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CN21-35

Washington State Department of Health

WASHINGTON STATE CERTIFICATE OF NEED PROGRAM
RCW 70.38 AND WAC 246-310

APPLICATION FOR CERTIFICATE OF NEED HOME HEALTH CARE PROJECTS

Certificate of Need applications must be submitted with a fee in accordance with the instructions on page 2 of this form. Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310 adopted by the Washington State Department of Health. I hereby certify that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer: President **Date:** 15 December 2020	**Person To Whom Questions Regarding This Application Should Be Directed:** Ernest Ibanga President Wellspring Home Health Center, LLC 8815 S. Tacoma Way, Suite 120 Lakewood, WA 98498 **Telephone Number: (253) 625-7606**
Legal Name of Applicant: Wellspring Home Health Center, LLC **Address of Applicant:** Wellspring Home Health Center, LLC 8815 S. Tacoma Way, Suite 120 Lakewood, WA 98498 **Telephone Number: (253) 625-7606**	**Type of Project (check all that apply):** [ ] New Agency [ ] Existing Medicare Certified/Medicaid Eligible Agency Expanding into Different County [x] Existing Licensed-Only Home Health Agency to Become Medicare Certified/Medicaid Eligible.
Project Summary: Wellspring Home Health Center requests CN approval to operate a Medicare and Medicaid eligible home health services agency to serve residents in King County. **Estimated capital expenditure: $25,000**	

APPLICATION INFORMATION INSTRUCTIONS:

These application information requirements are to be used in preparing a Certificate of Need application. The information will be used to evaluate the conformance of the project with all applicable review criteria contained in RCW 70.38.115 and WAC 246-310-210, 220, 230, and 240.

NOTE: **If this application is approved, the applicant will be expected to provide services to residents in the entire county.**

- Home Health applications are county specific. No more than one county per application.
- Include a table of contents for major application sections and appendices.
- Number **all** pages consecutively.
- **Do not** bind or 3-hole punch the application.
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc., cited in the application.
- Place extensive supporting data in an appendix.
- Provide detailed descriptions of assumptions used for **all** projections.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions in the application.
- **Do not** include a capital expenditure contingency.

Application Submission:

Number of Copies:
- Submit an **original, one copy, and an electronic (pdf) version**
- All subsequent submissions associated with this application must be submitted with an **original, one copy and an electronic (pdf) version**.

To be accepted, the application must include:
- A completed and signed Certificate of Need application face sheet
- The review fee of **$24,666** Make check payable to ***Department of Health***

Send application to:

Mailing Address:	**Other Than By Mail:**
Department of Health	**Department of Health**
Certificate of Need Program	**Certificate of Need Program**
P O Box 47852	**111 Israel Road SE**
Olympia, Washington 98504-7852	**Tumwater, Washington 98501**

If you have questions, call (360) 236-2955

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14	Key Personnel Information
15A	Wellspring Home Health Center CMS Survey Activity Report
15B	Community Health Accreditation Partner (CHAP) Letter and Certificate

I. APPLICANT DESCRIPTION:

A. Provide the legal name(s) of applicant(s).

Note: The term "applicant" for this purpose is defined as any person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity that engage in any undertaking which is subject to review under provisions of RCW 70.38.

The legal applicant name is Wellspring Home Health Center, LLC ("Wellspring Home Health"), otherwise known as Wellspring.

The members of Wellspring Home Health Center, LLC are:

- Dr. Ernest Ibanga (50% ownership)
- Joyce Ibanga (50% ownership).

B. For each licensed applicant, please provide the professional license number and specialty represented. If the license was not issued by Washington State, please identify the state it was issued.

Wellspring Home Health Center, LLC is an existing licensed-only in-home services provider. Wellspring Home Health's license number is IHS.FS.61055973.

C. For existing facilities, provide the name and address of the facility.

Note: The term "existing facility" for this purpose is defined as a home health agency that is currently providing licensed only home health care services OR a home health agency that is seeking to expand its Medicare certified service area.

Wellspring Home Health Center, LLC
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

D. Identify the type of ownership (public, private, corporation, non-profit, etc.).

Wellspring Home Health is a limited liability corporation ("LLC").

E. Provide the name and address of owning entity at completion of project (unless same as applicant).

This question is not applicable. The owning entity, Wellspring Home Health, will be the same at completion of the project.

F. Provide the name and address of operating entity at completion of project (unless same as applicant).

This question is not applicable. The operating entity, Wellspring Home Health, will be the same at completion of the project.

G. Identify the corporate structure and related parties. Attach a chart showing organizational relationship to related parties.

Wellspring Home Health is a limited liability company (LLC). Wellspring Home Health's Unique Business Identifier (UBI) number registered with the Washington Secretary of State's Office is 604 416 352.

Wellspring Home Health has home health operations in Washington State (one location) and Alaska (two locations). The address for which this application seeks Certificate of Need (CN) approval to provide Medicare and Medicaid certified home health services in King County is:

Wellspring Home Health Center, LLC
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

Please see Exhibit 1 for organizational charts of Wellspring Home Health's operations in Washington State and Alaska.

H. Provide a general description and address of each facility and other related business (es) owned and/or operated by applicant (include out-of-state facilities, if any).

Wellspring Home Health Center, LLC operates one home health office in Washington State:

Wellspring Home Health Center, LLC
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

Wellspring Home Health Center, LLC also operates two home health offices in Alaska:

Wellspring Home Health Center, LLC
201 E. Swanson Ave., Suite 7
Wasilla, AK 99654

Wellspring Home Health Center, LLC
5700 Old Seward Hwy., Suite 102
Anchorage, AK 99518

I. <u>For existing facilities</u>, identify the geographic primary service area.

Wellspring Home Health's existing Washington State licensed-only in-home services operate out of its Lakewood, WA office within Pierce County. The proposed geographic primary service area to operate CN approved Medicare and Medicaid certified home health services will be <u>King County</u>.

J. Identify the facility licensure/accreditation status.

Wellspring Home Health's license number for in-home services is IHS.FS.61055973 and is effective through 08/27/2022.

K. Is the applicant reimbursed for services under Medicare and Medicaid? List which ones.

Wellspring Home Health's operations in Alaska are currently reimbursed for Medicare and Medicaid.

Wellspring Home Health's operations in Pierce County currently do not receive Medicare and/or Medicaid reimbursement.

L. If applicable, identify the medical director and provide his/her professional license number, and specialty represented.

The proposed medical director is Dr. Amar Kapur, DO. Dr. Kapur is currently in the process to obtain a Washington State medical provider license.

M. If applicable, please identify whether the medical director is employed directly by or has contracted with the applicant. If services are contracted, please provide a copy of the contract.

Dr. Kapur's will be contracted to provide medical director services. Please see Exhibit 2 for the Medical Director Agreement between Wellspring Home Health and Dr. Kapur.

N. <u>For existing facilities</u>, please provide the following information broken down by discipline (i.e., RN/LPN, OT, PT, home health aide, social worker, etc.) <u>for each county</u> currently serving:

1. **Total number of home health *visits* per year for the last three years; and**
2. **Total number of unduplicated home health *patients* served per year for the last three years.**

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

II. PROJECT DESCRIPTION

Include the following elements in the project description. An amendment to a Certificate of Need is required for certain project modifications as described in WAC 246-310-100(1).

A. Provide the name and address of the proposed facility.

Wellspring Home Health Center, LLC
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

B. Describe the project for which Certificate of Need approval is sought.

Wellspring Home Health Center requests CN approval to operate a Medicare and Medicaid eligible home health services agency to serve residents in King County. The home health agency will be based out of Wellspring's Pierce County office located in Lakewood, WA.

C. List new services or changes in services represented by this project. In the following table, please indicate (by marking an 'X' in the appropriate column) which services would be provided directly by the agency and which services would be contracted.

	Direct	Contracted
Skilled Nursing	X	
Physical Therapy	X	
Occupational Therapy	X	
Speech Therapy	X	
Medical Social Work	X	
Home Health Aide	X	
Medical Director		X
Respite Care	X	
IV Therapy		X
Other (list):		

D. General description of types of patients to be served by the project.

Wellspring Home Health Center will serve all residents in King County in need of home health services. Wellspring Home Health offers a wide variety of home medical and support care services to meet the unique needs of each individual patient. As indicated above, Wellspring Home Health will directly provide skilled nursing physical therapy, occupational therapy, speech therapy, medical social work, home health aide, and respite care services while contracting medical director and IV therapy services. All Wellspring Home Health's programs are coordinated by highly trained, experienced, and licensed home care nurses whose focus is providing the most appropriate, professional, and compassionate care for our patients in a home care setting.

We also plan to offer the following specialty home care services for the pediatric and veteran populations:

Pediatric Home Care Services

Wellspring Home Health Center provides an effective and holistic treatment of children with medical complexity or developmental disabilities who otherwise may experience frequent and/or prolonged hospitalizations or who may enter chronic institutional care. Each child benefits from a readily accessible and comprehensive written plan of care that represents a consensus among the family, the patient, and the caregivers. Our Pediatric specialty providers interact with the child, family, and home health providers, using home visits and telehealth technologies to optimize care, minimize family disruptions, and avoid unnecessary medical utilization.

Veterans Home Care Services

Wellspring Home Health Center helps veterans or their surviving spouses receive personal care services to help them retain their quality of life and stay in their homes. We assist veterans who protected our freedom to stay in their homes and live with honor and dignity. Home care is delivered by our home health Agency through contract with VA. The program is for Veterans who need skilled services such as skilled nursing, case management, physical therapy, occupational therapy, speech therapy, wound care, or IV antibiotics. Skilled Home Health Care is used in combination with other home-based services.

E. List the equipment proposed for the project:

1. **Description of equipment proposed; and**
2. **Description of equipment to be replaced, including cost of the equipment, disposal, or use of the equipment to be replaced.**

Table 1: Wellspring Home Health Equipment List and Capital Expenditures

Wellspring Home Health Center, LLC Capital Expenditure

Tenant Improvements	Estimated Price
Workstation, cubicles, and installation	$5,500
Office upgrades: electricity, security, carpet, paint and cabling	$4,000
TI Subtotal	*$9,500*
Equipment	
Furniture	$3,000
3 computers	$4,000
4-in-one -printer/fax/copier/scanner	$1,500
Land lines phone systems	$1,000
Software and licenses	$2,000
Cellphones and iPads for visiting clinical staff	$4,000
Equipment Subtotal	*$15,500*
Total	**$25,000**

F. Provide drawings of proposed project:

1. Single line drawings, approximately to scale, of current locations which identify current department and services; and

Please see Exhibit 3 for a single line drawing of the Lakewood office.

2. Single line drawings, approximately to scale, of <u>proposed</u> locations which identify proposed services and departments; and

This is not applicable, as the proposed location is the same as the current location.

3. Total net and gross square feet of project.

Please see Exhibit 3 for a single line drawing of the Lakewood office. It is 1,026 square feet.

G. Identify the anticipated dates of both commencement and completion of project.

Given a CN review period of approximately 7 months, we anticipate project commencement to occur on or about mid-July 2021. Allowing about 3.5 months for Medicare certification, office upgrades, and acquisition of equipment, we expect the project completion date to be November 1, 2021.

H. Describe the relationship of this project to the applicant's long-range business plan and long-range financial plan (if any).

CN approval of this proposed project is integral to Wellspring Home Health Center's long-range business and financial plans. Wellspring's commitment to bringing its tradition of compassionate and high-quality care to Puget Sound residents resulted in the opening of its home health agency in Lakewood, WA in late 2019.

There is significant unmet need for home health services currently in the King County. This unmet need is only expected to grow further with population growth and population aging. Wellspring Home Health is well positioned to address this unmet need and provide King County residents with access to high quality and comprehensive home health services.

I. Provide documentation that the applicant has sufficient interest in the site or facility proposed. "*Sufficient interest*" shall mean any of the following:

1. **Clear legal title to the proposed site; or**
2. **A lease for at least one year with options to renew for not less than a total of three years; or**
3. **A legally enforceable agreement (i.e., draft detailed sales or lease agreement, executed sales or lease agreement with contingencies clause) to give such title or such lease in the event that a Certificate of Need is issued for the proposed project. These agreements may be in draft form if**

all parties identified in the draft agreements provide a signed "Letter of Intent to finalize" the agreement.

Please see Exhibit 4 for a copy of the signed lease between Wellspring Home Health and Lakewood Plaza, LLC, along with the Pierce County Assessor's Office Property Summary indicating ownership of the location by Lakewood Plaza, LLC.

III. PROJECT RATIONALE

A. Need (WAC 246-310-210)

1. Identify the proposed geographic service area.

The proposed geographic service area is King County.

2. If the proposed service area is designated as a Medically Underserved Area (MUA) as defined by HCFA or a Health Professional Shortage Area (HPSA), please provide documentation verifying the designation.

Within King County, Central Seattle, South Seattle, and South King County have Medically Underserved Area (MUA) designations.

Areas designated as Health Provider Shortage Areas (HPSA) include Enumclaw, Snoqualmie/North Bend, and Vashon Maury Island. An additional thirteen organizations operating in King County have Primary Care HPSA designations. These include:

- Country Doctor Community Clinic
- Healthpoint
- International Community Health Services
- Public Health — Seattle & King County
- Neighborcare Health
- Sea-Mar Community Health Center
- Seattle Indian Health Board
- Muckleshoot Behavioral Health Program
- Muckleshoot Tribal Clinic
- North Bend Family Clinic
- Raging River Recovery Center
- Seattle Indian Health Board Health Center
- Snoqualmie-Tolt Community Clinic[1]

Please see Exhibit 5 for documentation of MUA and HPSA designations.

3. Identify and analyze the unmet home health service needs and/or other problems toward which this project is directed.

a. Identify the unmet home health needs of the patient population in the proposed service area. *Note that the unmet patient need should not include physical plant deficiencies and/or increase facility operating efficiencies*.

[1] This organization is seeminlgly listed twice, as the Tolt Community Clinic-Snoqualmie as well as the Snoqualmie-Tolt Community Clinic. These separate listing have unique HPSA ID numbers, but identical addresses, so we list them together.

Certificate of need rules (WAC 246-310) do not contain specific WAC 246-310-210(1) need criteria as identified in WAC 246- 310-200(2)(a)(i). Therefore, Wellspring has developed a home health need model for King County consistent with the Department's prior evaluations of home health projects and based on the numeric methodology contained in the 1987 Washington State Health Plan (SHP).

The 1987 SHP numeric methodology can generally be summarized in the following four steps:

Step One: Project the population of the planning area, broken down by age cohort.

Table 2: King County Need Step One, Population Estimates.

	Base Year	Forecast Year 1	Forecast Year 2	Forecast Year 3
	CY2020	CY2021	CY2022	CY2023
0-64 Years Old	1,906,749	1,918,329	1,929,979	1,941,700
65-79 Years Old	254,184	263,080	272,288	281,818
80+ Years Old	70,476	73,730	77,135	80,697
Total	**2,231,409**	**2,255,140**	**2,279,403**	**2,304,216**

Source: OFM 2017 GMA Projections - Medium Series (Jan. 2018 Release)

Step Two: Project the number of home health patients.

Table 3: King County Need Step Two, Home Health Patient Projections.

	Use Rate	CY2020	CY2021	CY2022	CY2023
0-64	0.005	9,534	9,592	9,650	9,709
65-79	0.044	11,184	11,576	11,981	12,400
80+	0.183	12,897	13,493	14,116	14,768
Total		**33,615**	**34,660**	**35,746**	**36,876**

Source: Use rates specified in 1987 SHP, B-35.

Step Three: Project the number of home health visits.

Table 4: King County Need Step Three, Home Health Visit Projections.

	Visit Multiplier	CY2020	CY2021	CY2022	CY2023
0-64	10	95,337	95,916	96,499	97,085
65-79	14	156,577	162,058	167,730	173,600
80+	21	270,839	283,346	296,430	310,119
Total		**522,754**	**541,320**	**560,659**	**580,804**

Source: Visit multiplier rates specified in 1987 SHP, B-35.

Step Four: Determine the projected home health agencies need.

Table 5: King County Need Step Four, Net Need Projections.

	CY2020	CY2021	CY2022	CY2023
Gross Need	52.28	54.13	56.07	58.08
Supply	32	32	32	32
Net Need	**20.00**	**22.00**	**24.00**	**26.00**

Gross Need Source: As described in 1987 SHP, B-35, the maximum number of agencies needed in a planning area is determined by dividing the total projected number of visits (Step 3) by 10,000.

Supply source: DOH December 2020 Evaluation of CN20-02, p. 6-11.

Net Need source: calculated by subtracting supply from gross need. Per the 1987 SHP methodology, fractions are rounded down to the nearest whole number.

As demonstrated above, there is significant net need in the King County Planning Area for additional home health agencies. The need methodology estimates current (CY2020) net need for twenty (20) additional agencies, growing to twenty-six (26) additional agencies by CY2023.

Please see Exhibit 6 for the complete planning area forecast need model, including a list of agencies counted in the need methodology.

b. Identify the negative impact and consequences of unmet home health needs and deficiencies.

There is significant unmet need for home health services currently in the King County. This unmet need is only expected to grow further with population growth and population aging. If there is not sufficient capacity in the planning area, then King County residents will not have timely access to home health services, which will result in poorer quality, lower outcomes, and a reduced patient experience as patients may delay or forgo receiving the necessary skilled services. Further, without sufficient access to home health agencies, this can also lead to increased costs due to preventable emergency room visits or hospitalizations and patients having to receive care at more expensive alternatives.

4. Define the types of patients that are expected to be served by the project. The types of patients expected to be served can be defined according to specific needs and circumstances of patients (i.e., culturally diverse, limited English speaking, etc.) or by the number of persons who prefer to receive the services of a particular recognized school or theory of medical care.

Wellspring Home Health Center will serve all residents in King County in need of home health services. Wellspring Home Health offers a wide variety of home medical and support care services to meet the unique needs of each individual patient. As indicated above, Wellspring Home Health will directly provide skilled nursing, physical therapy, occupational therapy, speech therapy, medical social work, home health aide, and

respite care services, while contracting medical director and IV therapy services. All Wellspring Home Health's programs are coordinated by highly trained, experienced, and licensed home care nurses whose focus is providing the most appropriate, professional, and compassionate care for our patients in a home care setting.

As described above, we also plan to offer specialty home care services for the pediatric and veteran populations.

5. <u>For existing facilities</u>, include a patient origin analysis for at least the most recent three-month period, if such data is maintained, or provide patient origin data from the last statewide patient origin study. Patient origin is to be indicated by zip code. Zip codes are to be grouped by city and county, and include a zip code map illustrating the service area.

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

6. <u>For existing facilities</u>, please identify the number of patients currently receiving skilled services, broken down by type(s) of services (i.e., skilled nursing), by county served.

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

7. Please provide utilization forecasts for the following, broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) <u>for each county</u> proposing to serve:

a. Total number of home health *visits* per year for the first three years; and
b. Total number of unduplicated home health patients served per year for the first three years.

Table 6: Home Health Visit and Patient Projections, 2021 to 2024

Home Health Visits	**2021**	**2022**	**2023**	**2024**
Months of Operation	2	12	12	12
Total Visits	902	8,412	10,164	12,036
Total Unduplicated Patients	37	342	413	453
Visits by Occupational Category	**2021**	**2022**	**2023**	**2024**
Skilled Nursing	361	3,365	4,066	4,814
Physical Therapy	316	2,944	3,557	4,213
Occupational Therapy	108	1,009	1,220	1,444
Speech Pathology	18	168	203	241

Medical Social Services	9	84	102	120
Home Health Aid	90	841	1,016	1,204
Sources: Applicant; See Table 7 and Table 8.				

8. Provide the complete step-by-step quantitative methodology used to construct each utilization forecast. <u>All assumptions related to use rate, market share, intensity of service, and others must be provided.</u>

From Table 3, we project King County residents in need of Home Health services to equal 541,320 in 2021, 560,659 in 2022, and 580,804 in 2023. Extending this forecast for an additional year, we estimate this number to equal 601,790 in 2024. These numbers correspond to 45,110, 46,722, 48,400, and 50,149 visits per month in 2021, 2022, 2023, and 2024. We assume that, on a monthly basis, Wellspring Home Health will provide services to 1% of these patients in 2021, 1.5% in 2022, 1.75% in 2023, and 2% in 2024. Furthermore, we assume that, based on 2019 CMS numbers, the number of visits per patient are equal to 24.6.[2] These statistics and assumptions, along with the implied utilization, are summarized in Table 7.

Table 7: Wellspring Home Health Utilization Assumptions

Utilization Assumptions	Row	2021	2022	2023	2024
King County Visit Projections	1	541,320	560,659	580,804	601,790
Visits per Month	2	45,110	46,722	48,400	50,149
Assumed Market Share	3	1.00%	1.50%	1.75%	2.00%
Wellspring HH Visits per Month ([1]*[2]*[3])	4	451	701	847	1,003
Months of Operation	5	2	12	12	12
Wellspring HH Visits ([4]*[5])	6	902	8,412	10,164	12,036
Visits per Patient	7	24.6	24.6	24.6	24.6
Unduplicated Patients ([6]/[7])	8	37	342	413	453

Applicant and Medicare Home Health Agency Utilization by State, Current Year 2019 (https://www.cms.gov/files/document/cy-2019-medicare-home-health-utilization-state.pdf, Last Accessed November 5 ,2020)

The number of visits by occupational category are calculated based on Wellspring's historical service mix in its Alaska facilities, but adjusted for anticipated differences in home health needs in Washington State as observed in recent Certificate of Need decisions. We present these assumptions in Table 8.

[2] https://www.cms.gov/files/document/cy-2019-medicare-home-health-utilization-state.pdf, Last Accessed November 5 ,2020.

Table 8: Assumed Proportions of Home Health Visits by Occupational Category	
Occupational Category	**Proportion**
Skilled Nursing	40.00%
Physical Therapy	35.00%
Occupational Therapy	12.00%
Speech Pathology	2.00%
Medical Social Services	1.00%
Home Health Aid	10.00%
Sources: Applicant	

In support of the reasonableness of our utilization assumptions, we note that, based on the methodology above, there exists significant excess demand for home health services within King County. Our utilization assumptions imply that in 2024 (Year 3), the projected Wellspring visits account for only 5% of this excess demand.[3]

9. <u>Provide detailed information on the availability and accessibility of similar existing services to the defined population expected to be served.</u> This section should concentrate on other facilities and services which "*compete*" with the applicant.

a. <u>Identify all existing providers of services (licensed only and certified) similar</u> to those proposed and provide utilization experience of those providers that demonstrates that existing services are <u>not available</u> to meet all or some portion of the forecasted utilization.

Please see Exhibit 6 for a list of the existing supply of home health agencies located in King County or provide hospice services to King County residents.

The Department's need methodology (see Table 5 above and Exhibit 6), after accounting for all relevant supply of home health agencies, estimates current (CY2020) net need for twenty (20) additional agencies, growing to twenty-six (26) additional agencies by CY2023. Therefore, there is tremendous need for additional home health services in King County beyond the capacity of the existing providers.

[3] 2024 projected visit demand in King County equal to 601,790. Based on 36 existing agencies, visit supply equal to 360,000. Excess demand thus equal to 241,790. Wellspring HH projects 12,036 visits in 2024, equal to 5% of 241,790.

b. If existing services are available, demonstrate that such services are not accessible. Unusual time and distance factors, among other things, are to be analyzed in this section.

As demonstrated above, there exists significant unmet need for additional home health agencies in King County. Thus, resident demand for home health programs currently outstrips the present supply, thereby constraining resident access to these necessary services. Furthermore, since home health services are, by definition, provided in the home, it is not possible for King County residents to outmigrate to other areas.

c. If existing services are available and accessible, justify why the proposed project does not constitute an unnecessary duplication of services.

Since there exists a significant unmet need for additional home health agencies in King County, Wellspring's proposed project is by definition not an unnecessary duplication of services.

10. Document the manner in which low-income persons, racial and ethnic minorities, women, people with disabilities, and other under-served groups will have access to the services proposed. The department uses the applicant's current or proposed status as a Medicare and Medicaid certified provider of service as part of its evaluation of question.

Wellspring Home Health will seek Medicare and Medicaid certification and will not discriminate due to a patient's financial status and will not discriminate on the basis of age, sexual orientation, gender, mental/physical handicap, race, religion, ancestry or national origin. Our financial assistance policy is included in Exhibit 9.

11. Please provide copies (draft is acceptable) of the following documents:

a. Admissions policy; and
b. Charity care policy; and
c. Patient referral policy, if not addressed in admissions policy.

We have provided a copy of our Patient Referral Policy and Case Management Policy in Exhibits 7A and 7B, respectively. Our Admissions Criteria Policy is included in Exhibit 8. Our financial assistance policy is included in Exhibit 9.

12. As applicable, substantiate the following special needs and circumstances that the proposed project is to serve.

a. The special needs and circumstances of entities such as medical and other health professions' schools, multi-disciplinary clinics, and specialty centers that provide a substantial portion of their services, resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health services areas.

This question is not applicable.

b. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

This question is not applicable.

c. The special needs and circumstances of osteopathic hospitals and non-allopathic services with which the proposed facility/service would be affiliated.

This question is not applicable.

B. Financial Feasibility (WAC 246-310-220)

WAC 246-310-990(2) defines "total capital expenditure" to mean the total project costs to be capitalized according to generally accepted accounting principles. These costs include, but are not limited to, the following: legal fees; feasibility studies; site development; soil survey and investigation; consulting fees; interest expenses during construction; temporary relocation; architect and engineering fees; construction, renovation, or alteration; total costs of leases of capital assets; labor; materials; fixed or movable equipment; sales taxes; equipment delivery; and equipment installation.

1. **If applicable, provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following:**
   - **Land acquisition;**
   - **Site survey, tests, and inspections**
   - **Construction contract;**
   - **A financial feasibility study, architectural fees/engineering fees/consulting fees;**
   - **Fixed equipment (not in construction contract);**
   - **Movable equipment;**
   - **Freight and delivery charges;**
   - **Sales tax;**
   - **Cost of tuning up and trial runs;**
   - **Reconditioning costs (in case of used asset);**
   - **Cost of title investigations, legal fees, brokerage commissions;**
   - **Other activities essential to the acquisition, improvement, expansion, or replacement of plant and equipment due to the project; and**
   - **Financing cost statement, including interim interest expense, reserve account, interest expense, and other financing costs.**

   Please see Table 1 included in the Project Description section of this application for a listing of capital expenditures. The proposed project entails $9,500 in tenant improvements and $15,500 in equipment costs. Sales tax is included in these estimates.

2. **Explain in detail the methods and sources used for calculating estimated capital expenditures.**

   Wellspring developed the capital expenditure estimates in Table 1 based on its experience operating home health services in Alaska and developing its operations here in Washington State.

3. **Document the project impact on: (a) Capital costs (b) Operating costs and charges for health services.**

   The capital and equipment expenditures detailed in Table 1 reflect the capital required to become Medicare certified and Medicaid eligible and handle the expected increases in utilization therefrom. The $25,000 in capital and equipment expenditures represents a small expense relative to Wellspring Home Health Center's reserves, from which the

proposed project will be funded. Furthermore, in most cases Wellspring does not set its rates. They are based on fee schedules with CMS and principal payers. Thus, the proposed project will not impact costs or charges for health services.

See Exhibit 10, attached, for the required pro forma financial statements that shows the impact on operating costs of the proposed project.

4. Provide the total estimated operating revenue and expenses for the first three years of operation *(please show each year separately*) for the items listed below, as applicable. Include all formulas and calculations used to arrive at totals on a separate page.

Revenue	**Expenses**
Medicare	**Advertising**
Medicare Managed Care	**Allocated Costs**
Medicaid	**B & O Taxes**
Healthy Options [BHP]	**Depreciation and Amortization**
Private Pay	**Dues and Subscriptions**
Third Party Insurance	**Education and Training**
Other [CHAMPUS, Veterans, etc.]	**Employee Benefits**
Non-operating Revenue [United Way, etc.]	**Equipment Rental**
Deductions from Revenue:	**Information Technology/Computers, Repairs and Maintenance**
(Charity)	**Insurance, Payroll Taxes**
(Provision for Bad Debt)	**Interest, Purchased Services (utilities, other)**
(Contractual Allowances)	**Legal and Professional**
	Licenses and Fees, Rental/Lease
	Medical Supplies, Travel (patient care, other)
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Postage, Supplies and Telephone/Pagers

Exhibit 10 includes the required pro forma financial statements. Exhibit 10 also provides key financial pro forma assumptions used to prepare the projections.

5. Please note: according to revised HCFA regulations, home health agencies must have enough reserve funds (determined by an authorized fiscal intermediary) to operate for three months after becoming Medicare/Medicaid certified. Please provide the following information in relation to this requirement:

a. Provide the name and address of the fiscal intermediary you will be using to determine capitalization; and

National Government Services
P.O. Box 100142
Colombia, South Carolina 29202-3142

b. Provide a copy of the forms you are providing to the fiscal intermediary.

Wellspring's fiscal intermediary requires the Form 855 filing to be finalized within 60 days after initial filing. Completion and review of this application will take more

than 60 days. Therefore, Wellspring would agree to submission of the form as a condition of receipt of a Certificate of Need.

6. **Identify the source(s) of financing (*loan, grant, gifts, etc*.) for the proposed project. Provide all financing costs, including reserve account, interest expense, and other financing costs. If acquisition of the asset is to be by lease, copies of any lease agreements, and/or maintenance repair contracts should be provided. The proposed lease should be capitalized with interest expense and principal separated. For debt amortization, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.**

   The $25,000 in capital and equipment expenditures represents a small expense relative to Wellspring Home Health Center's reserves, from which the proposed project will be funded. Records of historical financials and balance sheets, provided in Exhibit 10A, demonstrate sufficient reserves for the proposed project.

7. **Provide documentation that the funding is, or will be, available and the level of commitment for this project.**

   Wellspring's historical balance sheets demonstrate sufficient reserves for the proposed project. A letter of financial commitment from Wellspring's owner is attached as Exhibit 11.

8. **Provide a cost comparison analysis of the following alternative financing methods: purchase, lease, board-designated reserves, and interfund loan or bank loan. Provide the rationale for choosing the financing method selected.**

   Since Wellspring's reserves are sufficient to fund the proposed project, and Wellspring does not have other concurrent projects which might otherwise compete for funds, this represents the most cost-effective method of financing. Other methods of financing carry financing costs, which funding through reserves avoids.

9. **Provide a pro forma (projected) balance sheet and expense and revenue statements for the first three years of operation.**

   Exhibit 10 includes the required pro forma financial statements. Exhibit 10 also provides key financial pro forma assumptions used to prepare the projections.

10. **Provide a capital expenditure budget through the project completion and for three years following completion of the project.**

    Wellspring Home Health Center anticipates no further capital expenditures beyond the $25,000 listed in Table 1 over the first three years of operation.

11. **Identify the expected sources of revenue for the applicant's total operations (e.g., Medicare, Medicare Managed Care, Medicaid, Healthy**

Options, Blue Cross, Labor and Industries, etc.) for the first three years of operation, with anticipated percentage of revenue from each source. Estimate the percentage of change per year for each payer source.

Table 9: Projected Payer Mix

Payer	% of Gross Revenue	% of Net Revenue
Medicare	77%	84.1%
Medicaid	6%	3.3%
Commercial/Other	17%	12.6%

Note: Because there have been no patients treated at our Washington location, no historical payer mix for Washington is available. The projections are based on Washington benchmarks based on public documents for other home health projects similar to Wellspring's proposed project

12. If applicant is an existing provider of health care services, provide expense and revenue statements for the last three full years.

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

13. If applicant is an existing provider of health care services, provide cash flow statements for the last three full years.

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

14. If applicant is an existing provider of health care services, provide balance sheets detailing the assets, liabilities, and net worth of facility for the last three full *fiscal* years.

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

15. For existing providers, provide actual costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source.

The Pierce County Wellspring Home Health Center has been licensed since November 2019, however it has yet to serve any patients. Thus, this question is not applicable.

16. Provide anticipated costs and charges per visit broken down by discipline (i.e., RN/LPN, OT, PT, social worker, etc.) and by payer source.

Table 10: Average Cost and Charge Per Visit by Discipline Category

	Cost Per Visit	Charge Per Visit
Skilled Nursing	$183	$243
Physical Therapy	$156	$207

Occupational Therapy	$160	$213
Speech Pathology	$182	$242
Medical Social Services	$171	$228
Home Health Aid	$93	$124

Source: Applicant calculations of Washington benchmarks.

Table 11: Total Cost and Charge by Payer, Year 3 (2024)

	Costs	Charges
Medicare	$1,384,281	$1,841,213
Medicaid	$107,866	$143,471
Commercial/Other	$305,620	$406,502

Source: Applicant calculations of Washington benchmarks.

17. Indicate the addition or reduction of FTEs with the salaries, wages, and employee benefits for each FTE affected, for the first three years of operation. Please list each discipline separately.

See Exhibit 10 that includes a staffing worksheet and assumptions worksheet documenting the salaries, wages, and employee benefits assumptions used to forecast projections for the first three years of operation upon project completion.

18. Please describe how the project will cover the costs of operation until Medicare reimbursement is received. Provide documentation of sufficient reserves.

