMENTS: \_\_\_\_\_

MENTAL CONDITION: Clear \_\_\_\_\_ Confused \_\_\_\_\_ Forgetful \_\_\_\_\_

Wanders \_\_\_\_\_ Any Behaviors \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**DOES APPLICANT USE/ABUSE OF ANY OF THE FOLLOWING:**

Alcohol: \_\_\_\_\_ (amount/type)

Smoking/Tobacco Products: \_\_\_\_\_ (amount/type)

Drugs/Substance Abuse: \_\_\_\_\_ (amount/type)

Ever Been Arrested: (explain) \_\_\_\_\_

**DOES APPLICANT NEED ASSISTANCE TO:** (check all that apply)

Dress/Undress \_\_\_\_\_ Get In/out of Bed \_\_\_\_\_ Use or find the Bathroom \_\_\_\_\_

Transfer In/out of Chair \_\_\_\_\_ Bathe \_\_\_\_\_ Eat \_\_\_\_\_

SPECIAL DIET & What: \_\_\_\_\_ OTHER ASSISTANCE NEEDED: \_\_\_\_\_

SPECIAL TREATMENTS OR OTHER CARES: \_\_\_\_\_

SPECIAL EQUIPMENT \_\_\_\_\_

**CURRENT HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**WEARS:** Glasses \_\_\_\_\_ Dentures/Partials: Both \_\_\_\_\_ Upper \_\_\_\_\_ Lower \_\_\_\_\_ OWN TEETH \_\_\_\_\_

Hearing aid: Both \_\_\_\_\_ or Right ear \_\_\_\_\_ Left ear \_\_\_\_\_ (& List serial # or bring card)

**HOSPITAL STAYS WITHIN THE LAST:** 30 days \_\_\_\_\_ 60 days \_\_\_\_\_ 90 days \_\_\_\_\_ E. R. VISITS: \_\_\_\_\_

**RECEIVING HOME HEALTH CARES:** Nursing Care OR Med set-up \_\_\_\_\_ Housekeeping \_\_\_\_\_

Bathing/Dressing \_\_\_\_\_ Meals on Wheels \_\_\_\_\_

Other \_\_\_\_\_ or FAMILY ASSIST with any of the above: \_\_\_\_\_

**REFERRED BY :** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

**Reason for referral :** \_\_\_\_\_

**PERSON TO BE CONTACTED REGARDING APPLICATION:** \_\_\_\_\_

**DAYTIME PHONE NUMBER:** \_\_\_\_\_

**A physical exam by physician will be required within 5 days prior to admission to nursing home.**

**Page 3. Elm Crest Manor Application Cont. NAME: \_\_\_\_\_**

On Medicaid:  Yes  No Medicaid # \_\_\_\_\_

Previously applied?  Yes  No Date \_\_\_\_\_ County \_\_\_\_\_

Will you need to apply for Medicaid soon?  Yes  No  Unsure

Have you and/or your spouse transferred and/or gifted anything of value including cash, real property, vehicles or any other assets to anyone (family, friends, etc) in the past 5 years?  Yes  No. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or your spouse have a Trust?  Yes  No. Please explain \_\_\_\_\_  
\_\_\_\_\_

Do you or your spouse have a Life Estate?  Yes  No. Name: \_\_\_\_\_  
\_\_\_\_\_

Do you or your spouse have ownership interest in a business, farm?

Yes  No If yes, please describe the nature of the interest and extent of ownership \_\_\_\_\_  
\_\_\_\_\_

If you have transferred or gifted assets or a stream of income, have a Trust, Life Estate or have granted someone financial POA: Will you apply for Medicaid assistance and/or complete an asset assessment through the county social services?

Yes  No

Will you authorize the ND medicaid to release information to Elm Crest Manor regarding your application, eligibility and reason for denial, etc?  Yes  No

Name and address of person responsible for payment:  
\_\_\_\_\_

I understand that providing false information could result in discharge and/or denial of my application. The answers provided herein are true and correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

# ELM CREST MANOR RESIDENT'S SOCIAL HISTORY

RESIDENT'S FULL NAME: (as it appears on medicare card) \_\_\_\_\_

SEX: \_\_\_\_\_ PREFERS TO BE CALLED/NICKNAME \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_ RELIGION: \_\_\_\_\_

