Fire
Pension Board
Meeting Schedule
March 21, 2024

Fire Pension Board
2:00pm
Aspen Conference Room, 1st Floor City Hall
Call In: 1 347-941-5324
Phone Conference ID: 200 534 175#
Teams Meeting ID: 278 362 808 657
Passcode: M47GPM

Please contact Caylee Tashiro at (360) 487-8403 or
Caylee.Tashiro@cityofvancouver.us
if you are unable to attend.
Thank you!

Police Pension Board

Thursday, Mar. 21, 2024
2:00p.m.
Vancouver City Hall
Aspen Conference Room, 1st Floor

MEETING ACCESS INFORMATION:
Click here to join the meeting
Call In: 1-347-941-5324
Phone Conference Number: 200 534 175#

AGENDA

1. Call to Order – McEnerny-Ogle
2. Approval of Minutes – McEnerny-Ogle
    a. August 17, 2023
3. Communications – Tashiro
    a. None
4. Reports – Glenn
    a. Budget Report
5. New Business – Tashiro
    a. Request for Long Term Care – Claimant A
6. Public Comment – McEnerny-Ogle
7. Old Business – Tashiro
    a. None
8. Expenses – Glenn
    a. Approval of Expenses for August - December 2023

Members

Anne McEnerny-Ogle
Chair

Anthony Glenn, City Treasurer
Natasha Ramras, CFO/Board Secretary
Patrick Kelly, Fire Retiree
Michael Lyons, Fire Retiree

Human Resources Department

P.O. Box 1995
Vancouver, WA 98668
360-487-8403
TTY: 711
cityofvancouver.us

To request accommodation or other formats, please contact:
Caylee Tashiro | 360-487-8403 | TTY: 711 | Caylee.Tashiro@cityofvancouver.us

Police Pension Board

Meeting Minutes

Thursday, Aug. 17, 2023
4:00 p.m.
Vancouver City Hall
Council Chambers
415 W. 6th Street
Vancouver, WA 98660

Board Members Present:
Ty Stober, Chair; Anthony Glenn, Treasurer; Natasha Ramras, CFO/Board Secretary; Patrick Kelly, Fire Retiree; Duane Royer, Fire Retiree

Board Members Absent:
Anne McEnerny-Ogle, Mayor

Staff Present: Nena Cook, Deputy City Attorney; Caylee Tashiro, Human Resources; Iasmina Giurgiev, Human Resources; Kelsey Sanfilippo, Human Resources.

Guests:
None

Item 1: Call to Order
The August 17, 2023, meeting of the Fire Pension Board was called to order at 4:01 p.m. by Chair Ty Stober in Council Chambers at Vancouver City Hall and via Microsoft Teams. Mayor McEnerny-Ogle was absent.

Item 2: Approval of Minutes:
Motion by Ramras, seconded by Royer, and approved unanimously to adopt the minutes from July 20, 2023, as written.

Item 3: Communications
None

Item 4: Budget Report

Members

Ty Stober
Chair

Anne McEnerny-Ogle, Mayor
Anthony Glenn, City Treasurer
Natasha Ramras, CFO Board Secretary
Patrick Kelly, Fire Retiree
Duane Royer, Fire Retiree

Human Resources Department

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cityofvancouver.us

Glenn reported that total expenditures through July 2023 were 54% of budget. Total revenues through July 2023 were 89% of budget. The budget report is on track and no adjustments are needed from the Accounting department.

Item 5: Request for Hearing Aids – Claimant A
Attached for board review is a request for hearing aids for Claimant A. Section V.S of the Board's Rules and Regulations requires:

"*Hearing Aids prescribed by physician and pre-approved by board. Charges are limited to those necessary to achieve functional correction. When seeking pre-approval, members must submit to the third-party administrator quotes from at least two providers. The member must also have a current hearing test, exam and referral from a physician. Hearing aids must have a three-year warranty.*"

Claimant A is seeking preapproval. Claimant A was seen by an audiologist who assessed that hearing loss was confirmed and completed the appointment with a physician that confirm the hearing loss diagnosis. Claimant A also received a recommendation from another audiologist for his hearing loss. He has provided two hearing tests, two audiologist evaluations, and two quotes for hearing aids with a three-year warranty that are adequate for his hearing loss. This will be Claimant A's first request for hearing aids.

Evergreen Audiology
- $4,748

PeaceHealth
- $5,624

Action Requested
Consider the request from Claimant A for hearing aids.

Motion by Ramras to approve the request for hearing aids payment in the amount of $4,748. Seconded by Royer and approved unanimously.

Item 6: Expenses
Expenses for July 2023 totaled $82,805.02.

Motion by Ramras, seconded by Royer, and approved unanimously to accept the expenses as presented.

Adjourned:
This meeting adjourned at 4:27 p.m.

COV - Composite Department Budget vs Actuals by Fund

Period FY 2024 - Feb

Fund 618 Fire Pension Trust Fund

Ledger Account Type Expenditures

				Current Year							Prior Year				
Fund	**Department**	**Cost Center**	**Ledger Account**	**Budget**	**Pre-Encumbrance**	**Encumbrance**	**Actuals**	**Actuals + Total Encumbrance**	**Available Budget**	**% Spent**	**Budget**	**Actuals (Years End)**	**Variance (Budget - Actual)**	**Actuals (PTD)**	**% Spent**
618 Fire Pension Trust Fund	Budget - Human Resources	CC0132 HR-Pension Payments	520000:Employee Benefits	1,400,000	0	0	236,646	236,646	1,163,354	17%	1,400,000	1,238,768	161,232	211,944	15%
618 Fire Pension Trust Fund	Budget - Human Resources	CC0132 HR-Pension Payments	540000:Services	32,250	0	0	0	0	32,250	0%	32,250	11,254	20,996	693	2%
618 Fire Pension Trust Fund	Budget - Human Resources	CC0132 HR-Pension Payments	590000:Interfund Services	27,051	0	0	4,660	4,660	22,391	17%	27,007	28,212	(1,205)	4,660	17%
Total				**1,459,301**	**0**	**0**	**241,307**	**241,307**	**1,217,994**	**17%**	**1,459,257**	**1,278,234**	**181,023**	**217,297**	**15%**

COV - Composite Department Budget vs Actuals by Fund

Period FY 2024 - Feb
Fund 618 Fire Pension Trust Fund
Ledger Account Revenues

				Current Year							Prior Year				
Fund	**Department**	**Cost Center**	**Ledger Account**	**Budget**	**Pre-Encumbrance**	**Encumbrance**	**Actuals**	**Actuals + Total Encumbrance**	**Available Budget**	**% Spent**	**Budget**	**Actuals (Years End)**	**Variance (Budget - Actual)**	**Actuals (PTD)**	**% Spent**
618 Fire Pension Trust Fund	Budget - Human Resources	CC0132 HR-Pension Payments	361110:Investment Earnings	0	0	0	(173)	(173)	173	0%	0	(801)	801	(95)	0%
618 Fire Pension Trust Fund	Budget - Human Resources	CC0132 HR-Pension Payments	369910:Miscellaneous Other Operating Revenues	0	0	0	(375,000)	(375,000)	375,000	0%	0	0	0	0	0%
618 Fire Pension Trust Fund		(Blank)	336000:State Shared Revenue, Entitlements & Impact Payments	(220,000)	0	0	0	0	(220,000)	0%	(220,000)	(265,630)	45,630	0	0%
618 Fire Pension Trust Fund		(Blank)	361110:Investment Earnings	0	0	0	(77,366)	(77,366)	77,366	0%	0	(304,054)	304,054	(42,941)	0%
618 Fire Pension Trust Fund		(Blank)	361300:Gains (Losses) on Sale of Investments	0	0	0	0	0	0	0%	0	(520,107)	520,107	0	0%
618 Fire Pension Trust Fund		(Blank)	369910:Miscellaneous Other Operating Revenues	(1,500,000)	0	0	0	0	(1,500,000)	0%	(1,500,000)	(1,500,000)	0	(375,000)	25%
Total				**(1,720,000)**	**0**	**0**	**(452,539)**	**(452,539)**	**(1,267,461)**	**26%**	**(1,720,000)**	**(2,590,591)**	**870,591**	**(418,035)**	**24%**

CITY OF Vancouver WASHINGTON

MEMORANDUM

DATE: March 21, 2024

TO: Fire Pension Board

FROM: Caylee Tashiro, Pension Board Coordinator

RE: **Request for Long Term Care – Claimant A**

Attached for Board review is a Long-Term Care Application and Physician's Statement supporting a request for an Adult Family Care Facility for Claimant A.

According to his wife, Claimant A suffered a major stroke which required surgery to remove the clot in his brain. During surgery he developed a bleed requiring the procedure to cease. As a result, Claimant A has left body paralysis which has not improved with two months of therapy. Recently, he has been able to eat pureed food supplemented by a stomach feeding tube. Claimant A has difficulty talking and breathing due to his emphysema. He also has a catheter in place due to kidney problems. Claimant A has fallen twice since being in a skilled nursing facility, which required an emergency room visit after the second fall. Claimant A needs full assistance with almost all the activities of daily living as noted in the Application Request and Physician Statement. Claimant A's wife would like him moved to an Adult Family Care Facility for more directed care. She has been traveling every day to see Claimant A in the skilled nursing facility located in Portland. However, she suffers from Vertigo and the long drives have been hard on her. She selected Senior Haven Adult Family Home because it is located near her address. She has secured Claimant A's spot with a $1000 deposit and $400 nurse evaluation for level of care needed. Claimant A is awaiting Board approval to move into the facility.

Items for consideration by the Board:

$400	Nurse Evaluation
$800	One-Time Community Fee
$1,000	Deposit
$11,500	Ongoing Monthly Room, Board and Care

The Pension Board Rule for long term care limits payment to the average daily rate of a semi-private room for Nursing Home Care services. The current average daily cost for a semi-private room in Washington State is $359/day or about $10,770/month.

Action Requested
Consider Claimant B's request for medically necessary long-term care at Senior Haven Adult Family Home and reimbursement for the nurse evaluation, community fee, and deposit.

Caylee,

Everything has been in place since Friday. We would like to make move on Wedx March 13th
Just awaiting authorization.

PS - would appreciate re-imbursement ASAP

CITY OF VANCOUVER HUMAN RESOURCES
415 W Sixth St – 3rd Floor/P.O. Box 1995
Vancouver WA 98668-1995
360.487.8403 phone 360.487.8418 fax
E-Mail – Caylee.Tashiro@cityofvancouver.us

Application Request

(To Be Completed by Member, Family Member or Legal Rep – please check one)

☐ Home Health Care ☐ Skilled Nursing Home Care Services ☒ Other Adult family care

Name:	SSN:	Telephone Number:
Claimant A		

	Pension Board:	Status:
	☐ Police ☑ Fire	☐ Active ☑ Retired

Medical Insurance:
☑ Medicare ☑ Kaiser Permanente ☐ Blue Cross
☐ Other _____

Veteran?
☑ Yes - Branch of Svc Air Force
☐ No

QUICK PERSONAL ASSESSMENT TOOL

(TO BE COMPLETED BY MEMBER, FAMILY MEMBER OR LEGAL REPRESENTATIVE)

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☑	☐	☐
Eating	☑	☐	☐
Toileting	☑	☐	☐
Bathing or Showering	☑	☐	☐
Dressing	☑	☐	☐
Transferring	☑	☐	☐
Continence	☑	☐	☐
Shaving, Hair Care	☑	☐	☐
Preparing Meals	☑	☐	☐
Transportation	☑	☐	☐
Housekeeping	☑	☐	☐
Personal Laundry	☑	☐	☐

Current Living Situation: ☐ Home (alone) ☐ Home (with services) ☐ Lives with family
☐ Hospital ☑ Other Skilled nursing / Rehab

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☑ Wheelchair ☑ Not Mobile

Memory Loss: ☐ Frequent loss ☐ Occasional loss ☐ No memory loss
☑ Dementia Diagnosis ☐ Alzheimer's Diagnosis

ADDITIONAL INFORMATION

What recent conditions or events have occurred causing you to consider a change in your circumstance? Please be specific.

Claimant A experienced a complete life changing major Stroke During surgery to remove the clot in his brain he developed a bleed requiring the procedure to cease. He has left body paralysis which has not improved w/ 2 months therapy. He has just recently begun to eat thick pureed food (2 meals eaten) in addition to stomach tube feeding. It is difficult for Claimant A to talk & breathe because of diagnosed Emphysema. There is a catheter in place for urination due to yet to be diagnosed kidney issue. *Appointment 3/28. Claimant A has fallen out of bed 2 times, the 2nd time required emergency Room care. After the 2nd fall precautions of 1. lower bed without air mattress 2. Pad on floor next to bed. We want to leave skilled ~~[illegible]~~ nursing care to Adult Family care facility which I selected & secured with a $1,000 deposit. A Registered nurse evaluation has also been completed at a cost of $400.00 which I also paid for. Our hope is for Claimant A to receive more directed care at a smaller facility in a less ~~[illegible]~~ clinical setting closer to home. This care facility also houses a couple other men which Claimant A could interact with.

Please Review included further info

*Nephrology

I hereby certify, under the penalty of perjury in the State of Washington, that this application contains no willful misrepresentation and that the information is true and complete to the best of my knowledge and belief.