The costs of operation until Medicare reimbursement will be covered by Wellspring Home Health Center's reserves. See the Balance Sheet demonstrating sufficient reserves in Exhibit 10A.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

1. Please provide the current and projected number of employees for the proposed project, using the following:

As discussed above, the Pierce County Wellspring Home Health Center has been licensed since November 2019. However, it has yet to serve any patients. Therefore, for the purposes of the staffing tables, please see Table 12 below for the anticipated number of staff FTEs upon project completion.

Table 12: Projected Staffing by Occupational Category

	Year 0 (Nov – Dec 2021)		Year 1 (2022)		Year 2 (2023)		Year 3 (2024)	
Staff	FTE	Contract	FTE	Contract	FTE	Contract	FTE	Contract
RN	0.36		3.40		4.11		4.50	
LPN	-		-		-		-	
HH Aide	0.07		0.65		0.78		0.86	
NURSING TOTAL	**0.43**		**4.05**		**4.89**		**5.36**	
Admin	0.17		1		1		1	
Medical Director		X		X		X		X
DNS	-		-		-		-	
Business/Clerical	0.33		2.50		2.50		3.00	
ADMIN. TOTAL	**0.50**		**3.50**		**3.50**		**4.00**	
PT	0.27		2.53		3.06		3.35	
OT	0.09		0.83		1.00		1.10	
Speech Therapist	0.02		0.14		0.17		0.19	
Med Social Work	0.01		0.07		0.09		0.10	
Other (specify):	-		-		-		-	
ALL OTHERS TOTAL	**0.39**		**3.57**		**4.32**		**4.73**	
TOTAL STAFFING	**1.32**		**11.12**		**12.71**		**14.09**	

Source: Applicant

2. Please provide your staff to visit ratio.

Table 13: Staff to Visit Ratio by Occupational Category

Type of Staff	**Staff / Visit Ratio**
Skilled Nursing (RN & LPN)	1.01 FTE per 1,000 Visits
Physical Therapist	0.86 FTE per 1,000 Visits
Occupational Therapist	0.82 FTE per 1,000 Visits
Medical Social Worker	0.84 FTE per 1,000 Visits
Speech Therapist	0.86 FTE per 1,000 Visits
Home Health Aide	0.77 FTE per 1,000 Visits
Other (list)	N/A
Total	0.906 FTE per 1,000 Visits

Source: Applicant

3. **Explain how this ratio compares with other national or state standards of care and existing providers for similar services in the proposed service area.**

   The staff to visit ratios were constructed based on Washington Benchmarks estimated from based on public documents for other home projects similar to Wellspring's proposed project.

4. **Identify and document the availability of sufficient numbers of qualified health manpower and management personnel. If the staff availability is a problem, describe the manner in which the problem will be addressed.**

   Table 12 provides the number of proposed FTEs, by type. By virtue of our geographic location, Wellspring Home Health anticipate recruiting additional staff from King County and Pierce County. To be effective in staff recruitment and retention, Wellspring Home Health offers competitive wage and benefit packages. Wellspring Home Health operates a Medicare and Medicaid certified home health agency in Alaska and will use similar methods (Zip Recruiter, Glassdoor, workforce, etc.) to recruit and retain qualified staff for its proposed project.

   For the above reasons, Wellspring Home Health believes that we will be successful in recruiting additional qualified, core staff to provide and promote quality of care.

5. **Please identify and provide copies of (if applicable) the in-service training plan for staff. (Components of the training plan should include continuing education, home health aide training to meet Medicare criteria, etc.).**

   Please see Exhibit 12 for a copy of the in-service staff training plan.

6. **Describe your methods for assessing customer satisfaction and quality improvement.**

   Please see Exhibit 13 for a copy of the Wellspring Home Health Quality Improvement Program policy.

7. **Identify your intended hours of operation. In addition, please explain how patients will have access to services outside the intended hours of operation.**

   The Wellspring Lakewood office will be open from 9:00am – 5:00pm, Monday through Friday. We will have staff on call 24 hours to assist with any patient needs.

8. **Identify and document the relationship of ancillary and support services to proposed services, and the capability of ancillary and support services to meet the service demands of the proposed project.**

Wellspring Home Health is currently developing its relationship with ancillary and support services in Washington State. It has experience developing similar relationships with medical supply companies, office supply companies, temporary staff agencies, accounting firms, legal firms, etc. for its Alaska operations.

9. **Explain the specific means by which the proposed project <u>will promote continuity</u> in the provision of health care to the defined population and <u>avoid unwarranted fragmentation</u> of services. This section should include the identification of existing and proposed formal working relationships with hospitals, nursing homes, and other health service resources serving your primary service area. This description should include recent, current, and pending cooperative planning activities, shared services agreements, and transfer agreements. Copies of relevant agreements and other documents should be included.**

   There is significant unmet need for home health services currently in the King County, as demonstrated by the Department's numeric need methodology for home health services. Wellspring Home Health's proposed project will help to address part of this net need and provided desperately needed capacity in the planning area to ensure King County residents will have continued access to home health services. Thus, the proposed will not result in unwarranted fragmentation.

   Wellspring Home Health is currently developing its working relationship with other healthcare providers in Washington State. It has experience developing similar relationships with hospitals, nursing homes, and other health service providers for its Alaska operations.

10. **Fully describe any <u>history of the applicant entity and principles in Washington</u> with respect to criminal convictions, denial or revocation of license to operate a health care facility, revocation of license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program. If there is such history, provide clear, cogent, and convincing evidence that the proposed project will be operated in a manner that ensures safe and adequate care to the public to be served and in conformance with applicable federal and state requirements.**

    a. **Have any of the applicants been adjudged insolvent or bankrupt in any state or federal court?**
    b. **Have any of the applicants been involved in a court proceeding to make judgment of insolvency or bankruptcy with respect to the applicant).**

    Wellspring Home Health Center has no history with respect to criminal convictions, denial or revocation of a license to practice a health profession, or decertification as a provider of services in the Medicare or Medicaid program.

11. List the licenses and/or credentials held by the applicant(s) and principles in Washington, as well as other states, if applicable. Include any applicable license numbers.

Please see Exhibit 14 for the resumes of Wellspring Home Health key personnel.

License Numbers
Dr. Ernest Ibanga: not applicable

Joyce Ibanga: RCP00075521 (Respiratory Care Practioner Certificate license for Texas)

Carol Tracy Schneer, RN (Director of Nursing): RN61004740 (Registered Nurse License for Washington)

12. Provide the background experience and qualifications of the applicant(s).

Wellspring Home Health has operated a Medicare and Medicaid certified home health agency in Alaska since 2017. Please see Exhibit 14 for the resumes of its key personnel.

13. For existing agencies, provide copies of the last three licensure surveys as appropriate evidence that services will be provided (a) in a manner that ensures safe and adequate care, and (b) in accordance with applicable federal and state laws, rules, and regulations.

Wellspring Home Health Center in Pierce County is not an existing CMS certified home health agency. Please see Exhibit 15A for the CMS home health agency survey activity report for Wellspring's Alaska agency available on CMS' Certification & Oversight Reports (QCOR) website. The last survey was on 05/17/2017 and showed no deficiencies were found.

Attached in Exhibit 15B is Wellspring Home Health's accreditation letter and certificate from Community Health Accreditation Partner (CHAP).

D. Cost Containment (WAC 246-310-240)

1. **Identify the <u>exploration of alternatives</u> to the project you have chosen to pursue, including postponing action, shared service arrangements, joint ventures, subcontracting, merger, contract services, and different methods of service provision, including different spatial configurations you have evaluated and rejected. Each alternative should be analyzed by application of the following:**

   - **Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.):***
   - **Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweighs each other by application of the decision-making criteria;**
   - **Capital costs;**
   - **Staffing impact.**

   The following three options were evaluated in the alternatives analysis:

   - Option One: Develop a Medicare/Medicaid Project in Pierce County
   - Option Two: Develop a Medicare/Medicaid Project in King County—The Project
   - Option Three: Do Nothing

   Please see Tables 14-18, respectively. They provide a summary of advantages and disadvantages of each of the two options based on the following evaluative criteria: Promoting availability, or access to healthcare services; Promoting Quality of Care; Promoting Cost and Operating Efficiency; and Legal Restrictions.

Table 14. Alternatives Analysis: Promoting Access to Healthcare Services.

Option:	Advantages/Disadvantages:
Option One Develop a Medicare/Medicaid Project in Pierce County	• Limited need for additional home health agency. (Neutral, "N")
Option Two Develop a Medicare/Medicaid Project in King County—The Project	• Significant unmet need for additional home health agency services based on the Department's numeric need methodology (Advantage, "A")
Option Three Do nothing	• Would do nothing to improve access (Disadvantage ("D")). • Without additional capacity, some patients may have to delay or not receive care altogether. (D)

Table 15. Alternatives Analysis: Promoting Quality of Care.

Option:	Advantages/Disadvantages:
Option One Develop a Medicare/Medicaid Project in Pierce County	• Residents of the Planning Area would have increased home health capacity--this improves quality of care inasmuch as it improves continuity of care. (A)
Option Two Develop a Medicare/Medicaid Project in King County—The Project	• Residents of the Planning Area would have increased home health capacity--this improves quality of care inasmuch as it improves continuity of care. (A)
Option Three Do nothing	• Without sufficient access home health, this can also lead to preventable emergency room visits or hospitalizations. (D)

Table 16. Alternatives Analysis: Cost Efficiency and Capital Impacts.

Option:	Advantages/Disadvantages:
Option One Develop a Medicare/Medicaid Project in Pierce County	• Limited capital expenditures necessary. (A) • Improved access prevents unnecessary emergency room and hospitalization visits. (A)
Option Two Develop a Medicare/Medicaid Project in King County—The Project	• Limited capital expenditures necessary. (A) • Improved access prevents unnecessary emergency room and hospitalization visits. (A)
Option Three Do nothing	• Least costly with respect to capital expenditures. However, lack of sufficient access to home health services leads to increased use of more expense alternatives (emergency room utilization, hospitalization, etc.). (D)

Table 17. Alternatives Analysis: Staffing Impacts.

Option:	Advantages/Disadvantages:
Option One Develop a Medicare/Medicaid Project in Pierce County	• Large concentration of skilled health service professionals. (A). • Competitive market in demand for skilled labor. (D).
Option Two Develop a Medicare/Medicaid Project in King County—The Project	• Large concentration of skilled health service professionals. (A). • Competitive market in demand for skilled labor. (D).
Option Three Do nothing	• No impact.

Table 18. Alternatives Analysis: Legal Restrictions.

Option:	Advantages/Disadvantages:
Option One Develop a Medicare/Medicaid Project in Pierce County	• This option requires certificate-of-need approval. • There is uncertainty in how much unmet need exists for additional home health agencies in Pierce County. (D)
Option Two Develop a Medicare/Medicaid Project in King County—The Project	• This option requires certificate-of-need approval.
Option Three Do nothing	• There are no legal implications with this option.

2. **Describe how the proposal will comply with the Medicare conditions of participation, without exceeding the costs caps.**

   Since home health agencies are not subject to Medicare cost caps, this question is not applicable.

3. **Describe the specific ways in which the project will promote staff or system efficiency or productivity.**

   There is significant unmet need for home health services currently in the King County, as demonstrated by the Department's numeric need methodology for home health services. The proposed Wellspring Home Health project will help increase capacity in the planning area, providing King County residents with timely access to home health services, which will result in enhanced quality, outcomes, and patient experience as patients won't have to delay or forgo receiving the necessary skilled services due to lack of access. Further, without sufficient access home health, this can also lead to increased costs due to preventable emergency room visits or hospitalizations and patients having to receive care at more expensive care alternatives.

4. **If applicable, in the case of construction, renovation, or expansion, capital cost reductions achieved by architectural planning and engineering methods and methods of building design and construction. Include an inventory of net and gross square feet for each service and estimated capital cost for each proposed service. Reference appropriate recognized space planning guidelines you have employed in your space allocation activities.**

   No construction is necessary; thus, this question is not applicable.

5. **If applicable, in the case of construction, renovation or expansion, an analysis of the capital and operating costs of alternative methods of energy consumption, including the rationale for choosing any method other than the least costly. For energy-related projects, document any efforts to obtain a grant under the National Energy Conservation Act.**

   No construction is necessary; thus, this question is not applicable.

Exhibit 1.

Wellspring Organizational Chart

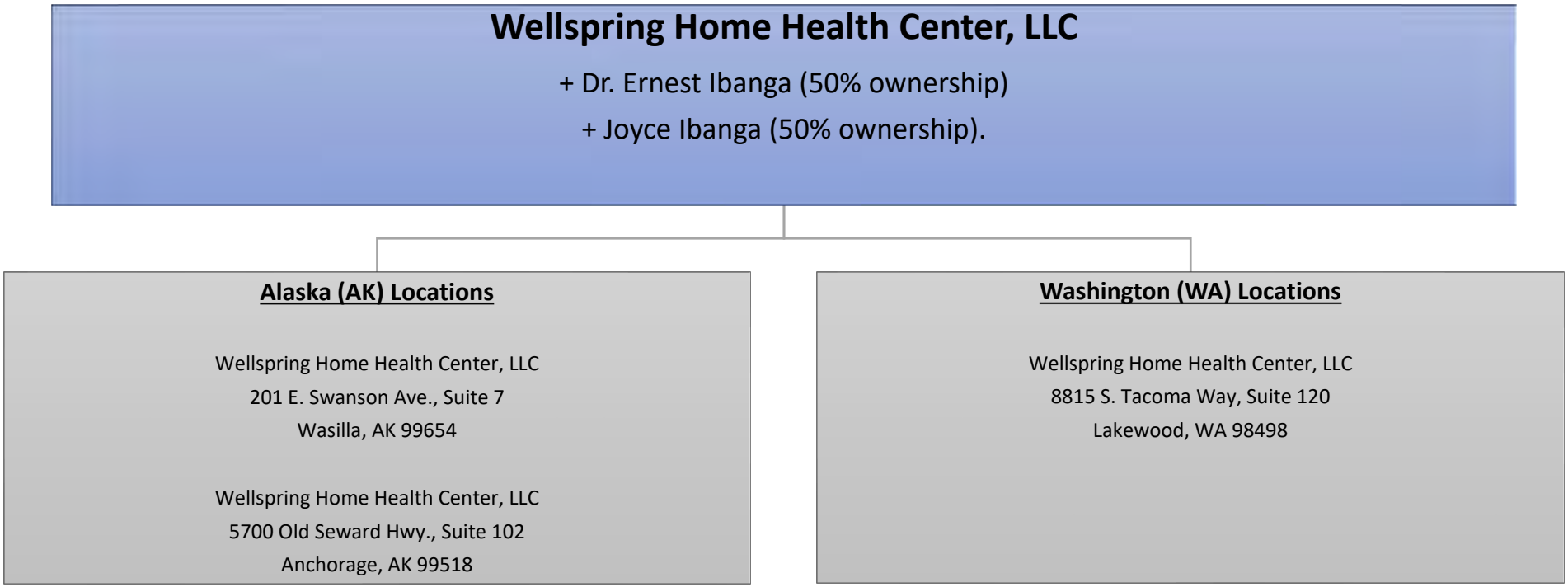

Wellspring Home Health Center, LLC
+ Dr. Ernest Ibanga (50% ownership)
+ Joyce Ibanga (50% ownership).
Alaska (AK) Locations
Wellspring Home Health Center, LLC
201 E. Swanson Ave., Suite 7
Wasilla, AK 99654
Wellspring Home Health Center, LLC
5700 Old Seward Hwy., Suite 102
Anchorage, AK 99518
Washington (WA) Locations
Wellspring Home Health Center, LLC
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

Exhibit 2.

Medical Director Agreement

WellSpring
8815 S. Tacoma Way, Suite 120, Lakewood, WA 98498 (253)625-7606 Fax: (253)625-7079
At Wellspring Home Health Center, You're Cared for Like Family

MEDICAL DIRECTOR AGREEMENT

Wellspring Home Health Center, LLL. (herein "agency") and Dr. Amar Kapur (herein "Medical Director") enter into this agreement on this, the 2nd day of October, 2020.

WHEREAS Agency is a home health agency as defined in 42 U.S.C.A. Section 1395x(o); and
WHEREAS Medical Director is a qualified Medical Director licensed in the State of Washington State; and
WHEREAS Agency desires to use the services of Medical Director to provide services; and
WHEREAS Medical Director desires to provide such services.
NOW, THEREFORE, in consideration of the mutual promises, covenants, and agreements hereinafter set forth, the parties hereto agree as follows:

1. Scope of Services:
   (a) Medical Director shall provide overall medical leadership for the Agency's operations
   (b) Medical Director shall provide medical direction and guidance for the nursing, and treatment staff, including participation in the MR and QI committee meetings as appropriate
   (c) Medical Director serves as a liaison to local medical staff as necessary
   (d) Medical Director assists in the resolution of medical care problems between unit staff and physicians
   (e) Medical Director works cooperatively with the Agency's clinical director and is available for consultation regarding medical/nursing patient care issues
   (f) Medical Director serves as a member of the Professional Advisory Board of the Agency
   (g) Medical Director shall be available for consultation regarding such things as health services for Agency staff, Universal Precautions, and Infection Control.

2. Terms and Conditions: This agreement shall before a term of one (1) year from the effective date above the signature line; provided, however, that this Agreement shall terminate automatically and immediately upon the revocation, suspension, termination or expiration of Medical Director professional license, or upon the occurrence of any circumstance that would legally, mentally, or physically prevent Medical Director from performing services under this Agreement. In the event this contract is cancelled by mutual agreement before the full one-year term has passed, the parties shall not enter another medical director contract until the full one-year term period has passed.

3. Independent Contractor: Medical Director agrees to perform the services hereunder as an independent contractor with discretion and control over the furnishing of services provided for herein where such discretion and control are not otherwise preempted by terms of this Agreement.

4. Fee for Services: Medical Director shall receive a fair market value fee of $20,000.00 per year for maintenance fees, and $150.00 per hour for services rendered. The maintenance fee will not go into effect until we are Medicare Certified. This fee cannot be raised during the term of this Agreement. Furthermore, Medical Director shall submit detailed invoices which describe the work performed, the dates on which that work was performed, and the duration of that work before payment is made.

5. Complete and Entire Agreement: This Agreement constitutes the entire Agreement between the parties hereto and there are no representations, warrants, or prior understandings except as expressly set forth herein. There is no obligation, of whatever nature, on either party, to refer patients to the other party.

6. Titles Not Controlling: The titles contained in this document are for the convenience of the parties only and shall not have binding effect.

7. Indemnification: Medical Director shall be indemnified against all expenses, penalties, and liabilities, including attorney's fees, reasonably incurred by or imposed upon him in connection with any claim, demand, action, or proceeding, whether civil or criminal, or in connection with any settlement thereof to which he may be made a party, or in which he may become involved, by

reason of his being or having been Medical Director, whether or not he is Medical Director at the time such expenses, penalties, or liabilities are incurred.

Insurance: Wellspring Home Health Center, LLC shall sole cost and expense, procure, keep and maintain throughout the term of the Agreement, medical malpractice insurance coverage in the minimum amounts of 1,000,000 per occurrence and 3,000,000 annual aggregate for professional liability, and issued by an insurer acceptable to Wellspring. In addition to the coverages specifically listed herein, Wellspring Home Health Center, LLC shall maintain any other usual and customary policies of insurance applicable to the Services being performed pursuant to the Agreement. Such policy(ies) shall cover all of Provider's Services provided hereunder.

8. State Law and Jurisdiction. To the extent not preempted by Federal Law, this agreement shall be construed in all respects under the Laws of the State of Washington and the parties hereto consent to the jurisdiction of the State and/or Federal Courts located within the State of Washington. If any part of this Agreement shall be held to be void or unenforceable, such part will be treated as severable, leaving valid the remainder of this Agreement notwithstanding the part or parts found to be void or unenforceable.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written. The effective date of the Agreement shall be the 2nd day of October, 2020

Medical Director

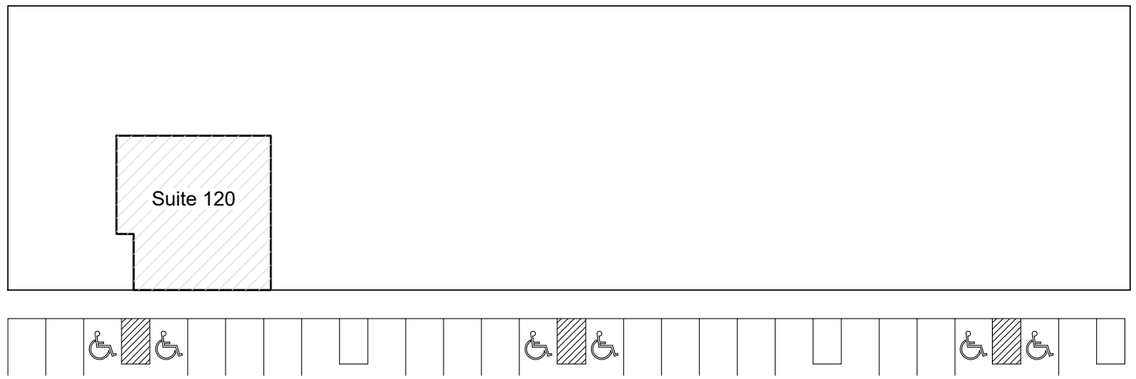
Amar Kaur, DO

WELLSPRING HOME HEALTH CENTER, LLC.

Dr. Ernest Ibonga

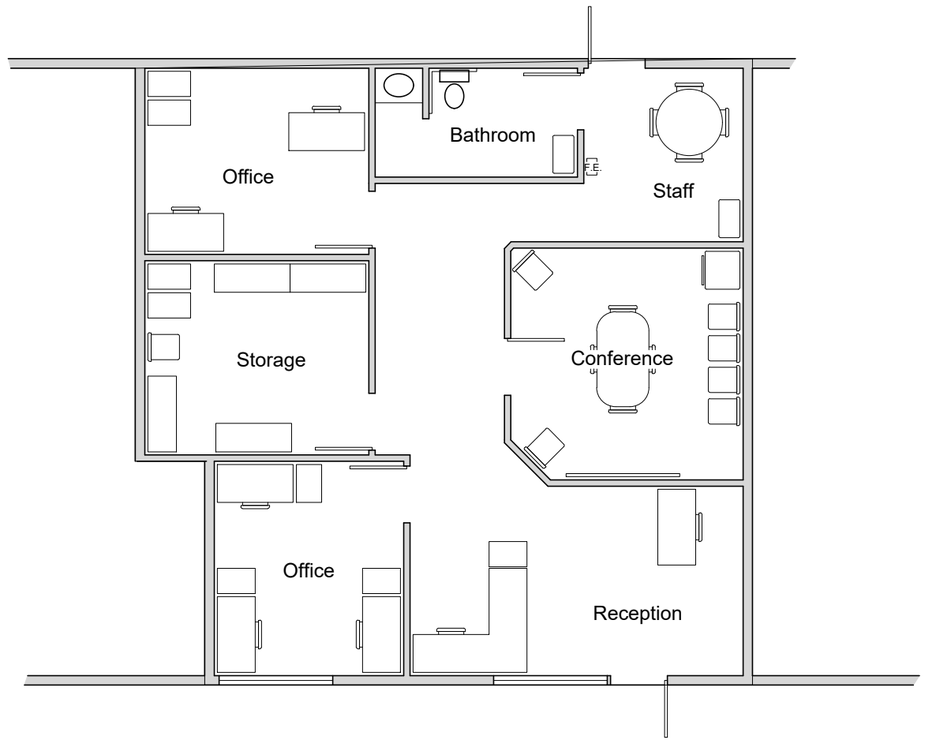
Exhibit 3.

Single-Line Drawing



8815 - Building

N.T.S.



Existing

Floor Plan - Suite 120

1/8"=1'-0"

WellSpring

HOME HEALTH

& Long-Term Care Services

8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

Floor Space Schedule
Gross Building Area: 14,220 S.F.
WellSpring Net: 1,026 S.F.

The Artisans Group, Inc.
1508 4th Avenue East
Olympia, WA 98506
360.570.0900 (p)
360.570.0727 (f)
www.ArtisansGroup.com

artisans group
ARCHITECTURE + PLANNING

WellSpring Home Health

Site Address:
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

Owner Address:
8815 S. Tacoma Way, Suite 120
Lakewood, WA 98498

Phone Number:
(253) 625-7606

www.wellspringhomehealth.com

Floor Plan

Designed By: TS
Drawn By: MsM
Date: 11/25/2020

Exhibit 4A.

Lease Agreement

COMMERCIAL LEASE

THIS COMMERCIAL LEASE ("***Lease***"), dated August 26, 2019 is made between **Lakewood Plaza, LLC,** a Washington Corporation ("***Landlord***"), and Ernest Ibanga; **DBA "Wellspring Home Health"**).

In consideration of the mutual covenants in this Lease, Landlord and Tenant agree as follows:

1. BASIC PROVISIONS AND DEFINITIONS. The following terms, whenever used in this Lease, with the first letter of each word capitalized, will have the meanings set forth in this Section, unless the context otherwise requires:

1.1 Premises. The leased portion of the property is shown on the floor plan attached as Exhibit A (the Premises). The Premises are located on the real property legally described on Exhibit B.

1.2 Premise Address. 8815 S Tacoma Way Suite 120, Lakewood, Washington 98498.

1.3 Tenant's Square Footage & Proportionate Share. Tenant's Square Footage is approximately **1000 square feet**.

1.4 Date of Execution. The date above written is the date of full execution hereof, and this Lease shall become effective upon both parties' execution of this document, including both parties' approval of Exhibit A

1.5 Commencement Date August 26, 2019

1.6 Term & Options to Extend (Section 3). The period beginning on the Commencement Date and ending on the last day of the month. **Five (5)** years (**66** months) following the Commencement Date ("Lease Term End Date").

1.7 Base Rent for the Initial Term (Section 7). The Base Rent monthly is as follows:
August 26th, 2019 to August 31st, 2019 = $300.00 rent + $58.20 NNN
September 1st, 2019 to February 28th, 2019 = $0.00 rent + $291.00 NNN
March 1st, 2020 to February 28th, 2025 = $1500.00 rent + $291.00 NNN

1.8 CPI Increase. Yes

1.9 Rent Payment. Due monthly in advance, on or by the 1st[th] calendar day of each month.

1.10 Late Fee. For any rent not received by Landlord by the sixth (6th) day of each calendar month, there shall be a late fee of $100.00 or 3% of the Base Rent, whichever is greater.

1.11 Deposits (Section 8). $2000.00 + First Month $1500.00 (February Rent) + $291.00 September NNN + $300.00 (August Rent) + $58.20 (August NNN) Total= $4149.20

1.12 Landlord's Notice and Payment Address (Section 24.15).
Lakewood Plaza, LLC
2222 Meridian Avenue East, Suite E
Edgewood, WA 98371-1009
Telephone: (253) 927-3076
Fax: (253) 517-5661

1.13 Tenant's Billing and Notice Address (Section 24.15).
Ernest Ibanga
2656 South 5th Street
JBLM, WA 98433
Phone: (706) 833-7205 **email:** info@wellspringhomehealth.com

1.14 Guarantor's Address (Section 24.18).
Same as above

1.15 Tenant's Trade Name (if any): Wellspring Home Health

1.16 State of Organization of Tenant (if other than individual): Washington

1.17 Use: In home care

1.18 Exhibits to the Lease (Section 24.20).
Exhibit A: Shopping Center
Exhibit B: Legal Description
Exhibit C: Rules & Regulations

1.19 Broker Fee (if any, owed by Landlord) (Section 25): First month rent

1.20 Inspection: Tenant agrees to allow Landlord to enter Premises and conduct audit and inspect inventory at Landlord's discretion

2. PREMISES. Landlord hereby leases the Premises to Tenant and Tenant hereby leases the Premises from Landlord, upon the terms and conditions set forth in this Lease. The Premises are a part of the building that is situated at the Building Address as set out in Section 1.2.

3. TERM. Tenant leases from Landlord the Premises for a Lease term described in Section 1.6 (the "Lease Term"). The Lease Term will begin on the Commencement Date and end at midnight on the Lease Term End Date unless sooner terminated or extended as provided elsewhere in this Lease.

3.1 Option to Extend. Provided Tenant is not in default at the time of exercise or upon the commencement of any extension term, Tenant shall have no options to extend the term of this Lease.

4. POSSESSION.

4.1 Surrender of Premises. At the expiration or sooner termination of this Lease, Tenant shall return the Premises to Landlord in the same condition in which received, broom clean, reasonable wear and tear excepted. Tenant shall remove all personal property. Tenant shall

return all keys to the Landlord within 12 hours following termination of this Lease or pay for the cost of new keys, if the Landlord so requires. Tenant's obligation to perform this covenant shall survive the expiration or termination of this Lease. Landlord may place and maintain "For Lease" signs in conspicuous places on the Premises for 120 days prior to the expiration or early termination of this Lease, and reserves the right upon one business day's (or 24 hours') notice to enter any part of the Premises during the same 120 day period to show the Premises to prospective tenants during business hours. Landlord may show space to prospective tenants at any time the tenant is open for business during such 120 day period with proper notice.

5. USE.

5.1 Use. Tenant covenants that at all times during the Lease term and such other time as Tenant occupies the Premises, Tenant shall use the Premises for the Permitted Uses and for no other purposes without the prior written consent of Landlord, as set out in Section 1.17. Tenant shall be the only business in the Building described in Section 2, on the real property described in Section 1.1.

5.2 Uses Prohibited. Tenant shall not do or permit anything to be done in nor about the Premises or bring or keep anything therein that will in any way increase or affect the existing rate of any fire or other insurance policy upon the Premises or the Building, or cause a cancellation of any such insurance policy covering said Premises, nor which will in any way obstruct or interfere with the right of other tenants or occupants of the Building or injure or annoy them, nor shall the Tenant use or allow the Premises to be used for any improper, immoral, unlawful, objectionable or offensive purpose, nor shall Tenant cause, maintain or suffer or permit any nuisance in, on or about the Premises. Tenant shall not commit or allow to be committed any waste in or upon the Premises and shall refrain from using or permitting the use of the Premises or any portion thereof as living quarters, sleeping quarters or for lodging purposes. Tenant shall not do or permit anything to be done in or about the Premises, nor bring or keep anything thereon that is or will constitute or create a hazardous waste or substance or violate any environmental law. Tenant will indemnify and hold the Landlord harmless from any and all damages related to the Tenant's introduction to, or creation of, hazardous waste on the Premises. Tenant shall advise Landlord in writing immediately of any environmental concern related to Tenant's use and occupancy of the Premises brought to Tenant's attention by any private party or governmental agency or official. Landlord shall have the right to remedy any environmental problem and to conduct any environmental tests reasonably necessary to discover a hazardous waste or other environmental problem and Tenant shall be liable for all costs and expenses related to such tests or remedial action if a hazardous waste or environmental problem caused by Tenant is found to exist.

5.3 Building Codes and Zoning. Tenant has investigated all applicable building and zoning codes, regulations and ordinances to determine whether Tenant's intended use of the Premises is permitted. Tenant accepts the Premises "as is", subject to all applicable statutes, ordinances, rules and regulations governing Tenant's use of the Premises as well as Landlord's promised work with regard to the Premises as specifically set forth herein. Any and all expenses required to comply with all applicable statutes, ordinances, rules, regulations and requirements in effect during the Lease Term or part thereof regulating Tenant's use of the Premises will be borne

exclusively by Tenant. Tenant agrees to comply with all such statutes, ordinances, rules and regulations throughout the Lease Term.

5.4 Condition of Premises. Tenant has inspected the plumbing, lighting, air conditioning, heating, doors, windows, interior walls, flooring and all other elements of the Premises prior to execution of this Lease. Tenant accepts the Premises "as is" subject to Landlord's promised work with regard to the Premises as specifically set forth herein. Tenant acknowledges that neither Landlord nor Landlord's agent has made any representation or warranty as to the present or future suitability of the Premises for the conduct of Tenant's business.

6. COMMON AREAS.

6.1 Common Areas. Landlord shall make available some areas and facilities for the common use of all tenants of the Building. The roof and exterior walls of the Building and the utility systems up to the exterior walls of the Premises are Common Areas but, are not accessible to Tenants. Landlord or its agents shall operate, manage, equip, light, repair, replace and maintain the Common Areas for their intended purposes in such manner as Landlord shall reasonably, in its sole discretion, determine. Landlord may, from time to time, change the size, location, nature and use of any Common Area, and make installations therein and move and remove the same, provided that neither Tenant's and Tenant's customer's access to the Premises nor the Premises' exposure to the general public is not materially altered. Subject to Landlord's obligations in Section 10.1, all expenses in connection with the Common Areas are Operating Expenses for the purposes of Section 9 below.

6.2 Rights. Tenant and its employees, agents and invitees shall have the non-exclusive right (in common with other tenants of the Building and Landlord) to use the Common Areas, subject to any Rules, as defined in Section 18. Landlord's Rules may include the designation of specific areas in which cars owned by Tenant, its employees, agents and invitees must be parked. Landlord may at any time temporarily close any Common Areas due to construction, maintenance, repair or changes to any part of the Building or the real property upon which the Building is located, with prior notice to Tenant.

6.3 Parking. Tenant shall be entitled to use, on a non-reserved basis, parking available to the Building. Tenant shall not at any time interfere with the rights of Landlord or of other tenants of the Building or other adjacent buildings or invitees of the same to use any of the parking areas. Twenty-four hour parking on the real property upon which the Premises are located shall not be permitted by Tenant, its employees, agents or invitees.