EDUCATION (last grade completed) \_\_\_\_\_ OCCUPATIONS: \_\_\_\_\_

If married, name of Spouse (include maiden name) \_\_\_\_\_

Date of Marriage: \_\_\_\_\_ Town & State where married: \_\_\_\_\_

If spouse is living, address; (if deceased: date and cause of death): \_\_\_\_\_

RESIDENT'S Ethnicity/Nationality: \_\_\_\_\_ RACE: \_\_\_\_\_

RESIDENT'S Father's Name: \_\_\_\_\_ & where was he born: \_\_\_\_\_

Mother's Name (include maiden name) : \_\_\_\_\_ where was she born: \_\_\_\_\_

**RESIDENT'S SIBLINGS: LIST IN ORDER** from oldest to youngest, and include Resident in the order, all Brothers and Sisters and include City/State if still living and list Dec'd if deceased. (for more room use the back of this sheet.)

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**RESIDENT'S CHILDREN: LIST IN ORDER** from oldest to youngest all children of Resident and City/State if still living and list **Dec'd** if deceased (for more room use the back of this sheet.)

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|--|--|
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|  |  |
|  |  |

EMAIL ADDRESS OF FIRST CONTACT: \_\_\_\_\_

Number of grandchildren \_\_\_\_\_ Number of great grandchildren \_\_\_\_\_ Number of great great grandchildren \_\_\_\_\_

**HOW DID HE/SHE PASS THE TIME IN THE PAST 10-20 YEARS:** IF RESIDENT LIKED TO READ (what types of books, newspapers); Watched TV (what programs); MUSIC (what types); SPEAK ANOTHER LANGUAGE; CLUBS or ORGANIZATIONS etc. **LIST:** HOBBIES, AWARDS RECEIVED, PLACES TRAVELLED TO and any other interesting facts. (Use back of the page for more information):

|  |  |
|--|--|
|  |  |
|  |  |

**\*PREFERRED LANGUAGE:**

Was Resident a Veteran: **YES/NO** Was Spouse a Veteran: **YES/NO**

List Branch of Service/Discharge Date: RESIDENT: \_\_\_\_\_ SPOUSE: \_\_\_\_\_

Did Resident and/or Spouse serve during wartime and what years? \_\_\_\_\_

Does Resident **VOTE** on a regular basis? **YES/NO** (We provide Absentee Ballots for all major elections)

# ELM CREST MANOR: FOR YOUR INFORMATION FACILITY RULES /RESIDENT RESPONSIBILITIES

The following information has been compiled for the benefit of the Resident and family for the purpose of making the admission and adjustment to Elm Crest Manor as smooth as possible. We are on Central Time.

## VISITING HOURS

Any family members, significant others, friends, personal representatives, governmental officials and visitors may visit you at **any** time. You have the right to private visits subject to restrictions to protect the health and safety of the residents. **The front door and wing doors are locked from 10:00 P.M. to 5:00 A.M.** If the main doors are locked, please call Elm Crest Manor at 843-7526 for admission.

## CLOTHING

Clothing should be wash and wear and the Resident should have from 5 to 6 changes of clothing and should include sleepwear. Our laundry staff will mark all Resident's clothing with special iron-on labels and we provide the hangers. We encourage all Residents to be dressed in street attire (clothes) from before breakfast to after supper and when in all our public areas, (i.e. Great Room, Dining Room, Commons Area, Family Rooms, and Activity Room). An exception is on their bath morning and they must be dressed in a robe when in public areas. All new clothing that needs to be tried on should be given to the wing nurse or Social Worker for monitoring and to get labeled. Seasonal clothes should be taken home. Hand Wash Only and Dry Cleaning items of clothing are discouraged and are the responsibility of the family to clean. Elm Crest Manor will not be responsible for damage to any special care clothing items, i.e. "Hand wash, cold water wash, lay flat to dry, dry clean only," etc. if they go through our laundry.

## PERSONAL BELONGINGS

The Resident may bring belongings to his or her room to make it look "homier". Rugs of any kind are not permitted in the room or bathroom. Size and space available, and also if sharing a room MUST be taken into consideration. The provided armoire holds many items and makes the room look very neat. Also, a familiar recliner may be brought to the room however **DUE TO SAFETY CONCERNS: NO SCOOTERS, GLIDER ROCKERS, ROCKING CHAIRS, SWIVEL ROCKERS or 3 WHEELED WALKERS ARE ALLOWED. Rocking recliners or swivel chairs will be accepted if they can be locked in a stationary position.** All other chairs in a Resident's room should have arms on them and all furniture must be in good – clean condition. Disposal of old TV, chairs etc., are the Resident's responsibility and they will be charged for any Landfill charges. ALL PERSONAL ITEMS to be marked with a label or laundry