_____ Date: 3/9/24

_____ Relationship to Member: wife

CITY OF VANCOUVER HUMAN RESOURCES
415 W Sixth St – 3rd Floor/P.O. Box 1995
Vancouver WA 98668-1995
360.487.8403 phone 360.487.8418 fax
E-Mail – Caylee.Tashiro@cityofvancouver.us

Physician's Statement

LEOFF I Member Name:	SSN:	Birth Date:

*The LEOFF I member, as listed above, has applied to the City of Vancouver Pension Board for approval of medical services. Please complete and sign the **PHYSICIAN** section of the form as listed below.*

Diagnosis:	Prognosis:
See List • Acute stroke due to embolism of unspecified artery. • hemiplegia, left dominant side	Guarded/Poor

Assistance Needed:	Full Assistance	Some Assistance	No Assistance
Taking Medications	☒	☐	☐
Eating	☐	☒	☐
Toileting	☒	☐	☐
Bathing or Showering	☒	☐	☐
Dressing	☒	☐	☐
Transferring	☒	☐	☐
Continence	☒	☐	☐
Shaving, Hair Care	☒	☐	☐
Preparing Meals	☒	☐	☐
Transportation	☒	☐	☐
Housekeeping	☒	☐	☐
Personal Laundry	☒	☐	☐

Walking Ability: ☐ Independent ☐ Walker ☐ Cane ☐ Wheelchair ☒ Not Mobile

Memory Loss: ☒ Frequent loss ☐ Occasional loss ☐ No memory loss
☐ Dementia Diagnosis ☐ Alzheimer's Diagnosis

Based on the needs of this patient, I would recommend the following type of service (please check one):

☒ Home Health Care ☐ Skilled Nursing Home Care Services ☐ Other_____

Based on the needs of this patient, I would recommend the following level of care (please check one):

☐ Skilled Care: nursing care performed under the orders of a doctor, supervised by a licensed registered nurse or practical nurse available around the clock on a daily basis. A person with professional training or skills must perform most daily procedures.

☐ Intermediate Care: nursing care performed under the orders of a doctor and under supervision of a licensed registered nurse or practical nurse. The patient is provided with skilled care on a periodic basis. These periodic procedures cannot be done without professional training or skill.

☒ Custodial Care: primarily meets the personal needs of the patient and can be provided by a person without professional training or skill.

Frequency of Need: 24 (#) hours a day, 7 (#) days a week

Duration (how long do you anticipate need): ☐ Less than 2 weeks ☐ 3 – 4 weeks ☐ 1 – 3 months ☐ 4 – 6 months ☒ over 6 months ☐ not sure ☐ other_____

ADDITIONAL INFORMATION

Please provide any additional opinions on the specific medical and other assistance this patient needs:

Physician's Signature: _____ Date: 3-8-2024

Typed or Printed Name CHINYERE EKECHUKU. Phone: 503-499-5200

Physical Address, including zip code:	Mailing Address, including zip code:
500 NE Multnomah Street Suite 100 Portland, OR 97232	500 NE Multnomah Street Suite 100 Portland, OR 97232

Please **SEND** this form to: City of Vancouver Human Resources/Pension Board, Attn: Caylee Tashiro
P.O. Box 1995, Vancouver, WA 98668-1995 **OR** Fax: (360) 487-8418

#1

ourpick

To whom it may concern,

I Ghadir Ali owner of (Senior Haven LLC) have met with Claimant A's wife regarding her husband's care, and interest to move him to my facility to receive proper medical care, as we can provide a high level of care and assist him to have the best quality of life. Claimant A will have an RN assessment done this week where we will be able to provide her with a monthly rate for services and estimate for services will be (11,500-12,500.00$).

Feel free to contact me any time for more information

Ghadir Ali
Principle Owner
Senior Haven LLC
Cell: (503) 217- 9342

SENIOR HAVEN LLC

Wave • Invoice Payment

acarleya <acarleya@aol.com>
Thu 3/7/2024 1:01 PM
To:skbetzing@hotmail.com <skbetzing@hotmail.com>

"

Senior Haven AFH
Invoice 7

$12,300.00
Due on March 6, 2024

Senior Haven AFH
12808 Northeast 7th Avenue
Vancouver, Washington 98685
United States
5032179342
Invoice Number:

7

Amount Due:

$12,300.00

Payment Due:

March 6, 2024

Bill To:

Carly Adams

ITEMS AMOUNT
800.00
1 x $800.00 $800.00
one time payment admission fee
11,500
1 x $11,500.00 $11,500.00
payment for care
Total (USD): $12,300.00
Carly Adams has placed a $1000.00 deposit to hold room #3 which will be used towards the first months invoice.

"

https://next.waveapps.com/a/invoices/15ccf777-dbb9-4e67-83b8-

#2

Compliments of WSRCC

UNIQUE CARE HOME

does not have current cost info

Levels of Care

THE EXTENT OF PERSONAL CARE NECESSARY FOR EACH RESIDENT AND THE EXPERTISE AND AMOUNT OF STAFF TIME THAT IS REQUIRED TO PROVIDE THAT CARE DETERMINES THE MONTHLY RATE CHARGED. RATES MAY VARY. THE DIRECT CARE IS GIVEN BY THE LIVE-IN RESIDENT MANAGER AND/OR ON SITE STAFF 24 HOURS A DAY. NORMAL NIGHT TIME SLEEPING HOURS IS EXPECTED OF THE RESIDENTS. (THE MONTHLY RATES AND CHARGES FOR CARE SERVICES ARE LISTED BELOW.) PRICES ARE ALWAYS NEGOTIABLE AND ARE SUBJECT TO CHANGE. THIS IS ONLY A GENERAL PRICE RANGE. AN ACTUAL ASSESSMENT WILL DETERMINE THE FINAL PRICE CHARGED AFTER THE FIRST TWO WEEKS AND AGAIN AT APPROPRIATE TIMES THROUGHOUT THE YEAR.

Retirement Level 1: **Independent living** **Ranges between: $6,000-$6,500**

This is the TRUE independence level.
The Resident simply needs a place to live, laundry, and room cleaning with meal service. There is very little that we need to provide for the resident other than this tree services.

Personal Care Level 2: **Attended independence** **Ranges between $6,500-$7000**

This level is for Residents who are ambulatory, continent and oriented to date and place; they simply need a minimal level of assistance. These are individuals who are fairly independent and have no significant medical problems. They may need some assistance with medication reminders, nutrition, hygiene and activities of daily living.
Services include the basic services plus medication management oversight, monitoring for general health and well being, monthly blood pressure monitoring, weight and nutritional assessment. Occasional light lifting or personal assistance may be needed.

Personal Care Level 3: **Helpful assistance** **Ranges between $7000-$7,500**

Residents with moderate medical problems who are able to perform some self care but may require reminding and general assistance. This client may have some memory and/or orientation loss and require assistance with dressing and grooming tasks.
Services include by-weekly assistance with bathing, supervision of hygiene and grooming, nutritional intake and some occasional incontinence management. This Resident might need two person assist on occasion or occasional redirecting.

Personal Care Level 4: **(1) Extended and (2) Intensive assistance** **Ranges between $8,000-$8,500**

(1) **Extended Care** includes Residents with incontinence of both bowel and bladder; more assistance is needed in medication management, eating, bathing, toileting, dressing, and transferring. More advanced dementia and Alzheimer's Residents are also included.

(2) **Intensive Care** includes care for catherization, dressing changes, diabetes and other care needs requiring the services of a Registered Nurse and other heavy care needs such as being bedridden, lifting (one or two person lifting or Hoyer lift required) or total non-ambulatory or advanced Alzheimer's disease witch requires more staff time. (Night wanderers, abusive or violent Resident or those who need two person assistance transfer may be beyond the realm of care we can provide)
Also included are special diets, low sodium, low cholesterol, high fiber, mechanical soft, etc. as prescribed by the Resident's attending Physicians.

Hospice Care Level 5: **That with dignity** **Ranges from $9000 and up**

Residents who are facing a life threatening illness without a cure are included in this category. Hospice provides for the special care needs of the dying with emphasis on pain management to allow the Resident to live each day to the fullest. The Hospice program follows the Doctor's orders by skilled, compassionate Nurses utilizing pain control and comfort. Hospice works with the family, friends, relatives, responsible parties and professional caregivers in the Adult Family Home.
Services include feeding, positioning every two hours changing Depends, bed bath, etc. as needed for the Residents well being and comfort till the end.

TRANSFER / DISCHARGE REPORT

5 Mar, 2024

Vancouver Operations, LLC
DBA Avamere Rehab of Cascade Park
801 Southeast Park Crest Ave
Vancouver WA 98683-1300 United States
(360) 260-2200

RESIDENT INFORMATION

Resident Name	Unit	Room/Bed	Admission Date	Resident No.
	100	101 2	01/08/2024	1126211

Sex	Birthdate	Age	Marital Status	Religion	Primary Language	Secondary Language
M			Married		English	

Medicaid Client ID#	Medicare (HIC) #		Medicaid #
Social Security #	**Insurance:**	**Medical Record #**	**Policy #:**
	Kaiser		
Provider One ID #:	**Insurance # 2**	**Policy # 2**	

OTHER INFORMATION

Allergies

Desipramine, Penicillins, Shellfish, Shrimp

Advance Directive	Copy Advance Directive/Living Will Enclosed	Diet Type	Diet Texture	Fluid Consistency
DO NOT RESUSCITATE (DNR); ADVANCED DIRECTIVE ON FILE	YES NO	Regular	Pureed	IDDSI Extremely Thick

PRIMARY CONTACT

Name	Notified	Relationship	Address	Phone
	YES NO	Wife		

PRIMARY PHYSICIAN

Physician	Phone	Address
EKECHUKU, CHINYERE	Office:(503) 499-5200	500 NE Multnomah St Portland,OR 97232

DIAGNOSES

APHASIA FOLLOWING CEREBRAL INFARCTION (I69.320)	ATHEROSCLEROSIS OF AORTA (I70.0)
ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10)	ATRIOVENTRICULAR BLOCK, FIRST DEGREE (I44.0)
BENIGN LIPOMATOUS NEOPLASM OF KIDNEY (D17.71)	CEREBRAL INFARCTION DUE TO UNSPECIFIED OCCLUSION OR STENOSIS OF RIGHT MIDDLE CEREBRAL ARTERY (I63.511)
CONSTIPATION, UNSPECIFIED (K59.00)	COVID-19 (U07.1)
DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED (R26.2)	DYSPHAGIA FOLLOWING CEREBRAL INFARCTION (I69.391)
DYSPHAGIA, UNSPECIFIED (R13.10)	ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED (D72.829)
ENCOUNTER FOR ATTENTION TO GASTROSTOMY (Z43.1)	ENCOUNTER FOR OTHER SPECIFIED PROPHYLACTIC MEASURES (Z29.89)
ENCOUNTER FOR PROPHYLACTIC MEASURES, UNSPECIFIED (Z29.9)	ENCOUNTER FOR SCREENING FOR COVID-19 (Z11.52)
ESSENTIAL (PRIMARY) HYPERTENSION (I10)	FUNCTIONAL DYSPEPSIA (K30)
GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9)	GOUT, UNSPECIFIED (M10.9)
HEMIPLEGIA AND HEMIPARESIS FOLLOWING NONTRAUMATIC SUBARACHNOID HEMORRHAGE AFFECTING LEFT NON-DOMINANT SIDE (I69.054)	HYPERLIPIDEMIA, UNSPECIFIED (E78.5)
HYPO-OSMOLALITY AND HYPONATREMIA (E87.1)	IMPAIRED FASTING GLUCOSE (R73.01)
INTERSTITIAL PULMONARY DISEASE, UNSPECIFIED (J84.9)	LONG TERM (CURRENT) USE OF INSULIN (Z79.4)
MODERATE PROTEIN-CALORIE MALNUTRITION (E44.0)	MUSCLE WEAKNESS (GENERALIZED) (M62.81)
NEED FOR ASSISTANCE WITH PERSONAL CARE (Z74.1)	NONTRAUMATIC SUBARACHNOID HEMORRHAGE, UNSPECIFIED (I60.9)
OLD MYOCARDIAL INFARCTION (I25.2)	ORTHOSTATIC HYPOTENSION (I95.1)
OTHER CHRONIC PAIN (G89.29)	OTHER SUPRAVENTRICULAR TACHYCARDIA (I47.19)
PAROXYSMAL ATRIAL FIBRILLATION (I48.0)	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF PROSTATE (Z85.46)
PRESENCE OF CARDIAC PACEMAKER (Z95.0)	SICK SINUS SYNDROME (I49.5)
UNSPECIFIED HEARING LOSS, BILATERAL (H91.93)	URINARY TRACT INFECTION, SITE NOT SPECIFIED (N39.0)

TRANSFER / DISCHARGE REPORT

5 Mar, 2024

Vancouver Operations, LLC
DBA Avamere Rehab of Cascade Park
801 Southeast Park Crest Ave
Vancouver WA 98683-1300 United States
(360) 260-2200

RESIDENT INFORMATION

Resident Name	Unit	Room/Bed	Admission Date	Resident No.
	100	101 2	01/08/2024	1126211

LAST VITAL SIGNS

Blood Pressure	Pulse	Temperature	Respirations	Date of last Tetanus Shot
108/70 Date: 03/05/2024	83 Date: 03/05/2024	97.2 Date: 03/05/2024	16 Date: 03/05/2024	