7. BASE RENT.

7.1 Amount. During the Lease Term, Tenant agrees to pay to Landlord at Landlord's Payment Address or such other place as designated, the Base Rent, in the manner described in Section 7.2.

7.2 Rent Payment. The Base Rent for the Lease Term shall be paid in advance of the sixth day of each calendar month of the Lease Term or thereafter on month to month bases. Should any taxes (with exception of taxes resulting from Landlord's income or Landlord's generation of same, or Washington State Real Estate Excise Taxes) apply during the term of this Lease, the Tenant shall reimburse Landlord such amount as Additional Rent. In the event any additional rent is payable by the Tenant under this Lease, it shall be paid in the manner and at the time set

forth in the Riders attached hereto and by reference made a part of this Lease. All Base Rent, Additional Rent (as hereinafter defined) and other amounts payable under this Lease shall be paid without deduction or offset.

8. DEPOSITS

8.1 Deposits. $2000.00

8.2 Applications on Default. If Tenant is in default under this Lease, Landlord may use the Security Deposit, or any portion thereof, to cure the default or to compensate Landlord for damages (including attorneys' fees) sustained by Landlord resulting from Tenant's default, including, but not limited to, the payment of rent and the cost of cleaning and/or repairing the Premises. Any payment to Landlord from the Security Deposit, whether during the Lease Term or upon termination of this Lease, shall not be considered a payment of liquidated damages. Tenant shall, within ten days after written demand, deposit cash with Landlord in an amount sufficient to restore the Security Deposit to the full amount provided in this Lease and Tenant's failure to do so shall be a material breach of this Lease. If Tenant is not in default at the expiration of the Lease Term and after Tenant has vacated the Premises, Landlord shall return the Security Deposit (less any amounts deducted by Landlord that Tenant has not restored pursuant to this Section 8.2 and less any amounts used by Landlord to restore the Premises to the condition required in Section 4.1) within 45 days of the latter of the expiration of this Lease or vacation of the Premise.

9. OPERATING EXPENSES.

9.1 Net Lease. The purpose of this Section 9 is to insure that, in addition to Base Rent, Tenant pays its Proportionate Share of all expenses relating to the use, maintenance, ownership, repair and insurance of the Premises, except costs specifically assumed by Landlord according to other terms of this Lease.

9.2 Direct Expense. The following expenses are to be paid directly by Tenant before delinquency: all charges for utilities to the premises, including but not limited to, water, electricity, gas, sewer, waste disposal, security, heating and air conditioning repairs, maintenance and replacement, plumbing repairs and replacement including clogged or backed up toilets, pest control, any window or plate glass breakage, locks and door repairs, premise sign maintenance, repair and replacement, personal property taxes, and any governmental fees pertaining to the premises throughout the Lease term.

9.2.1 Utilities and Building Services. Tenant agrees to pay before delinquency and at its sole cost and expense, all charges for utilities and building services supplied to the Premises including, without limitation, water, electricity, gas, sewer, waste disposal, security, heating and air conditioning, throughout the full Lease Term. Landlord shall not be liable for the failure of any of these services for any reason whatsoever. If charges for any or all of such utility services are charged for the Building as a whole, Tenant agrees to pay, upon demand, Tenant's Proportionate Share of such charges, unless any portion of the charges are specifically allocable to another tenant's location and/or business. If charges for any or all of such utility or building services are charged for a larger space containing the Premises, Tenant agrees to pay upon demand a share of any such charges based on the proportion that the square footage of the

Premises bears to such larger space or a share determined by Landlord based upon Landlord's reasonable estimate of Tenant's consumption relative to other Tenant's sharing such utilities or building services.

9.2.2 Insurance Procured by Tenant. Throughout the Lease Term and any other period(s) of occupancy of the Premises by Tenant, Tenant shall, at Tenant's expense, obtain and maintain the following insurance policies, naming the Landlord and Landlord's lender as additional insured.

(a) Liability Insurance. A commercial general liability insurance policy providing coverage for bodily injury liability, property damage liability and personal injury liability with minimum limits of not less than $1,000,000 Combined Single Limit per accident and $2,000,000 General Aggregate. Such insurance policies shall include Blanket Contractual Liability and Owners and Contractors Protective endorsements. Landlord may increase or decrease the required limit as it deems necessary based upon periodic insurance reviews. The insurance required by this Section shall be on an occurrence basis, and underwritten by an acceptable insurer licensed to do business in the State of Washington.

(b) Personal Property Insurance. A special form policy of property insurance (or the equivalent) covering all Tenant's Improvements that become a part of the Building in the amount of its full replacement costs. Such property insurance coverage shall at a minimum insure against loss resulting from fire, lightning and extended or broad form perils. Landlord shall be named as Loss Payee as its interest may appear in tenant improvements and betterments.

(c) Business Interruption Insurance. Business interruption insurance in an amount sufficient to protect Tenant against any additional costs and lost income associated with a move to temporary space due to a business interruption. The Insurance required in this Section 9.2.2 should be from companies reasonably acceptable to Landlord licensed to do business in the State of Washington. Before occupying the Premise, Tenant shall deliver to Landlord, or Landlord's agent, a copy of the insurance policies required by this Section 9.2.2, or certificates evidencing the existence and amount of such insurance. If required by Landlord, or Landlord's agent, Tenant shall deliver the original policy to Landlord's lender. Not later than ten days before expiration of these policies, the Tenant shall deliver to Landlord evidence that insurance required by this Section 9.2.2 has been continued. The policies shall not be cancelable until after 30 days prior written notice to Landlord, or its agent, and Landlord's lender, if any. If Tenant fails to maintain the required insurance, Landlord may, but it is not required to, procure the same at Tenant's expense.

(d) Commencing no later than the commencement of any construction activities on the Premises and continuing until the date no earlier than rent Commencement Date, Tenant shall require any general contractor retained by Tenant to install Tenant's Improvements to procure and maintain a policy of builder's risk or installation floater property insurance insuring the entire work on the Premises in an amount of the full replacement cost of the contracted work against (all risks) a physical loss or damage to the property insured including earthquake and flood and also for the increase cost of construction due to the operation of building laws.

9.2.3 Personal Property Taxes. Tenant shall pay, before delinquency, any and all taxes levied or assessed and payable during the Lease Term upon all Tenants' equipment, furniture, fixtures and any other personal property located on the Premises. If any of the same are assessed or

taxed with the building or real property upon which the Building is located, Tenant shall pay Landlord the amount of such taxes within ten days after receipt of a written statement setting forth the amount of such taxes that Landlord has determined to be attributable to Tenant's personal property.

9.2.4 Licenses and Taxes. Tenant shall be liable for, and shall pay throughout the Lease Term, all license and excise fees and occupation taxes (with the exception of Washington State Real Estate Tax or Business and Occupation Tax based on Landlord's generation of income) covering the business conducted on the Premises. If any governmental authority or unit under any present or future law effective at any time during the Lease Term shall in any manner levy a tax on rents payable under this Lease or rents accruing from use of the premises or a tax in any form against Landlord because of, or measured by, income derived from the leasing or rental of said property, such tax shall be paid by Tenant, either directly or through Landlord, and upon Tenant's default therein, Landlord shall have the same remedies as upon failure to pay the Base Monthly Rent. It is understood and agreed, however, that Tenant shall not be liable to pay any net income tax imposed on Landlord unless, and then only to the extent that, the net income tax is a substitute for real estate taxes.

9.3 Additional Rent. Tenant shall pay as additional rent ("Additional Rent") in the manner set forth in Section 9.4, Tenant's Proportionate Share of the following expenses:

9.3.1 Insurance Procured by Landlord. Throughout the Lease Term, Tenant's Proportionate Share of the following insurance policies, obtained and maintained by Landlord, insuring the Landlord or any other insurance that Landlord may deem necessary, including but not limited to earthquake and flood insurance.

(a) Liability Insurance. A commercial general Landlord's liability insurance policy providing coverage for bodily injury liability, property damage liability and personal injury liability with in such amounts (but not less than $2,000,000.00) and with such endorsements as Landlord may reasonably determine from time to time.

(b) Fire and Casualty Insurance. A fire and casualty insurance policy with extended coverage, earthquake, flooding, and building code-required enhancement endorsements for the full replacement value of the Premises as the Landlord may reasonably determine from time to time.

(c) Rental Loss Insurance. Rental loss insurance in an amount sufficient to protect Landlord from any loss of rental income resulting from any peril.

9.3.2 Real Property Taxes and Assessments. Tenant's Proportionate Share of all real property taxes (not including Washington State Real Estate Excise Tax) and general and special assessments levied and assessed against the Building improvements on the land of which the Premises are a part. Each year Landlord shall notify Tenant of Landlord's calculation of Tenant's Proportionate Share of the real property taxes and assessments. Tenant shall pay Tenant's Proportionate Share of said taxes or assessments in the manner set forth in Section 9.4. Upon written request, Landlord will furnish Tenant with a copy of the Tax assessment bill. Landlord may require from Tenant, upon reasonable written notice from Landlord, a payment of the Tenant's Proportionate Share of such real property taxes and/or assessments to Landlord on a periodic basis. If this Lease commences or terminates other than on January 1 and December 31 respectively, taxes and assessments payable shall be prorated.

9.3.3 Common Area Expenses. To the extent not covered by other provisions of this Lease, Tenant shall pay Tenant's Proportionate Share of the following costs associated with Common Areas of the Building in the manner set forth in Section 9.4:

(a) All real estate taxes, including assessments, all insurance costs, all sprinkler, fire, life safety systems, utility costs and all other costs to maintain, repair and replace Common Areas (including common area signage), parking lots, sidewalks, driveways and other areas used in common by the tenants of the Building (including, but not limited to signs and parking) as well as personal property used in common by the tenants of the Building.

(b) All costs to supervise and administer the Common Areas, parking lots, driveways and other areas used in common by the tenant or occupants of the Building. The costs shall include such fees as may be paid to a third party, and Landlord's reasonable management fees not exceeding 4% of gross rent in connection with the same.

(c) Any parking charges, utility surcharges, or any other costs levied, assessed or imposed by or at the direction of, or resulting from statutes or regulations, or interpretations thereof, promulgated by any governmental authority in connection with the use or occupancy of the Premises or the parking facilities serving the Premises.

(d) Landlord has the right to contract quarterly HVAC filter changes for all of the Buildings' HVAC units and charge back to Tenant as a Common Area expense.

9.4 Payment of Additional Rent. Tenant shall pay Additional Rent described in Section 9.3 or elsewhere, in the manner set forth herein:

9.4.1 Additional Monthly Rent. On the Commencement Date or as soon as possible thereafter, Landlord shall submit to Tenant a statement of the estimated total Additional Rent owed by Tenant under Section 9.3 for the period from the Commencement Date to the end of the calendar year. Tenant shall pay such estimated Additional Rent in monthly payments equal to the amount of the Additional Rent divided by the number of full months remaining in the period from the Commencement date to the end of the calendar year (the "Additional Monthly Rent"). The Additional Monthly Rent shall be paid concurrently with the monthly payment of the Base rent and shall be adjusted as provided in Section 9.4.2 herein.

9.4.2 Adjustments Statement. By March 1 of each year of the Lease Term, Landlord shall provide Tenant with a statement showing the actual Additional Rent for the prior calendar year (the "Adjustments Statement"). If the total of the Additional Monthly Rent payments which Tenant has made for the prior calendar year is less than Tenant's Proportionate Share of the actual Additional Rent for such period, Tenant shall pay within ten days after receipt of the Adjustments Statement, an amount equal to (I) the deficiency for the previous calendar year, plus (ii) the deficiency due to Additional Monthly Rent payments made in the current calendar year prior to such Additional Monthly Rent being adjusted as set forth in Section 9.4. 3. Failure of Landlord to submit Adjustment Statements shall not be deemed to be a waiver of Tenant's obligation to pay sums as required by this Section 9.4.

9.4.3 Adjustment of Additional Monthly Rent. The amount of Additional Monthly Rent owing in the current calendar year shall be adjusted concurrently with Landlord's provision of the Adjustments Statement to Tenant. Taking into account the actual amount of the Additional Rent for the previous calendar year, Landlord shall submit to Tenant as part of the Adjustments Statement (I) an estimate of the total Additional Rent for the current calendar year and (ii) the adjusted Additional Monthly Rent amount based on such estimate.

9.4.4 Deficiency/Overpayment. Even though the Term has expired and Tenant has vacated the Premises, when the final determination is made of Tenant's Proportionate Share of the Additional Rent for the year in which the Lease terminates, Tenant shall immediately pay any deficiency between the total of the Additional Monthly Rent payments made and the actual Additional Rent due. Any overpayment (whether during the Term of the Lease or after Termination of the Lease) made shall be immediately rebated by Landlord to Tenant, provided there are no outstanding rents or charges due. This provision shall survive termination of this Lease.

9.4.5 Tenant Audit. Tenant may have performed an audit of the amount or the calculation of the Additional Rent, provided that (a) Tenant shall have no right to have such an audit performed for any Additional Rent unless Tenant provides notice of Tenant's intention to do so within 180 days of the date that Tenant receives the Adjustments Statement related to such Additional Rent, (b) any such audit shall be at Tenant's sole cost and expense, (c) the audit shall be performed by a recognized independent accounting firm that is not being compensated on a contingency fee basis, and (d) the audit shall not unreasonably interfere with the business of Landlord or its agent.

10. MAINTENANCE, REPAIRS AND ALTERATIONS.

10.1 Landlord's Obligations. Landlord shall maintain and repair the foundations, exterior walls (excluding Paint) and the roof of the Building. Except as otherwise required by Section 13 regarding subrogation, if any of this maintenance and/or repair is required in whole or in part because of the gross negligence or willful misconduct of Tenant, its agents or invitees, Tenant shall pay to Landlord the reasonable cost of the repairs. Except as provided by Section 14 regarding reconstruction, there shall be no abatement of rent, and no liability of Landlord, due to any injury or interference with Tenant's business arising from Landlord's performance of any maintenance or repair, which it is required or permitted to perform. Tenant waives any right which it may have under any current or future law or ordinance to make repairs at Landlord's expense.

10.2 Tenant's Obligations. Tenant shall, at Tenant's sole cost and expense, keep in good condition and repair (ordinary and reasonable wear and tear excepted) all portions of the Premises not required to be maintained by Landlord under Section 10. 1, including but not limited to, the maintenance, repair and replacement of any storefront, all interior walls or partitions and interior portions of exterior walls, doors, all exterior and interior glass and window casements, and all utility systems within the Premises including heating, ventilation and air conditioning systems ("HVAC"), plumbing fixtures including stopped up/backed up toilets, pest control. Tenant shall, upon expiration or sooner termination of this Lease, surrender the Premises to Landlord in good and clean condition, ordinary and reasonable wear and tear accepted. Any damage to adjacent premises caused by Tenant's use of the Premises shall be repaired at the sole cost and expense of Tenant. If Tenant fails to perform the maintenance, repair or replacement required by this Section 10.2 or to surrender the Premises in the condition required by this Section, Landlord shall have the right, but not the obligation, to perform the necessary work at Tenant's expense, and Tenant agrees to reimburse all costs incurred by Landlord. Landlord shall have the right to contract for such services as HVAC maintenance and bill Tenant for cost for such service.

10.3 Government Repairs. In the event any governmental agency requires major repairs or modifications to be made to the Premises, which repairs are the obligation of Landlord and cannot, in Landlord's judgment, be justified by the Base Rent, the Landlord shall have the right to cancel and terminate this Lease by giving Tenant 90 day's written notice. Major repairs for purposes of this Section shall be repairs or modifications with a cost exceeding six months' Base Rent under this Lease. However, Tenant may elect in writing within 15 days of Tenant's receipt of the 90 days notice of cancellation from Landlord to make these repairs at its sole cost and expense, in which event this Lease shall remain in full force and effect. Notwithstanding the above, Landlord shall repair those portions of the Building for which it has the obligation.

10.4 Alterations and Additions. Tenant shall not make or permit any alteration, addition or improvement to the Premises without the prior written consent of Landlord, who shall not unreasonably withhold or delay its consent. Tenant shall pay any and all costs incurred by Landlord in reviewing and evaluating any request for the consent required by this Section, not to exceed $500. Any alteration, addition or improvement consented to by Landlord shall be made in a good workmanlike manner at Tenant's sole cost and expense and shall comply with all applicable laws, codes, ordinances, rules and regulations. All alterations, additions or improvements (including but not limited to wall and window covering, paneling and built-in cabinet work, but excluding movable furniture and trade fixtures) shall at once become a part of the Premises belonging to the Landlord and shall be surrendered with the Premises at the expiration of this Lease, unless Landlord demands their removal as set forth below. Upon expiration or sooner termination of the Lease Term, Tenant shall, at Tenant's sole cost and expense, with all due diligence, remove any alterations, additions or improvements made by Tenant and designated by Landlord to be removed; provided Landlord gives Tenant not less than 60 days advance written notice prior to termination of this Lease. Tenant shall, at its sole cost and expense, repair any damage to the Premises caused by such removal. If Tenant fails to remove any such alterations, additions or improvements, Landlord may do the same at Tenant's expense.

11. LIENS.

11.1 Liens. Tenant shall keep the Premises free from any liens arising out of any work performed, materials furnished or obligations by Tenant, and agrees to hold Landlord harmless from the same. Landlord may require, at Landlord's sole option, that Tenant provide, at Tenant's sole cost and expense, a material men's labor and performance bond acceptable to Landlord in an amount equal to one and one-half times the estimated cost of any improvements, additions or alterations to the Premises which the Tenant desires to make, to insure Landlord against any liability for mechanics' and material men's liens, and to insure completion of the work.

11.2 Encumbrances. The Tenant shall not cause or suffer to be placed, filed or recorded against the title to the Premises, the Building, or any part thereof, or against Tenant's leasehold interest in the Premises any mortgage, deed of trust, security agreement, financing statement or other encumbrances. Further, in no event shall Tenant lien or mortgage any leasehold improvements, alterations, additions or improvements thereto, except trade fixtures, appliances and equipment which are owned by Tenant and which are not, and which do not become a part of the Premises. The form of any such mortgage, deed of trust or other security

agreement or financing statement which includes a legal description of the Premises or the Building shall be subject to Landlord's prior written approval, which approval shall be subject to such conditions as the Landlord may reasonably deem appropriate.

12. HOLD HARMLESS. Tenant agrees to indemnify and hold Landlord and its agents harmless from any and all claims arising from the use of the Premises by Tenant, its agents and invitees, from the conduct of Tenant's business, or from any activity, work or things done or permitted to be done by Tenant and its employees in the scope of their employment on the Premises or elsewhere. Tenant further agrees to indemnify and hold Landlord and its agents harmless from any and all claims arising from, in connection with, or related to any default by Tenant in the performance of its obligations under this Lease, or any act, omission or neglect of Tenant and its employees in the scope of their employment for which Tenant is legally responsible. Tenant further agrees to indemnify and hold Landlord and its agents harmless from all costs (including but not limited to attorney's fees) incurred by Landlord in connection with its defense against any claim made against the Landlord as to which Tenant is required to indemnify Landlord pursuant to this Section. Tenant shall give prompt notice to Landlord of any casualty or accident in the Premises. Upon notice by Landlord, Tenant, at Tenant's expense, shall defend Landlord, through counsel reasonably satisfactory to Landlord, in any action or proceeding brought against Landlord by reason of any such claim. Tenant further assumes all risk of, and waives and releases all claims against Landlord for any damages to person or property sustained by Tenant, or any person claiming through Tenant, which damage results from any accident or occurrence in or on the Premises from any cause whatsoever.

13. SUBROGATION. To the extent permitted by their respective insurers, neither Landlord nor Tenant shall be liable to the other or to any insurance company (by way of subrogation or otherwise) insuring the other party for any loss or damage to any building, structure or other tangible property, or any resulting loss of income, or losses under worker's compensation laws and benefits, even though such loss or damage might have been occasioned by the negligence of such party, its agents or employees if any such loss or damage is covered by insurance benefiting the party suffering such loss or damage or was required to be covered by insurance pursuant to this Lease.

14. RECONSTRUCTION.

14.1 Effect of Insured Loss. Except as provided below, if the Premises are damaged by fire or other cause covered by Landlord's property insurance, Landlord agrees to repair the same, and this Lease shall remain in full force and effect.

14.2 Landlord's Options. Landlord shall have the option either to repair or rebuild the Premises or to terminate this Lease if the Premises or any portion of the Building is damaged if

(a) The damage results from any cause not covered by Landlord's insurance;

(b) Insurance proceeds are insufficient to fully pay for repair and restoration.

(c) The cost to repair exceeds 33 percent of the then complete replacement cost of the Premises and the Building,

(d) The repair or restoration cannot be completed within six months of obtaining all necessary permits, using reasonable diligence; or

(e) The damage occurs during the last 12 months of the Extended Lease Terms, or if Tenant has failed to exercise its right to extend/renew in the timely manner expressed in Section 3.1.

Landlord shall exercise its option to terminate this Lease by giving to Tenant, at any time within 60 days after the damage, written notice of its election to terminate this Lease as of the date specified in the notice. The termination date shall not be less than 30 or more than 60 days after the date of notice. If Landlord fails to give notice within the 60 days, it shall be deemed to have elected to repair or restore the damage. If Landlord terminates this Lease as provided by this Section 14.2, this Lease shall automatically terminate on the date specified in Landlord's notice. Neither party shall have further liability to the other, except for obligations which were accrued and unpaid as of the date of termination specified in Landlord's notice, and except that Landlord shall return any unused balance of the Security Deposit to Tenant.

14.3 Rent Abatement. This Lease shall remain in full force and effect if Landlord elects to repair the damage, or until the termination date specified in the notice of termination, as applicable, except that the Base Rent and any Additional Rent shall be proportionately abated from the date of damage until the repairs, including Tenant's repairs (using reasonable diligence) are completed, or until the specified termination date, as applicable. Such proportionate abatement shall be based upon the extent to which the damage materially interferes with the business carried on by Tenant in the Premises.

14.4 Tenant's Repair Obligations. Landlord shall not be required to repair or replace any leasehold improvements, fixtures or other personal property of Tenant, all of which shall be repaired or replaced promptly by Tenant.

15. EMINENT DOMAIN.

15.1 Totals or Partial Taking. If any portion of the Premises is taken or appropriated by any public or quasi-public authority under the power of eminent domain, or is purchased by the condemner in lieu of condemnation proceedings, either party shall have the right to terminate this Lease upon 30 days' written notice given to the other party within 60 days after the date that possession is surrendered to the condemner. If neither party elects to terminate, the Base Rent and any Additional Rent thereafter to be paid shall be equitably reduced. If any part of the Building other than the Premises is so taken or appropriated, or is purchased by the condemned in lieu thereof, Landlord shall have the right at its option to terminate this Lease upon 30 days written notice to Tenant given within 60 days after the date that possession is surrendered to the condemner.

15.2 Damages. Landlord reserves all rights to the entire damage award or payment for any taking by eminent domain and Tenant shall make no claim whatsoever against Landlord for damages for termination of its leasehold interest in the Premises or for interference with its business. Tenant hereby grants and assigns to Landlord any right Tenant may now have or hereafter acquire to damages related to any taking by eminent domain and agrees to execute and deliver such further instruments of assignment thereof as Landlord may from time to time request. Tenant shall, however, have the right to claim from the condemning authority all compensation that may be recoverable by Tenant on account of any loss incurred by Tenant in

removing Tenant's merchandise, furniture, trade fixtures and equipment or for damage to Tenant's business provided, however, that Tenant may claim such damages only if they are awarded separately in the eminent domain proceeding and not as part of Landlord damages.

16. ASSIGNMENT AND SUBLETTING.

16.1 Restriction. Tenant shall not, without the prior written consent of Landlord.

(a) Voluntarily, involuntarily or by operation of law, assign, transfer, mortgage, pledge, hypothecate or otherwise encumber this Lease, or any interest in it, or any right or privilege appurtenant to it;

(b) Sublet all or any part of the Premises; or

(c) Allow any other person, except the agents and invitees of Tenant, to occupy or use any portion of the Premises.

Landlord's consent may be withheld in Landlord's reasonable discretion. In determining whether to consent to any assignment, transfer, encumbrance or subletting, Landlord may consider any commercially reasonable basis for approving or disapproving any such request, including, without limitation, the following: (I) the experience or business reputation of the proposed transferee, (ii) whether the use clientele, personnel or foot traffic that will be generated by the proposed transferee is consistent, in Landlord's opinion, with the businesses of other tenants of the Building at the time of the proposed transfer, and (iii) notwithstanding that Tenant and others would remain liable upon transfer, whether the proposed transferee has a net worth and financial strength and credit record satisfactory to Landlord. Any assignment, transfer, encumbrance, subletting or use without Landlord's consent shall be void and shall, at the option of Landlord, constitute a material default under this Lease. An assignment or sublease consented to by Landlord shall not be binding upon Landlord unless the assignee or subtenant delivers to Landlord:

(a) An original executed assignment or sublease;

(b) Any collateral agreements; and

(c) An instrument containing said assignee's or sub lessee's assumption of all of the obligations of the Tenant under this Lease, in form and substance satisfactory to Landlord.

The assignee's or sub lessee's failure to execute such a covenant shall not waive, release or discharge the assignee or sub lessee from its liability for the performance of the Tenant's obligations under this Lease. Regardless of Landlord's consent, no subletting or assignment shall release Tenant or Guarantor of their obligations or alter the primary liability of Tenant to pay rent and to perform all the obligations of the Tenant under this Lease.

16.2 Costs. Tenant shall reimburse Landlord and Landlord's agent for all reasonable attorneys' fees and other costs incurred by Landlord in connection with the review of and preparation of documents incident to any request by Tenant for Landlord's consent. Each request for Landlord's consent shall be accompanied by a deposit in the amount of $200 to be applied to such costs.

16.3 Included Transfers. If Tenant is a corporation, partnership, Limited Liability Company or other entity, any transfer of this Lease by merger, consolidation, reorganization or dissolution shall constitute a transfer for the purposes of this Section. If Tenant is such an entity, any change in the ownership of, or power to vote, a percentage of Tenant's now-outstanding stock or ownership interest which results in a change of controlling persons (those holding 50% of the

ownership interest in and to Tenant) or any transfer of all or substantially all the assets of Tenant shall constitute a transfer for the purposes of this Section. If Tenant is a partnership, any partial or total withdrawal of any of the present general partners, and any transfer by a general partner of all or part of his partnership interest shall constitute a transfer for the purposes of this Section.

16.4 Judicially Imposed Assignment. If the non-assignment provisions of this Section are deemed to be unenforceable in any bankruptcy proceeding, Landlord and Tenant agree that a showing of adequate assurance of future performance by a prospective assignee of this Lease must include, without limitation, clear and convincing evidence that:

(a) Landlord will receive the full benefit of each and every term of its bargain in this Lease, except for the non-assignment and related termination clauses;

(b) The Premises will continue to be used solely for the use permitted by this Lease;

(c) A judicially imposed assignment will not cause an acceleration or increase in the interest rate on, or fees in connection with, any indebtedness of Landlord secured by Landlord's interest in the building or this Lease; and

(d) The prospective assignee has the means, expertise and experience to operate the business to be conducted upon the Premises in a first-class manner.

16.5 Assignment by Landlord. If Landlord shall assign its interest under this Lease or transfer its interest in the Premises, Landlord shall be relieved of any obligation accruing hereunder after such assignment or transfer, and such transferee shall thereafter be deemed to be the Landlord under this Lease. Landlord may transfer Tenant's Security Deposit to such transferee and Tenant shall look solely to the transferee for the return of such deposit.

17. DEFAULT.

17.1 Events of Default. The following events are referred to, collectively, as "Events of Default" or, individually, as an "Event of Default":

(a) Tenant defaults in the due and punctual payment of Base Rent or Additional Rent, and such default continues for three business days after written notice from Landlord; however, Tenant will not be entitled to more than two (2) written notices for monetary defaults during any 12 month period, and if after such written notice any rent or Additional Rent is not paid when due, an Event of Default will be considered to have occurred without further notice;

(b) Tenant vacates or abandons the Premises or fails to operate its business on the Premises;

(c) This Lease or the Premises or any part of the Premises are taken upon execution or by other of law directed against Tenant, or are taken upon or subject to any attachment by any creditor of Tenant or claimant against Tenant, and said attachment is not discharged or disposed of within 15 days after its levy;

(d) Tenant files a petition in bankruptcy or insolvency or for reorganization or arrangement under the bankruptcy laws of the United States or under any insolvency act of any state, or admits the material allegations of any such petition by answer or otherwise, or is dissolved or makes an assignment for the benefit of creditors;

(e) Involuntary proceedings under any such bankruptcy law or insolvency act or for the dissolution of Tenant are instituted against Tenant, or a receiver or trustee is appointed for all or substantially all of the property of Tenant, and such proceeding is not dismissed or such receivership or trusteeship vacated within 60 days after such institution or appointment; or

(f) Tenant makes, causes to be made or suffers to exist on the Premises noise of any type (including music) that, in the opinion of Landlord, could reasonably be expected to interfere with the rights of quiet enjoyment of other tenants in the Building or in the complex of which the Premises are a part, and such default continues or occurs for ten days after written notice from Landlord; however, Tenant will not be entitled to more than two (2) written notice of such defaults during any 12 month period, and if after such written notice a default under this provision exists or occurs, an Event of Default will be considered to have occurred without further notice;

(g) Tenant breaches any of the other agreements, terms, covenants, or conditions that this Lease requires Tenant to perform, and such breach continues for a period of 30 days after written notice from Landlord to Tenant or, if such breach cannot be cured reasonably within such 30-day period, if Tenant fails to diligently commence to cure such breach within 30 days after written notice from Landlord and to complete such cure within a reasonable time thereafter (but not to exceed 90 days).

17.2 Landlord's Remedies. If any one or more Events of Default set forth in Section 17.1 occur, then Landlord has the right, at its election:

(a) To give Tenant written notice of Landlord's intention to terminate this Lease on the earliest date permitted by law or on any later date specified in such notice, in which case Tenant's right to possession of the Premises will cease and this Lease will be terminated, except as to Tenant's liability, as if the expiration of the term fixed in such notice were the end of the term;

(b) Without further demand or notice, to reenter and take possession of the Premises or any part of the Premises, repossess the same, expel Tenant and those claiming through or under Tenant, and remove the effects of both or either, using such force for such purposes as may be necessary, without being liable for prosecution, without being deemed guilty of any manner of trespass, and without prejudice to any remedies for arrears of monthly rent or other amounts payable under this Lease or as a result of any preceding breach of covenants or conditions; or

(c) Without further demand or notice to cure any Event of Default and to charge Tenant for the cost of effecting such cure, including without limitation reasonable attorneys' fees and interest on the amount so advanced at the rate of 12 percent per annum, provided that Landlord will have no obligation to cure any such Event of Default of Tenant.

Should Landlord elect to reenter as provided in Section 17.2(b), or should Landlord take possession pursuant to legal proceedings or pursuant to any notice provided by law, Landlord may, from time to time, without terminating this Lease, relet the Premises or any part of the Premises in Landlord's or Tenant's name, but for the account of Tenant, for such term or terms (which may be greater or less than the period that would otherwise have constituted the balance of the term) and on such conditions and upon such other terms (which may include concessions of free rent and alteration and repair of the Premises) as Landlord, in its reasonable

discretion, may determine, and Landlord may collect and receive the rent. Subject to Landlord's duty to mitigate its damages and not to act negligently, Landlord will not be responsible or liable for a failure to relet the Premises, or any part of the Premises, or for a failure to collect any rent due upon such reletting. No such reentry or taking possession of the Premises by Landlord will be construed as an election on Landlord's part to terminate this Lease unless a written notice of such intention is given to Tenant. No written notice from Landlord under this Section 17.2 or under a forcible or unlawful entry and detainer statute or similar law will constitute an election by Landlord to terminate this Lease unless such notice specifically so states. Landlord reserves the right following any such reentry or reletting to exercise its right to terminate this Lease by giving Tenant such written notice, in which event this Lease will terminate as specified in such notice.

17.3 Certain Damages. In the event that Landlord does not elect to terminate this Lease as permitted in Section 17.2(a), but on the contrary elects to take possession as provided in Section 1 7.2(b), Tenant will pay to Landlord monthly rent and other sums as provided in this Lease that would be payable under this Lease if such repossession had not occurred, less the net proceeds, if any, of any reletting of the Premises after deducting all of Landlord's reasonable expenses in connection with such reletting, including without limitation all repossession costs, brokerage commissions, attorneys' fees, expenses of employees, alteration and repair costs, and expenses of preparation for such reletting. If, in connection with any reletting, the new Lease term extends beyond the existing term, or the Premises covered by such new lease include other Premises not part of the Premises, a fair apportionment of the rent received from such reletting and the expenses incurred in connection with such reletting as provided in this Section will be made in determining the net proceeds from such reletting, and any rent concessions will be equally apportioned over the term of the new lease. Tenant will pay such rent and other sums to Landlord monthly on the day on which the monthly rent would have been payable under this Lease if possession had not been retaken, and Landlord will be entitled to receive such rent and other sums from Tenant on each such day.