marker with the FIRST INITIAL AND FULL LAST NAME. Pictures should also have names of those pictured, which is helpful for doing Reality Orientation with the Resident. A Resident may bring their own bedspread or quilt etc. but these must be marked with Resident's name by our laundry dept. We provide sheets, blankets, pillows, and pillowcases. We discourage the use of feather pillows for sanitary & allergy reasons. No electric blankets or mattress pads can be used in our facility due to a safety concern for our Residents. IN CASE OF A DEATH, TWENTY-FOUR (24) HOURS OR ONE DAY WILL BE ALLOWED FOR REMOVAL OF PERSONAL PROPERTY. If you are unable to come within 24 hours you must contact Elm Crest Manor Administration to let us know. Then our housekeeping or other staff will pack and store belongings for a reasonable amount of time. WE DO NOT ACCEPT DONATIONS OF CLOTHING.

### **PERSONAL MONIES**

The Resident should not keep more than \$5.00 in their room or on themselves. Additional money may be kept in the Residents Personal Trust Fund that is placed in an interest bearing account and is covered by a surety bond. There is no charge for this service and the Resident and/or family should check with the office regarding this fund. Quarterly statements will be provided. Elm Crest Manor will not be responsible for any valuables or money left in the possession of a Resident while he or she is a Resident of Elm Crest Manor. We also discourage a Resident from keeping check books/blanks and credit/debit cards in their room. They may be kept in the office for safe keeping.

***\*\*\*PLEASE NOTE\*\*\* Closing a Resident Trust Account following a Resident's death: If they are Private Pay, the funds will be returned within 30 days AND payable to the Resident's Estate. If on Medical Assistance, Medicaid has 30 days to send us an Affidavit to return funds to Medicaid (Estate Recovery). If one is not received within that time frame, we will issue a check payable to the Resident's Estate for the balance in that account. Someone must have paperwork completed by an Attorney stating they are the Personal Representative in order to get this check cashed. This must be taken care of prior to the Resident's passing.***

### **TELEPHONES**

There are public telephones available for Resident use and are located in the Commons Area, Conference Room and Family Rooms. These are adaptive for hearing impaired and can be used to make or receive calls. For private conversations, the Family Rooms, or Conference Room may be used. Residents may have phones in their rooms. A form is to be signed upon admission if you wish to have a phone and whether or not you wish to have your phone number given to family or friends who may call the facility. Phone numbers are assigned to each room and the bill for **\$25.00 (effective 2/1/17)** per month will come from Elm Crest Manor, as we own the contract/system. It will be billed at the end of the month, with Resident/Responsible Party/Guardian responsible for the

bill. Admission month charges will be full price for any admits from the 1<sup>st</sup> of the month thru the 15<sup>th</sup> of the month and \$12.50 for any admits from the 16<sup>th</sup> thru the end of the month. Residents need to provide their own phones. **Any missed calls will show that the call came from Elm Crest Manor and not the Resident's personal phone # on your caller I.D.** (and Elm Crest Manor Employees will always leave a message).

## TELEVISION

If a Resident desires a television set in their room, they must furnish a **flat screen TV**. Cable TV is provided at no extra charge and the maintenance department will hook it up and provide a remote that will work with our system. If planning on buying a new TV, we recommend a TCL brand which can be purchased at Walmart among other places. We recommend a 40" or 43". The armoires have space for a TV that measure: 26 $\frac{1}{2}$ " tall, 48" wide. **Only a TV, DVD player, stereo and computer may be plugged into a surge protector power cord.** There are color televisions available to the Residents in the Family Rooms and Activity Areas.

## WI-FI AVAILABILITY

The Elm Crest Manor Skilled Facility Wi-Fi is available throughout the Skilled Facility building only. DSL in a Resident room is available upon request to Mary Kreidt, Office Manager.