CHIEF COMPLAINT(*reason for transfer*)

Fall

RELEVANT INFORMATION

Behavior(s)	Ambulation	Bladder	Bowel	Feeding

Usual Level of Functioning

MISCELLANEOUS INFORMATION

Date of Transfer/Discharge	Time	Transfer/Discharged to
02/15/2024	15:35	acute care hospital: PEACE HEALTH SOUTHWEST

Signature	Date	Time

Personal Effects Sent With	Relationship	Date	Time

Vancouver Operations, LLC
Order Summary Report

Resident: Claimant A Active Orders As Of: 03/05/2024

Resident:	Claimant A	**Location:**	101 2	**Admission:**	01/08/2024
Client Id Number:	1126211	**Gender:**	M	**Date of Birth:**	
Physician:	EKECHUKU, CHINYERE	**Pharmacy:**	ProPacPayless Vancouver		
Allergies:	Desipramine, Penicillins, Shellfish, Shrimp				
Diagnoses:	CEREBRAL INFARCTION DUE TO UNSPECIFIED OCCLUSION OR STENOSIS OF RIGHT MIDDLE CEREBRAL ARTERY(I63.511), NONTRAUMATIC SUBARACHNOID HEMORRHAGE, UNSPECIFIED(I60.9), FUNCTIONAL DYSPEPSIA(K30), CONSTIPATION, UNSPECIFIED(K59.00), OTHER CHRONIC PAIN(G89.29), ENCOUNTER FOR PROPHYLACTIC MEASURES, UNSPECIFIED(Z29.9), ESSENTIAL (PRIMARY) HYPERTENSION(I10), HYPERLIPIDEMIA, UNSPECIFIED(E78.5), GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS (K21.9), PERSONAL HISTORY OF MALIGNANT NEOPLASM OF PROSTATE(Z85.46), ATRIOVENTRICULAR BLOCK, FIRST DEGREE(I44.0), OLD MYOCARDIAL INFARCTION(I25.2), ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS(I25.10), ORTHOSTATIC HYPOTENSION(I95.1), HYPO-OSMOLALITY AND HYPONATREMIA(E87.1), GOUT, UNSPECIFIED(M10.9), OTHER SUPRAVENTRICULAR TACHYCARDIA(I47.19), PAROXYSMAL ATRIAL FIBRILLATION(I48.0), SICK SINUS SYNDROME(I49.5), BENIGN LIPOMATOUS NEOPLASM OF KIDNEY(D17.71), PRESENCE OF CARDIAC PACEMAKER(Z95.0), LONG TERM (CURRENT) USE OF INSULIN(Z79.4), IMPAIRED FASTING GLUCOSE(R73.01), MUSCLE WEAKNESS (GENERALIZED)(M62.81), DIFFICULTY IN WALKING, NOT ELSEWHERE CLASSIFIED(R26.2), NEED FOR ASSISTANCE WITH PERSONAL CARE(Z74.1), ENCOUNTER FOR OTHER SPECIFIED PROPHYLACTIC MEASURES(Z29.89), ENCOUNTER FOR SCREENING FOR COVID-19(Z11.52), DYSPHAGIA, UNSPECIFIED(R13.10), APHASIA FOLLOWING CEREBRAL INFARCTION(I69.320), URINARY TRACT INFECTION, SITE NOT SPECIFIED(N39.0), HEMIPLEGIA AND HEMIPARESIS FOLLOWING NONTRAUMATIC SUBARACHNOID HEMORRHAGE AFFECTING LEFT NON-DOMINANT SIDE(I69.054), ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED(D72.829), ATHEROSCLEROSIS OF AORTA(I70.0), ENCOUNTER FOR ATTENTION TO GASTROSTOMY(Z43.1), INTERSTITIAL PULMONARY DISEASE, UNSPECIFIED(J84.9), UNSPECIFIED HEARING LOSS, BILATERAL(H91.93), MODERATE PROTEIN-CALORIE MALNUTRITION(E44.0), DYSPHAGIA FOLLOWING CEREBRAL INFARCTION(I69.391), COVID-19(U07.1)				

Dietary - Diet

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Regular diet Pureed texture, IDDSI Extremely Thick consistency, Approved for snacks only for Nutritional Support	Prescriber Written	Active	02/15/2024	02/15/2024	

Enteral - Feed

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Enteral Feed Order two times a day for Nutritional Needs Provide Nutren 1.5 Fiber or equivalent @ 80mL/hr continuous for 18 hours via pump per PEG Tube. Goal: 1440mL. Okay to use Kate Farms Peptide 1.5 if Nutren is not available and contact RD.	Prescriber Written	Active	03/04/2024	03/04/2024	

Other

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
ACTIVITY LEVEL: as tolerated	Prescriber Written	Active	01/08/2024		

Resident: Claimant A Active Orders As Of: 03/05/2024

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Admit to Avamere Rehab of Cascade Park	Prescriber Written	Active	01/08/2024		
ADVANCED DIRECTIVE ON FILE	Prescriber Written	Active	01/08/2024		
Any PRN Medication or Treatment ordered and not administered for 60 Days may be discontinued after being assessed and documented by a licensed nurse. Primary physician informed that the medical director would intervene if resident visits are not timely.	Prescriber Written	Active	01/08/2024		
aspiration precautions every shift	Prescriber Written	Active	01/10/2024	01/10/2024	
assess respiratory status Q shift maintain sat at at least 90% every shift for O2	Prescriber Written	Active	02/14/2024	02/14/2024	
Change tube feeding set, syringe, adapter, and supplies daily. Label each with date and time changed. every evening shift	Prescriber Written	Active	01/08/2024	01/09/2024	
cleanse both eyelids with warm wash cloth with baby shampoo q am. use Artificial tears then wait two hours and use Dorzolamide timolol eye drops one time a day	Prescriber Written	Active	01/16/2024	01/17/2024	
continue urethral catheter. Change on the 6th of every month. 16 FR every day shift starting on the 6th and ending on the 7th every month	Prescriber Written	Active	02/06/2024	03/06/2024	
COVID 19 daily screening: Document Temperature, O2 Sats% and Document sx of COVID-19- Cough, Shortness of Breath, sore throat, Muscle pain, malaise, New dizziness, New loss of taste or smell, chills or diarrhea every evening shift If (+) for COVID-19 symptom, complete progress note detailing symptoms.	Prescriber Written	Active	01/08/2024	01/09/2024	
Delirium prevention and sleep promotion: -maximize daytime activity -open window shades during day and maximize sun exposure from 0800 to 1600 -apply warm blanket at bedtime -limit interruptions between 2200 and 0600 (e.g. TV off, quiet dark room) every shift	Prescriber Written	Active	01/08/2024	01/08/2024	
Dental, Vision, Auditory, and Podiatry consults as indicated	Prescriber Written	Active	01/08/2024		
DISCHARGE POTENTIAL: good	Prescriber Written	Active	01/08/2024		
Discontinue Current PRN Antacid Regimen and initiate KP Antacid Regimen	Prescriber Written	Active	01/08/2024		
DO NOT RESUSCITATE (DNR)	Prescriber Written	Active	01/08/2024		

Resident: Claimant A **Active Orders As Of: 03/05/2024**

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
DO NOT Send OTC's	Prescriber Written	Active	01/08/2024		
encourage resident to get up to chair TID every day and evening shift	Prescriber Written	Active	01/08/2024	01/09/2024	
Ensure mouth care is provided and palate is cleaned 6 times a day, approx every 2 hours. Oral Care: Swab mouth with chlorhexidine QAM and QHS every shift	Prescriber Written	Active	01/26/2024	01/26/2024	
FDA approved generically equivalent items may be dispensed unless otherwise noted	Prescriber Written	Active	01/08/2024		
Flush G tube with 30mL water before and after medication administrations every shift	Prescriber Written	Active	01/08/2024	01/08/2024	
HOB 30 degrees at all times when TF running every shift	Prescriber Written	Active	01/08/2024	01/08/2024	
Ice chips throughout the day during periods of alertness. Focus on midline head positioning and "quick hard swallow" to facilitate strengthening and coordination. Oral care q shift. every day and evening shift	Prescriber Written	Active	01/10/2024	01/11/2024	
If blood sugar less than 60 mg/dl, give 15 gm glucose tabs or 4 ounces of fruit juice. Repeat CBG every 15 minutes until blood sugar is greater than 60 mg/dl. Notify Physician as needed for hypoglycemia	Prescriber Written	Active	01/08/2024	01/08/2024	
If difficulty swallowing, May crush/alter oral medications and place them in medium to facilitate administration	Prescriber Written	Active	01/08/2024		
If no response to House Bowel Protocol interventions, fax or call MD as needed	Prescriber Written	Active	01/08/2024	01/08/2024	
Influenza Vaccine to be given annually during flu season unless record of prior administration of current year or allergy to chicken eggs	Prescriber Written	Active	01/08/2024		
Liberalized therapuetic diet order for special occasions, Textures remain in effect.	Prescriber Written	Active	01/08/2024		
LN/RN may discontinue medications and treatments for non use after 60 days.	Prescriber Written	Active	01/08/2024		
May collect specimen for COVID-19: SARS-CoV-2, RT-PCR, NAAT or rapid POC testing. as needed for possible exposure, symptoms or screening guidellines Indicate collection method per manufacturer	Prescriber Written	Active	01/08/2024	01/08/2024	
May have Dental, Eye, Podiatry, Audiology, Psychological consult PRN with resident/designee permission.	Prescriber Written	Active	01/08/2024		

Resident: Claimant A Active Orders As Of: 03/05/2024

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
May have pass (LOA) with responsible party with medications	Prescriber Written	Active	01/08/2024		
May use liquid form of medication if indicated.	Prescriber Written	Active	01/08/2024		
monitor blanchable redness to scrotum present on admission: + no issues, healing. - issues, notify providers and doc. in PCC. every evening shift every Mon	Prescriber Written	Active	01/08/2024	01/15/2024	
monitor bruising to bilateral forearms, lower abdomen, and left upper arm present on admission: + no issues, healing. - issues, notify providers and doc. in PCC. every evening shift every Mon	Prescriber Written	Active	01/08/2024	01/15/2024	
monitor G tube insertion site present on admission: + no issues, healing. - issues, notify providers and doc. in PCC. every evening shift every Mon	Prescriber Written	Active	01/08/2024	01/15/2024	
Monitor resident every shift for any signs of pacer malfunction: sudden lethargy, change in loc, dizziness, color change, chest pain, sob, prolonged hiccoughs, palpitations. every shift Document + for signs; - no signs; if + put on alert and notify MD.	Prescriber Written	Active	01/24/2024	01/24/2024	
monitor skin tear to back of left hand found on 2/27: + no issues, healing. - issues, notify providers and doc. in PCC. every evening shift every Mon	Prescriber Written	Active	02/27/2024	03/04/2024	
monitor small closed surgical incision to umbilicus present on admission: + no issues, healing. - issues, notify providers and doc. in PCC. every evening shift every Mon	Prescriber Written	Active	01/08/2024	01/15/2024	
Notify MD if blood sugar is <60 or >400 as needed for Diabetes	Prescriber Written	Active	01/08/2024	01/08/2024	
Occupational Therapy - Eval and Treat as indicated	Prescriber Written	Active	01/08/2024		
okay for ice chips with supervision every day and evening shift	Prescriber Written	Active	02/02/2024	02/02/2024	
Physical Therapy (PT)- Eval and Treat as indicated	Prescriber Written	Active	01/08/2024		
Physician signature indicates pharmacy refill authortzation for medications for 365 days unless otherwise specified	Prescriber Written	Active	01/08/2024		

Resident: Claimant A **Active Orders As Of: 03/05/2024**

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Please awake patient first thing in the morning, lights on, open blinds. If applicable, have patient wear glasses and hearing aids when awake. Please have patient out of bed 3 times daily to chair for meals. Please limit stimulation at night to facilitate sleep, turn off TV. Please orient patient to time and place twice daily. every shift	Prescriber Written	Active	01/10/2024	01/10/2024	
Please have Dietician/Nutrition address Vitamin D deficiency	Prescriber Written	Active	01/13/2024		
Please off load patient on that left shoulder q shift every shift for Shoulder	Prescriber Written	Active	03/01/2024	03/01/2024	
Pneumococcal Vaccine to be given unless history of prior administration at any time in the past.	Prescriber Written	Active	01/08/2024		
pressure ulcer precautions every shift	Prescriber Written	Active	01/13/2024	01/13/2024	
Pt to wear long sleeved shirts or geri sleeves every shift for skin protection	Prescriber Written	Active	01/15/2024	01/15/2024	
RD to order, modify, and discontinue nutrition-related orders	Prescriber Written	Active	01/08/2024		
skin tear to back of left hand: clean and pat dry. Apply new bandage QOD and PRN. as needed	Prescriber Written	Active	02/27/2024	02/27/2024	
skin tear to back of left hand: clean and pat dry. Apply new bandage QOD and PRN. every day shift every other day	Prescriber Written	Active	02/27/2024	02/29/2024	
Speech Therapy -Eval and Treat as Indicated	Prescriber Written	Active	01/08/2024		
Tap Water Enema as needed for Constipation give if no results from suppository after 1 hour	Prescriber Written	Active	01/08/2024	01/08/2024	
Tube Feeding: Change bags and tube sets w/each new TF set one time a day for tube feeding .	Prescriber Written	Active	01/19/2024	01/20/2024	
Tube Feeding: Provide free water flush 200mL QD and document. one time a day for hydration .	Prescriber Written	Active	03/04/2024	03/05/2024	
Tube Feeding: Provide free water flush 30mL before and after TF and 30mL q hour during TF. two times a day for hydration Refill water bag as needed.	Prescriber Written	Active	03/04/2024	03/04/2024	
turn/reposition q2h and float heels when in bed every shift	Prescriber Written	Active	01/08/2024	01/08/2024	
Twice weekly weight every day shift every Thu	Prescriber Written	Active	01/18/2024	01/25/2024	
Twice weekly weight every evening shift every Mon	Prescriber Written	Active	01/18/2024	01/22/2024	