17.4 Continuing Liability after Termination. If this Lease is terminated on account of the occurrence of an Event of Default, Tenant will remain liable to Landlord for damages in an amount equal to monthly rent and other amounts that would have been owing by Tenant for the balance of the term, had this Lease not been terminated, less the net proceeds, if any, of any reletting of the Premises by Landlord subsequent to such termination, after deducting all of Landlord's expenses in connection with such reletting, including without limitation the expenses enumerated in Section 17.3. Landlord will be entitled to collect such damages from Tenant monthly on the day on which monthly rent and other amounts would have been payable under this Lease if this Lease had not been terminated, and Landlord will be entitled to receive such monthly rent and other amounts from Tenant on each such day. Alternatively, at the option of Landlord, in the event this Lease is so terminated, Landlord will be entitled to recover against Tenant as damages for loss of the bargain and not as a penalty:

(a) The worth at the time of award of the unpaid rent that had been earned at the time of termination;

(b) The worth at the time of award of the amount by which the unpaid rent that would have been earned after termination until the time of award exceeds the amount of such rental loss that Tenant proves could have been reasonably avoided;

(c) The worth at the time of award of the amount by which the unpaid rent for the balance of the term of this Lease (had the same not been so terminated by Landlord) after the time of award exceeds the amount of such rental loss that Tenant proves could be reasonably avoided;

(d) Any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under this Lease or which would be likely to result there from.

The "worth at the time of award" of the amounts referred to in (a) and (b) above is computed by adding interest at the interest rate of 12 percent per annum from the Termination Date until the time of the award. The "worth at the time of award" of the amount referred to in (c) above is computed by discounting such amount at the discount rate of the Federal Reserve Bank of San Francisco, at the time of award plus I percent.

17.5 Cumulative Remedies. Any suit or suits for the recovery of the amounts and damages set forth in Sections 17.3 and 17.4 may be brought by Landlord, from time to time, at Landlord's election, and nothing in this Lease will be deemed to require Landlord to await the date upon which this Lease or the term would have expired had there occurred no Event of Default. Each right and remedy provided for in this Lease is cumulative and is in addition to every other right or remedy provided for in this Lease or now or after the Lease date existing at law or in equity or by statute or otherwise, and the exercise or beginning of the exercise by Landlord of any one or more of the rights or remedies provided for in this Lease or at law, in equity or by statute or otherwise will not preclude the simultaneous or later exercise by Landlord of any or all other rights or remedies provided for in this Lease or at law, in equity or by statute or otherwise. All costs incurred by Landlord in collecting any amounts and damages owing by Tenant pursuant to the provisions of this Lease or to enforce any provision of this Lease, including reasonable attorneys' fees from the date any such matter is turned over to an attorney, whether or not one or more actions are commenced by Landlord, will also be recoverable by Landlord from Tenant.

17.6 Waiver of Redemption. Tenant waives any right of redemption arising as a result of Landlord's exercise of its remedies under this Article 17.

17.7 Late Charges. Tenant acknowledges that late payment by Tenant to Landlord of rent and other sums due under this Lease will cause Landlord to incur costs not contemplated by this Lease, the exact amount of which will be extremely difficult to ascertain. These costs include, but are not limited to, processing and accounting charges and late charges which may be imposed on Landlord by the terms of any mortgage or deed of trust covering the Premises. Accordingly, if any installment of rent or other sums due from Tenant shall not be received by Landlord or Landlord's agent within five days after the amount shall be due or if payment is made with a check that is returned for lack of sufficient funds, then without any requirement of notice to Tenant, Tenant shall pay to Landlord a late charge equal to $75, plus 1 percent per month interest on the delinquencies from the date due until payment. The parties agree that this late charge plus interest represents a fair and reasonable estimate of the cost Landlord will incur by reason of late payment by Tenant. Acceptance of the late charge by Landlord shall in no event constitute a waiver of Tenant's default with respect to the overdue amount, nor prevent Landlord from exercising any of the other rights or remedies granted to Landlord under this Lease, or at law or equity.

17.8 Defaults by Landlord. Landlord shall not be in default unless Landlord fails to perform obligations required of Landlord within a reasonable time, but in any event no more than 20 business days after written notice by certified mail or personal delivery by Tenant to Landlord and to the holder of any first mortgage or deed of trust covering the Premises whose name and address shall have theretofore been furnished to Tenant in writing. Said notice shall specify wherein Landlord has failed to perform such obligation; provided, however, that if the nature of Landlord's obligation is such that more than 20 business days are required for performance, then Landlord shall not be in default if Landlord commences performance within such 20 business day period and thereafter diligently prosecutes the same to completion. Tenant further agrees not to invoke any of its remedies under this Lease until said 20 business days have elapsed. In such event Tenant shall have the right to cure minor defaults and charge the reasonable costs to Landlord as a set-off. In the event of a major default that materially interferes with Tenant's ability to carry out its business, Tenant may terminate this Lease upon giving Landlord further written notice of 20 business days, in which case Tenant shall vacate the Premises as soon as practicable but no later than 30 days following the date of the last such notice.

18. RULES AND REGULATIONS. Tenant shall faithfully observe and comply with all recorded covenants, conditions and restrictions affecting the Premises, all rules and regulations that Landlord may from time to time make to facilitate the reasonable operation of the Building of which the Premises are a part or the complex in which it is located or to comply with the requirements of any governmental entity or insurance company, including, without limitation, those rules and regulations attached to this Lease (collectively called "Rules"). Landlord reserves the right to reasonably modify the Rules from time to time. The Rules and any modifications shall be binding upon Tenant upon delivery of a copy of the Rules to Tenant. Landlord shall not be responsible to Tenant for the failure of any other tenants or occupants to comply with the Rules.

19. HOLDING OVER.

19.1 Holding Over. If Tenant remains in possession of the Premises or any part thereof, after the expiration of the Lease Term with the express written consent of Landlord (which consent may be granted, withheld or conditioned at the reasonable discretion of Landlord), such occupancy shall be a tenancy from month to month at a minimum rent in an amount equal to the last monthly Base Rent, plus all additional rent and other charges payable hereunder, and upon all the terms hereof applicable to a month-to-month tenancy. If Tenant remains in possession of the Premises over the written objection of the Landlord at the time of expiration of the lease term, the Base rent shall be in an amount equal to 150% of the last monthly minimum rent plus all additional rent and other charges payable hereunder.

19.2 Abandonment. Tenant agrees not to vacate or abandon the Premises at any time during the Lease Term. Should Tenant vacate or abandon said Premises or be dispossessed by process of law or otherwise, such abandonment, vacation or dispossession shall be deemed a breach of this Lease and, in addition to any other rights which Landlord may have, Landlord

may remove any personal property belonging to Tenant which remains on the Premises and store the same, the cost of such removal and storage to be Tenant's liability.

19.3 Voluntary Surrender. The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation thereof, shall not work a merger, but shall, at the option of Landlord, terminate all or any existing subleases or sub tenancies, or operate as an assignment to it of any or all such subleases or sub tenancies.

20. ENTRY BY LANDLORD. Upon giving Tenant no less than 1 business day's (or 24 hours') written notice (except for emergencies), Landlord reserves the right to enter the Premises to inspect the same, to show the Premises to prospective purchasers or tenants, to perform any alterations, improvements, repairs or maintenance, to provide any services that Landlord may deem necessary or desirable and to do any other act permitted under this Lease. Landlord may retain a key with which to enter all of the doors in the Premises (excluding Tenant's vaults, safes and files) in the event of an emergency. No entry by Landlord shall be construed or deemed to be a forcible or unlawful entry into, or a detainer of, the Premises, or an eviction of Tenant from all or any portion of the Premises. Any entry of Landlord shall be after notice to Tenant either personally delivered or in writing except that Landlord is entitled to enter the Premises without notice in the event of an emergency. This applies except as provided for in Section 4.1

21. ESTOPPEL CERTIFICATE. Upon not less than five business day's prior written notice from Landlord, Tenant shall execute, acknowledge and deliver to Landlord a written estoppels certificate stating certain facts including, but not limited to:

(a) That this Lease is unmodified and in full force and effect (or, if modified, stating the nature of such modification and certifying that this Lease as so modified is in full force and effect);

(b) The date to which the Base Rent and other charges are paid; and

(c) That there are not, to Tenant's knowledge, any uncured defaults on the part of the Landlord (or specifying such defaults if any are claimed).

The statement shall be in any form that Landlord provides to Tenant. Any such statement may be relied upon by any prospective purchaser or encumbrance of all or any portion of the Building or the real property upon which it is located.

22. SIGNS. Tenant shall not place any permanent signs or symbols in the windows or on the doors of the Premises or upon any part of the Building without the prior written consent of Landlord. Tenant may place temporary marketing signs and symbols in the windows or on the doors of the Premises without the prior written consent of Landlord. Any signs or symbols shall be in conformity with other signs on the Premises and the Building, the Rules, and all applicable laws, ordinances and regulations. Tenant shall maintain any such sign or symbol in good condition and repair at its sole cost and expense. Tenant shall remove such sign or symbol at its sole cost and expense upon termination of the Lease Term, and shall repair all damage caused by the removal. If Tenant fails to remove any sign or symbol and/or repair any damage caused by its removal, Landlord may have the same removed and/or repaired at Tenant's expense. Landlord has approved the signage depicted on Exhibit C.

23. AUTHORITY; LIABILITY.

23.1 Authority. If Tenant is a corporation, partnership, Limited Liability Company or other form of entity, each individual executing this Lease on behalf of said entity represents and warrants that he or she is duly authorized to execute and deliver this Lease on behalf of said entity.

23.2 Liability. If the Landlord herein is a limited or general partnership, it is understood and agreed that any claims by Tenant against Landlord shall be limited to the assets of the limited or general partnership, and furthermore, Tenant expressly waives any and all rights to proceed against the individual partners, or the officers, directors or shareholders of any corporate partner, except to the extent of their interest in said limited or general partnership.

24. GENERAL PROVISIONS.

24.1 Exhibits and Addendums. Any exhibits and addendums attached to this Lease are a part hereof and are fully incorporated in this Lease by this reference.

24.2 Non-Waiver of Default. Landlord's waiver of any term, covenant or condition of this Lease shall not be deemed to be a waiver of any other term, covenant or condition or any subsequent default under the same or any other term, covenant or condition. Landlord's acceptance of any sum shall not be deemed to be a waiver of any preceding default by Tenant, other than the failure of Tenant to pay particular sum so accepted, regardless of Landlord's knowledge of such preceding default at the time it accepts the sum.

24.3 Joint Obligations. If there is more than one Tenant, the obligations of the Tenants under this Lease shall be joint and several.

24.4 Section Titles. The Section titles of this Lease are not a part of this Lease and shall have no effect upon its construction or interpretations.

24.5 Time. Time is of the essence of this Lease and each and all of its provisions in which performance is a factor, including, but not limited to, Tenant's execution of estoppels certificates and subordinations and Tenant reimbursements to Landlord.

24.6 Successors and Assigns. The covenants and conditions of this Lease apply to and bind the heirs, successors, executors, administrators and assigns of all parties of this Lease.

24.7 Recordation. A short form memorandum may be recorded at the request of either party, and at the requesting party's expense.

24.8 Quiet Possession. Subject to all the provisions of this Lease and provided Tenant pays all sums due under this Lease and observes and performs all of the other covenants, conditions and provisions to be observed and performed by Tenant, Tenant shall have quiet possession of the Premises for the entire Lease Term, against any adverse claim of Landlord or any party claiming under Landlord.

24.9 Prior Agreements. This Lease contains the full agreement of the parties with respect to any matter covered or mentioned in this Lease. No prior agreements or understandings pertaining to any such matter shall be effective for any purpose. This Lease may be amended or supplemented only by an agreement in writing signed by the parties or their respective successors in interest. Tenant agrees to make reasonable modifications of the terms and provisions of this Lease required or requested by any lending institution financing for the Building, or project, as the case may be, provided that no such modifications will materially adversely affect Tenant's rights and obligations under this Lease.

24.10 Inability to Perform. Except as provided in Sections 14, and 15, this Lease and Tenant's obligations hereunder, including Tenant's obligation to make payments, shall not be affected or impaired because Landlord is unable to fulfill any of its obligations, or is delayed in doing so, if such inability or delay is caused by reason of weather, strike, labor troubles, acts of God, or any other cause beyond the reasonable control of the Landlord.

24.11 Severability. Any provision of this Lease which shall prove to be invalid, void or illegal, shall in no way affect, impair or invalidate any other provision, and all other provisions shall remain in full force and effect.

24.12 Cumulative Remedies. No remedy or election under this Lease shall be deemed to be exclusive but shall, whenever possible, be cumulative with all other remedies at law or in equity.

24.13 Choice of Law. This Lease shall be governed by the laws of State of Washington.

24.14 Attorneys' Fees. In the event any action or proceeding is brought by either party against the other arising out of or in connection with this Lease, the substantially prevailing party shall be entitled to recover its costs, including, but not limited to, reasonable attorneys' and accountants' fees, incurred in such action or proceedings, including any such costs and fees incurred on appeal, in any arbitration proceeding, and in any bankruptcy proceeding. In determining the substantially prevailing party and the equitable amount to award, the arbitrator or court, after announcing a decision on the merits, shall receive and consider evidence of the timing and substance of all offers of settlement and responses thereto.

24.15 Notices. All notices or demands which are required or permitted to be given by either party to the other under this Lease shall be in writing. Except as otherwise provided in any addendum, all notices and demands to the Tenant shall be either personally delivered or sent by the U.S. Mail, registered or certified, postage prepaid, addressed to the Tenant at the Premises, or at the address set forth below or to such other place as Tenant may from time to time designate in a notice to the Landlord. Except as provided in any addendum, all notices and demands to the Landlord shall be either personally delivered or sent by U.S. Mail, registered or certified, postage prepaid, addressed to the Landlord at the address set forth below or to such other person or place as the Landlord may from time to time designate in a notice to the Tenant. Any notices sent by US Mail as provided above shall be deemed to have been received three days after deposit into the mail.

24.16 Subordination. At Landlord's option, this Lease shall be subject to and subordinate to the lien of any existing or future mortgages or deeds of trust in any amount or amounts whatsoever, now or hereafter placed in or against the Building or the real property upon which it is located, and to any extensions, renewals or replacements thereof, without the necessity of the execution and delivery of any further instruments on the part of Tenant to effectuate such subordination. Within five business days of Landlord's request, Tenant will execute and deliver such further instruments as Landlord deems necessary to evidence such subordination of this Lease. As long as Tenant is not in default under this Lease, said subordination shall not disturb Tenant's right to possession of the Premises under the terms of this Lease.

24.17 Attornment. In the event of foreclosure, or the exercise of the power of sale under any mortgage or deed of trust made by Landlord covering the Premises, or in the event of any sale in lieu thereof, Tenant shall attorn to the purchaser upon any such foreclosure or sale and recognize such purchaser as Landlord under this Lease; provided said purchaser expressly

agrees in writing that, so long as Tenant is not in default under the Lease, Tenant's possession and occupancy of the Premises shall not be disturbed and said purchaser will thereafter perform all of the obligations of Landlord under this Lease.

24.18 Guarantor. In the event that there is a Guarantor of this Lease, Guarantor hereby agrees to jointly and severally performs all payment and other obligations of Tenant under this Lease. Guarantor waives all surety ship defenses that would otherwise be available to Guarantor.

24.19 Compliance with Environmental Laws. The parties acknowledge that there are certain federal, state and local laws, regulations and guidelines now in effect and that additional laws, regulations and guidelines may hereafter be enacted relating to or affecting the Premises and the larger parcel of land upon which the demised Premises may be a part, concerning the impact on the environment of construction, land use, the maintenance and operation of structures, and the conduct of business. Tenant shall not cause, or permit to be caused, any act or practice by negligence, or omission, or otherwise, that would adversely affect the environment or do anything or permit anything to be done that would violate any of said laws, regulations or guidelines. Any violation of this covenant shall be an Event of Default under this Lease. Tenant shall indemnify and hold Landlord harmless from any and all cost, expense, claims, losses, damages, fines and penalties, including reasonable attorneys' fees, which may in any manner arise out of or be imposed because of the failure of Tenant to comply with this covenant. The foregoing shall cover all requirements whether or not foreseeable at the present time and regardless of the expense attendant thereto.

24.20 Riders and Exhibits. The Riders and Exhibits referred to in Section 1.18 are attached to this Lease and made a part of it.

24.21 Limitation on Recourse. Tenant specifically agrees to look solely to Landlord's interest in the real property on which the Premises is located for the recovery of any judgments from Landlord. It is agreed that Landlord (and its shareholders, ventures, members and partners, and their shareholders, ventures, members and partners and all of their officers, directors, and employees) will not be personally liable for any such judgments. The provisions contained in the preceding sentences are not intended to and will not limit any right that Tenant might otherwise have to obtain injunctive relief against Landlord.

24.22 Tax Credits. Landlord is entitled to claim all tax credits and depreciation attributable to leasehold improvements (except for Tenant's Improvements) in the Premises. Promptly after Landlord's demand, Landlord and Tenant will prepare a detailed list of the leasehold improvements and fixtures and their respective costs for which Landlord or Tenant has paid. Landlord will be entitled to all credits and depreciation for those items for which Landlord has paid by means of any Tenant finish allowance or otherwise. Tenant will be entitled to any tax credits and depreciation for all items for which Tenant has paid with funds not provided by Landlord.

24.23 Loss of Business. Landlord shall not be responsible for any loss of business, inconvenience or annoyance arising from its repair or restoration of the Premises or the shopping center of which the Premises is a portion.

24.24 Landlord's Fees. Whenever Tenant requests Landlord to take any action or give any consent required or permitted under this Lease, Tenant will reimburse Landlord for all of Landlord's reasonable costs incurred in reviewing the proposed action or consent, including

without limitation reasonable attorneys, engineers, or architects fees, within ten days after Landlord's delivery to Tenant of a statement of such costs. Tenant will be obligated to make such reimbursement without regard to whether Landlord consents to any such proposed action.

24.25 Rules of Construction. The parties agree that (a) in the event of any inconsistency between the provisions of Section 1 and the other provisions of this Lease, the other provisions of this Lease shall govern; (b) in the event of any inconsistency between the provisions of the body of this Lease and the Riders attached hereto, the provisions set forth in the Lease shall govern; and (c) ambiguities shall not be construed against the party that drafted this Lease.

24.26 Waiver of Jury Trial. LANDLORD, TENANT AND GUARANTOR BY THIS SECTION WAIVE TRIAL BY JURY IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM BROUGHT BY EITHER OF THE PARTIES TO THIS LEASE AGAINST THE OTHER ON ANY MATTERS WHATSOEVER ARISING OUT OF OR IN ANY WAY CONNECTED WITH THIS LEASE, THE RELATIONSHIP OF LANDLORD AND TENANT, TENANT'S USE OR OCCUPANCY OF THE PREMISES, OR ANY OTHER CLAIMS (EXCEPT CLAIMS FOR PERSONAL INJURY OR PROPERTY DAMAGE), AND ANY EMERGENCY STATUTORY OR ANY OTHER STATUTORY REMEDY.

25. BROKERS. Tenant and Landlord each warrants that it has had no dealing with any real estate broker or agent in connection with the negotiation of this Lease and that it knows of no real estate broker or agent who is entitled to a commission in connection with this Lease.

26. LEGAL DOCUMENT. Tenant understands that this is a legally binding contract. Tenant has carefully read each of its provisions, and prior to execution of the Lease, represents and warrants that Tenant has been advised to discuss the legal effect of the Lease with Tenant's legal counsel.

IN WITNESS WHEREOF, the parties have executed this instrument as of the day and year first above written:

LANDLORD: Lakewood Plaza, LLC

By: _____

Name/Title Ajitpal Samra

TENANT: Wellspring Home Health

By: _____

Name/Title: Ernest Ibanga

STATE OF WASHINGTON)
) ss.
County of Pierce)

On this day personally appeared before me Karla Valencia, to me known to be the authorized member of Lakewood Plaza, LLC, executed the foregoing instrument, and acknowledged said instrument to be a free and voluntary act and deed for the uses and purposes therein mentioned, and on oath stated that he was authorized to execute said instrument on behalf of the Limited Liability Company.

GIVEN under my hand and official seal this 27 day of August, 2019

MARCEENA LYN PERCIVAL
Notary Public
State of Washington
My Appointment Expires
Apr 23, 2021

Notary Public in and for the State of Washington residing at Puyallup
My Commission expires: 4-23-21

STATE OF WASHINGTON)
) ss.
County of Pierce)

On this day personally appeared before me Ernest Imbanga & _____ to be known to be the sole members of Wellspring Home Health that executed the foregoing instrument and acknowledged said instrument to be the company's free and voluntary act and deed for the uses and purposes therein mentioned, and on oath stated that he was authorized to execute said instrument on behalf of the company.

GIVEN under my hand and official seal this 26 day of August, 2019

MARCEENA LYN PERCIVAL
Notary Public
State of Washington
My Appointment Expires
Apr 23, 2021

Notary Public in and for the State of Washington residing at Puyallup
My Commission expires: 4-23-21

Notary Public in and for the State of Washington residing at _____
My Commission expires: _____

EXHIBIT "A"

SHOPPING CENTER PLAN

*Applicant Note December 2020: no additional pages describing Exhibit A were provided by landlord. Therefore, Exhibit A is 'blank'.

EXHIBIT "B"

LEGAL DESCRIPTION

*Applicant Note December 2020: no additional pages describing Exhibit B were provided by landlord. Therefore, Exhibit B is 'blank'.

EXHIBIT "C"
RULES AND REGULATIONS

1. No sign, placard, picture, advertisement, name or notice shall be posted or affixed on or to any part of the outside or inside of the Building (other than the Premises) without the prior written consent of Landlord, and Landlord shall have the right to remove any sign, placard, picture, advertisement, name or notice posted in violation of this rule, without notice to and at the expense of Tenant.

2. The sidewalks, halls, passages, exits, entrances, elevators and stairways shall not be obstructed by any Tenant or used for any purpose other than for ingress to and egress from the Premises. The halls, passages, exits, entrances, elevators, stairways, balconies and roof are not for the use of the general public and the Landlord shall in all cases retain the right to control and prevent access thereto by all persons whose presence in the judgment of the Landlord shall be prejudicial to the safety, character, reputation and interests of the Building and its tenants. No Tenant and no employees, invitees, or licensees of any Tenant shall enter the mechanical rooms, air conditioning rooms, electrical closets, janitorial closets, or similar area or go upon the roof of the Building without the prior written consent of the Landlord.

3. The Landlord shall designate appropriate entrances for deliveries or other movement to or from the Premises of equipment, materials, supplies, furniture and other bulky or heavy articles, and Tenant shall not use any other entrances or elevators for such purposes. All means or methods used to move equipment, materials, supplies, furniture or other property in our out of the Building must be approved by Landlord prior to any such movement. All floors must be properly protected including hallway, lobby and elevator carpet. Landlord will not be responsible for loss of or damage to any property during movement into or out of the Building or Premises, and all damage to the Building during the course of moving any article of Tenant's property shall be repaired at the expense of Tenant. Except for donated items, Tenant shall move all freight, supplies, furniture, fixtures and other personal property only at such times as may be designated by Landlord. Unattended vehicles will be towed at the Owner's expense.

4. Tenant shall not place or keep furniture or other items on the terraces or roof of the Building without first obtaining the written approval of the Landlord.

5. Tenant, tenant's vendors, tenant's employees or tenant's invitees are not allowed on the roof for any reason without prior permission from Landlord.

6. Tenant shall not alter any lock or install any new or additional locks or any bolts on any door of the Premises without the prior written consent of Landlord.

7. Landlord reserves the right to exclude from the Premises all persons who disrupt the quiet enjoyment of the Building. Each Tenant shall be liable to the Landlord for any loss or injury to the property of the Landlord or other Tenants, for which loss or injury Tenant is legally responsible. Landlord shall in no case be liable to anyone for any error with regard to the admission to or exclusion from the Building of any person. In the case of invasion, mob, riot, public excitement or other circumstances rendering such action advisable in Landlord' opinion, Landlord reserves the right to prevent access to the Building during the continuance of the same by such action as Landlord may deem appropriate, including closing doors.

8. The restrooms and the fixtures and equipment contained therein shall not be used for any purpose other than that for which they were constructed. Restroom fixtures shall not be used for the disposal of foreign substances (e.g. coffee grounds) and the expense of any breakage, stoppage or damage resulting from violation of this rule shall be borne by the responsible Tenant.

9. Tenant specifically agrees on a daily basis to clean-up and remove any recycle items that are left on the Premises by the public.

10. Tenant shall not permit the Premises to be occupied or used in a manner offensive or objectionable to the other occupants of the Building, persons having business therein, or the occupants of neighboring Buildings. Specifically, tenants shall not use, keep or permit to be used or keep any noxious gas or odorous substance in the Premises. Except for certified aid animals, Tenant shall not allow any animals of any kind to be brought into or kept in or about the Premises of the Building. Tenant shall not make or permit to be make any loud or disturbing noises, whether by the use of any musical instrument, radio, phonograph, appliance, or in any other way. Tenant shall not install any radio or television antenna, loudspeaker, or other device on the room or exterior walls or windows of the Building.

11. Tenants shall not use or keep in the Premises or the Building any kerosene, gasoline, combustible fluid, toxic chemical, radioactive substance, explosives or fireworks or any other dangerous materials.

12. Tenant shall not disturb, solicit, or canvass any occupant or parking lot cars of the Building and shall cooperate to prevent same.

13. Tenant shall not duplicate keys or have keys made. Tenant, upon termination of the tenancy, shall deliver to the landlord all keys which shall have been furnished to Tenant by the Landlord. In the event that Tenant or Tenant's employees or visitors lose a key, Tenant shall pay Landlord the cost of replacing same or of changing the lock or locks opened by such lost key if Landlord deems it necessary to make such change.

14. Tenant shall not lay linoleum, tile, carpet, or other similar floor covering so that the same shall be affixed to any floor of the Premises in any manner except as approved by the Landlord. The expense of repairing any damage resulting from a violation of this rule or of removing any floor coverings affixed in violation of this rule shall be borne by the Tenant.

15. Before leaving the Building, Tenant and Tenant's employees shall (1) see that the doors of the Premises are closed and securely locked; (2) shut off all water faucets and water-using appliances; and (3) shut off all lights and appliances which consume electricity, so as to prevent waste or damage. Tenant shall indemnify the Landlord and other Tenants for any injuries sustained by any of them as a result of any violation of this rule.

16. Landlord reserves the right to exclude or expel from the Building any person who, in the judgment of Landlord, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the Rules and Regulations of the Building.

17. The requirements of Tenant will be attended to only upon application at the Building management office. Employees of Landlord shall not perform any work or do anything outside of their regular duties unless under special instructions from the Landlord, and no employee will admit any person (Tenant or otherwise) to any office without specific instructions from the Landlord.

18. The name of the Building is Lakewood Plaza, LLC and Landlord shall have the right, exercisable without notice and without liability to Tenant, to change the name and the street address of the Building of which the Premises are a part.

19. Without the prior written consent of Landlord, Tenant shall not use the name of the Building to promote or advertise the business of Tenant except as Tenant's address.

20. Tenant agrees that it shall comply with all fire and security regulations that may be issued from time to time by Landlord at the direction of a governmental agency having appropriate jurisdiction. Tenant shall also provide Landlord with the name of a designated employee to represent Tenant in all matters pertaining to fire or security regulations.

21. Tenant shall not use any method of heating, ventilation, or air conditioning other than that supplied by the roof-top units for Tenant; without Landlord's advance permission. In no event shall Tenant shall not use any type of space heater(s) that violate the building fire codes.

22. No curtains, draperies, blinds, shutters, shades, screens or other coverings, hangings, or Decorations in any window of the Building without the prior written consent of Landlord. Such window coverings as the Landlord approve shall be installed on the office side of Landlord's standard window covering and shall in no way be visible from the exterior of the Building.

23. Except with the prior written consent of Landlord, Tenant shall not sell any retail merchandise in or on the Premises other than the defined Use. Tenant shall not carry on or permit any employee or other person to carry on the business of stenography, typewritten, printing or photocopying or any similar business in or from the Premises for the service or accommodation of other occupants of the Building, nor shall the Premises of Tenant be used for manufacturing of any kind, for lodging of any kind, or for any business or activity other than that specified in the Tenant's Lease Agreement.

24. Tenant shall store all its trash and garbage within its Premises. No material shall be placed in the hallways or left for disposal by the Landlord's janitorial services if such material is of such nature that it may not be disposed of in the ordinary and customary manner of removing and disposing of office Building trash and garbage in the City of Lakewood without being in violation of any law or ordinance governing such disposal. All garbage and refuse disposal shall be made only through entryways and elevators provided for such purposes and at such times as Landlord shall designate.

25. Tenant shall not mark, paint, drive nails or drill into, cut string wires within, or on any way deface any part of the building or the Premises, without the prior written consent of Landlord and as Landlord and as landlord may direct. Should Landlord grant approval, Tenant agrees to assume full responsibility and warrants that Tenant's contractor will strictly abide by Landlord's guidelines for work contracted directly by Tenant. Upon removal of any decorations, installations, or floor coverings by Tenant, any damage to the walls or floor shall be repaired by Tenant at Tenant's sole cost and expense. This paragraph shall apply to all work performed in the Building, including without limitation installation of telephone or computer equipment, electrical devices and attachments and installations of any nature affecting floors, walls, woodwork, trim, windows, ceilings, equipment or any other portion of the Building. Plans and specifications for such work, prepared a Tenant's sole expense, shall be submitted to Landlord and shall be subject to Landlord's prior written approval in each instance before the commencement of work. All installations, alterations, and additions shall be constructed by tenant in a good and workmanlike manner and only good grades of materials shall be used in

connection therewith. The means by which telephone cable, computer and telex lines and other wires and cables are to be introduced to the Premises and the location of telephones, computers, and other office equipment affixed to the Premises shall be subject to the prior written approval of the Landlord. Landlord will direct electricians and other contractors as to where and how lines and cables are to be installed. Tenant shall obtain any and all necessary or required permits for any such work at its sole cost and expense.

26. Tenant shall not obstruct, alter or in any way impair the efficient operation of Landlord's heating, ventilating, electrical, fire, safety or lighting systems (including fire escapes), nor shall Tenant tamper with or change the setting of any thermostat or temperature control valves in the Building.

27. In all carpeted areas where desks and chairs are utilized, Tenant shall, at Tenant's own cost, place mats under each and every chair in order to protect said carpeting from unnecessary wear and tear.

28. Tenant shall not use in the Premises or the Building any machines other than standard offices machines such as typewriters, calculators, copying machines, desktop computers and similar machines, without the prior written approval of Landlord. All office equipment and any other device of any electrical or mechanical nature shall be placed by Tenant in the Premises in settings approved by Landlord, so as to absorb or prevent any vibrations, noise, or annoyance to other occupants of the Building. No vending machine shall be installed, maintained or operated on the Premises without the prior written consent of the Landlord.

29. No one is permitted to live or remain overnight in the Premises.

30. No overnight parking of any vehicle, truck or RV is permitted. Landlord has the right to tow away any cars, trucks, RV's, campers or motor cycles who park in the parking lot overnight and shall not be responsible for the cost of towing, storage or damage incurred by such event.

31. Landlord reserves the right to rescind, alter or waive, by written notice to Tenant, any rule or regulation prescribed for the Building when, in Landlord's judgment, it is necessary, desirable or proper to take such action in the best interest of the Building and its tenants. The Waiver of a rule or regulation for the benefit of a particular tenant or tenants shall not be construed as a waiver of such rule or regulation in favor of any other tenant or tenants, nor shall any such waiver prevent Landlord from thereafter enforcing the rules or regulations in question against any or all of the tenants of the Building.

32. These Rules and Regulations supplement and shall not be construed to modify or amend the provisions of the Lease Agreement or other agreement between Landlord and Tenant. In the event of any conflict between these Rules and Regulations and the Lease Agreement and any agreement executed by Landlord and Tenant, the Lease Agreement shall prevail.