## HAIR CARE AND BATHS

Volunteers set and comb-out the female Resident's hair every week, usually on Thursday mornings. Resident or family needs to provide hair curlers, combs and brushes. Combs and brushes should be marked with the Resident's name and the curlers are kept in the hairdressing cabinet in labeled boxes, which we provide. There is no charge for haircuts, if using our beautician, as this is a grooming aid for both men and women. It is recommended that haircuts be done every 3-5 weeks. For a haircut, perm or color, please contact the **ACTIVITY DIRECTOR** to schedule an appointment at the next available time. The cost for a perm is **\$40.00** when using our beautician and this includes a haircut. Other hair treatments are charged as per beautician's fee schedule. If you are having someone other than our beautician and using our beauty shop, **please schedule through Activity Director**, so the beauty shop is available when they come. When using another beautician, you will be charged per their fee schedule.

A minimum of 2 baths a week are given, which consist of a tub, whirlpool, or shower; or if ill or refusing, a bed bath is given. Hair is washed at least 1 time each week.

## OUTINGS

Residents have the right to and are encouraged to participate in the community events as they desire. You may go on outings, overnight stays or on a minimal leave of absence. We ask for a 24 hour notice if a Resident is leaving the building overnight and 3 BUSINESS DAYS if they will be gone more than 48

hours. We ask that family members **personally notify the wing nurse** and **sign the book at the nurse's station** when taking a Resident out of the facility **and inform wing nurse when you return**. There is a limit on the number of days a Medicaid Resident may be out of the facility overnight during a calendar year. If you have any questions, see the **Social Worker, RITA SCHULZ**. If taking a Resident to an appointment, there is paperwork that **must** go along and be filled out and signed by the Provider and brought back to Elm Crest Manor. Elm Crest will provide transportation and attendant care for medical appointments to Bismarck/Mandan with the exception of the Chiropractor. Ambulance service is to the Bismarck Hospitals only.

## **MEALS**

Families are welcome to share a meal with a Resident. The cost of each meal is **\$5.00** for breakfast, dinner or supper. **The kitchen needs to be notified at least twenty-four (24) hours in advance for a meal. The cost is \$10.00 (effective 1/1/17) for the following holidays: New Year's Day, Easter, Mother's Day, Memorial Day, Father's Day, 4<sup>th</sup> of July, Labor Day, Thanksgiving, & Christmas Day, per each meal. **We will require one (1) week prior notice for all holiday meals.** If not, we may not be able to accommodate guests. Please check with the kitchen for the best time to come during the open dining meal times. If we can't provide a meal, we will have coffee available all day. MEAL TICKETS ARE ALSO AVAILABLE TO BE PURCHASED - CONTACT THE DIETARY DEPARTMENT. \*\*\*Any meals charged for family or friends will be automatically reimbursed from the Resident's Personal Trust Account\*\*\*. All our meals are open dining (no assigned seating or meal time). **BREAKFAST:** Served from 7:15 to 8:30 A.M.; **DINNER:** Served from 11:15 A.M. to 1:00 P.M.; and **SUPPER:** Served from 5:15 to 6:30 P.M. We are on Central time. **Coffee/snack** is served at 9:45 AM and 2:45 PM each day with coffee available at all times of the day from the self-serve machine located in the dining room. The first meal is free for immediate family members during the first 7-day period. If you wish to provide a birthday or anniversary party for a Resident, we need at least one (1) week advance notice to schedule and make the necessary arrangements. Please contact the **DIETARY MANAGER: BERNADINE DOLL**. All room reservations are on a first come/first serve basis.**

## **FOOD ITEMS**

All food items brought in **MUST** be approved by the nurse on duty and needs to be in approved containers and dated. No refrigerators or microwaves are allowed in the Resident rooms. A small refrigerator is located at the nurses' station.

## **SAFETY AND FIRE CODE**

All chargers must have the phone or shaver plugged in it or it must be unplugged from the wall outlet and put away per Fire Code. No personal humidifiers, space heaters, electric blankets, electric mattress pads or Halogen

lamps can be used, as these are a safety concern for the Residents. We provide the waste paper basket, as they must meet fire regulations/code.

Any Resident with a powered wheelchair needs to be evaluated by our Occupational/Physical Therapy Department **prior to use** in our facility and will be re-assessed quarterly. The Resident is financially responsible for any and all repairs on their powered wheelchair including but not limited to new batteries, wheels, and transportation to and from a service center in Bismarck, etc. For more information see our Power Wheelchair Policy or visit with the Occupational Therapist.