Resident: Claimant A **Active Orders As Of: 03/05/2024**

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Weekly Skin Audits to be completed (-) no skin issues, (+) New skin issues - Document in PCC every evening shift every Mon .	Prescriber Written	Active	01/08/2024	01/15/2024	
Wound care: G tube insertion site. Remove old drainage and debris with NS. Apply split drain gauze. Change daily and PRN. every day shift	Verbal	Active	01/27/2024	01/28/2024	

Pharmacy

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Acetaminophen Tablet 325 MG Give 650 mg via G-Tube every 6 hours as needed for Pain not to exceed 3000 mg from all sources within 24 hours	Prescriber Written	Active	01/08/2024	01/08/2024	
Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 1 puff inhale orally every 4 hours as needed for shortness of breath Take 1-4 puffs q4h as needed	Prescriber Written	Active	01/08/2024	01/08/2024	
Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet via G-Tube at bedtime for prevention of further CVAs	Prescriber Written	Active	01/08/2024	01/08/2024	
Calcium Carbonate Tablet Chewable 500 MG Give 2 tablet via G-Tube every 4 hours as needed for Dyspepsia	Prescriber Written	Active	01/08/2024	01/08/2024	
Dextromethorphan-guaIFENesin Oral Liquid 5-100 MG/5ML (Dextromethorphan-Guaifenesin) Give 20 ml via G-Tube every 6 hours as needed for Cough	Prescriber Written	Active	01/19/2024	01/19/2024	
Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % (Dorzolamide HCl-Timolol Maleate) Instill 1 drop in both eyes two times a day for glaucoma	Prescriber Written	Active	01/10/2024	01/10/2024	
Dulcolax Suppository (Bisacodyl) Insert 1 suppository rectally as needed for Constipation If no medium sized BM by 4th day If no result in 1 hour give tap water enema (see TAR)	Prescriber Written	Active	01/29/2024	01/29/2024	
Insulin Regular Human Injection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 450 = 10; 451 - 1000 = 12 >450, give 12 units and contact provider, subcutaneously two times a day for blood sugar control on TF	Prescriber Written	Active	02/29/2024	02/29/2024	
Lidocaine External Patch 4 % (Lidocaine) Apply to Affected area topically one time a day for Pain remove after 12 hours and remove per schedule	Prescriber Written	Active	02/07/2024	02/08/2024	

Resident: Claimant A **Active Orders As Of: 03/05/2024**

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date
Maalox Regular Strength Suspension 200-200-20 MG/5ML (Alum &Mag Hydroxide-Simeth) Give 20 ml via G-Tube as needed for Dyspepsia four times daily	Prescriber Written	Active	01/08/2024	01/08/2024	
Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 25 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10)	Prescriber Written	Active	01/09/2024	01/09/2024	
Nitrostat Sublingual Tablet Sublingual 0.4 MG (Nitroglycerin) Give 1 tablet sublingually every 5 minutes as needed for chest pain Take 1 tablet every 5 minutes as needed up to 3 tabs in 15 minutes. Call 911 if chest pain persists after 3rd tablet.	Prescriber Written	Active	01/08/2024	01/08/2024	
oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl) Give 0.5 tablet via G-Tube every 8 hours for left shoulder pain	Prescriber Written	Active	03/01/2024	03/01/2024	
Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk)) Give 17 gram via G-Tube one time a day for bowel care	Prescriber Written	Active	02/20/2024	02/21/2024	
Senna Tablet 8.6 MG (Sennosides) Give 2 tablet via G-Tube as needed for Constipation If no medium sized BM by 3rd day	Prescriber Written	Active	01/08/2024	01/08/2024	
Senna-Docusate Sodium Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 1 tablet via G-Tube two times a day for bowel care Hold for loose stool	Prescriber Written	Active	01/24/2024	01/24/2024	
Tiotropium Bromide Monohydrate Inhalation Aerosol Solution 2.5 MCG/ACT (Tiotropium Bromide Monohydrate) 2 puff inhale orally one time a day for emphysema	Prescriber Written	Active	01/08/2024	01/09/2024	
Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 1000 mg by mouth three times a day for pain	Prescriber Written	Active	02/14/2024	02/14/2024	
Vitamin D3 Oral Liquid 125 MCG/ML (Cholecalciferol) Give 10 ml via G-Tube one time a day every Fri for Supplement for 8 Weeks	Prescriber Written	Active	01/16/2024	01/19/2024	03/15/2024
Xarelto Oral Tablet 20 MG (Rivaroxaban) Give 1 tablet by mouth one time a day for Prevention Daily with dinner	Prescriber Written	Active	02/08/2024	02/08/2024	

Vancouver Operations, LLC
Order Summary Report

Resident: Claimant A **Active Orders As Of: 03/05/2024**

Resident: **Location:** 101 2 **Admission:** 01/08/2024

Order Summary	Communication Method	Order Status	Order Date	Start Date	End Date

I have approved these orders for Claimant A Total pages 8. **Physician:**

Signature: _____ _____ **Date:** _____

INVOICE

Senior Haven AFH
12808 Northeast 7th Avenue
Vancouver, Washington 98685
United States

5032179342

Bill to
Claimant A

Invoice Number:	6
Invoice Date:	March 3, 2024
Payment Due:	March 3, 2024
Amount Due (USD):	$1,000.00

Deposit	1	$1,000.00	$1,000.00

pd by check #3852 3/3/24

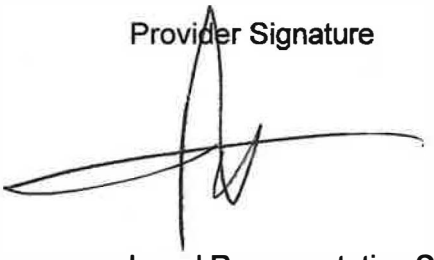
Total:	$1,000.00
Amount Due (USD):	**$1,000.00**

Deposit statement:

$1,000

On March 3, 2024, a deposit was made for (Room # 3) , Placed by Claimant A's wife on behalf of Claimant A, this deposit will reserve (Room # 3) from this date of March 3, 2024 till March 22, 2024. The deposit will be used towards the first month's payment, otherwise will be kept for the holding fee of the room.

Provider Signature

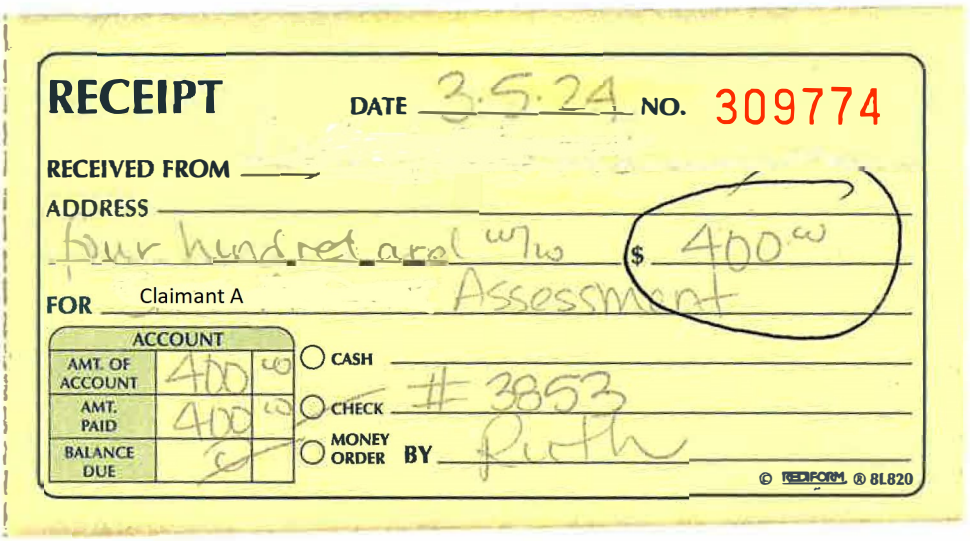


Date

03/03/24

Legal Representative Signature

Date



RECEIPT DATE 3.5.24 NO. 309774

RECEIVED FROM →

ADDRESS

four hundred and no/100 $ 400.00

FOR Claimant A Assessment

ACCOUNT		
AMT. OF ACCOUNT	400	00
AMT. PAID	400	00
BALANCE DUE	0	

○ CASH

○ CHECK #3853

○ MONEY ORDER BY Ruth

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Name of Client

Claimant A

Assessment
&
Preliminary Care Planning

Initial Assessment & Preliminary Care Plan

Done by Qualified Assessor/RN/ SW with 3 years clinical experience or MD all licensed in WA & following WAC requirements

Negotiated Care Plan

Done by Provider with client (if able) & family/POA input within 1 month of admission to facility

Re-Assessment

- Done yearly
- Done when permanent changes within the year

Completed by Elizabeth Eneas, RN
PMB 1009 16420 SE McGillivray BLVD
Vancouver, WA 98683
(360) 931-6270

Assessment Date

3/5/24

Allergies

PENICILLIN, DESIPRAMINE SHELLFISH (Shrimp)

ASSESSMENT

Background Information

Initial Date 3/5/24 EE

Individual's Name: Claimant A Nickname: _____

Age: _____ Birthdate: _____ Place of Birth: _____

Primary Language: English Ethnic Background: Caucasian

Social Security # _____ Gender M ☑ F ☐

Marital Status: Married Children: 3

Hospice Client N/A

Primary Contact Person: _____ **Phone:** _____

SUBSTITUTE DECISION-MAKER? Yes ☑ No ☐ (supply copy to adult family home)

Name: Claimant A Relationship: Wife/POA Decision Maker? Y ☑ N ☐
Phone: _____ Cell: _____ Work: _____

_____ Decision Maker? Y ☐ N ☑
_____ Work: _____

Veteran? Y ☑ N ☐ Branch of Service: Air Force

ADVANCE DIRECTIVES: Yes ☑ No ☐ (supply copy to adult family home, where is original kept?)

☑ Do Not Resuscitate ☑ Power of Attorney ☐ Durable Power of Attorney ☐ Guardianship ☑ POLST

☐ Physician's Directive ☐ Advance Directives ☐ Other

Funeral Arrangements Made? Yes ☑ No ☐

With whom: _____ Phone: *wife has the info

Type of Assessment

Type of Assessment ☑ **Initial Assessment** ☐ **Change in condition Reassessment** ☐ **Annual Reassessment**

Source(s) of Information ☑ **Medical Records** ☑ **Family** ☑ **Resident** ☐ **Provider/Caregiver** ☐ **Other, specify**

Assessment Location Avamere Rehabilitation Vancouver Operations LLC

Client Name

Claimant A

Current Height: stated approx. 5'10" Current Weight: stated approx. 180lbs

HEALTHCARE PROVIDERS

PRIMARY PHYSICIAN: Dr Linn
Phone: 800-813-2000 Fax:
Clinic Address: Kaiser Permanente

Name/Group: Urologist, cardio (for pacemaker), neurologist, nephrology
Phone: 800-813-2000 Fax:
Clinic Address: Kaiser Permanente

Name/Group:
Phone: Fax:
Clinic Address:

PREFERRED HOSPITAL: Legacy Medical Center Salmon Creek Phone: 360-487-1000
Address:

PHARMACY: Kaiser Permanente Pharmacy
Phone: 503-261-2000 Fax:
Address:

Insurance Information

Medicare # 5P72UV5JN86 Medicaid # N/A

Health Insurance: KAISER PERMANENTE
Policy# 1006-63-50 Pre-authorized required ☐ Yes ☐ No
Phone: Fax:

Other Insurance Coverage:
Policy #: Pre-authorized required ☐ Yes ☐ No
Phone: Fax:

CURRENT MEDICAL DIAGNOSIS

(Only include diagnoses made by licensed medical professionals)

Date of most recent exam: currently in SNIF

Also include if appropriate:

- ☐ History of mental illness
- ☐ Diagnoses of a development disability
- ☐ Recent surgeries and hospitalization
- ☐ Current/Past Diagnosis
- ☐ Hospice Care With _____
- ☐ Information Source _____