Exhibit 4B.
Proof of Landlord Ownership

Pierce County Assessor-Treasurer
Property Summary

8815 S TACOMA WY

LAKEWOOD PLAZA LLC
0320313125

Tax Description

Section 31 Township 20 Range 03 Quarter 32 : THAT POR GOVT LOT 3 DESC AS FOLL COM NW COR SD GOVT LOT 3 TH ALG N LI SD GOVT LOT N 86 DEG 09 MIN 18 SEC E 352.93 FT TH S 04 DEG 55 MIN 01 SEC E 30 FT SD PT BEING ON S R/W LI S 88TH ST & POB TH CONT S 04 DEG 55 MIN 01 SEC E 316.04 FT TH S 86 DEG 08 MIN 36 SEC W 322.93 FT TO E R/W LI S TAC WAY TH ALG SD E R/W LI N 04 DEG 55 MIN 01 SEC W 158.10 FT TH N 86 DEG 09 MIN 18 SEC E 210 FT TH N 04 DEG 55 MIN 02 SEC W PAR/W W LI SD GOVT LOT 3 DIST OF 158 FT TO S R/W LI S 88TH ST TH ALG SD S R/W LI N 86 DEG 09 MIN 18 SEC E 112.93 FT TO POB OUT OF 3-121 & 3-120 SEG N-1573 DL EMS EASE OF RECORD PER ETN 658650 (DC3167ES8-13-86)

Property Details

Parcel Number	0320313125
Site Address	8815 S TACOMA WY
Account Type	Real Property
Category	Land and Improvements
Use Code	6199-MISC OFFICE SPACE

Taxpayer Details

Taxpayer Name	LAKEWOOD PLAZA LLC
Mailing Address	7220 PACIFIC HWY E MILTON, WA 98354

Appraisal Details

Neighborhood	104 / 820
Value Area	PI4
Appr Acct Type	Commercial
Business Name	SOUTH TACOMA BUSINESS PARK BLDG #1
Last Inspection	04/24/2017-Physical Inspection
Appraisal Area	1

Related Parcels

Group Account Number	2077
Located On	n/a
Associated Parcels	1200191400 2093000405 2094004685 2890001065

Assessed Value

Value Year	2020	**Assessed Total**	2,684,900
Tax Year	2021	**Assessed Land**	1,448,100
		Assessed Improvements	1,236,800
Taxable Value	2,684,900		
Tax Code Area	760	**Current Use Land**	0
Tax Code Area Rate	0	**Personal Property**	0
Notice of Value Mailing Date	06/25/2020		

Assessment Details

2020 Values for 2021 Tax

Taxable Value	$2,684,900
Assessed Value	$2,684,900

Tax Amounts Due

Tax Year	Minimum Due	Total Due
TOTAL	**0.00**	**0.00**

Property Tax Exemptions

No exemptions

Land Details

Land Economic Area	2014
RTSQQ	03-20-31-32
Value Area	PI4
Neighborhood	104 / 820
Square Footage	68,891
Acres	1.582
Front Foot	158
Electric	Power Installed
Sewer	Sewer/Septic Installed
Water	Water Installed

Building 1 Details

General Characteristics

Property Type	Commercial
Condition	Average
Quality	Average
Neighborhood	104
Occupancy	Office Class C
Square Feet	30,480
Net Square Feet	27,097
Attached Garage Square Feet	0
Detached Garage Square Feet	0
Carport Square Feet	0
Finished Attic Square Feet	0
Total Basement Square Feet	0
Finished Basement Square Feet	0
Basement Garage Door	0
Fireplaces	0

Built-As

DESCRIPTION	Office Building
YEAR BUILT	1972
ADJUSTED YEAR BUILT	1992
SQUARE FEET	30,480
STORIES	2
BEDROOMS	0
BATHROOMS	0
EXTERIOR	n/a
CLASS	Wood Frame
ROOF	n/a
HVAC	Package Unit
UNITS	0
SPRINKLER SQUARE FEET	30,480

Improvement Details

Type	Description	Units
Add On	Asphalt (AV)	50,000
Add On	Concrete	1,952

Sales History

SALE DATE	06/24/2014
ETN	4343036
PARCEL COUNT	1
GRANTOR	FIRST SAVINGS BANK NORTHWEST
GRANTEE	LAKEWOOD PLAZA LLC
SALE PRICE	1,200,000
DEED TYPE	Bargain & Sale Deed
SALES NOTES	Foreclosure Sale

SALE DATE	05/21/2011
ETN	4261343
PARCEL COUNT	1
GRANTOR	RAINIER FORECLOSURE SERVICES I
GRANTEE	FIRST SAVINGS BANK NORTHWEST
SALE PRICE	1,500,000
DEED TYPE	Trustee Deed (Foreclosure)
SALES NOTES	

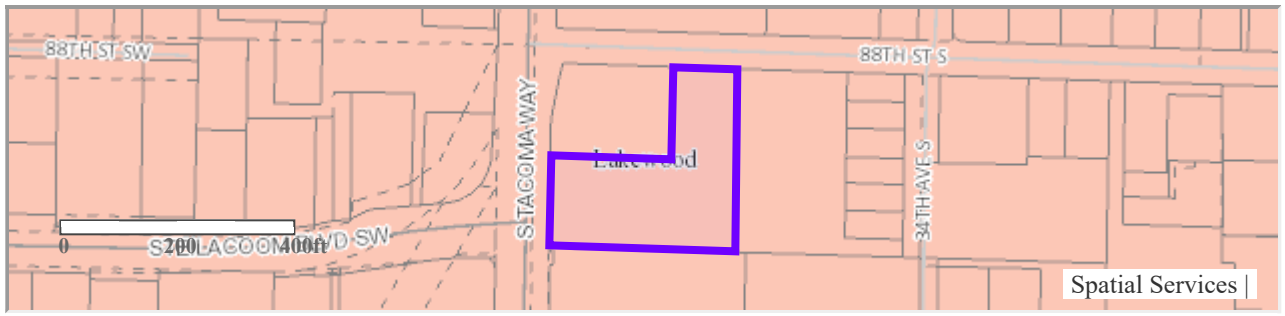
SALE DATE	04/12/2006
ETN	4122185
PARCEL COUNT	1
GRANTOR	OH JOSEPH S & HAE Y
GRANTEE	AHN YONG K & SUNNIE
SALE PRICE	3,500,000
DEED TYPE	Statutory Warranty Deed
SALES NOTES	

SALE DATE	08/11/2005
ETN	4095016
PARCEL COUNT	1
GRANTOR	STBP LLC & STBP II LLC & II11
GRANTEE	OH JOSEPH S & HAE Y
SALE PRICE	3,150,000
DEED TYPE	Statutory Warranty Deed
SALES NOTES	

SALE DATE	08/01/2001
ETN	1069690
PARCEL COUNT	2
GRANTOR	TURNER RORY & LAUREL V
GRANTEE	STBP II LLC
SALE PRICE	330,000
DEED TYPE	Statutory Warranty Deed
SALES NOTES	Partial interest

SALE DATE	08/01/2001
ETN	1069689
PARCEL COUNT	2
GRANTOR	TURNER RORY & LAUREL V
GRANTEE	8811 STW LLC
SALE PRICE	660,000
DEED TYPE	Statutory Warranty Deed
SALES NOTES	Partial interest

Map


88TH ST SW
88TH ST S
S TACOMA WAY
34TH AVE S
0
200
400ft
Spatial Services |

Photos

Sorry, no photo available for display

Sketches

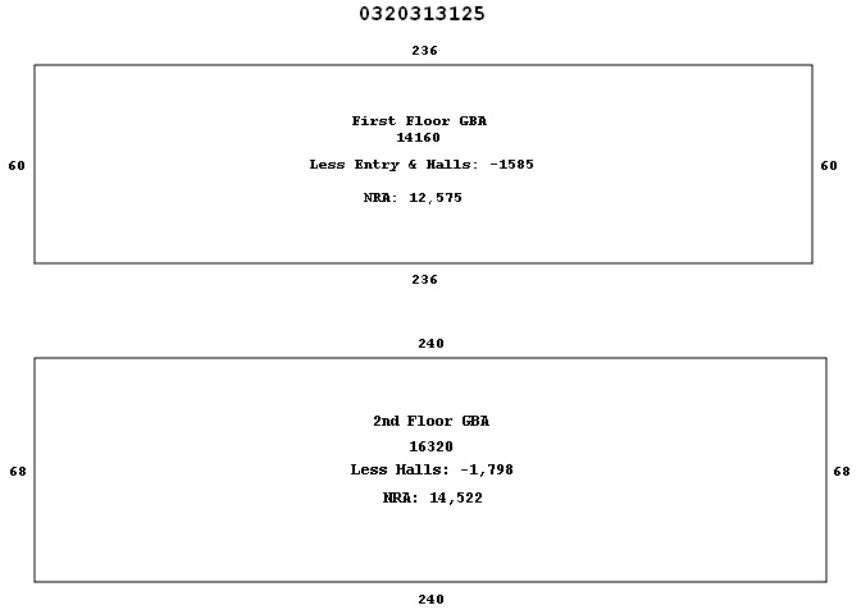


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Exhibit 5.

Planning Area MUA and HPSA Designations

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	03695	King Service Area	Medically Underserved Area	Washington	King County, WA	57.7	Designated	Non-Rural	06/08/1982	05/04/1994

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	03696	King Service Area	Medically Underserved Area	Washington	King County, WA	52.46	Designated	Non-Rural	05/11/1994	05/11/1994

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King	100.01	Census Tract	53033010001	Non-Rural
Washington	King	100.02	Census Tract	53033010002	Non-Rural
Washington	King	101	Census Tract	53033010100	Non-Rural
Washington	King	103	Census Tract	53033010300	Non-Rural
Washington	King	104.01	Census Tract	53033010401	Non-Rural
Washington	King	104.02	Census Tract	53033010402	Non-Rural
Washington	King	107.01	Census Tract	53033010701	Non-Rural
Washington	King	107.02	Census Tract	53033010702	Non-Rural
Washington	King	108	Census Tract	53033010800	Non-Rural
Washington	King	109	Census Tract	53033010900	Non-Rural
Washington	King	110.01	Census Tract	53033011001	Non-Rural
Washington	King	110.02	Census Tract	53033011002	Non-Rural
Washington	King	111.02	Census Tract	53033011102	Non-Rural
Washington	King	112	Census Tract	53033011200	Non-Rural
Washington	King	113	Census Tract	53033011300	Non-Rural
Washington	King	114.01	Census Tract	53033011401	Non-Rural
Washington	King	114.02	Census Tract	53033011402	Non-Rural
Washington	King	115	Census Tract	53033011500	Non-Rural
Washington	King	116	Census Tract	53033011600	Non-Rural
Washington	King	264	Census Tract	53033026400	Non-Rural
Washington	King	265	Census Tract	53033026500	Non-Rural
Washington	King	9901	Census Tract	53033990100	Not Applicable

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	03692	Governor King Service Area	Medically Underserved Area – Governor's Exception	Washington	King County, WA	0.0	Designated	Non-Rural	07/29/1992	02/03/1994

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King	71	Census Tract	53033007100	Non-Rural
Washington	King	72	Census Tract	53033007200	Non-Rural
Washington	King	73	Census Tract	53033007300	Non-Rural
Washington	King	80.01	Census Tract	53033008001	Non-Rural
Washington	King	80.02	Census Tract	53033008002	Non-Rural
Washington	King	81	Census Tract	53033008100	Non-Rural
Washington	King	82	Census Tract	53033008200	Non-Rural
Washington	King	83	Census Tract	53033008300	Non-Rural
Washington	King	84	Census Tract	53033008400	Non-Rural
Washington	King	85	Census Tract	53033008500	Non-Rural
Washington	King	91	Census Tract	53033009100	Non-Rural
Washington	King	92	Census Tract	53033009200	Non-Rural
Washington	King	9901	Census Tract	53033990100	Not Applicable

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King	252	Census Tract	53033025200	Non-Rural
Washington	King	253.01	Census Tract	53033025301	Non-Rural
Washington	King	253.02	Census Tract	53033025302	Non-Rural
Washington	King	254	Census Tract	53033025400	Non-Rural
Washington	King	262	Census Tract	53033026200	Non-Rural
Washington	King	291.01	Census Tract	53033029101	Non-Rural
Washington	King	291.02	Census Tract	53033029102	Non-Rural
Washington	King	292.04	Census Tract	53033029204	Non-Rural
Washington	King	292.05	Census Tract	53033029205	Non-Rural
Washington	King	292.06	Census Tract	53033029206	Non-Rural
Washington	King	295.02	Census Tract	53033029502	Non-Rural
Washington	King	295.04	Census Tract	53033029504	Non-Rural
Washington	King	296.02	Census Tract	53033029602	Non-Rural
Washington	King	297	Census Tract	53033029700	Non-Rural
Washington	King	298.01	Census Tract	53033029801	Non-Rural
Washington	King	305.01	Census Tract	53033030501	Non-Rural
Washington	King	305.03	Census Tract	53033030503	Non-Rural
Washington	King	306	Census Tract	53033030600	Non-Rural
Washington	King	307	Census Tract	53033030700	Non-Rural
Washington	King	308.01	Census Tract	53033030801	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	153999532F	Country Doctor Community Clinic	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	12/03/2003	08/18/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
CAROLYN DOWNS FAMILY MED CENTER	2101 E Yesler Way	Seattle	WA	98122-5959	King	Non-Rural
CDCHC After Hours Clinic	550 16th Ave Ste 100	Seattle	WA	98122-5636	King	Non-Rural
COUNTRY DOCTOR COMMUNITY CLINIC	500 19th Ave E	Seattle	WA	98112-4007	King	Non-Rural
Country Doctor Dental Clinic	510 19th Ave E	Seattle	WA	98112-4095	King	Non-Rural
Meany Middle School - School Based Health Center	301 21st Ave E	Seattle	WA	98112-5318	King	Non-Rural

Primary Care	153999532G	International Community Health Services	Federally Qualified Health Center	Washington	King County, WA		19	Designated	Non-Rural	12/03/2003	08/18/2019

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	153999532J	Seattle Indian Health Board	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	12/03/2003	08/18/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
ACRS	3639 Martin Luther King Jr Way S	Seattle	WA	98144-6847	King	Non-Rural
Finance Office	500 SW 7th St Ste 201	Renton	WA	98057-2983	King	Non-Rural
ICHS - HOLLY PARK MEDICAL & DENTAL CLINIC	3815 S Othello St	Seattle	WA	98118-3510	King	Non-Rural
ICHS - International District Medical & Dental Clinic	720 8th Ave S	Seattle	WA	98104-3032	King	Non-Rural
ICHS Bellevue Medical and Dental Clinic	1050 140th Ave NE	Bellevue	WA	98005-2972	King	Non-Rural
ICHS Mobile Dental Clinic	720 8th Ave S	Seattle	WA	98104-3032	King	Non-Rural
ICHS Shoreline Medical and Dental Clinic	16549 Aurora Ave N	Shoreline	WA	98133-5308	King	Non-Rural
ICHS Vision Clinic	718 8th Ave S	Seattle	WA	98104-3006	King	Non-Rural
Legacy House Clinic	803 S Lane St	Seattle	WA	98104-3044	King	Non-Rural
SBHC at Highland Middle School	11650 SE 60th St	Bellevue	WA	98006-3702	King	Non-Rural
Seattle World School	1700 E Union St	Seattle	WA	98122-4140	King	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
SEATTLE INDIAN HEALTH BOARD	611 12th Ave S	Seattle	WA	98144-2007	King	Non-Rural
SEATTLE INDIAN HEALTH BOARD - Chief Seattle Club	410 2nd Avenue Ext S	Seattle	WA	98104-2876	King	Non-Rural
SEATTLE INDIAN HEALTH BOARD - Thunderbird Treatment Center	9236 Renton Ave S	Seattle	WA	98118-5322	King	Non-Rural
Seattle Indian Health Board- Cowlitz Tribal Health	6450 Southcenter Blvd	Tukwila	WA	98188-2552	King	Non-Rural

Primary Care	153999531P	Healthpoint	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	09/22/2003	08/18/2019

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
HealthPoint School-based Health Clinic Renton High School	400 S 2nd St	Renton	WA	98057-2007	King	Non-Rural
HealthPoint Administration	955 Powell Ave SW	Renton	WA	98057-2908	King	Non-Rural
HealthPoint Administration 841	841 Powell Ave SW	Renton	WA	98057-2991	King	Non-Rural
HealthPoint Auburn	126 Auburn Ave	Auburn	WA	98002-5057	King	Non-Rural
HealthPoint Auburn North	923 Auburn Way N	Auburn	WA	98002-4117	King	Non-Rural
HealthPoint Bothell	10414 Beardslee Blvd	Bothell	WA	98011-3205	King	Non-Rural
HealthPoint Central Fill Pharmacy	947 Powell Ave SW Ste 100	Renton	WA	98057-2975	King	Non-Rural
HealthPoint Evergreen SBHC	830 SW 116th St	Burien	WA	98146-2257	King	Non-Rural
HealthPoint Federal Way	33431 13th Pl S	Federal Way	WA	98003-6357	King	Non-Rural
HealthPoint Kent	403 E Meeker St	Kent	WA	98030-5904	King	Non-Rural
HealthPoint Kent Urgent Care	219 State Ave N	Kent	WA	98030-4543	King	Non-Rural
HealthPoint Midway	26401 Pacific Hwy S	Des Moines	WA	98198-9247	King	Non-Rural
HealthPoint Redmond Dental	16345 NE 87th St Ste C2	Redmond	WA	98052-3503	King	Non-Rural
HealthPoint Redmond Medical	16315 NE 87th St Ste B6	Redmond	WA	98052-3537	King	Non-Rural
HealthPoint Renton	200 S 2nd St	Renton	WA	98057-2011	King	Non-Rural
HealthPoint SeaTac	4040 S 188th St Ste 201	Seatac	WA	98188-5070	King	Non-Rural
HealthPoint Tukwila	13030 Military Rd S Ste 200	Tukwila	WA	98168-3001	King	Non-Rural
HealthPoint Tyee SBHC	4424 S 188th St	Seatac	WA	98188-5028	King	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	HealthPoint Valley Cities Auburn	2704 I St NE	Auburn	WA	98002-2411			King	Non-Rural		
	HealthPoint Valley Cities Kent	325 W Gowe St	Kent	WA	98032-5892			King	Non-Rural		
	The Cynthia A. Greene Family Center	12704 76th Ave S	Seattle	WA	98178-4811			King	Non-Rural		
Primary Care	153999531V	Neighborcare Health	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	12/02/2003	08/18/2019

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Beacon Hill International School	2025 14th Ave S	Seattle	WA	98144-4205	King	Non-Rural
Garfield High School	400 23rd Ave	Seattle	WA	98122-6025	King	Non-Rural
Madrona K-8 School-Based Health Center	1121 33rd Ave	Seattle	WA	98122-5129	King	Non-Rural
Meridian Center for Health	10521 Meridian Ave N	Seattle	WA	98133-9509	King	Non-Rural
Neighborcare Health Administration	1200 12th Ave S Ste 901	Seattle	WA	98144-2712	King	Non-Rural
Neighborcare Health at 45th Street - Dental	1629 N 45th St	Seattle	WA	98103-6701	King	Non-Rural
Neighborcare Health at 45th Street - Medical	1629 N 45th St	Seattle	WA	98103-6701	King	Non-Rural
Neighborcare Health at Bailey Gatzert Elementary	1301 E Yesler Way	Seattle	WA	98122-5430	King	Non-Rural
Neighborcare Health at Central District	2101 E Yesler Way Ste 300	Seattle	WA	98122-5959	King	Non-Rural
Neighborcare Health at Chief Sealth International High School	2600 SW Thistle St	Seattle	WA	98126-3748	King	Non-Rural
Neighborcare Health at Columbia City	4400 37th Ave S	Seattle	WA	98118-1609	King	Non-Rural
Neighborcare Health at Dearborn Park International School	2820 S Orcas St	Seattle	WA	98108-3066	King	Non-Rural
Neighborcare Health at Denny International Middle School	2601 SW Kenyon St	Seattle	WA	98126-3562	King	Non-Rural
Neighborcare Health at Georgetown	6200 13th Ave S	Seattle	WA	98108-2706	King	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Neighborcare Health at High Point	6020 35th Ave SW	Seattle	WA	98126-3002			King	Non-Rural		
	Neighborcare Health at Highland Park Elementary	1012 SW Trenton St	Seattle	WA	98106-2421			King	Non-Rural		
	Neighborcare Health at Lake City	12721 30th Ave NE	Seattle	WA	98125-4498			King	Non-Rural		
	Neighborcare Health at Lincoln High School	4400 Interlake Ave N Rm 132	Seattle	WA	98103-7519			King	Non-Rural		
	Neighborcare Health at Madison Middle School	3429 45th Ave SW	Seattle	WA	98116-3330			King	Non-Rural		
	Neighborcare Health at Magnuson	7101 62nd Ave NE Ste 4	Seattle	WA	98115-7170			King	Non-Rural		
	Neighborcare Health at Mercer Middle School	1600 S Columbian Way	Seattle	WA	98108-1565			King	Non-Rural		
	Neighborcare Health at Pacific Tower	1200 12th Ave S Ste 401	Seattle	WA	98144-2730			King	Non-Rural		
	Neighborcare Health at Pike Place Market	1930 Post Aly	Seattle	WA	98101-1074			King	Non-Rural		
	Neighborcare Health at Rainier Beach	9245 Rainier Ave S	Seattle	WA	98118-5569			King	Non-Rural		
	Neighborcare Health at Rising Star Elementary	8311 Beacon Ave S	Seattle	WA	98118-4323			King	Non-Rural		
	Neighborcare Health at Robert Eagle Staff Middle School	1330 N 90th St Rm M111	Seattle	WA	98103-4016			King	Non-Rural		
	Neighborcare Health at Roosevelt High School	1410 NE 66th St	Seattle	WA	98115-6744			King	Non-Rural		
	Neighborcare Health at Roxhill Elementary	7740 34th Ave SW	Seattle	WA	98126-3503			King	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Neighborcare Health at St. Vincent de Paul - Aurora	13555 Aurora Ave N	Seattle	WA	98133-7511			King	Non-Rural		
	Neighborcare Health at Vashon	10030 SW 210th St	Vashon	WA	98070-6584			King	Non-Rural		
	Neighborcare Health at Vashon Island High School	9600 SW 204th St Rm 1009	Vashon	WA	98070-6135			King	Non-Rural		
	Neighborcare Health at West Seattle Elementary	6760 34th Ave SW	Seattle	WA	98126-4208			King	Non-Rural		
	Neighborcare Health at West Seattle High School	3000 California Ave SW	Seattle	WA	98116-3302			King	Non-Rural		
	Neighborcare Health Ballard Homeless Clinic at Nyer Urness House	1753 NW 56th St Ste 200	Seattle	WA	98107-5279			King	Non-Rural		
	Neighborcare Health Dental at Providence St. Peter Hospital	525 Lilly Rd NE Ste 110	Olympia	WA	98506-5101			Thurston	Non-Rural		
	Neighborcare Health Development	1537 Western Ave	Seattle	WA	98101-1521			King	Non-Rural		
	New Horizons	2709 3rd Ave	Seattle	WA	98121-1217			King	Non-Rural		
	Savvis SE2 Data Center	12301 Tukwila International Blvd	Tukwila	WA	98168-2577			King	Non-Rural		
	Simons Senior Apartments	2119 3rd Ave # 428	Seattle	WA	98121-2333			King	Non-Rural		
	The Morrison	509 3rd Ave	Seattle	WA	98104-3282			King	Non-Rural		
Primary Care	153999532C	KING, COUNTY OF	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	12/03/2003	08/18/2019

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Auburn Public Health Center	901 Auburn Way N Ste A	Auburn	WA	98002-4100	King	Non-Rural
Ballard Homeless Clinic	1753 NW 56th St Ste 200	Seattle	WA	98107-5279	King	Non-Rural
Boren & Virginia Homeless Clinic	1930 Boren Ave	Seattle	WA	98101-1406	King	Non-Rural
Cleveland School-Based Health Center	5511 15th Ave S	Seattle	WA	98108-2823	King	Non-Rural
COLUMBIA PUBLIC HEALTH CTR	4400 37th Ave S	Seattle	WA	98118-1609	King	Non-Rural
COUNTRY DOCTOR HOMELESS YOUTH CLINIC	500 19th Ave E	Seattle	WA	98112-4007	King	Non-Rural
Downtown Public Health Center	2124 4th Ave	Seattle	WA	98121-2308	King	Non-Rural
Eastgate Public Health Center	14350 SE Eastgate Way	Bellevue	WA	98007-6458	King	Non-Rural
EVERGREEN TREATMENT CENTER	1700 Airport Way S	Seattle	WA	98134-1618	King	Non-Rural
FEDERAL WAY PUBLIC HLTH CTR	33431 13th Pl S	Federal Way	WA	98003-6357	King	Non-Rural
Ingraham School-Based Health Center	1819 N 135th St	Seattle	WA	98133-7709	King	Non-Rural
Jefferson Terrace (Respite Floor)	800 Jefferson St	Seattle	WA	98104-2473	King	Non-Rural
Kent Public Health Center	25742 104th Ave SE	Kent	WA	98030-7691	King	Non-Rural
KENT PUBLIC HEALTH CENTER-Birch Creek	13111 SE 274th St	Kent	WA	98030-8929	King	Non-Rural
Mobile Medical Van 2	3005 NE 4th St	Renton	WA	98056-4122	King	Non-Rural
Mobile Van #1	3005 NE 4th St	Renton	WA	98056-4122	King	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	NAVOS Public Health Center	1210 SW 136th St	Burien	WA	98166-1214			King	Non-Rural		
	Neighborcare Health	1629 N 45th St	Seattle	WA	98103-6701			King	Non-Rural		
	North Public Health Center at Meridian	10521 Meridian Ave N	Seattle	WA	98133-9509			King	Non-Rural		
	NORTH PUBLIC HEALTH CENTER-LAKE CITY DENTAL	12359 Lake City Way NE	Seattle	WA	98125-5401			King	Non-Rural		
	Northshore Public Health Center at Totem Lake	13030 121st Way NE Ste 202	Kirkland	WA	98034-3008			King	Non-Rural		
	PIONEER SQUARE CLINIC	206 3rd Ave S	Seattle	WA	98104-2697			King	Non-Rural		
	Rainier Beach School-Based Health Center	8815 Seward Park Ave S	Seattle	WA	98118-4743			King	Non-Rural		
	Renton Public Health Center	3201 NE 7th St	Renton	WA	98056-3729			King	Non-Rural		
	Robert Clewis Center	2124 4th Ave	Seattle	WA	98121-2308			King	Non-Rural		
	SEATTLE KING CO DEPT OF PUB HLTH	401 5th Ave Ste 1000	Seattle	WA	98104-1818			King	Non-Rural		
	STD Program Public Health	908 Jefferson St	Seattle	WA	98104-2433			King	Non-Rural		
	TB CONTROL PROGRAM-PUBLIC HEALTH	325 9th Ave	Seattle	WA	98104-2420			King	Non-Rural		
	Temporary - Bellevue ACRC	13620 SE Eastgate Way	Bellevue	WA	98005-4462			King	Non-Rural		
	Temporary - Shoreline ACRC	18560 1st Ave NE	Shoreline	WA	98155-2148			King	Non-Rural		
	Temporary - SODO ACRC (South of Downtown)	1033 6th Ave S	Seattle	WA	98134-1305			King	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Temporary Site - Harborview Hall	326 9th Ave N Fl 1	Seattle	WA	98109-5121			King	Non-Rural		
	THIRD AVE CENTER AT OPPORTUNITY PLACE	2028 3rd Ave	Seattle	WA	98121-2413			King	Non-Rural		
	White Center Public Health Center	9934 8th Ave SW	Seattle	WA	98106-3036			King	Non-Rural		
Primary Care	153999531Y	Sea-Mar Community Health Center	Federally Qualified Health Center	Washington	King County, WA		20	Designated	Non-Rural	12/02/2003	08/18/2019

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Sea Mar CHC - Aberdeen Sumner Ave.	1813 Sumner Ave	Aberdeen	WA	98520-4600	Grays Harbor	Rural
Sea Mar CHC - Administration	1040 S Henderson St	Seattle	WA	98108-4720	King	Non-Rural
Sea Mar CHC - Anacortes M Avenue	1004 M Ave Ste 107	Anacortes	WA	98221-1954	Skagit	Rural
Sea Mar CHC - Auburn 12th St. SE	735 12th St SE Fl 1	Auburn	WA	98002-6709	King	Non-Rural
Sea Mar CHC - Battle Ground	118 S Parkway Ave	Battle Ground	WA	98604-9215	Clark	Non-Rural
Sea Mar CHC - Battle Ground NE 189th St.	11117 NE 189th St	Battle Ground	WA	98604-6244	Clark	Non-Rural
Sea Mar CHC - Bellevue 116th Ave. NE	2000 116th Ave NE	Bellevue	WA	98004-3047	King	Non-Rural
Sea Mar CHC - Bellevue 150th Ave. SE	3801 150th Ave SE	Bellevue	WA	98006-1668	King	Non-Rural
Sea Mar CHC - Bellevue 156th Ave. NE	1811 156th Ave NE Ste 2	Bellevue	WA	98007-4344	King	Non-Rural
Sea Mar CHC - Bellevue Bell-Red Rd.	12835 NE Bel Red Rd Ste 100	Bellevue	WA	98005-2625	King	Non-Rural
Sea Mar CHC - Bellingham Behavioral Health	3350 Airport Dr	Bellingham	WA	98226-8048	Whatcom	Non-Rural
Sea Mar CHC - Bellingham Cordata Parkway	4455 Cordata Pkwy	Bellingham	WA	98226-8037	Whatcom	Non-Rural
Sea Mar CHC - Burien 8th Ave. S.	18010 8th Ave S Ste 416	Seatac	WA	98148-1908	King	Non-Rural

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Burien Ambaum Blvd. SW	14434 Ambaum Blvd SW	Burien	WA	98166-1438			King	Non-Rural		
	Sea Mar CHC - Concrete	7438 S D Ave	Concrete	WA	98237-9642			Skagit	Rural		
	Sea Mar CHC - Des Moines S. 242nd St.	2781 S 242nd St	Des Moines	WA	98198-5166			King	Non-Rural		
	Sea Mar CHC - Elma W. Main St.	515 W Main St	Elma	WA	98541-9285			Grays Harbor	Rural		
	Sea Mar CHC - Everett 100th St. SE	1920 100th St SE	Everett	WA	98208-3832			Snohomish	Non-Rural		
	Sea Mar CHC - Everett Claremont Way	5007 Claremont Way	Everett	WA	98203-3321			Snohomish	Non-Rural		
	Sea Mar CHC - Everson Hannegan Rd.	6884 Hannegan Rd	Everson	WA	98247-9637			Whatcom	Non-Rural		
	Sea Mar CHC - Federal Way 18th Ave S	31405 18th Ave S	Federal Way	WA	98003-5433			King	Non-Rural		
	Sea Mar CHC - Gig Harbor 50th St Ct NW	3208 50th Street Ct Ste 202-203	Gig Harbor	WA	98335-8590			Pierce	Non-Rural		
	Sea Mar CHC - Kelso Allen St.	1710 Allen St	Kelso	WA	98626-4907			Cowlitz	Non-Rural		
	Sea Mar CHC - Kent 104th Ave SE	25028 104th Ave SE	Kent	WA	98030-9310			King	Non-Rural		
	Sea Mar CHC - Kent 233 2nd Ave. S.	233 2nd Ave S	Kent	WA	98032-5852			King	Non-Rural		
	Sea Mar CHC - Lacey Woodland Square Loop	669 Woodland Square Loop SE	Lacey	WA	98503-1038			Thurston	Non-Rural		
	Sea Mar CHC - Lakewood Bridgeport Way W	7424 Bridgeport Way W	Lakewood	WA	98499-8120			Pierce	Non-Rural		
	Sea Mar CHC - Lynnwood Alderwood Mall Blvd.	4111 Alderwood Mall Blvd	Lynnwood	WA	98036-6765			Snohomish	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Marysville Grove St. NE	4922 Grove St	Marysville	WA		98270-4427		Snohomish		Non-Rural	
	Sea Mar CHC - Marysville State Ave.	9710 State Ave	Marysville	WA		98270-2232		Snohomish		Non-Rural	
	Sea Mar CHC - Mercy Housing Bellingham	512 Sterling Dr	Bellingham	WA		98226-5503		Whatcom		Non-Rural	
	Sea Mar CHC - Monroe Fryelands Blvd. SE	14090 Fryelands Blvd SE	Monroe	WA		98272-2693		Snohomish		Non-Rural	
	Sea Mar CHC - Monroe W. Main St.	17707 W Main St	Monroe	WA		98272-1967		Snohomish		Non-Rural	
	Sea Mar CHC - Mt. Vernon E. College Way	1010 E College Way	Mount Vernon	WA		98273-5624		Skagit		Non-Rural	
	Sea Mar CHC - Mt. Vernon N. LaVenture Rd.	1400 N Laventure Rd	Mount Vernon	WA		98273-2766		Skagit		Non-Rural	
	Sea Mar CHC - Mt. Vernon Old Hwy 99	2203 Old Highway 99 S Rd	Mount Vernon	WA		98273-9009		Skagit		Non-Rural	
	Sea Mar CHC - Oak Harbor 31775 SR 20	31775 WA-20, Ste A3	Oak Harbor	WA		98277-5104		Island		Rural	
	Sea Mar CHC - Oak Harbor BH	31640 State Route 20	Oak Harbor	WA		98277-3128		Island		Rural	
	Sea Mar CHC - Ocean Shores Point Brown Ave.	597 Point Brown Ave NW	Ocean Shores	WA		98569-9632		Grays Harbor		Rural	
	Sea Mar CHC - Olympia 3030 Limited Lane NW	3030 Limited Ln NW	Olympia	WA		98502-2704		Thurston		Non-Rural	
	Sea Mar CHC - Olympia Ensign Rd NE	3622 Ensign Rd NE	Olympia	WA		98506-5081		Thurston		Non-Rural	
	Sea Mar CHC - Port Angeles W. 1st St.	228 W 1st St, Ste L	Port Angeles	WA		98362-2639		Clallam		Rural	
	Sea Mar CHC - Puyallup 101st Avenue Ct. E.	12812 101st Avenue Ct E	Puyallup	WA		98373-9101		Pierce		Non-Rural	