NO KNIVES, JACK KNIVES OR PARING KNIVES ARE ALLOWED IN THE ROOMS. IN ADDITION, NO WEAPONS OF ANY KIND ARE ALLOWED IN THE FACILITY/ROOMS OR ON THE PREMISIS. **We are a NO SMOKING/NO SMOKELESS TOBACCO/NO E-CIGARETTES facility, and per ND State Law, no smoking is allowed within 20' of any outside opening, including doors and windows, by visitors or staff.** No candles or lighters are allowed in the Resident rooms. **No pets are allowed to live in facility.** Nothing can be permanently attached to the bathroom door, room door or wardrobe/armoire door or to any wall without prior consent of the Administrator. We encouraged you to use sheet rock hooks (Monkey Hooks) or the 3-M hooks instead of nails. If you have lots of small photos, please purchase a bulletin board. Humidifiers are NOT allowed in resident rooms.

All personal care items must be stored away from public view. This includes but not limited to: lotions, powders, make-up, deodorants, soaps, etc. and if in a shared room items should be marked with Resident's initials or name. A medicine cabinet, with a small wire basket in it, is located in the bathroom of each room, and we also provide a bedside table for storing these items.

If you chose to put a **bird feeder** outside your resident's window, we ask that you NOT use the cake type feed as it melts in the heat and makes a slippery mess. Families are responsible for filling the bird feeder and storing the food off the property. **WE DO NOT ALLOW THE BIRD SEED, FEED, NECTAR, ETC, TO BE STORED IN THE RESIDENT'S ROOM OR ANY WHERE IN THE BUILDING.**

**FORM 2567 AND/OR THE STATEMENT OF DEFICIENCIES AND OUR PLAN OF CORRECTION CAN BE FOUND IN THE BINDER ON THE WALL NEAR THE FRONT OFFICE FOR YOUR INSPECTION AT ANY TIME.**

Any questions, please contact:

**RITA SCHULZ, LBSW**

**ELM CREST MANOR**

**100 ELM AVE./PO Box 396, NEW SALEM, ND 58563-4031**

**Telephone #: (701) 843-7526 Fax #: (701) 843-8376**

**E-mail address: [elmcrest@westriv.com](mailto:elmcrest@westriv.com) (& PLEASE REMEMBER to address your e-mail by listing the Resident's name on the subject line)**

**Web site: [www.elmcrestmanor.com](http://www.elmcrestmanor.com)**



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(701) 843-7526 FAX # (701) 843-8376  
Providing Quality Skilled Care Since 1969

June 1<sup>st</sup>, 2026

Residents and Resident Representatives of Elm Crest Manor,

We have received another notice from the North Dakota Department of Human Services of our rates changing for the next 6 months of this calendar year. The change is due to the State Department re-analyzing the PDPM data on our rate settings. The rates are applicable from July 1<sup>st</sup> of 2026 through January 1<sup>st</sup> 2027.

The rates are determined by the North Dakota Department of Human Services (NDDHS) per the rate-setting methodology established in the North Dakota statute. Rates are based upon a cost report submitted to NDDHS. **This is your official 30-day notice of rate change.**

The next 6 month's rates continue to be calculated under the new Patient Driven Payment Model (PDPM), which was implemented for each nursing home across the State of North Dakota on January 1<sup>st</sup> of this year. The new system utilizes different criteria and formulas to determine your classification level.

While the new system is designed to be "revenue neutral" for the facility overall, each resident's rates will be impacted differently by the new PDPM level of care classification system.

Elm Crest Manor's base PDPM rate components are as follows:

- Direct Care: \$ 207.40  
(Note: Direct Care component is adjusted based on case mix weight associated with your PDPM classification)
- Other Direct Care: \$ 38.57
- Indirect Care: \$ 112.35
- Property and Passthrough: \$ 47.81
- Total Base Rate: \$ 407.59
- Facility Average Rate: \$ 402.06

Rates can range from \$ 332.93 to \$ 969.64 depending on the new PDPM classification level. Under the new system there are over 1800 potential classifications.

If you receive Medical Assistance, you will continue to pay the assigned recipient liability. If you have questions about the new payment system or how your assessment determined your assigned classification, please call Heather Gappert or Annette Doll, MDS Care Coordinators at 701-843-7526.

Sincerely,

Carrie Zazeski  
Administrator  
Elm Crest Manor

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*North Dakota Patient Driven Payment Model  
Quick View – Resident/Family*

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*This is provided to show how the rates are determined*

## **Resident Care Resource**

Starting January 1, 2026, the way classifications for North Dakota nursing facility residents are set will change. Classifications will be based on the North Dakota Patient Driven Payment Model (ND PDPM).