Date	Diagnosis	By Whom
	Status post Cerebral infarction due to unspecified occlusion or stenosis of R middle cerebral artery (non- traumatic subarachnoid hemorrhage), L side (non- dominant) Hemiparessis, Dysphagia, Aphasia (improved significantly from initial), UTI: hospitalized, then sent to Rehab.	
	Ongoing: Interstitial pulmonary disease	
	Atherosclerosis of the Aorta without angina pectoris	
	Moderate protein- calorie malnutrition	
	Hyperlipidemia	
	Hearing loss	
	Atrial Fibrillation	
	Hypertension	
	Gastroesophageal Reflux Disease/ Functional Dyspepsia	
	Gout	
	Sick sinus syndrome/ Pacemaker	
	Glaucoma	
	History of: Malignanant Neoplasm of the Prostate, Impaired fasting glucose, COVID 19, MI, Benign Lipomatous neoplasm of kidney, Orthostatic Hypotension, UTI	
	Surgeries: Cataracts	
	Code status: DNR	

Current Prescribed Medications

Claimant A

Medication Include prescribed, Over the counter & Herbal	What is medication being used for	Dosage, Route, Frequency	Special Instructions, Notes Regarding Contraindications, Common Side Effects
ATORVASTATIN	Hyperlipidemia	40 mg per GT at bedtime	
DORZOLAMIDE Hcl opht	Glaucoma	1 drop in both eyes twice daily	
DULOXETINE Hcl	Depression/ pain	20 mg 1 per GT daily	
LIDOCAINE patch	Pain (shoulder)	4% 1 applied to affected area daily	Remove after 12 hrs.
METOPROLOL tartrate	Hypertension	25 mg 1 tab per GT twice daily	
OXYCODONE Hcl	Pain	5 mg 1/2 tab (2.5 mg)per GT 3 times/ day	
MIRALAX pow	Constipation	17 gm in 8 oz fl per GT daily	HOLD if loose stools.
SENNA plus	Constipation	8.6-50 mg 1 tab per GT daily	HOLD if loose stools
TIOTROPIUM bromide inh	Emphysema	2 puffs orally daily	
TYLENOL ES	Pain	500 mg 2 tabs (1,000 mg) per GT 3 times/ day	
VIT D3 125 mcg/ mk	Supplement	10 ml per GT weekly	Fridays
XARELTO	A Fib	20 mg 1 tab per GT daily	*need to clarify if can crush for GT or given PO
TAMSULOSIN	Prostate	0.4 mg 1 cap per GT daily	
Insulin sliding scale	while in Rehab	but not at home	

This is a list of medication as of 3/5/24 EE **when the initial interview was done.**

Please, follow the medication list given at discharge, as that is the most current one and fax it to the PCP to ensure accuracy.

You may contact the Pharmacist or the Physician to inquire about contraindications.

ALLERGIES:

PENICILLIN, DESIPRAMINE SHELLFISH (Shrimp)

Preferences and Choices in Daily Life

Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan What are the individual's strengths, needs, and preferences? When will assistance be provided? Who will provide assistance?
Current or Prior Occupations Education	Retired Fireman. Finished High School.
Lifetime Hobbies	In younger years client loved fishing, hunting and cooking.
Involvement Patterns Prefer to be alone? ☐ Yes ☑ No At ease with others? ☑ Yes ☐ No Self-initiates activities? ☑ Yes ☐ No Enjoys group activities? ☑ Yes ☐ No Enjoys new activities? ☐ Yes ☑ No Limitations that impact involvement? ☑ Yes ☐ No	Client is described as being very social. He always enjoyed being around people (liked going grocery shopping because he knew everyone there, had his bar stool at the bar he went, etc.). As he improves after recent Stroke, he will be more around people, despite limitations. *CAREGIVER to build a trusting relationship with the client (introduce him to the other residents, their families, and stuff; introduce him to surroundings; show activity calendar, obtain information as of preferred activities, preferred time for activities, etc.)* *Caregiver to gently offer client's participation in activities appropriate for his ability to participate. Assist client as needed (get ready for the activity, bring to activity room, etc.)* ***Remember, client has the right to refuse to participate in activities.***
Family/Friends Relationship Close Relationships? ☑ Yes ☐ No Whom: family, friends Someone to confide in? ☑ Yes ☐ No Recent loss of family/friend? ☐ Yes ☐ No Whom: Strategies/items to increase comfort?	Client states he is close with family and friends. *CAREGIVER to assist client in facilitating communication with family member and friends (assist with contacting family member/ friends on the phone, assist client with operating the phone, or writing; get client presentable for outings, or appointments with family, etc.).*

Preferences and Choices in Daily Life

Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan What are the individual's strengths, needs, and preferences? When will assistance be provided? Who will provide assistance?
Social/Cultural Preferences Cultural considerations or preference: ☑ Enjoys children ☑ Enjoys Pets ☐ Has a pet they want to keep?	Client celebrates American and religious holidays.
Usual Patterns ☐ Stays up late ☑ Arises Early ☐ Sleeps In ☑ Awake at night ☐ Irreg. Sleep	Per own admission, client was up for the day around 3am. In Rehab he is laying in bed until nurses come get him; naps throughout the day and goes to bed around 7:30- 8 pm (sometimes at 6 pm). Client falls asleep easily, but he wakes up throughout the night. *CAREGIVER to observe and encourage healthy patterns of rest/ activity without infringing on client's right to direct his preferences (eg go to bed after midnight).Caregiver to notify MD if patterns are disruptive for him, and to collaborate a plan that would assist client to choose healthier patterns.*

Preferences and Choices in Daily Life

Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan What are the individual's strengths, needs, and preferences? When will assistance be provided? Who will provide assistance?
☐ **Finds Strength in faith** ☐ Attends church activities? Where?	Client describes himself as "not really religious; he says prayers, but doesn't practice".
Preferred Household Activities Enjoys helping with: ☐ Laundry ☐ Housecleaning ☐ Dishes ☐ Cooking	Not currently able to participate in household activities.
Preferred Activity Time ☑ Morning ☐ Afternoon ☐ Evening ☐ Night	Client states he is more energetic in the morning.
Activity Preferences ☐ Music ☐ Card Games ☐ Trips/Shopping ☐ Gardening Plants ☐ Time Outdoors ☑ Talking/Conversation ☐ Helping Others ☐ Computers ☐ Reading/Writing ☐ Exercise/Sports ☑ TV ☐ Crafts/Arts ☐ Other Activity Interests	Prior the Stroke client loved to go shopping and be involved in household activities, visit with his family/ friends, lift his weights, watch TV. Since the Stroke he is limited in what he can entertain with (visits with family, watches TV), but he can direct preferences.

Delirium, Depression and Cognition Screening

It is helpful to screen for delirium and depression before looking at cognitive abilities

Delirium Screening

Delirium can be due to a medical condition, such as (not limited to) the following: a fall, an infection or an electrolyte imbalance; or do to a substance induced situation, such as medication change or an abuse or misuse of a medication or another toxic substance. One or both of the following can be indicators of delirium if this represents a change to the individual's regular functioning:

- ☐ Sudden or new onset/change in mental functioning, this includes changes in one's ability to pay attention, awareness or surrounding, being coherent, or an unpredictable variation over the course of the day.
- ☐ Episodes of disorganized speech (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought).

(*If a box is checked, consider immediate referral to medical health professional*)

Depression Screening

The following is a list of possible indications of depression. It is important that individuals who are experiencing several of these signs for a period of two weeks or more seek advice from a health care professional that is licensed to treat depression.

- Depressed mood, irritable mood, or loss of interest or pleasure in nearly all activities. ☑ Yes ☐ No ☐ Unable to asses
- Changes in appetite ☑ Yes ☐ No ☐ Unable to assess
- Weight gain or loss (>5% of body weight) ☑ Yes ☐ No ☐ Unable to assess Loss
- Insomnia or hypersomnia (sleeping all the time) ☑ Yes ☐ No ☐ Unable to assess Hypersomnia
- Psychomotor agitation (inability to sit still/pacing/hand wringing/pulling or rubbing of the skin, clothing or other objects) or retardation (slowed speech/thinking and body movements) ☑ Yes ☐ No ☐ Unable to assess
- Decreased energy and fatigue without physical exertion ☑ Yes ☐ No ☐ Unable to assess
- Feelings of worthlessness or guilt ☐ Yes ☑ No ☐ Unable to assess
- Difficulty thinking, concentrating, or making decisions (pseudo dementia) ☑ Yes ☐ No ☐ Unable to assess
- Recurrent thoughts of death, suicide ideation, do they have a plan or has there been an attempt: ☐ Yes ☑ No ☐ Unable to assess

NOTES:
Client is noted to fidget a lot during the interview.

Claimant A

Relevant History of Depression and need for follow-up

History	Need for follow-up
☐ Hospitalizations ☐ Prior Medication ☐ Prior Treatments What has worked? What hasn't worked?	Client denies having had a history of Depression, but states "feeling down" lately (frustrated for not being able to do the things he used to do without assistance). From files client is treated with antidepressant. *CAREGIVER to encourage client to vent feelings, and to offer opportunities for activities that client used to enjoy as a distraction to his feelings. Caregiver to monitor for signs of Depression despite medication (lethargy, withdrawal from socializing, sad facial expression, statements, crying, etc.) and to report them promptly to family and MD.*

History of Anxiety

Excessive worry, apprehension, fears, nervousness or agitation are often indications of anxiety

History	Need for follow-up
☐ Hospitalizations ☐ Prior Medications ☐ Prior Treatments What has worked? What hasn't worked	Client is noted to be restless/ fidgity. He is not diagnosed/ treated for anxiety at the time of the interview. *CAREGIVER to examine environment and to remove potential stressors that would trigger client's anxiety. Encourage client to vent feelings. Listen to client's "worries/ concerns. Keep routines/ staff consistent. Anticipate response to changes. Spend 1:1 time with client reassuring, and redirecting behavior(offer alternative activities to distract, gentle change the topic of discussion,etc). Assist with PRN medication and monitor client's response to it; call MD if medication not effective.*

Geriatric Depression Scale

Choose the best answer for how you felt over the past week:

			* score
1. Are you basically satisfied with your life?	yes	* no	
2. Have you dropped many of your activities and interests?	*yes	no	
3. Do you feel that your life is empty?	* yes	no	
4. Do you often get bored?	* yes	no	
5. Are you in good spirits most of the time?	yes	* no	
6. Are you afraid that something bad is going to happen to you?	* yes	no	
7. Do you feel happy most of the time?	yes	* no	
8. Do you often feel helpless?	* yes	no	
9. Do you prefer to stay at home rather than going out and doing new things?	* yes	no	
10. Do you feel you have more problems with memory than most?	* yes	no	
11. Do you think it is wonderful to be alive?	yes	* no	
12. Do you feel pretty worthless the way you are now?	* yes	no	
13. Do you feel full of energy?	yes	* no	
14. Do you feel that your situation is hopeless?	* yes	no	
15. Do you feel that more people are better off than you are?	* yes	no	
		Total:	

Response score of 5 or more * indicates depression
Reference: Sheikh J.I. and Yesavage J.A. (1986). Geriatric Depression Scale Recent Evidence and Development of a shorter version. Clinical Gerontologist, 5. 165-172.

NOTES: This page was not completed. EE

Short Portable Mental Status Questionnaire (SPMSQ)*

	Answer	Score
What is the date today? (Month, Day, Year. All 3 correct to score.)		
What day is it today?		
What is the name of this place? (Any correct description)		
What is your telephone number? (If no telephone) What is your street address?		
How old are you?		
When were you born? (Month, Day, Year. All 3 correct to score)		
Who is the President of the United States now?		
Who was President just before him?		
What was your mother's maiden name?		
Subtract three from 20 and keep subtracting three from Each new number all the way down (Whole series to score.)		
	Subtotal	
Potential error score: 10 Adjustments to error score	Add one if educated beyond high school	
	Subtract one if not educated beyond grade school	
	Total Score	

0-2 Intact Intellectual Function
3-4 Mild Intellectual Impairment
5-7 Moderate Intellectual Impairment
8-10 Severe Intellectual Impairment

Cognitive Screening

☐ Individual is comatose? ☐ Yes ☑ No (If yes, do not continue)

Memory

Short-Term Memory

Method #1: Ask the individual to describe a recent event that you both had the opportunity to remember. This might be breakfast, a recent meal, or the weather the day before. Ask him or her for details.

Method #2: Ask the individual if you may test his memory. Then say the names of 3 unrelated objects (i.e. table, comb, tree) clearly and slowly, about one second for each. Ask him to repeat them to verify that you were heard and understood, and ask him to remember the objects. Proceed to talk about something else for five minutes and then ask him to recall the objects. If the individual is unable to recall all three items, there is evidence of memory problems.

☐ Short-term memory is OK ☑ Short-term memory problem

short term memory affected post recent Stroke

Long-Term Memory and Orientation

Ask the individual several of the following questions:
What is his name? What day is it today? Where does he live? What is the address? Is he married? What is his spouse's name? Does he have any children? How many? What are their names? When is his birthday? What year was he born? Verify answers for accuracy.

☑ Long-term memory is OK ☑ Long-term memory problem

Long term memory better and improving than short term.

Oriented to person?	☑ Yes	☐ No
Oriented to place?	☑ Yes	☐ No
Oriented to time?	☐ Yes	☑ No

Cognitive Skills for Daily Decision Making/Judgement

Determine how the individual makes decisions about everyday tasks or activities of daily living. *It is also important to consult with caregivers, family and other persons who know this individual in order to understand how this individual is presently functioning.*
How does the individual make decisions about organizing the day, e.g. when to get up or have meals: which clothes to wear or activities to be involved in? Is the individual aware of his or her need for assistive devices and use them appropriately? How would this individual respond in an emergency, is he or she aware of personal strengths and weaknesses? Is the individual currently making his or her decisions about daily living?