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Puyallup 125th Street Ct. E.	10217 125th Street Ct E	Puyallup	WA	98374-2761			Pierce	Non-Rural		
	Sea Mar CHC - Seattle 17th Place S.	10001 17th Pl S Lowr Levl	Seattle	WA	98168-1615			King	Non-Rural		
	Sea Mar CHC - Seattle 8720 14th Ave. S.	8720 14th Ave S	Seattle	WA	98108-4807			King	Non-Rural		
	Sea Mar CHC - Seattle 8801 14th Ave S	8801 14th Ave S	Seattle	WA	98108-4809			King	Non-Rural		
	Sea Mar CHC - Seattle 8915 14th Ave. S.	8915 14th Ave S	Seattle	WA	98108-4813			King	Non-Rural		
	Sea Mar CHC - Seattle Des Moines Memorial Drive S	9635 Des Moines Memorial Dr	Seattle	WA	98108-5061			King	Non-Rural		
	Sea Mar CHC - Skagit Valley Women's Health Center	125 N 18th St Ste A	Mount Vernon	WA	98273-3902			Skagit	Non-Rural		
	Sea Mar CHC - Tacoma 1215 S. 11th St.	1215 S 11th St	Tacoma	WA	98405-4020			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 1307 S. 11th St.	1307 S 11th St	Tacoma	WA	98405-3644			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma 6th Ave	1112 6th Ave Ste 301	Tacoma	WA	98405-4048			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S 14th St	702 S 14th St	Tacoma	WA	98405-4407			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 11th St.	1516 S 11th St	Tacoma	WA	98405-3332			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. 19th St.	2121 S 19th St	Tacoma	WA	98405-2922			Pierce	Non-Rural		
	Sea Mar CHC - Tacoma S. Cedar St.	3712 S Cedar St	Tacoma	WA	98409-5715			Pierce	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
	Sea Mar CHC - Tacoma S. Cushman Ave.	1112 S Cushman Ave	Tacoma	WA	98405-3631			Pierce	Non-Rural		
	Sea Mar CHC - Tillicum Community Center	14916 Washington Ave SW	Lakewood	WA	98498-2271			Pierce	Non-Rural		
	Sea Mar CHC - Tumwater 6334 Littlerock Rd. SW	6334 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater 6336 Littlerock Rd. SW	6336 Littlerock Rd SW	Tumwater	WA	98512-7332			Thurston	Non-Rural		
	Sea Mar CHC - Tumwater Capitol Blvd SE	6004 Capitol Blvd SE	Tumwater	WA	98501-8520			Thurston	Non-Rural		
	Sea Mar CHC - Vancouver 1601 E Fourth Plain Blvd	1601 E Fourth Plain Blvd Bldg 17	Vancouver	WA	98661-3717			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 317 E 39th St	317 E 39th St	Vancouver	WA	98663-2233			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 34th St.	19005 SE 34th St	Vancouver	WA	98683-1450			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 5411 E. Mill Plain Blvd.	5411 E Mill Plain Blvd	Vancouver	WA	98661-7057			Clark	Non-Rural		
	Sea Mar CHC - Vancouver 7803 NE Fourth Plain Rd.	7803 NE Fourth Plain Blvd	Vancouver	WA	98662-7294			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Behavioral Health	5501 NE 109th Ct	Vancouver	WA	98662-6177			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Delaware Lane	7410 Delaware Ln	Vancouver	WA	98664-1408			Clark	Non-Rural		
	Sea Mar CHC - Vancouver Fourth Plain	6100 NE Fourth Plain Blvd	Vancouver	WA	98661-6830			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 20th Ave.	14508 NE 20th Ave	Vancouver	WA	98686-6424			Clark	Non-Rural		
	Sea Mar CHC - Vancouver NE 65th St.	11801 NE 65th St	Vancouver	WA	98662-5527			Clark	Non-Rural		

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Sea Mar CHC - Vancouver NE 88th St.	1412 NE 88th St	Vancouver	WA	98665-9620	Clark			Non-Rural			
Sea Mar CHC - White Center 15th Ave. SW	9650 15th Ave SW Ste 100	Seattle	WA	98106-2576	King			Non-Rural			
Sea Mar CHC - Yelm Cullens St. NW	202 Cullens St NW	Yelm	WA	98597-9417	Thurston			Non-Rural			
Sea Mar CHC – Everett W Mukilteo Blvd	215 W Mukilteo Blvd	Everett	WA	98203-2057	Snohomish			Non-Rural			
Primary Care	1538109934	Muckleshoot Behavioral Health Program	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		17	Designated	Non-Rural	08/18/2019	08/18/2019
Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**			**Rural Status**			
Muckleshoot Behavioral Health Program	17500 SE 392nd St	Auburn	WA	98092-9705	King			Non-Rural			
Primary Care	15399953H8	Muckleshoot Tribal Clinic	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		17	Designated	Non-Rural	10/26/2002	09/09/2019
Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**			**Rural Status**			
Muckleshoot Tribal Clinic	17500 SE 392nd St	Auburn	WA	98092-9705	King			Non-Rural			
Primary Care	1533741900	North Bend Family Clinic	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		11	Designated	Non-Rural	10/26/2002	09/09/2019
Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**			**Rural Status**			
North Bend Family Clinic	404 Main Ave S	North Bend	WA	98045-8215	King			Non-Rural			
Primary Care	1539251991	Raging River Recovery Center	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		13	Designated	Non-Rural	08/18/2019	09/09/2019
Site Name	**Site Address**	**Site City**	**Site State**	**Site ZIP Code**	**County**			**Rural Status**			
Raging River Recovery Center	1308 Boalch Ave NW	North Bend	WA	98045-8908	King			Non-Rural			

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Primary Care	1539421184	Seattle Indian Health Board Health Center	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		17	Designated	Non-Rural	08/18/2019	09/09/2019

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Seattle Indian Health Board Health Center	611 12th Ave S Ste 200	Seattle	WA	98144-2007	King	Non-Rural

Primary Care	1533584224	Tolt Community Clinic-Snoqualmie	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		15	Designated	Non-Rural	02/11/2020	02/11/2020

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Tolt Community Clinic-Snoqualmie	4334 Tolt Ave	Carnation	WA	98014	King	Non-Rural

Primary Care	15399953PE	Snoqualmie-Tolt Community Clinic	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Washington	King County, WA		15	Designated	Non-Rural	10/26/2002	02/11/2020

Site Name	Site Address	Site City	Site State	Site ZIP Code	County	Rural Status
Snoqualmie-Tolt Community Clinic	4334 Tolt Ave	Carnation	WA	98014	King	Non-Rural

Primary Care	1531111612	Vashon Maury Island	Geographic HPSA	Washington	King County, WA	2.3000	15	Designated	Non-Rural	07/28/2017	07/28/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King County	277.01	Census Tract	53033027701	Non-Rural
Washington	King County	277.02	Census Tract	53033027702	Non-Rural

Primary Care	1538700586	Enumclaw	Geographic HPSA	Washington	King County, WA	3.2500	10	Designated	Non-Rural	09/18/2017	09/18/2017

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King County	312.02	Census Tract	53033031202	Non-Rural
Washington	King County	313.01	Census Tract	53033031301	Non-Rural
Washington	King County	313.02	Census Tract	53033031302	Non-Rural
Washington	King County	314	Census Tract	53033031400	Non-Rural
Washington	King County	315.01	Census Tract	53033031501	Non-Rural
Washington	King County	315.02	Census Tract	53033031502	Non-Rural
Washington	King County	316.03	Census Tract	53033031603	Non-Rural

Primary Care	1535586501	Snoqualmie/North Bend	Geographic HPSA	Washington	King County, WA	6.1700	10	Designated	Partially Rural	10/16/2017	10/16/2017

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	King County	320.03	Census Tract	53033032003	Non-Rural
Washington	King County	321.02	Census Tract	53033032102	Non-Rural
Washington	King County	322.10	Census Tract	53033032210	Non-Rural
Washington	King County	325	Census Tract	53033032500	Non-Rural
Washington	King County	326.01	Census Tract	53033032601	Non-Rural
Washington	King County	326.02	Census Tract	53033032602	Non-Rural
Washington	King County	327.02	Census Tract	53033032702	Non-Rural
Washington	King County	327.03	Census Tract	53033032703	Non-Rural
Washington	King County	327.04	Census Tract	53033032704	Non-Rural
Washington	King County	328	Census Tract	53033032800	Rural

Exhibit 6.

Planning Area Forecast Need Model and Planning Area Supply

King Home Health Planning Area Need Model

Step 1: Population Estimates

	Base year	Forecast year 1	Forecast year 2	Forecast year 3
	CY2020	CY2021	CY2022	CY2023
0-64 Years Old	1,906,749	1,918,329	1,929,979	1,941,700
65-79 Years Old	254,184	263,080	272,288	281,818
80+ Years Old	70,476	73,730	77,135	80,697
Total	**2,231,409**	**2,255,140**	**2,279,403**	**2,304,216**

Source: OFM 2017 GMA Projections - Medium Series (Jan. 2018 Release)

Step 2: Projected Patients

	Use Rate	CY2020	CY2021	CY2022	CY2023
0-64	0.005	9,534	9,592	9,650	9,709
65-79	0.044	11,184	11,576	11,981	12,400
80+	0.183	12,897	13,493	14,116	14,768
Total		**33,615**	**34,660**	**35,746**	**36,876**

Step 3: Projected Visits

	Visit Multiplier	CY2020	CY2021	CY2022	CY2023
0-64	10	95,337	95,916	96,499	97,085
65-79	14	156,577	162,058	167,730	173,600
80+	21	270,839	283,346	296,430	310,119
Total		**522,754**	**541,320**	**560,659**	**580,804**

Step 4: Net Need

	CY2020	CY2021	CY2022	CY2023
Gross Need	52.28	54.13	56.07	58.08
Supply	32	32	32	32
Net Need	**20.00**	**22.00**	**24.00**	**26.00**
Note: the methodology states fractional numbers are to be rounded down.				

Source: DOH December 2020 Evaluation of CN20-02

King Home Health Agency Supply

Source: DOH December 2020 Evaluation of CN20-02

License #	Agency Name	Included in Supply Count?	Notes
IHS.FS.60904213	ICHS PACE at Legacy House	Yes	CN Approved for King County
IHS.FS.00000278	Evergreen Health	Yes	CN Approved for King County
IHS.FS.60007888	Careage Home Health	Yes	CN Approved for King County
IHS.FS.60532952	Brookdale Home Health	Yes	CN Approved for King County
IHS.FS.00000305	Kaiser Permanente Home Health and Hospice	Yes	CN Approved for King County
IHS.FS.60276500	Wesley Health and Homecare	Yes	CN Approved for King County
IHS.FS.00000220	Signature Home Health	Yes	CN Approved for King County
IHS.FS.00000293	Kindred at Home	Yes	CN Approved for King County
IHS.FS.00000295	Kindred at Home	Yes	CN Approved for King County
IHS.FS.00000419	Providence Home Services	Yes	CN Approved for King County
IHS.FS.60081744	MultiCare Home Health, Hospice and Palliative Care	Yes	CN Approved for King County
IHS.FS.60497952	Assured Home Health	Yes	CN Approved for King County
IHS.FS.60506466	CHI Franciscan Health at Home	Yes	CN Approved for King County
IHS.FS.60521160	Envision Home Health	Yes	CN Approved for King County
IHS.FS.60103742	Kline Galland Community Based Services	Yes	CN Approved for King County
IHS.FS.00000382	Signature Home Health	Yes	CN Approved for King County
IHS.FS.60751653	Puget Sound Home Health of King County	Yes	CN Approved for King County
IHS.FS.00000433	Sea Mar Home Health	Yes	CN Approved for King County
IHS.FS.00000206	Advanced Health Care Inc	Yes	Website states the agency serves Pierce, Thurston & King counties; 80 home health FTEs to serve 3 Washington State counties.
IHS.FS.00000156	Advisacare Healthcare Solutions Inc	Yes	Website states the agency is located in Tacoma and Seattle; 15 home health FTEs to serve 2 Washington State counties.
IHS.FS.00000204	Alliance Nursing Inc	Yes	Website states the agency provides pediatric & adult private duty nursing for patients with medically intensive needs. Services provided for technology-dependent or developmentally disabled patients; 57 home health FTEs to serve 17 Washington State counties.
IHS.FS.61035006	Amedisys Washington LLC	Yes	Website states located in Bellevue; 12 home health FTEs to serve 1 Washington State county
IHS.FS.00000231	Avail Home Health Inc	Yes	Website states home health provider in King County; 125 home health FTEs to serve 39 Washington State counties.
IHS.FS.00000243	Careforce Inc	Yes	Website states home care and home health provider in King County; 50 home health FTEs to serve 6 Washington State counties.
IHS.FS.00000184	CHC Services LLC	Yes	Website states home care and home health provider in King County; 11 home health FTEs to serve 10 Washington State counties; located in Edmonds.
IHS.FS.00000265	Coram Alternate Site Services Inc	Yes	Website states home care and home health provider in King County; 15 home health FTEs to serve 14 Washington State counties; located in Redmond.
IHS.FS.60955703	Infinity Home Health Solutions Inc.	Yes	Website states home health provider in King County; 5 home health FTEs to serve 5 Washington State counties; located in Federal Way.
IHS.FS.00000142	New Care Concepts Inc.	Yes	Website states home health provider in King County; 99 home health FTEs to serve 11 Washington State counties.
IHS.FS.00000415	Providence Health and Services - Washington	Yes	Website states home health provider in King County; 16 home health FTEs to serve 1 Washington State county.
IHS.FS.00000417	Providence Health and Services - Washington	Yes	Website states home health provider in King County; 47 home health FTEs to serve 22 Washington State counties.
IHS.FS.60660148	Serengeti Care Partners LLC	Yes	Website states home health provider in King County; 24 home health FTEs to serve 2 Washington State counties.
IHS.FS.00000028	Wesley Homes Community Health Services	Yes	Website states home health provider in King and Pierce counties; 2 home health FTEs to serve 2 Washington State counties.
IHS.FS.60844133	A and K Health Care Services LLC	No	2 home health FTEs and no website found
IHS.FS.60034694	Accredo Health Group Inc	No	Therapeutic Resource Center
IHS.FS.60474800	Act for Health Inc.	No	Agency serves children and adolescents only
IHS.FS.60876117	Agape Healthcare Services LLC	No	4 home health FTEs and no website for Washington State found
IHS.FS.00000214	American Healthcare Services Inc	No	Durable Medical Equipment Provider and no website found
IHS.FS.00000215	Amicable Health Care Inc	No	1 home health FTE; home care provider; 2018 survey response identified 0 home health admissions
IHS.FS.60674651	Beam Senior Care LLC	No	No specific website; information found on Better Business Bureau website focuses on home care services; 2 locations in King County: Bellevue & Seattle.
IHS.FS.60966822	Bethany Home Health LLC	No	No specific website for the home health agency; 2018 survey response identifies 0 home health admissions
IHS.FS.00000253	Children's Country Home	No	Serves pediatric only
IHS.FS.60959298	Childress Nursing Services LLC	No	Home health agency that focuses on women & families from pre-conception to post-delivery
IHS.FS.60852239	Critical Nurse Staffing LLC	No	No specific website for the home health agency; appears to be home care only. 2018 survey response identifies 0 home health admissions

King Home Health Agency Supply

Source: DOH December 2020 Evaluation of CN20-02

License #	Agency Name	Included in Supply Count?	Notes
IHS.FS.60871359	D.C.S, LLC	No	No website for Washington State found; 4 home health FTEs to serve 3 Washington State counties.
IHS.FS.60871865	Eden Home Health of King County, LLC	No	Located in Kirkland; website states full-service agencies when Medicare certified; 1 home health FTE associated with agency.
IHS.FS.60001472	EKL Health LLC	No	No specific website; located in Woodinville; info on web focuses on home care; 4 home health FTE associated with agency.
IHS.FS.61028960	Fedelta Home Care LLC	No	Website focuses on home care, not home health.
IHS.FS.60720687	Goldencare Agency LLC	No	No specific website; located in Woodinville; information on web focuses on home care, not home health.
IHS.FS.60266397	Guardian Home Care Inc	No	Website focuses on home care, not home health.
IHS.FS.60892797	Harbor Health Solutions LLC	No	Website focuses on home care, not home health.
IHS.FS.60934498	Haylo Care Inc.	No	No specific website for the home health agency.
IHS.FS.00000309	Health People Inc	No	No specific website for the home health agency.
IHS.FS.00000134	Helping Hands for the Disabled	No	No specific website for the home health agency
IHS.FS.60291296	HumanGood Washington	No	No specific website for the home health agency; located in Judson Park a continuing care retirement community; services focus on residents of community, not entire county.
IHS.FS.60082962	Husky Senior Care LLC	No	Website focuses on senior care; but not home health services. 4 home health FTEs to serve 4 Washington State counties.
IHS.FS.00000342	Infant Home Phototherapy Inc	No	Services for newborns only.
IHS.FS.60164493	Infusion Solutions Inc	No	Infusion services only
IHS.FS.00000375	Maxim Healthcare Services Inc	No	Website focuses on healthcare staffing; not home health agency
IHS.FS.60542868	Miraluna SU Ventures LLC	No	Website focuses on owner, but does not identify home health services.
IHS.FS.00000372	Multicare Health System	No	Infusion services only.
IHS.FS.60503577	Nogah Home Care LLC	No	Website focuses on home care, not home health. 5 home health FTEs to serve 4 Washington State counties.
IHS.FS.00000096	Northwest Homecare and Staffing Services LLC	No	No website found; probable healthcare staffing agency. Did not complete 2018 survey identifying any services.
IHS.FS.60670421	Nuclear Care Partners LLC	No	Website focuses on personal care services; not home health. 39 home health FTEs to serve 39 Washington State counties.
IHS.FS.00000396	Option Care Enterprises Inc	No	Website focuses on infusion therapy; not home health
IHS.FS.00000398	Option Care Enterprises Inc	No	Website focuses on infusion therapy; not home health
IHS.FS.60073462	Optum Women's and Children's Health LLC	No	No website found. 39 home health FTEs to serve 39 Washington State counties.
IHS.FS.00000423	Pediatric Services of America Inc	No	No website found; pediatric only.
IHS.FS.60510592	Pediatric Services of America Inc	No	No website found; pediatric only.
IHS.FS.60083889	Popes Kids Place	No	Pediatric only.
IHS.FS.60263077	Rehab Without Walls Inc	No	Website focuses on rehab services only; not home health
IHS.FS.61034384	Respect Nursing Care LLC	No	Website focuses on nursing care, not home health; 2 home health FTEs to serve 2 Washington State counties
IHS.FS.61090653	Restoration Home Health Services LLC	No	Website states it is a nursing pool.
IHS.FS.60610351	Ro Health Inc.	No	No specific website for the home health agency. 9 home health FTEs to serve 7 Washington State counties.
IHS.FS.00000097	Seattle Children’s Hospital	No	No specific website for the home health agency; pediatric only
IHS.FS.60950400	Sofavi Home Health LLC	No	Website focuses on home care, not home health. 3 home health FTEs to serve 2 Washington State counties
IHS.FS.00000227	The Ashley House	No	No specific website for the home health agency; pediatric only
IHS.FS.00000452	Total Care Inc	No	No specific information on the website for the home health agency
IHS.FS.61057211	Transitions Care Management, LLC	No	No specific information on the website for the home health agency
IHS.FS.61043336	Tulamore Inc. Company	No	No specific information on the website for the home health agency
IHS.FS.60631342	Universal Home Care LLC	No	Website focuses on home care, not home health
IHS.FS.60863143	VillagePlan Care Options LLC	No	No specific information on the website for the home health agency
IHS.FS.61055973	Wellspring Home Health, LLC	No	Website does not identify any specific home health services; agency located in Tacoma; 0 home health FTEs to serve 3 Washington State counties.
IHS.FS.60055610	Wilderness Shores Nursing LLC	No	Website focuses on skilled nursing, not any other home health services; 4 home health FTEs to serve 2 Washington State counties.

Exhibit 7A.

Patient Referral Policy

WellSpring
HOME HEALTH

Wellspring Home Health Center, LLC

PATIENT REFERRAL POLICY

Referral and Acceptance of Patients:

1. Requests for home health services may be received from a variety of sources, including but not limited to hospital discharge planners, physicians, patients family, friends, social services, skilled nursing home facilities, case managers, community agencies or hospitals.

2. Referrals may be accepted by telephone, facsimile (fax), mail or in person by family members or concerned individuals. Acceptance of individuals who request home care services is based on a reasonable expectation that the individual's medical, nursing, and social needs will be met when home care staff members visit the applicant's place of residence.

3. Only qualified staff may take referral information. A log of all persons referred for service will be maintained. Persons rejected will be noted along with the reason for rejection. Persons residing outside of the service area or in need of services not provided by the Agency will be assisted in contacting the appropriate resources.

4. When a request is received for home health services, the patient will be considered for acceptance as a patient if he/she is:

a. Homebound, if Medicare billing or private insurance requirements are met.

b. In need of intermittent skilled intervention (nursing, therapy or social services).

c. In need of private duty services, either skilled or unskilled.

d. If there is a reasonable expectation that their medical nursing and social needs can be adequately met in their place of residence

WellSpring
HOME HEALTH

Process of Accepting Patients:

Upon receipt of a referral, an evaluation by an RN and/or appropriate therapist will be made to determine that the care can be adequately and safely performed at home, to assess the patient care needs, and to ensure that the patient meets the admission criteria. Patients will be evaluated by a nurse or appropriate staff member within 48 hours of referral or discharge from a facility whenever possible.

1. The Director of Clinical Services assigns clinical Agency staff to conduct an initial assessment of eligibility for services within 48 hours of acceptance of referral information and/or discharge from the referring facility.

2. The nurse assesses the referral for admission to the Agency based on the established admission criteria. Information is documented on the Intake form which is signed and dated.

3. The RN:

    a. Contacts the applicant or family by telephone to obtain additional information regarding the applicant's need for services.

    b. Documents and reviews applicant information on the Intake form.

    c. Determines if the applicant should be accepted or not accepted for admission to the Agency following an on-site visit to the patient's home.

    d. Informs the applicant or family of the decision to accept or not accept the applicant for admission.

    e. Documents the appropriateness of the applicant's admission on the Intake form.

4. The completed Intake form is filed in the clinical record.

5. Patients will be assigned to the appropriate staff members by an RN or under the supervision of the RN according to geographical location, clinical needs of the patient, and the qualifications and availability of staff.

6. At any time that a patient requires additional services, he/she may be referred for care by other disciplines within the Agency or the appropriate additional community resources. The referral will be communicated to all staff members. The patient may be seen by the referred discipline when physician orders are obtained.

Exhibit 7B.

Case Management and Assignment Policy

Wellspring Home Health Center, LLC

CASE MANAGEMENT AND ASSIGNMENTS POLICY

Purpose:

To ensure efficient and effective care management.

Policy:

Agency staff provides case management according to home health care Agency policies and procedures.

Procedure:

1. Patients are accepted for admission to home care according to established admission criteria.

2. An RN or physical therapist will be assigned to each patient as the case manager.

3. A verbal/written order for admission is obtained from the admitting coordinator as required by state regulation.

4. A written certification is obtained from the admitting physician indicating that:

a. Home health care services are required.
b. The patient needs skilled nursing care on an intermittent basis or needs physical, occupational, or speech therapy services.
c. A plan for furnishing home health care services to the patient has been established and is periodically reviewed by the physician.
d. Home health care services are furnished while the patient is under the care of a physician.
e. Home health care services are necessary and reasonable for the treatment of the patient's illness or injury.
f. Homebound status is indicated for Medicare patients.

5. A written plan of treatment and orders will be obtained from the admitting physician when applicable.

6. The case manager or designee will make an initial home visit for the purpose of:
a. Introduction to the patient, family, and/or caregiver(s)
b. Explaining the home care visit procedure to the patient/ patient/family and/or caregiver(s)
c. Advising the patient of the Bill of Rights/Responsibilities and the State Hotline number
d. Explain how to contact the Agency 24/7, as needed.

7. Answering questions and concerns relevant to home care.

8. Obtaining the patient's signature (or that of a duly authorized representative) on appropriate forms.

9. Performing a comprehensive nursing assessment, physical therapy, or speech pathology assessment.

10. Developing and implementing a nursing care plan or physical therapy plan with the patient/family based on the initial assessment and the admitting physician's plan of treatment.

11. Obtaining and implementing physician orders when applicable.

12. Informing the patient, family, and/or caregiver(s) of the Agency staff assignments.

13. Orienting the assigned Agency staff member to the home care environment and tasks.

14. Developing the Home Health Aide/CNA care plan with the patient/family.

15. Informing the clinical supervisor or designee of staffing needs and other pertinent information regarding the patient.

16. Discussing the patient case management at the first scheduled case conference or as needed following admission to the Agency.

17. Informing patient/family of emergency preparedness classification.

18. Discharge planning.

Exhibit 8.

Admissions Criteria Policy

Wellspring Home Health Center, LLC

ADMISSION CRITERIA POLICY

ELIGIBILITY CRITERIA:

Admission criteria are standards by which a patient can be judged for admission. These standards include assessment of the adequacy and suitability of Agency personnel to meet the patient's needs, the Agency's resources to provide the required services, and a reasonable expectation that the patient's needs may be adequately met in the patient's place of residence. Patients are accepted for care without regard to age, race, color, creed, sex, national origin or handicap(s).

Admission Criteria:

1. Patients shall be accepted for care without discrimination on the basis of age, sexual orientation, gender, mental/physical handicap, race, religion, ancestry or national origin.
2. Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health and social needs can be met safely and adequately by the Agency in the patient's place of residence.
3. The Agency shall consider the medical, nursing and social aspects of the patient's condition in making the decision to accept the patient for care. Considerations relevant to the acceptance of patients shall include, but not necessarily be limited to:
    a. Adequacy and suitability of Agency personnel and resources to provide the services required by the patient.
    b. Attitudes of patient and his family toward his care at home. Patient and/or family must desire home care services. If at any time during the course of treatment of patient, because of the patient's general attitude towards care, i.e., patient can be discharged upon reasonable written notice to him and the attending physician and proper community agencies notified.
    c. Reasonable expectation that the patient's medical, nursing and social needs can be met adequately in his residence, including a plan to meet medical emergencies.
    d. Adequate physical facilities and equipment in the patient's residence for safe, effective care.
4. Patients needing skilled care must be under the care of a physician. The physician's plan of treatment shall include orders for all services except household, chore, or sitter services unless such orders are required by the state.
5. The patient must reside within the geographical area that the Agency services.
6. Services and care must conform to current standards of practice for the respective discipline and should be reasonable and necessary to the treatment of a medical or psychiatric disorder.
7. The RN will determine type, appropriateness, and adequacy of requested services including at a minimum an initial home visit for assessment of the patient's needs and development of the patient care plan within 48 hours of the start of service.

8. Patient signature: On admission, each patient will sign admission forms as outlined in the admission packet. Should the patient be unable to sign their full name, the patient will make their mark (i.e. X), which will be witnessed by an individual that has no direct connection to the agency.
9. On admission, each patient shall receive:
    a. A copy of the patient Bill of Rights and Responsibilities which includes the State Hotline number.
    b. A copy of the Agency's Patient Grievance Policy.
    c. A description of available services, service charges, payment sources, discharge planning process, and geographic area served.
    d. The Agency brochure.
    e. Information on Advance Directives.
    f. A copy of the Agency's policy on Abuse, Neglect and Exploitation.

Types of Patients Admitted:

1. Patients with acute, non-chronic, episodic type disease or disability who will return to pre-illness level of functioning.
2. Patients with chronic disease or disability that are experiencing acute episodes of illness but have the potential for returning to pre-episodic level of functioning.
3. Patients with chronic disease or disability who, even though a return to pre-illness level of functioning is not possible, do have the potential for increasing their level of functioning and will eventually function without Agency services.
4. Patients with advanced stage chronic disease who can only be maintained at home if they have ongoing Agency services.
5. Patients with end stage disease.

Non Admittance Services:

If it is determined that a patient does not meet Agency guidelines and hence cannot be admitted or of a patients declines service, then:

    a. Notify the Director of Clinical Services or designee.
    b. Notify the physician.
    c. Write a brief note on the referral or using a narrative, if necessary, describing the reason the person could not be admitted to service.
    d. The above should be completed within 24 hours.

Exhibit 9.

Financial Assistance Policy

FINANCIAL ASSISTANCE POLICY

A. FINANCIAL ELIGIBILITY CRITERIA

1. Financial eligibility criteria differ with the individual payment source. The need for service criteria (such as needing skilled care) will be the same for all patients as will the requirement that the service be under the direction of a physician's plan of care.

   a. Private payment--all eligible

   b. Private insurance--Patient policy criteria determine coverage.

   c. Champus (Military Medicare)--Patient is cleared through military business office.

   d. Title XIX (Medicaid)--Patient must have approval of payment, i.e., current Medicaid care cleared through local DSS Health and Welfare Office prior to coverage.

   e. Veterans Administration Hospital--by arrangement of VA hospital for specific service connected conditions.

   f. Partial payment or free service--financial inability to pay full fee, such as no insurance, does not qualify for Medicare or Medicaid. Financial information form must be completed and reviewed by the Administrator prior to sliding fee application.

Sliding Scale

Sliding scale is provided through partial payment or free service - financial inability to pay full fee, such as no insurance, does not qualify for Medicare or Medicaid. Sliding scale is utilized whenever there is non-coverage of needed services or in the case of private pay patients, they cannot afford the full payment.

Financial information must be provided to the Agency and reviewed by the Administrator prior to sliding fee application.

B. REDUCED AND NO-FEE SERVICES

1. The Agency will not discriminate due to a patient's financial status.

2. If, at the time of admission, it is determined that the patient may be unable to meet their financial responsibility for payment for services, the patient will be consulted to determine their eligibility for reduced or no-fee services.

3. If there are questions regarding eligibility, the Administrator will determine whether the Agency can provide indigent care or collect partial payment for products and services rendered.

4. Approval from the Director of Operations for reduced or no-fee service will be required.

5. If the Agency is unable to admit the patient, appropriate referrals will be made.

Exhibit 10A.

Historical Financial Statements

Wellspring Home Health
Historical Income Statement
(AK + WA Facilities)

	2017	2018	2019
Revenue			
Total Net Revenue	$ 390,499	$ 1,129,422	$ 2,376,063
Expenses			
Employee Salaries and Benefits	$ 407,551	$ 584,938	$ 854,154
Supplies	$ 14,591	$ 39,652	$ 51,842
Rent/Lease Building	$ 23,270	$ 30,345	$ 36,065
Information Technology	$ 10,978	$ 16,624	$ 38,186
Building Maintenance	$ 1,068	$ 180	$ 116
Purchased Services	$ 159	$ 118	$ 565,070
Other Expenses	$ 201,338	$ 466,206	$ 114,503
Lakewood Facility Lease	$ -	$ -	$ 22,570
Overhead Allocation	$ -	$ -	$ 2,000
Other Income/Expenses	$ (0.12)	$ (5)	$ 47
Total Expenses	$ 658,955	$ 1,138,058	$ 1,684,552
Net Income Before Interest	**$ (268,456)**	**$ (8,635)**	**$ 691,512**
Interest Expense	$ 23,462	$ 10,026	$ 4,295
Net Income Less Interest Expense	**$ (291,918)**	**$ (18,661)**	**$ 687,216**

Wellspring Home Health
Balance Sheet
(AK & WA Facilities)

	December 31, 2017	December 31, 2018	December 31, 2019
Assets			
Current assets:			
Cash and Cash Equivalents	$ 47,822	$ (26,438)	$ 169,061
Other Current Assets	0	0	2,500
Total Current Assets	47,822	(26,438)	171,561
Property, Plant, and Equipment, Net	7,802	14,704	132,374
Other Assets	0	0	28,525
Total Assets	**$ 55,624**	**$ (11,734)**	**$ 332,460**
Liabilities			
Total Current Liabilities	8,625	(1,991)	0
Long Term Liabilities	32,767	86,135	0
Total Liabilities	**41,392**	**84,144**	**0**
Equity			
Member Draws/Equity, Net	317,471	223,941	(50,379)
Retained Earnings	(18,226)	(301,157)	(319,819)
Net Income	(285,013)	(18,661)	702,658
Total Equity	**14,232**	**(95,878)**	**332,460**
Total Liabilities and Equity	**$ 55,624**	**$ (11,734)**	**$ 332,460**

Exhibit 10B.