The ND PDPM looks at each resident's health and care needs. The nursing facility completes an assessment every 3 months that sets a three-letter classification for each resident. This three-letter classification is communicated in the classification notice and is used to set a daily rate.

Each letter in the classification stands for a part of the ND PDPM:

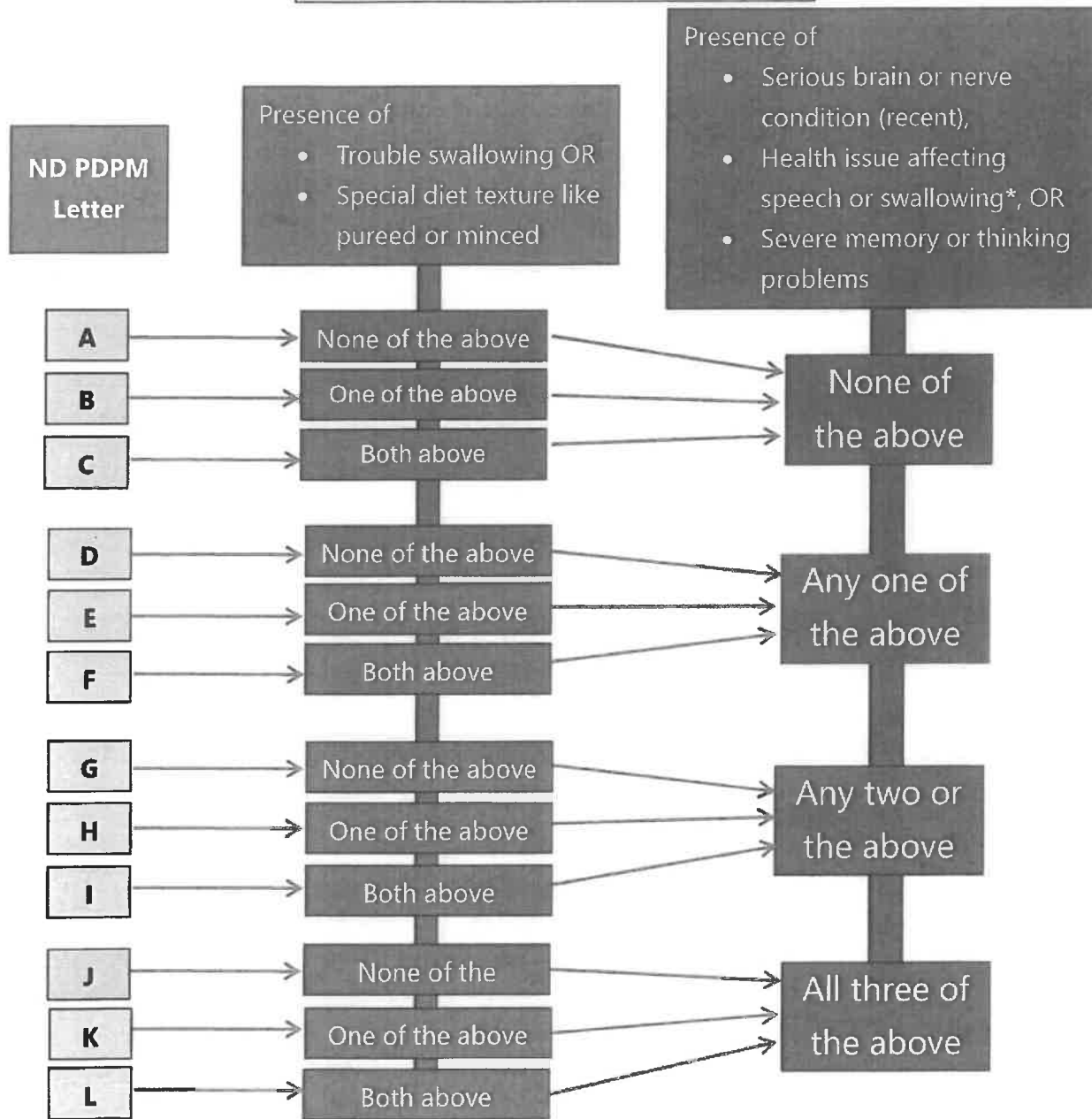
- 1 – Speech Language Pathology (SLP)
- 2 – Nursing
- 3 – Non-Therapy Ancillaries (NTA)

This guide will show, step by step, how the classifications are developed. Charts and examples will help explain what health conditions and care needs affect the SLP, Nursing, and NTA letters. The goal is to help residents and families understand what health conditions and care needs influence the classification. Each ND PDPM classification will have its own daily rate.