☐ Decisions are consistent, reasonable, and organized – reflecting lifestyle, culture, values. (Independent)
☑ Organized daily routine, safe decisions in familiar situations, experiences some difficulty in new situations. (Modified Independence)
☑ Decisions are poor; requires reminders, cues, and supervision in planning, organizing daily routines. (Moderately Impaired)
☐ Decision-making severely impaired; never/rarely makes decisions. (Severely Impaired)

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of info Date and Initial Entries : 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
VISION Date of last exam?. ☑ Impaired- sees large print ☐ Limited vision, can see shapes, headlines and identify objects ☐ Significantly impaired vision, difficulty identifying Objects ☐ Severely impaired, sees only light/colors, can't track objects Blind: ☐ Left ☐ Right Cataracts: ☐ Left ☐ Right Surgery: ☑Left ☑ Right Cataracts Glasses: ☑ Contact Lenses: ☐ Other: ☐ Legaly Blind ☐	☐ No problem Identified Client is diagnosed/ treated for Glaucoma. Unsure of vision status post recent Stroke. *had bilateral cataract surgery 10 years ago *CAREGIVER to keep the environment well lit and free from clutter. AFH will assist client with glasses (clean, put them on/ take them off, make sure they are kept in a safe place when not worn, etc.). Caregiver will monitor and report promptly changes such as: itching (client complains of it or rubs the eyes frequently), yellow discharge matting the eyes, redness, watery eyes, discomfort, decreased vision (client "squints" the eyes when reading, or watching TV, etc.), or discomfort (client complains of eyes hurting, etc.). Caregiver to remind client/ family to have vision checked at least each 2 years.*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date and Initial Entries : 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
HEARING Date of last exam? unknown ☐ Changes in last 6 months? ☑ Difficulty when not in quiet setting ☐ Hears only in special situations, must adjust tonal quality and volume ☐ Highly impaired – no useful hearing Loss: ☑ Left ☑ Right Aids: ☐ Left ☐ Right Devices? ☐ Other:	☐ No problem Identified Client is hard of hearing, but does not have hearing aids. *CAREGIVER will reduce backdrop noise when speaking with client, also, will adjust tonal quality and volume to ensure client hears what is being said. Caregiver will use simple words, and re wording/repetition as needed to ensure client understands in a conversation. Caregiver will alert family/ MD to check client's hearing if significant change is being noted (eg client's hearing is deteriorating to the point he may need ears checked for earwax impaction or hearing aids/ other device to assist hearing, etc.).Caregiver will assist client with hearing aids (clean, check and replace batteries, safe keep when they are not worn, etc.).Caregiver will monitor body language as other means of communication, and use picture pointing, pictures, writing tab to communicate with client if hearing is poor.*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Document Source of Info Claimant A	Date of Initial Entries Significant Symptoms Preliminary and Negotiated Care Plan: 3/5/24 EE What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
COMMUNICATION	☐ No problem Identified
Making Self Understood	
✔ Usually able - difficulty finding words or finishing thoughts	Client was non-verbal following recent Stroke but that has improved and he can speak now fairly well. He is not entirely accurate historian (recovering from Stroke). *becomes very breathy as he talks * has a great sense of humor
✔ Sometimes able - makes simple requests regarding needs and preferences	
Rarely/never able - someone else must interpret sounds or body language	
Problems with speech clarity	Ability to make self understood: how you make yourself understood to those closest to you: express or communicate requests, needs, opinions, urgent problems and social conversations, whether in speech, writing, sign language, symbols or a combination of these including use of communication board or keyboard. Understood- you express ideas clearly Usually understood: you have difficulty finding the right words or finishing thoughts resulting in delayed responses or you require some prompting to make self understood Sometimes understood: you have limited ability but are able to express concrete requests regarding at least basic needs (eg food, drink, sleep, toilet). Rarely/ never understood: at best, understanding is limited to caregiver's interpretation of client specific sounds or body language (indicate d presence of pain, or need to toilet)
Uses sign language, reads lips, communication device	
Ability to Understand Others	No problem Identified
✔ Usually able – demonstrates understanding in words or actions – may miss some part or intent	Client can understand and respond to questions, but sometimes he needs to take time to think about answer.
Sometimes able – frequent difficulty – responds to simple and direct questions and directions	
Rarely or never able – very limited ability	*CAREGIVER to encourage client to express himself, also, to monitor body language for possible cues (eg sad facial expression, moaning, etc.). Do not rush client and allow enough time to verbalize needs and to comprehend. Keep environmental noises to a minimum, speak into the "good ear", close to / facing the client, adjust tonal volume, use simple wording and repetition, assist with glasses/ hearing aids if they are being used, employ writing tabs, pointing to pictures to communicate with client. Give instructions/ directions one step at a time and provide frequent cueing. Ask clarification questions as needed. Inform family/ MD if client's vision/ hearing and client's ability to express change*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Document Source of Info Claimant A	Date of Initial Entries Significant Symptoms Preliminary and Negotiated Care Plan: 3/5/24 EE What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Oral Problems Date of Last Exam: Own teeth ☐ Dentures: ☑ Upper ☑ Lower Partials: ☐ Upper ☐ Lower ☐ Missing teeth, does not use dentures or partials ☐ Broken/loose teeth ☐ Inflamed/bleeding gums ☐ Dry mouth ☐ Sore Tongue ☐ Mouth Odor ☐ Other:	☑ No Problem Identified Dentures uppers and lowers are in fair condition. *CAREGIVER to encourage or assist client with proper oral hygiene. Report to MD gums with excessive bleeding, discomfort, and inflammation. Monitor and inform MD if client has loose teeth, cavities, or old dental work that is falling apart*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date of Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Lungs/Breathing Problems ☑ Difficulty breathing/shortness of breath ☑ During activity ☐ Resting ☐ Wheezing ☑ Coughing: dry, productive ☐ Sinus problems ☐ Other: Lung sounds: ☐ Left: ☐ Right: ☐ Oxygen Use (type):	☐ No problem Identified inhaler Client is diagnosed with/ treated for interstitial pulmonary disease with inhaler. He is noted to have a productive cough (former smoker, Fireman exposed to toxic materials). *becomes short of breath with activities (eg. talking) *CAREGIVER to monitor client's breathing and report to MD if patterns of shortness of breath, wheezing, coughing, etc.*
Cardiovascular Problems ☐ Chest pain ☐ Irregular heartbeat/ palpitations ☑ Heart Disease ☑ Pacemaker Blood Pressure: ☑ High ☐ Low ☐ Dizziness ☐ Edema (pitting/ non- pitting) Where? ☑ Cold feet ☑ Numbness ☐ Varicose veins ☐ Other: ☐ Color Skin ☐ flushed ☐ mottled ☐ jaundice, ☐ cyanotic ☐ pale ☐ ashen ☐ Capillary Refill: ☐ delayed ☐ normal ☐ Heart Tones: ☐ irregular ☐ murmur ☐ soft ☐ med. ☐ loud) ☐ Diaphoresis: ☐ clammy ☐ moist	☐ No problem Identified Client is diagnosed/ treated for heart disease. Pacemaker present. No acute cardiac issues at the time of the interview. *CAREGIVER to monitor and report promptly to MD if any of the signs are noted: oscilating BP; BP out of range for this client; dizziness especially when changing position; localized or generalized edema; chest pain, increased coughing or shortness of breath; etc. Encourage client to keep legs elevated a times.*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? Who will provide care?
Gastrointestinal ☐ Heartburn ☐ Regurgitates food ☐ Abdominal pain ☐ Hemorrhoids ☐ Black/bloody stools ☐ Other:	☑ No problem Identified Client is diagnosed with GERD, but is not currently treated for it. No complaints of gastric discomfort. *CAREGIVER to monitor and report promptly toMD if client experiences heartburn, abdominal pain, changes in BM (pattern, consistency, color, etc.), etc.*
Kidney/Urinary Tract Problem ☐ Chronic Infections ☐ Stones ☑ Other	☐ No problem Identified Client has a history of UTI. He is diagnosed with benign lipomatous neoplasm of kidney and will be seen soon by Nephrology specialist. *CAREGIVER to monitor client's urination and report promptly: difficulty initiating urine flow, painful urination, urine appearance (blood in the urine, dark, thick and foul odor urine), too little or too large urinary outputs ,etc.*

Recent Medical History/ Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? Who will provide care?
Bowel and Bladder Bladder ☐ Usually continent – incontinent no more than 1/wk ☐ Occasionally incontinent – 2/wk or more, urgency ☐ Frequently incontinent – daily ☐ Totally incontinent Bowel ☐ Occasionally incontinent – 1/wk ☑ Frequently incontinent – 2-3/wk ☐ Totally incontinent	☐ No problem Identified Client is incontinent of BM, but continent of urine drained by Foley catheter. *CAREGIVER will monitor client's emptying pattern ready to intervene as appropriately (eg constipation- increase dietary fiber, and fluid intake; offer PRN medication as ordered, inform MD if interventions not successful).*
Muscular – skeletal ☑ Limited range of motion ☐ Contractures ☐ Foot Probs. ☑ Bone/Joint pain ☐ Missing limbs ☐ Ortho. Devices ☐ Other:	☐ No problem Identified Post recent Stroke client has left side weakness. Range of motion is affected by pain in left shoulder (has pain meds) from being pulled by caregivers for turns and general weakness. *CAREGIVER to encourage client to walk as tolerated to prevent further stiffness, also, to increase strength and endurance.*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? Who will provide care?
Nervous System ☐ Tremors ☐ Seizures ☐ Spasticity ☑ Weakness ☐ Other: headaches, unequal grasps, Unsteady gait, sudden disorientation	☐ No problem Identified Weakness in L side post Stroke. *CAREGIVER to monitor for possible seizure activity and inform MD.*
Communicable Disease History ☐ Tuberculosis ☐ Viral Infections ☐ Hepatitis ☐ Other:	☑ No problem Identified Had COVID 19.
Immunizations (dates if known) ☐ TB test ☐ Hepatitis ☐ Flu ☐ Tetanus ☐ Pneumonia ☐ Other:	☐ No problem Identified Client "does not participate in vaccines".

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? Who will provide care?
Pain Management ✔ Has pain/ severity: 1-10 Describe: Location / Duration / Cause Frequency of complaints Relieved By: ☐ Rest ☐ Medication ☐ Other Aggravated with:	No problem Identified Pain in L shoulder and some lower back are managed with pain meds and rest. *CAREGIVER will monitor for signs of pain (eg moaning, wincing, guarding, crying, verbally expressing feeling pain, refusing to move/ participate in activities because client anticipates pain, etc.) and report them promptly to family/ MD for further direction.*

Recent Medical History/Significant Symptoms Assessment

Recent Medical History Significant Symptoms Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? Who will provide care?
Substance Use Drinks alcohol ☐ Yes ☐ No ☐ History of problem/treatment ☐ Tobacco use ☐ Current or past drug addict	☑ No problem Identified *former smoker
Other Problems: (Changes in health status)	☐ No Problem Identified Gout Wife says there is no Diabetes/ history of Insulin dependence, but since recent Stroke/ Rehab client's blood sugar levels are monitored.

Activities of Daily Living Assessment

Include specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Positioning: Ability to move about in bed or a chair, turn side to side, and position body for comfort in bed or chair ☐ Standby for safety, cueing, monitoring, or encouragement ☐ Able to turn or reposition but requires help to guide limbs in order to turn or reposition ☐ Able to assist, requires one person to support while moving or lifting part of body ☑ Dependent on one person to turn or reposition ☐ Reposition every _____hrs. ☐ Daytime ☐ nighttime **Special Equipment** ☐ Draw Sheet ☐ Hospital bed ☐ Special mattress ☐ Trapeze ☐ Wedge ☐ Foot cradle ☐ Bed rails ☐ Other: bedridden, up in the chair/ wheelchair	☐ Moves independently without assistance Post recent Stroke client cannot position self in bed and thus he is dependent on 1 person for it. *precautions with Foley catheter *CAREGIVER will assist client with positioning daily. Use pillows to support body in good alignment, keep heels floating off the mattress, monitor body prominences for redness that seems to last after 5 minutes client changed position. Give simple instructions to client that can participate in adjusting position, remind client to adjust position as able when in a chair or bed.* *Use foam cushion in the chair. Use overlay foam mattress for comfort and to prevent pressure sores.* ***If hospital bed will be ordered it is provider's responsibility to inform this assessor to make necessary adding.***

Activities of Daily Living Assessment

Include specialized body care Consider functioning in last seven days	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Transfers: Ability to move to/from bed, chair, Wheelchair, stand to sit, sit to stand ☐ Able to transfer, requires standby for safety, encouragement or cueing ☐ Able to support own weight, requires lifting assistance to stand or sit ☐ Unable to assist, requires full lifting by one person ☐ Unable to assist, requires full lifting by two or more ☑ Requires mechanical lifting	☐ Transfers independently and safely without assistance Post recent Stroke client is not able to bear weight and thus all transfers are done with Hoyer lift. *precautions with the Foley catheter. *CAREGIVER to stand by assist within arm length distance from client ready to assist as needed.* *Encourage good body mechanics when moving from one place to another. Encourage client to move slowly to minimize dizziness.* *Offer hands on support, or devices (walker/ wheelchair kept close to the client, with brakes on for safety) as appropriate.* *Assess client for safety during transfer. Inform MD if client seems to be unsteady, and further at risk for falling.* *Caregiver to remind client to ask for assist with all transfers. Check on client if he has difficulty remembering. May use tab alarms to alert when client moves unattended.*

Activities of Daily Living Assessment

Include Specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?