Financial Pro Forma

Wellspring Home Health Center, LLC
Revenue and Expense Statement

	Partial Year 2021 (Nov - Dec)	2022	2023	2024
# of Months	2	12	12	12
Total Gross Revenue				
Medicare	$ 149,154	$ 1,390,706	$ 1,680,574	$ 1,841,213
Medicaid	11,622	108,367	130,954	143,471
Commercial/Other	32,930	307,039	371,036	406,502
Total Gross Revenue	193,707	1,806,112	2,182,563	2,391,186
Deductions from patient service revenue				
Contractual Adjustments	28,785	268,388	324,329	355,330
Bad Debt	2,518	23,479	28,373	31,085
Charity Care	3,099	28,898	34,921	38,259
Total Deductions	34,402	320,765	387,623	424,675
Total Net Revenue	**159,305**	**1,485,347**	**1,794,940**	**1,966,511**
Operating Expenses				
Salaries	97,844	829,762	959,004	1,055,399
Benefits	29,549	250,588	289,619	318,731
Medical Director	4,833	38,000	38,000	38,000
Supplies	3,337	31,121	37,607	41,203
Base Rent	3,000	18,000	18,000	18,000
Other Property Expenses	582	3,492	3,492	3,492
Information Technology	3,783	22,700	22,700	22,700
Equipment	933	5,600	5,600	5,600
Maintenance	117	700	700	700
Purchased Services	8,389	78,222	94,525	103,565
Mileage & Travel	4,510	42,055	50,820	55,680
B & O Tax	2,390	22,280	26,924	29,498
Other Expenses	992	9,252	11,180	12,250
Total Operating Expenses	160,259	1,351,773	1,558,171	1,704,817
Non-Operating Expenses				
Overhead Allocation	7,169	66,841	80,772	88,493
Depreciation & Amortization	743	4,457	4,457	4,457
Total Non-Operating Expenses	7,912	71,298	85,229	92,950
Total Expenses	**168,171**	**1,423,071**	**1,643,400**	**1,797,767**
Net income	**(8,866)**	**62,276**	**151,539**	**168,744**

Wellspring Home Health Center, LLC
Staffing Worksheet

	PY 2021	2022	2023	2024
# of Months	2	12	12	12

			PY 2021	2022	2023	2024
Visits	Skilled Nursing		361	3,365	4,066	4,454
	Physical Therapy		316	2,944	3,557	3,898
	Occupational Therapy		108	1,009	1,220	1,336
	Speech Pathology		18	168	203	223
	Medical Social Services		9	84	102	111
	Home Health Aid		90	841	1,016	1,114
	Total Visits		**902**	**8,411**	**10,164**	**11,136**

		FTEs Per 1,000 Visits	PY 2021	2022	2023	2024
Clinical FTEs	Skilled Nursing	1.01	0.36	3.40	4.11	4.50
	Physical Therapy	0.86	0.27	2.53	3.06	3.35
	Occupational Therapy	0.82	0.09	0.83	1.00	1.10
	Speech Pathology	0.84	0.02	0.14	0.17	0.19
	Medical Social Services	0.86	0.01	0.07	0.09	0.10
	Home Health Aid	0.77	0.07	0.65	0.78	0.86
	Total Clinical FTEs		**0.82**	**7.62**	**9.21**	**10.10**

			PY 2021	2022	2023	2024
Non-Clinical FTEs	Manager / Administrator		0.17	1.00	1.00	1.00
	Administrative and Clerical		0.33	2.50	2.50	3.00
	Total Non-Clinical FTEs		**0.50**	**3.50**	**3.50**	**4.00**

		Salaries Per FTE	PY 2021	2022	2023	2024
Salaries	Skilled Nursing	81,101	29,196	275,743	333,325	364,955
	Physical Therapy	89,911	24,276	227,475	275,128	301,202
	Occupational Therapy	89,817	8,084	74,548	89,817	98,799
	Speech Pathology	91,280	1,826	12,779	15,518	17,343
	Medical Social Services	67,169	672	4,702	6,045	6,717
	Home Health Aid	35,814	2,507	23,279	27,935	30,800
	Manager / Administrator	89,496	15,214	89,496	89,496	89,496
	Administrative and Clerical	48,696	16,070	121,740	121,740	146,088
	Total Salaries		**97,844**	**829,762**	**959,004**	**1,055,399**

Wellspring Home Health Center, LLC
Contractual Allowances and Deductions

	Partial Year 2021	2022	2023	2024
# of Months	2	12	12	12
Gross Revenues				
Medicare	$ 149,154	$ 1,390,706	$ 1,680,574	$ 1,841,213
Medicaid	11,622	108,367	130,954	143,471
Commercial/Other	32,930	307,039	371,036	406,502
Total Gross Revenue	193,707	1,806,112	2,182,563	2,391,186
Contractual Allowances				
Medicare	$ 10,441	$ 97,349	$ 117,640	$ 128,885
Medicaid	6,160	57,434	69,406	76,040
Commercial/Other	12,184	113,604	137,283	150,406
Total Contractual Allowances	28,785	268,388	324,329	355,330
Total Deductions				
Contractual Adjustments	$ 28,785	$ 268,388	$ 324,329	$ 355,330
Bad Debt	2,518	23,479	28,373	31,085
Charity Care	3,099	28,898	34,921	38,259
Total Deductions	34,402	320,765	387,623	424,675

Wellspring Home Health Center, LLC
Depreciation Worksheet

	Capital Expenditures	Useful Life (Years)	Monthly Depreciation
Tenant Improvements	$9,500	7	$113
Equipment	$15,500	5	$258

	Partial Year 2021	2022	2023	2024
# of Months	2	12	12	12
Depreciation (TI)	$226	$1,357	$1,357	$1,357
Depreciation (Equipment)	$517	$3,100	$3,100	$3,100
Total Depreciation	**$743**	**$4,457**	**$4,457**	**$4,457**

Wellspring Home Health Center, LLC
Financial Model Assumptions

Unless otherwise noted, the assumptions are based on public documents for other home projects similar to Wellspring's proposed project ("Washington Benchmarks")

Gross Revenue Per Visit	Calculation Method	Estimate
Skilled Nursing	Gross Revenue Per Visit	$243
Physical Therapy	Gross Revenue Per Visit	$207
Occupational Therapy	Gross Revenue Per Visit	$213
Speech Pathology	Gross Revenue Per Visit	$242
Medical Social Services	Gross Revenue Per Visit	$228
Home Health Aid	Gross Revenue Per Visit	$124

Gross Revenue Payer Mix	Calculation Method	Estimate
Medicare	% of Gross Revenue	77%
Medicaid	% of Gross Revenue	6%
Commercial/Other	% of Gross Revenue	17%
Deductions from patient service revenue	Calculation Method	Estimate
Contractual Adjustments		
Medicare	% of [Payer] Gross Revenue	7%
Medicaid	% of [Payer] Gross Revenue	53%
Commercial/Other	% of [Payer] Gross Revenue	37%
Bad Debt	% of Gross Revenue	1.3%
Charity Care	% of Gross Revenue	1.6%
Operating Expenses	Calculation Method	Estimate
Salaries	See Staffing Worksheet	See Staffing Worksheet
Benefits	% of Salaries	30.2%
Medical Director	MDA Section 4	$20K annual maintenance fee. $150/hr service fees assumed at 5 hours per month in 2021 and 10 hours per month assumed in 2022-2024
Supplies	Per Visit	3.7
Base Rent	Lease Section 1.7 (Monthy)	1,500
Other Property Expenses	Lease Section 1.7 (Monthy)	291
Information Technology	Annual Amount Adj by # Months	22,700
Equipment	Annual Amount Adj by # Months	5,600
Maintenance	Annual Amount Adj by # Months	700
Purchased Services	Per Visit	9.3
Mileage & Travel	Per Visit	5.0
B & O Tax	% of Net Revenue	1.50%
Other Expenses	Per Visit	1.1
Non-Operating Expenses	Calculation Method	Estimate
Overhead Allocation	% of Net Revenue	4.5%
Depreciation & Amortization	See Depreciation Worksheet	See Depreciation Worksheet

Exhibit 11.

Letter of Financial Commitment

WellSpring
HOME HEALTH

8815 S Tacoma Way, Suite 120 Lakewood, WA 98498 Tel: (254)625-7606 Fax: (254) 625-7079

At Wellspring Home Health Center, you're cared for like family.

November 25, 2020

Department of Health
Certificate of Need Program
PO Box 47852
Olympia, WA 98504-7852

RE: Financial Commitment Letter for Wellspring Home Health Center, LLC.

Dear Mr. Hernandez:

Please accept this letter as evidence of Wellspring Home Health Center, LLC's financial commitment for its certificate of need application to establish a Medicare certified/Medicaid eligible home health agency in King County.

Wellspring Home Health Center, LLC's is pleased to commit to fund the estimated capital expenditures and other costs of operations associated with the project. Wellspring Home Health Center, LLC has sufficient cash reserves to fully fund the intended project.

Sincerely,

Joyce Ibanga
Administrator
Wellspring Home Health Center, LLC

Exhibit 12.

In-Service Training Plan

Incontinence and constipation teaching guide

The lesson should take about one hour to complete.

INTRODUCTION

This lesson discusses urinary incontinence, bowel incontinence, and constipation. You and your staff can make a big difference in your patients' lives by helping them overcome incontinence and constipation through the use of these guidelines. There is also a teaching sheet included here for your incontinent patients to read.

LEARNING GOALS

At the conclusion of this lesson, learners will:

1. Know the causes of common urinary and bowel elimination problems.
2. Be able to state the best ways to help patients with these problems.
3. Understand various behavioral, nutritional, and care interventions for urinary and bowel incontinence and constipation.

SUGGESTED TEACHING PROCEDURES

To deliver the learning guide content to a group, refer to the learning guide and follow these procedures:

1. Ask your learners, "How many of you think that being unable to control your bladder or your bowels is a normal part of aging?" This is a common misconception, and it is likely that many of your learners will agree that your statement is true. Then ask, "Do you think anything can be done to improve the problem in older people?" Many times, we just accept there is nothing that can be done for these conditions except to wear protective clothing. However, there are things that can be done by caregivers that can help control these problems, thereby improving the patient's quality of life.
2. Present the following success stories: (1) A senior care facility cut the number of incontinent residents by 65% in 14 months, doubling the number of normally dry residents, including six that were previously considered untreatable. (2) Another senior residence reduced by half the number of incontinent residents in just six months. (3) One facility improved the continence status of 72% of their residents, with 26% becoming fully continent. (4) Urinary incontinence can be improved in eight out of ten cases.
3. Ask your learners to study the first two pages of the learning guide. Review the uses of scheduled toileting, prompted voiding, and habit training. Discuss how you could use these with your patients.
4. Go over the material on the next two pages of the learning guide. Discuss dietary management and how your workers can assist patients with diet, habit training, exercises, toileting, and skin care.
5. If you will use it, go over the sample bladder record, or review the one already in use in your agency.
6. Administer the test. Grade the test as a group and discuss any wrong answers. Give out certificates.

Incontinence and constipation learning guide

What causes urinary incontinence?

People who cannot control when or where they urinate suffer from urinary incontinence, or U.I. There are things that can be done to improve this condition, but it is important to know what the cause is so the right care and treatment can be given. This condition is not the person's fault, and it is not a necessary or normal part of growing older. It is not caused by laziness or meanness. U.I. is a health problem with a number of possible causes. Some of the most common causes include the following:

- Urinary tract infections (U.T.I.)
- Confusion and forgetfulness
- Muscle weakness
- Vaginal problems (in women)
- Prostate problems (in men)
- Medication reactions
- Problems with clothing
- Trouble getting to the bathroom
- Constipation

What are the symptoms of urinary incontinence?

Any patient who wets the bed or him- or herself, leaks urine on the way to the bathroom, or has to use protective pads or padded briefs is suffering from U.I. If you notice a resident, a bed, or a room that has urine stains or a urine odor, then you know the resident needs help with this condition. However, you probably don't know what kind of U.I. the resident might have. You can often determine this by watching the resident closely and keeping track of his or her urinating habits on a *bladder record*. There is an example included with this learning guide. It shows regular daily habits as well as accidents. Keeping a bladder record is an excellent way to get information about a resident's U.I. so ways can be found to treat it.
There are three different types of U.I.:

- ***Urge incontinence***. With this type, people may leak urine on their way to the bathroom, after they drink just a little bit of liquid, or as soon as they feel the urge to go.
- ***Stress incontinence*** may cause urine to leak when they sneeze, cough, or laugh, or when they exercise or move a certain way (getting out of bed nor up from a chair, walking, lifting). This is common in women.
- ***Overflow incontinence*** causes people to feel they need to urinate again right after going, or to feel as though they never totally empty the bladder, or to pass small amounts of urine without feeling any need to go. It may be a sign of prostate problems in men.

What can YOU do to help a patient with urinary incontinence?

Your first responsibility is to report U.I. to your supervisor or the patient's doctor. A doctor or nurse should check a resident with U.I., and your observations about the resident, such as a bladder record, will help them determine the cause and type of U.I.

The three treatments for U.I. are:
1. Medicine.
2. Surgery.
3. Behavioral treatments, which help people control their urine and use the toilet at the right time. They work well for patients who have problems getting to the bathroom or are not able to tell you when they need to urinate. We will discuss three behavioral treatments for U.I. that you can assist with
   - Scheduled toileting
   - Prompted voiding
   - Habit training

Behavioral treatments for urinary incontinence

Scheduled toileting

Use scheduled toileting for patients who can't get out of bed or can't get to the bathroom alone. To do this treatment, assist the patient to the bathroom every two to four hours on a regular schedule.

Prompted voiding

Use prompted voiding for patients who know when they have a full bladder but do not ask to go to the bathroom. To do this treatment:

1. Check the patient often for wetness.
2. Ask, "Do you want to use the toilet?"
3. Help the patient to the toilet.
4. Praise the patient for being dry.
5. Tell the patient when you will come back to take him or her to the bathroom again.

Habit training

Use habit training for patients who tend to urinate at about the same time every day. To do this:

1. Watch the patient to find what times he or she urinates. A bladder record can help you do this.
2. Take the patient to the bathroom at those times every day.
3. Praise the patient for being dry and using the toilet.

For all behavioral treatments, remember these things

1. Be patient. These treatments take time.
2. Treat the patient as an adult.
3. Do not rush the patient.
4. Give the patient plenty of time to completely empty his or her bladder.
5. Give privacy by closing the door, even if you must stay in the bathroom.
6. NEVER yell or be angry with the patient if he or she is wet. Say, "You can try again next time."
7. Respect dignity and confidentiality.

Other ways to help patients with urinary incontinence

1. Pelvic exercises can make muscles around the bladder stronger and help with U.I. These are called Kegel exercises, and to do them, the person tightens the pelvic muscles that stop and start the flow of urine. The muscles should be squeezed tightly for a few seconds and then released, up to ten times at one sitting, four times every day. Then, whenever the person feels that urine might leak, he or she tightens those same muscles and prevents urine from leaking.
2. People who can't get out of bed or can't get to the bathroom for some reason may need to use a bedpan, urinal, or bedside commode. These articles, if needed, should be kept by the bed.
3. If a patient uses a wheelchair, walker, or cane to get to the bathroom, you can help by keeping the item near the bed and keeping the path to the bathroom clear and well lit.
4. Encourage the patient to wear clothes that are easy to remove and that have simple fasteners.
5. If a patient needs to wear special pads or clothing to help keep the skin dry, they should be changed often. Use soft pads and clothing, keep them wrinkle-free, keep the skin clean and dry, and use protective skin creams if allowed. Remember that wet skin can develop sores and rashes.
6. If the patient wets the bed at night, it might be helpful to restrict evening liquids, but you should only do this if a doctor or nurse orders it. This is usually done in the three hours before bedtime. The patient should use the bathroom just before going to bed.
7. Some patient need to use a urinary catheter, which is a tube inserted into the bladder by a doctor or nurse. It drains urine into a bag. Sometimes men use a condom catheter that fits over the penis. Catheters can cause infections, and condom catheters that are too tight can be harmful. Catheters should be checked often. They are <u>not recommended</u> for most incontinence problems.

What causes bowel incontinence?

People who cannot control when or where they pass gas or stool suffer from bowel incontinence. There are things that can be done to improve this condition, but it is important to know what the cause is so the right care and treatment can be given. This condition is not the person's fault, and it is not a necessary part of growing older. It is a health problem that is not caused by laziness or bad behavior.

Some of the most common causes include:

- Incorrect diet or fluid intake
- Confusion and forgetfulness
- Muscle injury or weakness (the anal muscles)
- Nerve injury
- Medication reactions or laxative abuse
- Trouble getting to the bathroom
- Constipation or impaction
- Diarrhea

What can YOU do to help a patient with bowel incontinence?

Your first responsibility is to report episodes of bowel incontinence to your supervisor or the patient's doctor. A doctor or nurse should check the resident, and your observations may help them determine the cause of the problem. Treatments for bowel incontinence include:

1. Medicine
2. Surgery
3. Dietary management
4. Bowel management and retraining, with establishment of a habit regimen
5. Biofeedback

Two of these treatments involve the care you provide: diet management and bowel retraining. These treatments are the same as those used to help people with constipation, so we will discuss the treatments together after examining the issue of constipation.

What causes constipation?

People usually say they are constipated when they are having infrequent bowel movements, but constipation is also used to refer to a sense of bloating or intestinal fullness, a decrease in the amount of stool, the need to strain to have a bowel movement, or the need to use laxatives, suppositories, or enemas to maintain regular bowel movements. It is normal for most people to have bowel movements anywhere from three times a day to three times a week, but some people may go a week or longer without discomfort or harmful effects. Many things can cause constipation, but the most common causes include:

- Inadequate fiber and fluid intake
- Inactivity or a sedentary lifestyle
- Change in routine
- Abnormal growths or diseases
- Damaged or injured muscles (sometimes from repeatedly ignoring the urge to go)
- Medication side effects and laxative abuse (it is NOT necessary to have a B.M. every day)

Constipation may be diagnosed if movements occur fewer than three times weekly on an ongoing basis.

What can YOU do to help a patient with constipation?

Your first responsibility is to report a patient's constipation problems to your supervisor or the patient's doctor. A doctor or nurse should check the patient, and your observations may help them determine the cause of the problem. Treatments for constipation include:

1. Medicine
2. Surgery
3. Dietary management
4. Bowel management and retraining, with establishment of a habit regimen

Two of these treatments involve the care you provide: diet management and bowel retraining. These treatments are the same as those used to help people with bowel incontinence. We will discuss them now.

Dietary management for urinary incontinence

Although there is no dietary treatment for urinary incontinence, some foods and drinks can irritate the bladder, such as sugar, chocolate, citrus fruits (oranges, grapefruits, lemons, limes), alcohol, grape juice, and caffeinated drinks like coffee, tea, and cola. Patients with U.I. could try eliminating these foods and beverages from their diet and see if the condition improves.

Dietary management for bowel incontinence and constipation

The average American diet contains 10–15 grams of fiber a day. The amount of fiber recommended for good bowel function is ***25–30 grams of fiber per day***, plus 60–80 ounces of fluid. Look at the table below to get an idea of the fiber we get in different foods. Most people can successfully treat their bowel irregularities, both incontinence and constipation, by adding high fiber foods to their diets, along with increasing fluid intake to desired levels. Increase dietary fiber slowly to give the bowel time to adjust. ***People with diverticulosis or diverticulitis should not consume a high-fiber diet.***

Type of Food	Lower Fiber Foods	Fiber grams	Higher Fiber Alternatives	Fiber grams
Breads	White bread, 1 slice	0.50	Whole wheat bread, 1 slice	2.11
Cereals	Corn flakes, 1 oz.	0.45	Oat bran cereal, 1 oz.	4.06
Rice	White rice, ½ cup	1.42	Brown rice, ½ cup	5.27
Vegetables	Lettuce, ½ cup raw	0.24	Green peas, ½ cup	3.36
Beans	Green beans, ½ cup	1.89	Pinto beans, ½ cup	5.93
Fresh Fruits	Banana, 1 medium	2.19	Blackberries, 1 cup	7.20

Food sensitivities: Some people are sensitive to, or even allergic to, certain foods that cause them constipation or diarrhea. Dairy products such as milk and cheese, wheat products such as bread, and foods containing chocolate are some of the more common problem foods. A physician should evaluate a resident who seems to have particular food sensitivities.

Bowel retraining for bowel incontinence and constipation

Habit training

Habit training means designating a specific time each day to have a bowel movement. Keep a record of the patient's bowel habits, just as you do with a bladder record. If a pattern develops, that pattern can be used to set up a habit regimen that will reinforce a scheduled time each day to have a bowel movement. If no pattern can be seen in the patient's bowel activities, then a regimen can be established by selecting a convenient time each day, or even three times a day in the case of someone with bowel incontinence, for the patient to try to have a bowel movement. Be sure to help the patient stick with this schedule, even when he or she does not feel the need to go. Over time, the body will develop a habit that conforms to the scheduled routine.

Exercises

The Kegel exercises that are used to prevent urinary incontinence can be slightly modified to strengthen the anal muscles that control the outflow of stool. To do them, the person tightens the muscles around the rectum. The muscles should be squeezed tightly for a few seconds and then released, up to ten times at one sitting, four times every day.

Other: Refer to item numbers 2, 3, 4, and 5 in the section called "other ways to help patients with urinary incontinence." The same things apply to the care of those with bowel incontinence.

Sample bladder record

NAME: _____

DATE: _____

INSTRUCTIONS: Place a check in the appropriate column next to the time you urinated in the toilet or when an **incontinence** episode occurred. Note the reason for the **incontinence** and describe your liquid intake (for example, coffee, water) and estimate the amount (for example, one cup).

Time interval	Urinated in toilet	Had a small incontinence episode	Had a large incontinence episode	Reason for incontinence episode	Type/amount of liquid intake
6–8 a.m.					
8–10 a.m.					
10–noon					
Noon–2 p.m.					
2–4 p.m.					
4–6 p.m.					
6–8 p.m.					
8-10 p.m.					
10–midnight					
Overnight					
No. of pads used today:			No. of episodes:		

Comments: _____

Retraining your bladder: Information for patients

It is possible to retrain your bladder if you have trouble controlling your urine flow.

First, keep a record of your normal drinking and urinating patterns. Next, schedule your urination at regular intervals and begin to gradually increase the amount of time between urinating. Eventually, you want to train yourself to urinate no more than once every three to four hours.
Follow these steps:

1. Keep a record—write everything down on the bladder record.

2. Schedule urination.

    a. Begin by going to the bathroom every hour or two, whether or not you feel the need.

    b. If you feel the need to urinate more often than that, practice tightening your pelvic muscles to hold the urine. Relax, concentrate, and breathe slowly and deeply until the urge decreases or goes away.

    c. After the urge goes away, wait a few minutes, then go to the bathroom and urinate, even if the urge has passed. Don't wait for the next urge, because it may be difficult to control.

    d. After a week of this kind of training, if you are able to wait for two or three minutes easily, increase the waiting time (between feeling the urge and using the bathroom) to five minutes, then ten minutes.

    e. Work toward intervals of three or four hours between urination. If you have an accident, don't let it discourage you. Just keep trying.

3. Helpful hints:

    a. Be sure you can reach your bathroom or commode easily.

    b. Walk to the bathroom slowly.

    c. Urinate just before going to bed.

    d. Set an alarm clock to remind you when to use the toilet. Do this in the daytime and also once or twice at night.

    e. Drink eight to ten glasses of fluid every day to prevent urinary tract infections and constipation.

    f. Avoid caffeine drinks and alcoholic beverages.

    g. Do your Kegel exercises to increase bladder tone (ask the nurse to teach you how).

Incontinence and constipation test

Name: _____ Score: _____ (9 correct required)

Circle or write the correct answer.

1. What are some causes of both bowel and urinary incontinence?
    a. Muscle weakness, confusion, or medication reactions
    b. Laziness, poor manners, or meanness
    c. Stupidity, uncooperativeness, and sloppiness

2. Scheduled toileting, prompted voiding, and habit training are:
    a. Not encouraged by physicians, nurses, or state regulations
    b. Responsibilities of the nurse or facility manager, not the attendant
    c. Recommended behavioral treatments for urinary incontinence
    d. Too time-consuming to be practical

3. For the best bowel function, we should consume how much dietary fiber every day?
    a. 10–15 grams
    b. 25–30 grams
    c. 45–50 grams

4. Kegel exercises are done by:
    a. Circling the ankles around and around and then up and down
    b. Lowering the chin to the chest, then turning the head side to side
    c. Tightening the pelvic muscles that control the flow of urine

5. Urinary catheters are often recommended to treat urinary incontinence. T or F

6. Bowel retraining and behavioral treatments for urinary incontinence usually work quickly, fixing the problem within a week or less. T or F

7. Most fruits and beans contain higher dietary fiber than white breads and rice. T or F

8. It is important to keep patients with urinary or bowel incontinence clean and dry so their skin is protected from developing sores. T or F

9. Habit training can be used to help both urinary and bowel incontinence. It consists of:
    a. Assisting the patient to the bathroom every two to four hours.
    b. Checking the patient often and asking him if he wants to use the bathroom.
    c. Assisting the patient to the bathroom at scheduled times every day.
    d. Writing the patient's habits down on a form.

10. Stress incontinence might cause urine to leak when someone sneezes or laughs. T or F

11. A person who has a bowel movement only three or four times a week is constipated. T or F

12. A patient with incontinence should be treated as an adult, with dignity. T or F

Incontinence and constipation answer key

Name: _____ Score: _____ (9 correct required)

Circle or write the correct answer.

1. What are some causes of both bowel and urinary incontinence?
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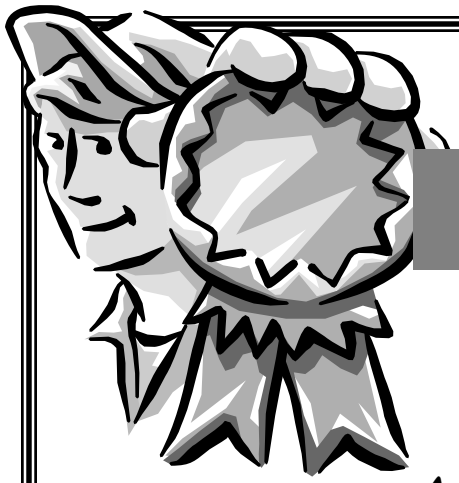


Certificate of Achievement

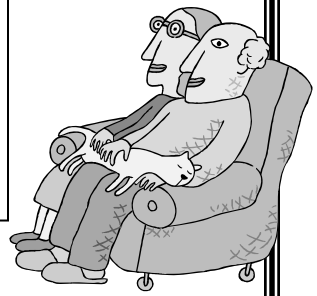
Awarded to: _____

For Completing the One-Hour Course Entitled
"Incontinence and Constipation"

Date of Course: _____ Presented by: _____

(Presenter's name, or write "self-study")

Facility Name: _____



INFECTION CONTROL GUIDELINES: *STANDARD PRECAUTIONS & ADDITIONAL PRECAUTIONS:* LESSON PLAN

Lesson overview

Time: One hour

This lesson covers the guidelines developed by the U.S. Centers for Disease Control (CDC) in 1996 for preventing the spread of infection. These guidelines are in two sections, called **Standard Precautions** and **Additional Precautions**, and are designed especially for healthcare workers. The guidelines are an updated version of the 1985 CDC **Universal Precautions.**

Learning goals

At the end of this session, the learner will:

1. Understand the four disease transmission categories.
2. Understand Standard Precautions and how and when they should be used.
3. Understand Additional Precautions and how and when they should be used.
4. Be able to apply this understanding at work.

Teaching plan

1. Begin by asking the learners to tell you what they already know about Universal Precautions or Standard Precautions. Ask if any learner can give an example of an incident that taught them the importance of following infection control guidelines. Have your own story ready as an illustration if no one volunteers.
2. Explain the content in the lesson overview and list the learning goals, using a blackboard, grease board, or flip chart if available.

Section 1: Disease transmission

1. State: Diseases are transmitted from one person to another by four basic methods. Ask your learners to refer to the learning guide and tell you what those methods are.
2. Briefly discuss each of the four methods of disease transmission, allowing for input and questions.
3. Ask your learners to fill out the matching quiz on the learning guide. Discuss the answers: **1.C.; 2.A.; 3.D.; 4.B.**

Section 2: Standard Precautions

1. State: "Standard Precautions are basic infection control guidelines. They should be used at all times as you perform your work. They protect others and us from diseases that are spread by bloodborne transmission."
2. Indicate the list of Standard Precautions on the handout. Ask learners to read parts of the list to the group.
3. Demonstrate proper hand washing with these three rules: 1. Use friction (rub hands together); 2. Wash for ten seconds (sing "Happy Birthday" while washing—takes ten seconds to sing); 3. Use soap and water (disinfectant gels are not adequate).
4. Show your learners how to use Standard Precautions when using and cleaning client care equipment—refer to the learning guide and your facility's procedures for specifics.
5. Allow for comments and discussion.

Section 3: Additional Precautions

1. Review the Additional Precautions for the three types of transmission included in the learning guide.
2. Ask the learners for examples of when these precautions should be used.

Conclusion

1. Have the learners complete the test. Grade the test in class so any wrong answers can be discussed and corrected.

Answers: 1.c; 2.b; 3.a.; 4.d; 5.d; 6.F; 7. airborne, bloodborne, contact, droplet; 8. wash hands, wear gloves, wear gown, mask, goggles if will get splashed, keep everything clean; 9.F.; 10.T.

2. Be sure your learners sign the achievement certificate and your sign-in sheet.

INFECTION CONTROL GUIDELINES:
STANDARD PRECAUTIONS & ADDITIONAL PRECAUTIONS:
LEARNING GUIDE

Disease transmission

Four ways diseases are passed around:

A—Airborne transmission:
Airborne germs can travel long distances through the air and are breathed in by people. Examples of diseases caused by airborne germs: TB, chickenpox.

B—Bloodborne transmission:
The blood of an infected person somehow comes in contact with the bloodstream of another person, allowing germs from the infected person into the other person's bloodstream. Blood and bloodborne germs are sometimes present in other body fluids, such as urine, feces, saliva, and vomit. Examples of diseases caused by bloodborne germs: AIDS, hepatitis.

C—Contact transmission:
Touching certain germs can cause the spread of disease. Sometimes you touch an infected person, having <u>direct</u> contact with the germ. Sometimes you touch an object that has been handled by an infected person, having <u>indirect</u> contact with the infection. Examples of diseases caused by contact germs: pink-eye, scabies, wound infections, MRSA.

D—Droplet transmission:
Some germs can only travel short distances through the air, usually not more than three feet. Sneezing, coughing, and talking can spread these germs. Examples of diseases caused by droplet germs: flu, pneumonia.

What kinds of germs are being spread in the following cases? Match the activity with the type of transmission by writing "A", "B", "C", or "D."

1. Changing the bed linens of a client with a rash, without wearing gloves. _____
2. Keeping a fan blowing and the door open when a client has shingles. _____
3. A client who has a cold sneezes on others sitting at her table. _____
4. Wipe urine off the floor without gloves. _____

Standard Precautions

1. Wash hands
- After touching blood, body fluids, or objects contaminated by blood or body fluids. Do this even if you were wearing gloves.
- After removing gloves.
- Between each client's care.

2. Wear gloves
- Whenever you touch blood, body fluids, or contaminated objects.
- Before touching a client's broken skin or mucous membranes (mouth, nose), put on clean gloves.
- Change gloves between tasks and between each client's care. Dirty gloves spread germs, just like dirty hands!

3. Wear a gown, mask, and goggles
- **<u>If</u>** you know you might get splashed with blood or body fluids. Use a waterproof gown if you might get heavily splashed.
- Remove dirty protective clothing as soon as you can and wash your hands afterward.

4. Keep everything clean
- Clean up spills as soon as possible.

USE *<u>STANDARD PRECAUTIONS</u>* FOR <u>ALL</u> CLIENT CARE. THIS IS BASIC INFECTION CONTROL FOR BLOODBORNE DISEASES—TO PROTECT YOU AND YOUR CLIENTS.

Standard Precautions for handling objects

1. Clean any equipment that has been used by one client before giving it to another client. Follow your facility's cleaning procedures.
2. Use disposable equipment only once.
3. Dirty linens should be rolled, not shaken, and should be held away from your body. Linens soiled with body fluids can be washed with other laundry, using your facility's procedures.
4. No special precautions are needed for dishes or silverware. Normal dish soap and hot water (water temperature must be hot enough to meet state requirements) will kill germs.
5. Change cleaning rags and sponges frequently.
6. Stethoscopes, blood pressure cuffs, and thermometers should be cleaned between each use, using your facility's procedures.
7. Dispose of dangerous waste such as needles VERY CAREFULLY. Needles and other sharp devices should go into clearly marked puncture-proof containers, NOT the regular trash container! DO NOT RECAP used needles—put them in the puncture-proof container without the cap on.
8. Trash that is contaminated with germs, such as wound dressings, should be disposed of according to your facility's procedures.
9. Any container marked "Biohazard" is only for discarding contaminated waste—don't remove anything from it! If you must handle anything in the container, always use gloves. Don't put your hand in anything that contains needles or other sharp objects.
10. Check your gloves and other protective clothing frequently. If you see tears or holes, remove the gloves, wash your hands, and apply clean gloves.

TIP: Don't touch your face (nose, mouth, eyes) when giving client care, unless you remove your gloves and wash your hands first. Protect yourself from infection.

Additional Precautions

If you know that a client has a disease that is spread in one of the following ways, use these extra precautions:

1. Airborne

- The client should have a private room, possibly one with a special air filter.
- Keep the client's room door closed.
- Wear a mask. If the client has, or might have, tuberculosis, wear a special respiratory mask (ask your supervisor). A regular mask will not protect you.
- Remind the client to cover nose and mouth when coughing or sneezing.
- Ask the client to wear a mask if he or she wants or needs to be around others.

2. Contact

- The client should be in a private room, but the door may stay open.
- Put gloves on before entering the room.
- Change gloves after touching a contaminated object (bed linens, clothes, wound dressings).
- Remove gloves right before leaving the room. Don't touch anything else until you wash your hands. Wash your hands ASAP!
- Wear a gown in the room if the client has drainage, has diarrhea, or is incontinent. Remove the gown right before leaving the room.
- Use a disinfectant to clean stethoscopes, blood pressure cuffs, or any other equipment used on the infected client.

3. Droplet

- The client should be in a private room, but the door may stay open.
- Wear a mask when working close to the client (within three feet).
- Ask the client to wear a mask if he or she wants or needs to be around others.

Handwashing rule: Rub hands together with soap and running water for at least 10 seconds. Germicidal gels are not enough!

USE *ADDITIONAL PRECAUTIONS* IN ADDITION TO STANDARD PRECAUTIONS WHEN A CLIENT HAS AN ILLNESS REQUIRING EXTRA INFECTION CONTROL MEASURES.

INFECTION CONTROL GUIDELINES:
STANDARD PRECAUTIONS & ADDITIONAL PRECAUTIONS: TEST

Name: _____ Date: _____ Score:_____
(number correct)

Circle the right answer.