- More information is available at Medicaid Long Term Care Services (<https://www.hhs.nd.gov/healthcare/medicaid/provider/long-term-care-services>)  
Nursing Facility Payment System FAQs booklet – Read more about frequently asked questions and what to do if you disagree with a classification. The nursing facility can give you a copy, or you can find it online.
- Daily Rate Lookup – An online tool to look up the daily rate. To use it, you enter the three-letter classification from the notice letter and the seven-digit nursing facility provider number. The tool will then show the daily rate for that classification.
- Nursing Facility Rates – See the base daily rate for each nursing facility. This lets you compare costs between different nursing facilities.

Elm Crest Manor ID # 1452839

## Speech Language Pathology (SLP)



**\*SLP related health issues:**

Aphasia, stroke, hemiplegia or hemiparesis, traumatic brain injury (TBI), tracheostomy, invasive mechanical ventilator, Amyotrophic Lateral Sclerosis (ALS), laryngeal cancer, dysphagia, apraxia, trach care, vent use.

**Nursing**

| ND PDPM Letter | Category           | Health Issue   | Support Needed for Daily *Self-Care Score | Restorative Nursing Services | Depression |
|----------------|--------------------|--|---|------------------------------|------------|
| A              | Extensive Services | <ul style="list-style-type: none"> <li>Tracheostomy AND Ventilator</li> </ul>  | 0-14                                      | -                            | -          |
| B              |                    | <ul style="list-style-type: none"> <li>Tracheostomy OR Ventilator</li> </ul>   |   | -                            | -          |
|                |                    | If none of the above continue below. If Self-care score 15 or 16 = Clinically Complex Category   |   |                              |            |
| D              | Special Care High  | <ul style="list-style-type: none"> <li>In a coma &amp; fully dependent on select Activities of Daily Living (ADLs)</li> <li>Blood infection (Septicemia)</li> <li>Diabetes requiring insulin shots every day, plus changes to the insulin dose on 2+ days</li> </ul>   | 0-5                                       | -                            | Yes        |
| E              |                    | <ul style="list-style-type: none"> <li>Quadriplegia with Self-care score &lt;= 11</li> </ul>   |   | -                            | No         |
| F              |                    | <ul style="list-style-type: none"> <li>Chronic lung disease (COPD) &amp; shortness of breath while lying flat</li> </ul>   | 6-14                                      | -                            | Yes        |
| G              |                    | <ul style="list-style-type: none"> <li>Fever and one of the following: pneumonia, vomiting, weight loss, or specific amount of nutrition provided from a feeding tube</li> <li>Nutrition given through an IV (parenteral feeding)</li> <li>Daily respiratory (breathing) treatments</li> </ul>   |   | -                            | No         |
|                |                    | If none of the above continue below. If Self-care score 15 or 16 = Clinically Complex Category   |   |                              |            |
| H              | Special Care Low   | <ul style="list-style-type: none"> <li>Daily Self-care needs score &lt;=11 and has Cerebral Palsy, multiple sclerosis or Parkinson's disease</li> </ul>  | 0-5                                       | -                            | Yes        |
| I              |                    | <ul style="list-style-type: none"> <li>Respiratory Failure AND requires oxygen while a resident of the facility</li> <li>Feeding tube used to provide a significant portion of nutritional need</li> <li>2 or more moderate (stage 2) pressure sores with select treatment</li> <li>Any severe pressure sore (stage 3 or 4) or cannot be measured because of dead tissue (unstageable) with select treatments</li> </ul> |   | -                            | No         |
| J              |                    | <ul style="list-style-type: none"> <li>Two or more leg ulcers (vein or artery related) with select treatments</li> <li>One moderate pressure sore (stage 2) plus one leg ulcer (vein or artery related) with select treatments</li> </ul>  | 6-14                                      | -                            | Yes        |
| K              |                    | <ul style="list-style-type: none"> <li>Foot infection, diabetic foot ulcer, or other open lesion of foot that needs dressings</li> <li>Radiation treatment while a resident of the facility</li> <li>Dialysis treatments while a resident of the facility</li> </ul>   |   | -                            | No         |
|                |                    | If none of the above continue below. If Self-care score 15 or 16 = Clinically Complex Category   |   |                              |            |