Personal Hygiene

Ability to shave; do make-up; wash hands, face and perineum; care for hair, teeth, dentures, hearing aids, glasses

- ☐ Requires setup What?
- ☐ Requires monitoring, encouragement, and/or cueing
- ☐ Able to perform, but requires hands-on assistance to guide through task completion
- ☑ Able to assist, but dependent in at least on sub task
- ☐ Unable to assist, dependent
- ☐ Care of prosthetic devices

☐ Independent with personal hygiene

As he is rehabilitating, client now can wash face and comb hair, but is shaved and have peri area washed by others.
*Foley catheter precautions

SKIN: skin on elbows healing, but had some skin breakdown
*open lesion on left hand
*skin seems to be thinner lately and tearing
bruises easily (usually after PT- on anticoagulants)

NAILS- regular thickness
*wife keeps nails trimmed neat

Skin Problems

- ☑ Dry skin ☐ Fragile/tears
- ☐ Moles/growths ☑ Bruises easily
- ☐ Rashes/Itchy skin ☐ Skin allergies
- ☐ Other: redness, lesions, vascular ulcers, pressure ulcers, surgical wounds, skin graft, fungal infection, shingles lesions, diabetic ulcer
- ☐ Lotions/soaps/linens ☑ nail care
- ☐ Menstruating Normal cycle?
- ☐ Other:

Body care: how you perform with passive range of motion, applications of dressings, and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet. In AFH dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with WAC. Body care excludes food care if you are diabetic or have poor circulation

CAREGIVER will:

-encourage client to adhere to good hygiene practices: establish routine for care, and encourage client to perform tasks as able. Praise efforts.
- set up utensils needed for care and place them within easy arm reach
- do not rush client, but allow ample time for tasks completion and rest periods, as appropriately.
- monitor and inform client when toiletries need re- filling
- encourage or assist client with combing hair throughout the day
*- monitor need for haircut and encourage client to have haircut * may have in- house hairdresser)*
- monitor nail status and intervene as appropriately: file/ trim fingernails (diabetic nail care only by professional or family member); have MD refer toenail care to podiatrist if toenails fungal*
- encourage or assist client to wash hands frequently during the day
- encourage or assist male client to shave (recommend electrical shaver use): ensure shaver is being kept charged; clean the electrical shaver after each use; inform family if malfunction
- encourage or assist client to brush teeth daily. Monitor toothbrush to ensure it is not hurting the gums. Encourage use of Listerine mouth rinse as tolerated. Examine and report gums bleeding, or sensitive; teeth decayed, and causing discomfort.
- assist client with glasses daily: clean and apply them, also, place them securely when not worn.

SKIN- *asses skin status for redness, excessive dryness, rash, open areas, itching, burning, etc.*
-report findings to family/ MD for further approach (eg doctor's office visit and treatment, etc.).
-monitor incontinence, change soiled diaper/ clothing promptly.
-lubricate dry skin with OTC moisturizing lotion.
- apply skin barrier protective ointment to peri area.
- encourage good nutrition and fluid intake to keep skin healthy and hydrated.

Activities of Daily Living Assessment

Include Specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Dressing Ability to put on, take off, fasten/unfasten clothing; laying out clothes and retrieving from closet ☑ Requires monitoring, encouragement, and/or cueing ☑ Laying out of clothing ☑ Help with shoe/socks/TED ☐ Able to assist, but requires guiding of limbs and/or help with tying or buttoning ☐ upper ☐ lower ☐ Able to assist, but requires supporting of limbs ☐ upper ☐ lower ☑ Unable to assist, dependent on: ☑ 1 person ☐ 2 person	☐ Dresses independently and appropriately As he rehabilitated after the recent Stroke, client now can undress himself, but cannot dress himself (dependent on caregiver for dressing). *Foley catheter precautions He wears pajamas, sweatpants and tshirts during the day and does not change into pajamas at night. *CAREGIVER to ensure client is dressed appropriately for season and occasion. Encourage client to change clothes daily.* *Caregiver to encourage client or assist client with dressing as needed: encourage client to choose clothing, place clothes within client's reach ,assist with dressing or undressing upper/ lower body, etc.).* *Caregiver to monitor clothes' condition and fitting and inform him when they need mending or replacing. Ensure clothing is clean, free of stains, or foul odors.* *Caregiver to encourage client to perform as much as able, and to praise his efforts.*

Activities of Daily Living Assessment

Include Specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Ambulation/Mobility Ability to walk, move between locations with or without assistive devices ☐ Independent in walking, uses assistive devices ☐ Does not walk, mobile with wheelchair (WC) ☐ Independent in walking with or without assistive devices, needs stand-by assist, for safety and cueing. ☐ Walks with weight bearing support from 1 person ☐ Walks with weight bearing support from 2 persons ☑ Does not walk or use WC ☐ Bed bound	☐ Independent, no assistance or assistive devices Post recent Stroke client is not able to ambulate and thus he is totally dependent on caregiver for ambulation. *CAREGIVER to keep pathways free of clutter, well lit, and accessible. Caregiver to stand by or assist client with ambulation at all time. Caregiver to encourage client to take rest breaks, as needed. Caregiver to inform client's family and MD if client's ambulation starts to change (client is unsteady) or she falls(see AFH protocol for falls).*
Ambulation ☐ Limited to_____ ft. Limitations due to : L weakness ☐ General stamina: poor_____	No Problem Identified
Ability to Negotiate Stairs ☐ Able to go up or down stairs, requires assistive devices or ☑ Not able to go up/down stairs ☐ Unable to assess	No Problem Identified *Fall risk:* *-Gait/ Mobility: unsteady, using equipment, shuffling steps, immobility/ amputation -* *Level of Consciousness: lethargic, confused* *- Diagnosis: Arthritis, CVA/ TIA, Dementia, Parkinson's, Orthostatic Hypotension -* *Medication: diuretics, laxatives, antihypertensives, sedatives, benzodiazepines, hypnotics* *-History of falls(1-?)*

Activities of Daily Living Assessment

Include Specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Equipment used ☐ Cane ☐ Crutches ☐ Walker ☐ Quad Cane ☐ Gait Belt ☐ Requires prosthesis ☑ Wheelchair ☑ Reg. ☐ Elec. ☐ Self-propels ☑ Needs Assist	☐ No equipment used In case of emergency client needs to be assisted to safety (man- power and equipment). *CAREGIVER will transport client in his wheelchair to the safe place in case of emergency.*

Activities of Daily Living Assessment

Include Specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?

Toilet Use

Ability to use the commode, bedpan, urinal; transfer on/off toilets, manage clothing, cleanse, and change pads, manages ostomy/ catheter

- ☐ Set up supplies only
- ☐ Requires monitoring, encouragement, and/or cueing
- ☐ Able to assist, but requires assistance with cleansing/ care/pads/clothing and/or stand by assistance for transfers
- ☐ Able to assist, dependent in at least one task and/or Requires lifting assistance to transfer ☐ 1 person ☐ 2 person
- ☑ Unable to assist, dependent for all toileting tasks 1 person 2 person
- ☐ Needs assistance at night how often?
- ☐ Urinates
- ☐ Defecates in inappropriate places. Where?

Bowel

- ☐ Training Program
- ☐ Impaction
- ☑ Constipation
- ☐ Bowel Aids
- ☐ Enemas
- ☐ Diarrhea

Bladder

- ☐ Bladder Training/Program
- ☐ Dribbling ☐ Urgency
- ☐ Stress incontinence with exercising, sneezing, Coughing
- ☐ Difficulty starting urine flow

USES:

- ☑ Pads ☐ Undergarments
- ☐ Nights ☐ Days ☐ Full Time
- ☐ Catheter ☐ Bed ☑ Leg Size
- ☐ Indwelling ☐ Intermittent
- ☐ Ostomy type:
- ☐ Self-care ☐ Assist
- ☐ Other:

☐ Independent with toileting tasks

Client does not alert caregivers when/ if he feels the urges to eliminate. He is continent of urine (drained by Foley catheter) and incontinent of BM. Wears Depends. After the Stroke client is dependent on caregiver for it.

*from files client is treated for enlarged prostate and constipation
*history of UTIs and prostate cancer

Catheter precautions.

CAREGIVER will assist client with toileting as needed throughout the day (remind and encourage client to toilet regularly- Q2 hrs while awake; assist with ambulation to and from the bathroom; assist with transfers on and from the toilet). Monitor skin for possible rashes, or pressure areas (red areas that remain red after 5 minutes, especially over bony prominences). Do not leave client at risk for fall unattended. Allow privacy. Monitor elimination and inform MD if issues with constipation, diarrhea, or signs of UTI.

Activities of Daily Living Assessment

Include specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Bathing – *Ability to take bath, shower, or sponge bath; Dry off; transfer in/out of tub/shower.* ☐ Set up supplies only ☐ Requires monitoring, encouragement and/or cueing ☐ Bathes self, needs help getting in/out of tub/shower ☐ Requires physical assistance with part of bathing ☑ Requires complete bathing ☑ 1 ☐ 2 person assistance ☑ Bath bench ☐ Transfer bench ☐ Tub ☑ Shower Frequency: wkly and PRN ☑ Bed Bath ☐ Skin care ☐ Other:	Independent with bathing After recent Stroke client is not able to participate in bathing and thus he is dependent on caregiver for it. *showers to alternate with bed baths *Foley catheter precautions *CAREGIVER will keep bathing and hygiene steps simple* *Will assist with bathing as needed. Ensure client is being bathed at the best time for him. Maintain modesty. * use male caregiver. Monitor skin condition and inform client if rashes, bruises, or pressure areas are being noted. Caregiver will ensure client is bathed according to his preferences for water, and environment temperature. Use safety precautions (rubber floor mat, bench/ shower chair, etc). Apply lubricating lotion to skin. Encourage client's participation as able to tolerate, praise efforts.*

Activities of Daily Living Assessment

Include specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Eating/Drinking – *Ability to eat/drink food/liquids, Including equipment and preferences* ☐ Requires monitoring, encouragement and/or cueing ☐ Requires set up (includes cutting up meat and opening containers) ☐ Able to feed self, but requires hands-on assist to guide or hand food/drink item ☐ Able to feed self some foods, but always needs to be fed a meal or part of a meal ☑ Must be fed, dependent for all foods/fluids **Needs/Concerns** ☐ Therapeutic diet ☐ Supplements ☐ Mech. Altered ☐ Chewing/Swallowing Problems (choking, coughing, pocketing good, drooling.) Weight ☑ Loss ☐ Gain ☐ Food Allergies ☐ Food Preferences:	Independent, no help or oversight needed Until 3/5 / 24 client was fed through Gtube. Prior the interview he had a swallowing test and was cleared for pudding and pureed foods, nectar thick fluids (unclear if the PO recommendations are for "recreational feedings" done by caregiver versus client, or if they are to replace G-Tube feedings). CAREGIVER to follow discharge orders clarified with MD. *CAREGIVER to ensure client's nutritional needs are being met (monitor solid/ fluid intake, and weight). Notify MD if weight fluctuating.* *Prepare and serve nutritious meals and snacks based on client's preferences and doctor's dietary recommendations. May include client in menu planning.* *Adjust portion size to elicit better intake (eg smaller portion size more often).* *Monitor and report changes in appetite, or eating habits. Assist with tube feeding as per doctor's order. Monitor for chewing/ swallowing issues and report them promptly to MD for further evaluation.*

Treatments, Therapies and Medicines, and Appointments

Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Therapies ☐ Speech ☐ Occupational ☐ Physical ☐ Mental Health ☐ Respiratory ☐ Cardiovascular ☐ Daily Management of Pain ☐ Health Monitoring ☐ Range of Motion/Strength ☐ Pressure ulcers ☐ Nebulizer ☐ Other:	☐ No Therapies at present. While in Rehab client worked with PT, OT and Swallow specialist and it is expected the therapies will continue after discharge.
Medical Treatments ☐ Alcohol/Drug ☐ Wound Care ☐ Feeding tube Specify: ☐ Chemotherapy ☐ Radiation ☐ Dialysis ☐ Suctioning ☐ Tracheotomy Care ☐ IV Medications ☐ Injections ☐ Oxygen ☐ Intake/Output Monitoring ☑ Catheter Care type: Foley ☑ Sliding scale insulin ☐ Blood glucose monitoring: Frequency ☐ Other:	☐ No Medical treatments *blood sugar monitoring done before meals and at HS to determine the insulin sliding scale. Per wife, client is not diabetic, he was not on insulin prior the Stroke. From files client is diagnosed with Impaired fasting glucose (pre-diabetic, possible exacerbated by the stress of the Stroke?). FOLEY catheter precautions: -ensure patency (it should drain at least 30 cc/ hr). Call Home Health or the Agency that will care for it if issues -ensure the tubing is unobstructed (mechanically or by sediment). Secure the tubing and be mindful to not pull/ dislodge the catheter during the care -ensure the urine collection bag is secured lower than the bladder at all times -monitor urine apparence and report urine cloudy, dark, odorous, full of sediment or blood/ blood clots

Treatments, Therapies and Medicines, and Appointments

Include specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Self-Medication/Admin – *The ability to take one's Own medication in a safe and reliable manner. If the level of assistance varies, this should be described in the care plan.* ☐ For one or more medications needs assistance ☑ For one or more medications requires administration **See RCW 69.41.010 (11) and RCW 69.41.085 for Information**	☐ all medications are independent LEVEL III per WAC- all medication is administered by the caregiver through g-tube. NURSE DELEGATION needed for medication management (per GT, patch, eye drops, inhaler, possible CBG and insulin?). *CAREGIVER to assist client to take medication as per doctor's order:* - *Remind client when it is time to take medication* - *Take medication form containers and offer client the medication*

Treatments, Therapies and Medicines, and Appointments

Include specialized body care Consider functioning in last seven days Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: What are the individual's strengths, needs and preferences? When will care be provided? Who will provide care?
Transportation/Appointments ☑ Requires assistance with setting up appointments or Arranging transportation ☐ Other:	☐ Independent with transportation and making appointments *wife to arrange appointments and transportation (W/c transport). *CAREGIVER will ensure client is ready for the appointment in timely manner:* - *client is clean, and free of offensive odors.* - *Client is wearing clean clothes* - *Client has appropriate papers for the appointment.*
Cancer ☐ Type: ☐ Location: ☐ Treatment: ☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Other	☐ No Problem Identified *history of prostate cancer15 years ago treated with pellets, no re-occurance

Significant Behaviors

Current and Past Behaviors/Problems Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: Significant Details Frequency What triggers the behavior?	Current or Past?
☐ Hoarding/Squirreling ☐ Hiding items/ misplacing ☐ Breaking, throws items ☐ Injures staff/others ☐ Uses foul language ☐ Resistive to care ☐ Accuses others of stealing ☐ Not sleeping at night, up when others Are sleeping ☐ Wandering ☐ Exit Seeking ☐ Has left home and gotten lost	✔ No problem Identified All behaviors denied.	

Significant Behaviors

Current and Past Behaviors/Problems **Claimant A**	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: Significant Details Frequency What triggers the behavior?	Current or Past?
	✔ No problem identified	
☐ Accidental fires	All behaviors denied.	
☐ History of arson		
☐ Unsafe when smoking		
☐ Unsafe cooking — has left stove on		
☐ Yelling		
☐ Screaming		
☐ Inappropriate verbal noises		

Significant Behaviors

Current and Past Behaviors/Problems Claimant A	Document Source of Info Date and Initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: Significant Details Frequency What triggers the behavior?	Current or Past
	☐ No problem identified	
☐ Mood swings	*treated for Depression (frustrated versus being " clinically depressed").	
☐ Manic	All other behaviors denied.	
☑ Depressed		
☐ Cries frequently or constantly		
☐ Withdrawn or lethargic		
☐ Delusions		
☐ Hallucinations		
☐ Paranoid		
☐ Suicidal thoughts or behaviors		
☐ Injures self		
☐ Unrealistic fears or suspicions		

Significant Behaviors

Current and Past Behaviors/Problems Claimant A	Document Source of Info Date and initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: Significant Details Frequency What triggers the behavior? What can be done to prevent or address behavior? When will care be provided?	Current or Past?
☐ Predatory sexual behavior (seeks vulnerable or unwilling partners)	✔ No problem identified	
☐ Sexual acting out	All behaviors denied.	
☐ Sexual aggression		
☐ Undresses in public in order to expose self		
☐ Aggressive/intimidating		
☐ Manipulative		
☐ Spitting		
☐ Verbally abusive		
☐ Combative		
☐ Assaultive		
☐ Eats non-edible objects		
☐ Inappropriate toileting activity Specify:		

Significant Behaviors

Current and Past Behaviors/Problems Claimant A	Document Source of Info Date and initial Entries 3/5/24 EE Preliminary and Negotiated Care Plan: Significant Details Frequency What triggers the behavior? What can be done to prevent or address behavior? When will care be provided?	Current or Past?
	☐ No problem identified	
☑ Easily worried or anxious	Fidgity/ restless especially when tired.	
☐ Easily irritable/agitated		
☐ Seeks/demands constant attention/reassurance	All other behaviors denied.	
☐ Unrealistic fears or suspicions		
☐ Inability to control own behaviors		
☐ Repetitive anxious complaints or Questions		
☐ Obsessive about health or body Functions		
☐ Repetitive physical movement/pacing, Hand wringing,		
☐ Disrobes		
☐ Medication abuse or misuse		
☐ Drug or alcohol abuse		

Dementia Specialty Placement Criteria

Effective October 1, 1999, this form is required to be completed along with resident assessments, **unless:**
I. ☐ The individual is already residing in a Dementia Specialty Home; **or**
II. ☐ The individual is already residing in a Developmental Disability or Mental Health Specialty Home, and that individual meets the criteria in WAC 388-76-59020 requiring them to be served in a Mental Health or Developmental Disability Specialty Home.

An individual is assessed to need special care in a Dementia Specialty Adult Family Home if the individual meets the criteria in all three categories below:

1. **Evidence of short-term memory loss.**
   (If there is no evidence of short-term memory loss, the assessor may go to 4b and skip 2 and 3)

   AND:

2. One of the following conditions exists for the individual:
   - ☑ Is not oriented to place or time
   - ☐ Has limited ability to make him or her self understood through speech, writing, sign language or any other method the individual uses to communicate
   - ☑ Requires hands-on assistance with eating or drinking

   AND:

3. Needs special care in a Dementia Specialty Home due to at least one of the following behaviors or symptoms which has been exhibited by the individual within the last thirty days:

   - ☑ Ability to make decisions about daily life is poor; requires reminders, cues, and supervision in planning daily routines
   - ☐ History of physical injury to staff / others
   - ☐ Combative
   - ☐ Resistive to care
   - ☐ Sexual acting out
   - ☐ Sexual Aggression
   - ☐ Agitated or wanders at night
   - ☐ Eats non-edible objects
   - ☐ Inappropriate screaming, yelling or verbal noises
   - ☐ Has left home and gotten lost when trying to return
   - ☐ Repetitive physical movement/pacing, hand-wringing, fidgeting
   - ☐ Leaves stove on after cooking
   - ☐ Aggressive / intimidating
   - ☐ Exit-seeking behaviors
   - ☑ Easily irritated / upset / agitating
   - ☐ Seeks / demands constant attention/ reassurance
   - ☐ Pattern of inability to control own behaviors
     Specify:_____
   - ☐ Unrealistic fears or suspicions
   - ☐ Inappropriate toileting activity
     Specify:_____

Name of Individual: _____

4a ■ This individual meets the criteria
4b ☐ This individual does not meet the criteria

_____ 3/5/2024
Qualified Assessor Signature Date

CLIENT NAME: Claimant A

FUNCTIONAL ABILITIES, SPECIAL NEEDS, PREFERENCES						
Item	INDEPENDENT NEEDS LITTLE ASSISTANCE	SOME SUPERVISION OR MINIMAL ASSISTANCE	NEEDS SUPERVISION BUT COOPERATIVE	NEEDS TOTAL ASSISTANCE ONE ON ONE ATTENTION	POINTS FOR THIS CLIENT	CHECK IF SPECIAL NOTES BELOW
BATHING	1	2	3	4	4	
ASSISTANCE W/ MEDS	1	2	3	4	4	
MENTAL HEALTH	1	2	3	4	2-	
ORIENTATION	1	2	3	4	2-	
EATING	1	2	3	4	-4	
DEBILITATION	1	2	3	4	-4	
TOILETING	1	2	3	4	4	
SENSORY DEFICIT	1	2	3	4	3	
DRESSING	1	2	3	4	-4	
AMBULATION	1	2	3	4	4	
COMMUNICATION	1	2	3	4	-3	
TRANSFERRING	1	2	3	4	4	
POSITIONING	1	2	3	4	4	
SPECIAL BODY CARE	1	2	3	4	4	
PERSONAL HYGIENE	1	2	3	4	-3	
ACTIVITIES	1	2	3	4	4	
NURSE DELEGATION	1	2	3	4	4	
				TOTAL	61+	

Functional Level

LEVEL I **25 POINTS OR LESS**
LEVEL II **26 – 40 POINTS**
LEVEL III **41 – 60 POINTS *****

SPECIAL INSTRUCTIONS FOR ADLS:

INDEPENDENT= without assistance or assistive device (no set- up required)
MODIFIED INDEPENDENT= without assistance, but with use of an assistive device and excessive time for safety concerns related to task completion.
SUPERVISION/ STABD BY ASSISTANCE= without assistance, but with someone continuously nearby for safety concerns.
MINIMUM ASSISTANCE/ CONTACT QUARD= assistance from another party, but no more than 25%. Patient doing 75% or more of the work: may have additional safety concerns.
MODERATE ASSISTANCE= Assistance from another party with patient and support person each providing 50% of the work. High level of safety concern.
MAXIMUM ASSISTANCE= patient is doing less than 25% of the work and needing a high level of assistance with ADLs. High level of safety concern. Patient is dependent on caregiver for care.
TOTAL ASSISTANCE= patient is doing 0% of the work and is completely dependent on caregiver for care. Hightly unsafe to be unsupervised.

I completed this assessment and I meet the qualifications for an assessor stated in WAC 388-76-61050.

Name: **ELIZABETH ENEAS, RN** Date:3/5/2024 Phone: **360-931-6270**

Name: Date: Phone:

Name: Date: Phone:

Preliminary and Negotiated Care Plan Signatures

Name of Individual: Claimant A Date of Original Plan: _____

Signature	Date	Date	Date	Date	Date	Date
Individual:	Preliminary Service Plan:	Negotiated Care Plan:	Review:	Review:	Review:	Review:
Provider:	Preliminary Service Plan:	Negotiated Care Plan:	Review:	Review:	Review:	Review:
Resident Representative:	Preliminary Service Plan:	Negotiated Care Plan:	Review:	Review:	Review:	Review:

This form was created by a group of Adult Family Home providers, resident advocates, Washington State DSHS/Aging and Adult Services staff and professional assessors, and was designed to include the elements of an assessment required in WAC 388-76-61020.

This is a sample form and not a required form. Assessors and providers can make copies of this form, add to it, and modify it as appropriate.

The use of the word "individual" throughout this document refers to the individual being assessed for long-term care services.

PLEASE NOTE: THIS FORM DOES NOT TAKE THE PLACE OF KNOWLEDGE OF RULE AND LAW.

ITEM VI.a.

Fire Pension Board
August 2023 - February 2024

EXPENSES:

August	*2023 Pensions Paid*	**$36,508.46**
September	*2023 Pensions Paid*	**$36,508.46**
October	*2023 Pensions Paid*	**$36,508.46**
November	*2023 Pensions Paid*	**$36,508.46**
December	*2023 Pensions Paid*	**$36,508.46**
January	*2024 Pensions Paid*	**$42,023.66**
February	*2024 Pensions Paid*	**$42,023.66**
August	*2023 Claims paid by Allegiance*	**$6,763.48**
September	*2023 Claims paid by Allegiance*	**$0.00**
October	*2023 Claims paid by Allegiance*	**$239.49**
November	*2023 Claims paid by Allegiance*	**$20.49**
December	*2023 Claims paid by Allegiance*	**$5,099.24**
January	*2024 Claims paid by Allegiance*	**$0.00**
February	*2024 Claims paid by Allegiance*	**$0.00**
August	*2023 Claims paid by CoV*	**$13,500.00**
September	*2023 Claims paid by CoV*	**$13,500.00**
October	*2023 Claims paid by CoV*	**$14,500.00**
November	*2023 Claims paid by CoV*	**$13,800.00**
December	*2023 Claims paid by CoV*	**$13,800.00**
January	*2024 Claims paid by CoV*	**$13,800.00**
February	*2024 Claims paid by CoV*	**$13,800.00**
August	*2023 Allegiance Admin Fees*	**$19.25**
September	*2023 Allegiance Admin Fees*	**$57.75**
October	*2023 Allegiance Admin Fees*	**$0.00**
November	*2023 Allegiance Admin Fees*	**$38.50**
December	*2023 Allegiance Admin Fees*	**$19.25**
January	*2024 Allegiance Admin Fees*	**$615.50**
February	*2024 Allegiance Admin Fees*	**$0.00**
August	*2023 Medicare B Reimbursements*	**$9,626.00**
September	*2023 Medicare B Reimbursements*	**$2,133.30**
October	*2023 Medicare B Reimbursements*	**$2,472.80**
November	*2023 Medicare B Reimbursements*	**$1,664.60**
December	*2023 Medicare B Reimbursements*	**$989.40**
January	*2024 Medicare B Reimbursements*	**$48,520.20**
February	*2024 Medicare B Reimbursements*	**$3,056.40**
TOTAL EXPENSES FOR APPROVAL:		**$444,625.27**

APPROVAL OF EXPENSES

We, the undersigned members of the Fire Pension Board of the City of Vancouver do hereby certify and attest that the above expenses have been approved for payment in the amount of $444,625.27 this 21st day of March 2024.