| Nursing Continued |                           |  |  |                              |            |
|-------------------|---------------------------|--|--|------------------------------|------------|
| ND PDPM Letter    | Category                  | Health Issue   | Support Needed for Daily Self-Care Score | Restorative Nursing Services | Depression |
| L                 | Clinically Complex        | <ul style="list-style-type: none"> <li>Pneumonia (lung infection)</li> <li>Paralysis or weakness on one side of the body with Self-care score &lt;=11</li> <li>Open wound (other than ulcers, rashes, cuts) or surgical wounds with select treatment</li> <li>Serious burns (second or third degree)</li> <li>Any of the following while a resident of the facility: chemotherapy, oxygen therapy, IV medications or transfusions</li> </ul> | 0-5                                      | -                            | Yes        |
| M                 |                           |  | -  | -                            | No         |
| N                 |                           |  | 6-14                                     | -                            | Yes        |
| O                 |                           |  | 15-16                                    | -                            | No         |
| P                 |                           |  | 6-14                                     | -                            | Yes        |
| Q                 |                           |  | 15-16                                    | -                            | No         |
|                   |                           | If none of the above continue below  |  |                              |            |
| R                 | Behavior and Cognitive    | <ul style="list-style-type: none"> <li>Significant memory or thinking problem (BIMS summary score &lt;=9)</li> <li>Severe problem with thinking skills needed for daily life</li> <li>Communication problems being understood, short-term memory problems, and thinking skills needed for daily life</li> <li>Behavioral symptoms such as hallucinations, delusions, physical or verbal aggression, refusal of care, or wandering</li> </ul> | 11-16                                    | 2 or more                    | -          |
| S                 |                           |  |  | 0-1                          | -          |
|                   |                           | If Self Care score <11, continue to Reduced Physical Function Category   |  |                              |            |
| T                 | Reduced Physical Function | <ul style="list-style-type: none"> <li>Has health issue that qualifies for the Behavior Symptoms and Cognitive Performance category with a Self-care score &lt;11</li> <li>Does not fit into any of the other Nursing component categories</li> </ul>  | 0-5                                      | 2 or more                    | -          |
| U                 |                           |  |  | 0-1                          | -          |
| V                 |                           |  | 6-14                                     | 2 or more                    | -          |
| W                 |                           |  | 15-16                                    | 2 or more                    | -          |
| X                 |                           |  | 6-14                                     | 0-1                          | -          |
| Y                 |                           |  | 15-16                                    | 0-1                          | -          |

**\*Support needed for daily self-care score:**

- 0-5 = Dependent or mostly dependent
- 6-14 = Moderate support needed
- 15-16 = Minimal to no support needed

**Non-Therapy Ancillary (NTA)**

The Non-Therapy Ancillary (NTA) part of the ND PDPM payment model looks at certain health conditions that make a resident’s care more complex and costly. Each condition is given points, and those points are added up to create a score. The score helps decide the payment rate for care. More than 40 health conditions and services are included in this component, such as organ transplants, multiple sclerosis, diabetes, chronic lung disease, morbid obesity, malnutrition, cirrhosis, and certain infections, including wound infections.

| <b>ND PDPM NTA Letters and Points</b> |                         |
|---------------------------------------|-------------------------|
| <b>ND PDPM Letter</b>                 | <b>NTA Points Range</b> |
| <b>A</b>                              | 12+                     |
| <b>B</b>                              | 9-11                    |
| <b>C</b>                              | 6-8                     |
| <b>D</b>                              | 3-5                     |
| <b>E</b>                              | 1-2                     |
| <b>F</b>                              | 0                       |

Elm Crest Manor  
 Nursing Facility Daily Rates  
 Effective January 1, 2026  
 Medicaid Provider ID 1452839

Example

|  | ND<br>PDPM<br>Code | Case-Mix<br>Weight | Direct<br>Rate | Case-Mix<br>Direct<br>Rate | Other<br>Direct<br>Rate | Indirect<br>Rate | Property<br>Rate | Passthrough<br>Rate | Total<br>Rate |
|--|--------------------|--------------------|----------------|----------------------------|-------------------------|------------------|------------------|---------------------|---------------|
|--|--------------------|--------------------|----------------|----------------------------|-------------------------|------------------|------------------|---------------------|---------------|

Base Rate  $1.00 \times \$205.99 = \$205.99 + \$38.57 + \$112.35 + \$47.81 + \$1.46 = \$406.18$

to be determined.

It becomes this number which falls in the range of .64 to 3.71