1. If a client has the flu, you should use the following Additional Precautions:
   a. No Additional Precautions are necessary.
   b. Wear a mask, gown, gloves, and goggles whenever you are in the client's room.
   c. Wear a mask when working close to the client.
   d. Isolate the client from all contact with others.

2. You should use Standard Precautions when:
   a. A client appears to be sick.
   b. Doing all client care.
   c. You are sick.
   d. You know the client has AIDS or hepatitis.

3. When disposing of a needle or other sharp object, always:
   a. Place it carefully in a biohazard puncture-proof container without touching the sharp end.
   b. Recap it very carefully.
   c. Leave it alone and tell your supervisor.

4. When changing a bed or handling linens, the correct Standard Precautions procedure is to:
   a. Shake out the linens to remove any objects or dirt.
   b. Place the used linens on the floor or a table.
   c. Wash linens soiled with body fluids separately from other laundry.
   d. Roll the dirty linens up and hold them away from you until they can be placed in a laundry bag.

5. If a client has an infected wound, use the following Additional Precautions:
   a. Standard Precautions are good enough.
   b. Wear a gown, gloves, mask, and goggles while in the client's room.
   c. The client should not go to the dining room until the wound is healed.
   d. Put gloves on before entering the client's room and remove them right before leaving.

6. Clients may share walkers, wheelchairs, and other equipment without worrying about cleaning it between clients. True or False

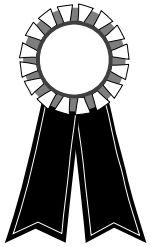
7. Write the four types of disease transmission:
_____
_____

8. List the four basic rules of Standard Precautions:
_____
_____

9. Standard Precautions only protect against airborne diseases. For bloodborne, contact, and droplet transmission, Additional Precautions must be used. True or False

10. Airborne germs, like tuberculosis, can travel long distances through the air. True or False

Certificate of Achievement



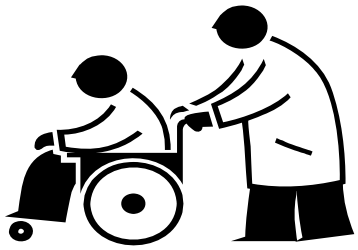
Awarded to: _____

For Completing the One-Hour Course Entitled
"Infection Control: Standard and Additional Precautions"

Date of Course: _____ **Facility:** _____

Presented by: _____
(Signature of presenter, or write “self-study”)

Lifting & transferring



Teaching plan

To use this lesson for self-study, the learner should read the material, do the activity and take the test. For group study, the leader may give each learner a copy of the learning guide and follow this teaching plan to conduct the lesson. You may copy certificates for everyone who completes the lesson.

Objectives:

A participant in this lesson will be able to:

- Demonstrate safe lifting and transferring techniques.
- Practice skills that will prevent injuries.
- Use devices to make tasks safer.

Activity and lesson

Have learners read the three stories in the activity entitled "What is wrong in these stories?" Ask them to identify the correct and incorrect things the workers did. After they have had a chance to find all the problems, begin reviewing the material in the learner's guide.

As you talk about each item in the learning guide, give the participants an opportunity to practice the skill. Use light boxes or books to demonstrate proper body mechanics when lifting objects. Instruct workers to practice transferring each other from one chair to another, using the correct posture and procedure.

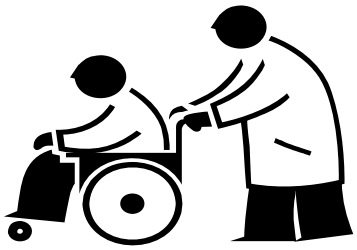
After the learners have reviewed and practiced all the procedures in the learning guide, look at the stories again and see if they can find any additional correct or incorrect actions. Be sure they identify everything before you conclude the lesson.

Answers to stories: Sharon should have bent at the knees instead of the waist; she should not have let Mr. Smith put his arms around her neck, she should not have twisted her body, she should have raised the bed to the right height, and she should not have bent over to lift his legs. If she had raised the bed to waist height after sitting him on the bed, she could have moved his legs without bending. She could have injured the client by pulling him under his arms and by not blocking his knees. She correctly locked the brakes on the bed and wheelchair, kept her feet widely spaced, and placed the chair close to the bed. Mike should not have kept his feet close together, he should not have put his hands under Mrs. Jones' arms to pull her up, and he should have locked the wheelchair's brakes. He correctly approached the client from behind the chair, but he should have bent with his knees instead of bending at the waist. In the third story, Patty should have tried to guide Mr. Smith to the floor instead of trying to stop his fall.

Conclusion

Have participants take the test, and then review the answers together. Each participant who answers 70% correctly (at least 12 points) may receive a certificate. Answers: 1. job, worker 2. Good posture, Stretching and exercise, Proper lifting and transferring skills, Lifting equipment, Teamwork. 3. b, c, d. 4. True. 5. Posture. 6. Safety. 7. True. 8. True. 9. False. 10. True

Lifting & transferring



Learning guide

Caring for people who are not very mobile tends to involve a great deal of lifting. You may need to assist them from the bed to the chair or the wheelchair and back to bed, and at times, you may need to help a person who has fallen onto the floor.

Improper lifting could injure your back and jeopardize your future ability to work. Do you know correct techniques for lifting and transferring that might keep you from injuring yourself or the person you are assisting?

Fast facts

Practice preventative care

- Good posture
- Stretching and exercise
- Lifting & transferring skills
- Proper lifting devices
- Teamwork

Ergonomics! What's that?

Ergonomics is the science of fitting workplace conditions and job demands to the capabilities of workers. It is the science of fitting the job to the worker.

When the physical requirements of the job and the physical capacity of the worker do not match, then work-related injuries can result. Stress on the musculoskeletal system causes the majority of job injuries. Some of these muscular injuries have been linked to work habits that result in temporary or permanent disability.

Ergonomics includes:

- using equipment that will take the strain out of lifting and transferring
- organizing work in new ways, such as storing items that are used daily on easy-to-reach shelves rather than near the floor or above the shoulders
- changing how tasks are done

Ergonomics can prevent injuries by helping us understand which tasks and body movements can hurt us and by finding new ways to do these tasks.

Keeping your back strong, stretched, and healthy is good. Good posture and mobility, proper lifting skills, and exercises are very important, but they are not enough to prevent injuries. Too much lifting and lifting in awkward ways can lead to injuries. Teamwork is important so you do not lift and transfer by yourself and do not get in awkward positions to do your tasks. Proper lifting devices help prevent injuries.

What does posture have to do with work-related injuries?

Good posture means more than just sitting up straight, particularly when speaking of protecting workers from work-related musculoskeletal disorders. How does good posture affect the musculoskeletal system? Good posture ensures that muscles will receive a good blood supply, thereby allowing the muscles to eliminate waste, receive nourishment, and repair damage caused by stress. Good posture helps the body work more effectively and efficiently.

Because the body is designed to be in motion, standing or sitting in the same position for an extended period puts strain on the musculoskeletal system as tendons are pulled and joints compressed. This leads to a reduction of the blood supply to these areas, causing inflammation and pain.

Bad postures increase the risk of injury:

- Do not slouch.
- Do not push the head forward beyond the plane of the shoulders.
- Do not stand in an awkward position that unevenly distributes your weight.
- Do not hold the head in an awkward or twisted position.

Good postures decrease the risk of injury:

- Sit or stand tall.
- Keep the ears over the shoulders.
- Keep the shoulders over the hips.
- Hold the head straight, not tilted.
- Position the head over the neck.
- Keep your abdomen and buttocks tucked in.

Proper way to sit

- Always sit all the way back on a chair.

- Your lower back can be supported with a pillow.
- Try to keep your knees at the same height as your hips. If necessary, elevate your knees by putting your feet on the rungs of a chair or stool, or support your feet on a phone book.
- You may need to raise the height of the seat in order to keep your knees at the same height as your hips. If possible, adjust the height of the chair, or sit on a phone book if necessary.

Proper way to stand

- Spread your feet at shoulder width and put equal weight on each foot.
- Put one foot up on something stable, such as the rung of a chair or stool.

Proper way to sleep

- Never sleep on your stomach.
- Sleep on your side with the knees slightly bent and one pillow between the knees.
- When sleeping on your side, pull your pillow down toward the shoulder to support the neck.
- When sleeping on your back, place two pillows under the knees to reduce stress to the middle and lower back and the neck.
- When on your back, support the neck with a pillow under the back of the head and neck.

Poor posture can create problems by destroying the balance of the spine's natural curves. Strain on muscles adds stress to the spine that may harm the discs. Poor body mechanics upset the balance of the natural curves of the spine. Good body mechanics keep your spine balanced during movement.

Why exercise?

Exercise relieves stress through activity. Stretching and strengthening exercises combine to balance the strength and tone of the muscles and ligaments. The muscles and ligaments are the supporting structure of the spine, so fitness benefits spinal health.

Lifting and transferring techniques

Serious back, shoulder, and neck injuries occur as a result of poor lifting and transferring habits. Following are some tips to reduce the strain on your back and the possibility of injuries. Protecting your back is working smarter, not harder.

General tips for lifting and transferring

- When lifting and transferring, the most important consideration is safety for yourself and the client.
- Ask for help and use teamwork. Talk to your helpers about what you plan to do, and talk to each other about what you are doing as you do it.
- When needed, use the right equipment.
- Plan the job. Move anything that is in the path.
- Maintain the correct posture: Keep your back straight and knees bent. If you must bend from the waist, tighten your stomach muscles while bending and lifting. Bending your knees slightly will put the stress on your legs, not your back.
- Never twist when lifting, transferring, or reaching. Pick up your feet and pivot your whole body in the direction of the move. Move your torso as one unit. Twisting is one of the leading causes of injuries.
- Maintain a wide base of support. Keep your feet at least shoulder-width apart or wider when lifting or moving.
- Hold the person or object close to you, not at arm's length. Holding things close to your body can minimize the effects of the weight.
- Pushing is easier than pulling because your own weight adds to the force.
- Use repeated small movements of large objects or people. For example, move a person in sections, by moving the upper trunk first and then the legs. Repeated small movements are easier than lifting things or people as a whole all at once.
- Always face the client or object you are lifting or moving.
- Always tell a client what you are planning to do, and find out how he or she prefers to be moved.

Transferring from the bed to a wheelchair or bedside chair

- Plan the job and prepare to lift.
- Place the chair at a slight angle to the side of the bed.
- If using a wheelchair, lock both brakes. Fold up the foot pedals and remove the footrests.
- Stabilize the bed so it will not move.
- Put footwear on the client.
- Lower the bed so the client's feet will reach the floor.
- Move the person to the edge of the bed. First, move the upper trunk, then the legs one at a time.
- Place the person's legs over the side of the bed.
- Place your arms around the person, circling the back in a sort of hug.
- Raise the person to a sitting position on the side of the bed.

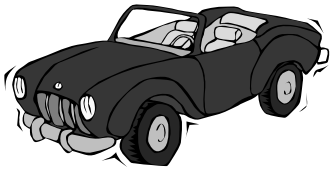
- Place a gait belt around the client's waist if you so desire (recommended).
- Gradually slide or "walk" the person's buttocks forward until his feet are flat on the floor. "Walk" the buttocks by grasping both legs together under the knees and swinging them gently back and forth as the buttocks move forward.
- Place your feet on both sides of the person's feet for support. Your feet should be far enough apart to give you a good base of support.
- Have the person lean forward and if possible place his arms around your shoulders. Do not allow his arms around your neck, as this can injure your neck.
- Allow the person to reach for the far wheelchair arm.
- Bend your hips and knees while keeping your back straight.
- Place your arms around the person's waist. If using a gait belt, grasp the belt at the sides of the back with both hands. Do not hold the person under the arms—this can cause injury to the client.
- Keep the person's knees stabilized by holding your knees against his.
- Pull up to lift the client, straightening your knees and hips as you both stand.
- Keep the client close to your body. Keep your knees and hips slightly bent.
- When the person is high enough to clear the armrest or chair surface, turn by taking small steps. Keep the person's knees blocked with your own knees.
- When turned, bend your hips and knees to squat, lowering the client to the seat.
- Replace the footrests. Adjust the height of the foot pedals so the person will be sitting with a 90-degree angle at the hips and knees.
- When transporting a person in a wheelchair, pull it backwards up steps or curbs.
- Follow the same principles to return the person to bed.

If a client begins to fall

- Once a client has started to fall, it is almost impossible to stop the fall.
- Instead of trying to stop the fall, try to guide the client to the floor.
- Once the client is on the floor, get help to lift him.

Lifting from the floor

- You might find that someone has slipped to the floor but is not seriously injured. He or she may be able to help you help him or her up.
- Always get a coworker to help you get a client up if the client cannot assist you. Assistance of four to six people may be required. When appropriate, use a mechanical lift or hoist to raise a client.
- Roll the client onto a blanket or lift sheet.
- Have two or more people stand on each side. Each person should kneel on one knee and get a secure hold on the blanket. On the count of three, everyone should lift the client and stand up, moving the client onto a bed or stretcher.



Transferring in and out of a car

- Put the front seat of the car as far back as possible.

- Position the wheelchair at a 90° angle to the car seat.
- Bend your knees and hips in a squat.
- Place your arms underneath the person's armpits and around the upper part of his back. He may place his arms around your shoulders, not your neck. Grasp the person's upper back and do not pull under his arms. Hold him close to you.
- Straighten your legs and hips slightly as you smoothly lift the person's torso into the car, placing his buttocks on the seat. Move your feet to turn, do not twist.
- Be sure his buttocks are as far back towards the driver's side as possible before lifting his legs into the car. When lifting his legs, keep your back straight.

Pulling a client up in bed

- Always get help when pulling a client up.
- Place a draw or lift sheet under the client.
- Remove the client's pillow from under his head and place it against the head of the bed to provide a cushion between the client's head and the headboard.
- Place the bed at a comfortable height for you and your coworker.
- Both you and the coworker should bend your knees and push with your feet.
- Grasp the draw or lift sheet firmly, holding the sheet close to the client's body.
- Lean in the direction you want to move the client.
- Instruct the client to lower his chin to his chest if possible. If the client cannot hold his head up, be sure the lift sheet is supporting his neck and head.
- Ask the client to bend his knees so he can assist by pushing backwards.
- On the count of three, lift the draw sheet and pull the client up.

Pulling a client up in a chair

- Have the client fold his arms across his chest. Lock the wheelchair brakes.
- Stand behind the client, bend your knees, and wrap your arms around him, hugging his torso securely by folding your arms just under his in front.
- Straighten your legs, lifting the client's torso up and back in the chair.

Moving a person from the bed to a stretcher

- Put the person on a lift sheet.
- Position the bed at waist height.
- Position the bed slightly higher than the stretcher and lock the brakes on both the bed and the stretcher.
- The worker pulling the client toward them should be the stronger of the two. This worker will stand on the opposite side of the stretcher and may need to kneel on the stretcher.
- Pull the client to the edge of the bed.
- Place the client's legs on the stretcher. Have the pusher kneel on the bed, holding the lift sheet.

- On the count of three, grasp the pull sheet and slide the client on to the stretcher. Do not reach across the client.

Turning a client from side to side

- Stand at one side of the bed, with the bed raised to waist height.
- Place your arms under the client's shoulders and hips, or grasp the lift sheet.
- Pull the client to the edge of the bed, trunk first and then legs.
- Cross the client's leg closest to you over the other leg.
- Place your hands on the client's shoulder and hip closest to you.
- Lean in toward the client and push the client's torso away from you.
- Place the top leg in front of the bottom leg.
- Support the client's shoulders, back, and hips with pillows. Place a pillow between the client's legs to support the top leg. Adjust for comfort.

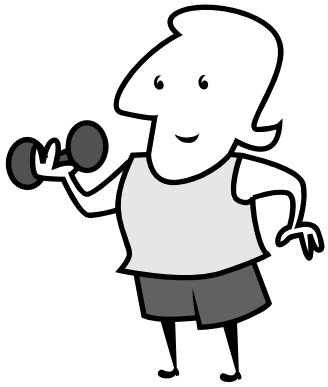
Devices that can help you work smarter, not harder

- Draw sheets—make it easier to pull a person up in bed or move them to the side. To place a draw sheet under a client, turn the client on his or her side and lay the draw sheet on the bed. Roll half of the draw sheet up against the client. Turn the client to his other side, rolling him over the rolled-up draw sheet, and pull the rolled draw sheet out and straighten it on the bed. The lift sheet should extend from above the shoulders to below the hips and should support the neck and head if the client cannot do so.
- Bed controls—raise or lower the bed to a comfortable and safe position for you, your coworker, and the client.
- Slide boards—help to reduce friction so the client can slide from the bed to another surface.
- Trapeze over the bed—can allow clients to help you move them. They can grasp the trapeze, pull themselves up and assist as you move them.
- Gait belt—is made from heavy canvas with a sturdy buckle. Place the belt around the client's waist and use it to assist you in moving him or her.
- Mechanical lifters/hoists—can lift a client who is heavy, or one who has fallen. Ask your supervisor for instructions before using these devices.

Conclusion

Protect yourself

- Work in teams
- Call for support to prevent unsafe transfers
- Use lifting equipment



- Exercise to maintain a strong, healthy back
- Use proper posture and body mechanics

Most companies have an ergonomic plan to prevent back sprain and strain injuries from happening. These plans should include:

- Regular inspections to discover hazards that might lead to strain and sprain injuries
- Training for everyone on how to prevent injuries
- Safe staffing levels so workers don't get hurt lifting heavy clients alone
- Useful and safe lifting devices

Your body has natural limits. Some tasks can lead to injuries when you go beyond these limits. Jobs should be designed to fit the worker. This is ergonomics. This is working smarter, not harder.

What is wrong in these stories?

Sharon is helping Mr. Smith move from a chair into bed. She positions the chair close to the bed at a slight angle. She locks the brakes on both the bed and the wheelchair. She places her feet widely apart but does not block Mr. Smith's knees. She bends over, puts her hands under Mr. Smith's arms and instructs him to place his arms around her neck. She pulls Mr. Smith to a standing position, twists her body to pivot him so his back is to the bed and then sits him down on the bed. The bed's position is at the lowest level. Sharon lays Mr. Smith back on the bed, then bends over and lifts his legs onto the bed. As she straightens up, she feels a sharp pain in her back. Identify at least five things Sharon did that may have contributed to her injury, and at least two things she did that could have harmed the client. Did she do anything right?

Mike sees that Mrs. Jones has slipped down in her chair. He leans over her from the back, grasps her under the arms and pulls her up. He keeps his feet close together and stands so the wheelchair will push against his legs as it rolls backward. What did Mike do wrong? What did he do right?

Patty is walking with Mr. Smith when he begins to fall. She tries to stop the fall, but instead he pulls her to the floor with him. What should she have done differently?

Lifting and transferring test

Name _____ Date _____ Score _____

1. Ergonomics is fitting the _____ to the _____. (2 pts.)

2. List five ways to practice preventive care for injuries. (5 points)
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____

3. Putting ergonomics to work might include the following. Choose three. (3 pts.)

   (a) making sure the worker is strong enough to handle a heavy client
   (b) using appropriate equipment
   (c) changing how tasks are done
   (d) organizing work in new ways

4. As a rule, you should not sleep on your stomach. True or False

5. Good _____ helps the body work more effectively and efficiently.

6. _____ for yourself and the client is the most important consideration when lifting and transferring.

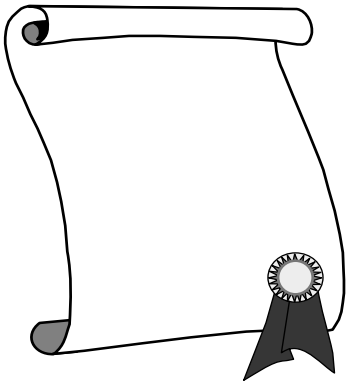
7. When moving a person to the edge of the bed, you should move the upper trunk and then the legs one at a time. True or False

8. You should always face the client when you are lifting and moving him. True or False

9. If a client begins to fall, you should grab him and try to keep him from falling. True or False

10. Good standing posture includes spreading your feet to shoulder width and putting equal weight on each foot. True or False

Certificate of Completion



Presented to

_____

(Name of Participant)

For completing the 1-hour course

Lifting & Transferring

Date _____

Company _____

Presented by _____

(Signature of presenter or write “self study”)

September 2008

IMPROVING PATIENT CARE BY REPORTING PROBLEMS WITH MEDICAL DEVICES

Learning Objectives:

Upon completion of this program, health professionals should be able to:

- Describe what constitutes a medical device
- Explain the importance of medical device postmarket surveillance
- List the three broad types of medical device adverse events
- Define their responsibility to report medical device adverse events
- Define the user facility's responsibility to report to FDA and/or manufacturers
- Describe methods used by FDA to inform health professionals regarding medical device safety

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Healthcare practitioners are the primary users of medical devices for direct patient care. As such, they are in the best position to recognize problems (such as in the example above) that result from the use of medical devices. 82% of all device-related incidents are discovered by nurses or physicians. The outcome of a device-related adverse event or product problem, as with any other medical product (i.e., drug, biologic, or special nutritional product), can be serious and result in illness, injury, or even death.

The active monitoring and reporting of medical device problems by health professionals and the facilities in which they work leads to improved patient care and increased safety, both for the patient and for the operator of the device. The reporting of device problems to the manufacturer and/or the Food and Drug Administration (FDA), the federal agency which regulates medical devices, is a critical communication link to ensure the safety and effectiveness of medical devices marketed in the United States.

The sooner that FDA learns about a problem, the sooner the agency can take action to protect patient and user safety. Sometimes a single report can initiate this action. Several case examples, based on actual reports received by FDA, are found throughout this article.

DEFINITION OF A MEDICAL DEVICE

"There probably are not many terms in the English language that cover as much ground as 'medical devices.' Those words encompass a great diversity of products from bandages to heart valves, from thermometers to the most advanced therapeutic and diagnostic machinery" David A. Kessler, MD , Former Commissioner Food and Drugs

The Federal Food, Drug, and Cosmetic Act) defines a medical device a "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article,...which is...intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease...,or intended to affect the structure or any function of the body..., and which does not achieve any of its principal intended purposes through chemical action within or on the body...and which is not dependent upon being metabolized for the achievement of any of its principal intended purposes." Therefore, medical devices are different from drugs, which work by chemical or metabolic reactions within or on the body to achieve their principal intended effects.

There are over 1800 categories of medical devices, and they vary in both complexity and risk potential. Some of the more common medical devices include ventilators , heart valves , pacemakers, X-ray machines, infusion pumps, implants, biopsy equipment, and ultrasound. Accessories to devices such as hoses, tubing, or software controlling a device are also regulated as devices. Less complicated devices include sutures, bedpans, thermometers, sharps containers, and medical gloves. Examples of lesser known products that are also regulated as devices are laboratory diagnostic tests; sterilants and disinfectants used for medical devices; water treatment used for dialysis; cementing agents; sunglasses; topical wound dressings; home diagnostic kits; and even leeches.

CASE EXAMPLE: An 81 year old female was undergoing surgery for a left hip implant. The surgery was proceeding routinely until the surgeon placed bone cement into the acetabular area in preparation to fit the hip implant. The patient went into anaphylactic shock and died.
Q - Is bone cement a medical device?
A - Yes.

Simply, if a product is not a medication (drug or biologic) and is used for diagnosis or treatment, it is probably a medical device.

An understanding of the routes by which medical devices come to be marketed, and the limitations of what is known about a device before it is marketed, offers valuable insight into why it is so important that health professionals closely monitor medical devices which they use in their clinical practice.

THE PREMARKET REVIEW

Before medical devices can be made available for use by the healthcare community, the manufacturer must first gain approval or permission for marketing by F DA. Part of the premarket review requires that device manufacturers develop good testing and manufacturing practices (which are inspected by FDA). The desired outcome of this process is the production of a consistently well-made, reliable, safe, and effective medical device which the user can depend upon to function for the specified life of the product.

In 1976, Congress amended the Food, Drug, and Cosmetic Act, and the FDA received the authority to require that new medical devices be proven safe and effective before being marketed. Prior to that time, FDA could only take action against hazardous or misrepresented devices after they were in the marketplace. The 1976 law created two primary routes to market medical devices, based on risk potential and product complexity:

1) **The 510(k) or premarket notification** is the simplest and most common route. For a device to be cleared via this route, the manufacturer must demonstrate t h at the new product is "substantially equivalent" to a device that is already on the market (the assumption is that the new product is safe and effective for the intended use, performs consistently, and is as good as what is currently available on the market). FDA then reviews the device by assessing the similarities to a device(s) already on the market. Examples include infusion pumps, foley catheters, and endotracheal tubes.

2) **The PMA or premarket approval application** route must be used if the new medical device is not similar to a device already on the market. In this case, the manufacturer must conduct clinical and pre clinical scientific studies to demonstrate that the device is safe and effective for its intended uses. Examples of devices in which a PMA was filed include stentless heart valves, coated vascular grafts, and implantable devices that combine cardiac pacing with defibrillation.

Note: Medical devices which were on the market prior to 1976 were "grandfathered," which means they were allowed to remain in general use, but are subject to an FDA request for safety and effectiveness data from studies.

In spite of a rigorous premarket review process, medical devices (or any other medical products) are only as safe as the information known at that moment in time. For example, clinical trials for a medical device may involve only a few hundred patients; medical devices are typically "bench-tested" (rather than tested in real-life clinical situations); and unlike drugs, most durable medical devices have no established end-of-life (i.e. it is unknown how long a device can be used and how frequently it can be used). **Therefore, healthcare professionals cannot assume that FDA has determined definitively that a device cleared for marketing is absolutely safe for human use.**

The accumulation, review, and evaluation of information that is gained about a product once it is cleared and available for marketing is called **Postmarket Surveillance.**

THE IMPORTANCE OF POSTMARKET SURVEILLANCE

Once the premarket process is completed and a device goes into widespread use, unforeseen problems can still arise. For example, adverse effects that occur relatively rarely or relate to product labeling (including instructions) or user technique and skill, cannot always be detected during the premarket review. Furthermore, questions related to durability, biocompatibility, and toxicology in humans may not be answered with certainty until a device has been on the market for a number of years.

Hospitals and other clinical settings monitor for problems with devices and other products within their facilities . These internal surveillance systems help to track and trend problems within the facility to improve the delivery of patient care.

FDA and manufacturers utilize a variety of postmarket surveillance tools to signal important events or trends in order to help identify the cause of device failures and to take appropriate action. In addition, medical devices continue to be tested by the manufacturer even after approval. FDA also performs in-house laboratory research to further analyze problems related to device safety.

To optimize postmarket surveillance in the detection of medical device problems, FDA and manufacturers are dependent upon individual healthcare professionals and the facilities in which they work to report problems with medical devices.

IDENTIFYING AND AVOIDING PROBLEMS WITH MEDICAL DEVICES

Types of Problems

Problems with medical devices generally fall into one of the following three broad categories:

- **Device Problems:**

Device problems include malfunctions (e.g., mechanical, electrical, or software - related) , manufacturing defects in product design or development, or material problems such as product instability.

- **Use Problems:**

Use problems may be caused by inadequate or misleading labeling, confusing instructions, inadequate

confusing instructions, inadequate packaging, design problems which make the device difficult to use, or inadequate training in the use of the device.

Use problems can cause or induce user errors. (See boxed information "Human Factors" on this page).

• Clinical Problems:
Clinical problems can occur with a patient who is sensitive or allergic to a device, has a preexisting condition that makes the device difficult or risky to use, or in whom the device would have an inherent risk.

Avoiding problems

Healthcare professionals can do some simple things to avoid common problems with medical devices:

- understand how a device should be used, and for which patients it is probably not safe
- be familiar with the instructions and other labeling
- inspect and test equipment prior to use make sure that devices are properly maintained and serviced
- do not use a device that has malfunctioned until it has been "cleared" by the appropriate facility staff (i.e., biomedical engineering)
- understand that the manufacturer may not be held liable for patient injury if a medical device is used in a manner not specified in the labeling (8,9,10)
- do not use a device past its expiration date

REPORTING DEVICE-RELATED PROBLEMS:

Healthcare professionals are **encouraged** to report medical device problems directly to the manufacturer and/or FDA whenever it is suspected that the product caused or contributed to an adverse outcome. However, health professionals who practice in hospitals, outpatient treatment, diagnostic, and surgical facilities, or long term care facilities need to be aware that **their facility is responsible** for reporting serious device-related events to the manufacturer and/or FDA. These types of facilities are called device "user facilities." The key to effective reporting is to understand the two complementary avenues for national adverse event reporting:

- Medical Device Reporting (MDR) **requires** device user facilities, manufacturers, and distributors to promptly notify FDA about device-related events that may have caused or contributed to a death, serious illness or injury; and
- MedWatch, the FDA Medical Products Reporting Program, which **encourages** individual health professionals to notify FDA and/or the manufacturer about serious adverse events and product problems with medical products. (i.e., events not reportable under MDR).

MEDICAL DEVICE REPORTING (MDR) BY USER FACILITIES

The purpose of MDR is to ensure that the most serious problems with medical devices will be identified at the level of the user and will be reported by the user facility to the manufacturer and/or the FDA. The MDR regulation was published on December 11, 1995 and became effective on July 31, 1996. This regulation facilitates the implementation of the user facility reporting requirements of the Safe Medical Devices Act of 1990 (11) and adds new requirements for (12) manufacturers and user facilities, as well as requirements for written procedures, complaint files, and reporting forms. Since the user facility has direct access to the patient and the device, it is in the best position to obtain the information that manufacturers and FDA need to determine whether the event presents a public health risk (13)

What is a device user facility?

Healthcare professionals who practice in any of the following types of clinical settings are working in a device user facility (i.e., facilities which are subject to MDR reporting):

• Hospitals (providers of diagnostic, therapeutic, surgical, and other patient services which include general, chronic disease, rehabilitative, psychiatric, and other special-purpose facilities)

• Long-Term Care Facilities (providers of skilled nursing care, hospice care, or rehabilitation services)

• Ambulatory Surgical Facilities (providers of same-day outpatient surgical services)

• Outpatient Treatment Facilities (providers of nonsurgical therapeutic care on an outpatient basis, which includes ambulance providers, rescue services, and home healthcare services)

• Outpatient Diagnostic Facilities (providers of diagnostic testing on an outpatient basis, such as diagnostic radiography, mammography, ultrasonography, electrocardiography, magnetic resonance imaging, computerized axial tomography, and *invitro* testing services).

HUMAN FACTORS

(the study of the interaction between the user and the device) FDA is interested in knowing about device use problems in order to minimize error and patient injuries that result from user error (5) Human factors problems are more likely to occur with technologically advanced devices, such as programmable devices (6) Device use problems can happen in spite of adequate training and a high level of caution.

Examples of design problems that tend to induce user error include: complicated or unconventional arrangements of controls, displays, and tubing; poor design that makes installation and maintenance unnecessarily complex; ambiguous or difficult to read displays; confusing or unnecessarily intrusive alarms; hard to remember or confusing device operating procedures; inadequate device feedback or status indication that causes user uncertainty; and poorly designed labeling (7)

On the other hand, well-designed devices are those that are consistent with the user's experience; are logical and not confusing; minimize the need for depending on memory and making mental calculations; do not overtax the user's strength, dexterity, visual ability, or auditory capacity; alert the user to device-related problems; prevent users from making fatal errors that could otherwise occur easily; and are supported by readable and understandable labeling (7)

Health care practitioners can play an active role in device design by reporting information that they believe will help a manufacturer make a better device.

There are clinical settings which are **exempt** from MDR reporting requirement. These facilities include offices of physicians, dentists,

chiropractors, optometrists,nurse practitioners, school-based clinics, employee health clinics, and freestanding care units. **However, health professionals who work under the auspices of a user facility are subject to their facility's mandatory reporting requirements.**

How and what must user facilities report?

User facilities are required to complete a mandatory reporting form (FDA 3500A) whenever they receive or otherwise become aware of information that reasonably suggests that a device has or may have caused or contributed to the **death, serious illness, or serious injury** of a patient in the facility. Mandatory reporting requirements by user facilities could also include **device malfunctions** and/or **user error** which results in **death or serious illness/injury.** See TABLE 1 for further clarification of the meaning of "caused or contributed" and TABLE 2 for the FDA definition of "serious illness/serious injury" related to device reporting.

The user facility has the responsibility for determining if the **device-related event** is reportable based on the facts and circumstances observed by its medical or nursing personnel

User facilities have an add i t i o n a l responsibility to report, on a semiannual basis, all reports they submitted to FDA and the manufacturer within the previous 6 months. FDA uses these reports to monitor the compliance of the manufacturer with their reporting requirements.

Note: There are no mandatory reporting requirements for user facilities to report adverse events or problems with other medical products, such as medications. However, healthcare professionals a re encouraged to report these occurrences via the voluntary MedWatch reporting mechanism.

Death: Must be reported by the user facility to the **FDA and the manufacturer** of the device within 10 working days of the facility becoming aware of the event.

CASE EXAMPLE: A 35 year old female suffered a severe head injury in a car accident. Upon discharge from the hospital, she remained disoriented and easily agitated, and was followed by a home care agency for further care. Her physician's orders included IV medications to be infused via an infusion pump, physical therapy, and an electric hospital bed for long-term use. The patient was unattended one day for about 45 minutes, after which time the caregiver entered the room and found the patient's body hanging between the side rail of the bed and the floor. It appeared that the patient had attempted to get out of bed by slipping through the side rails. Her head became entrapped between the side rails and, unable to extricate herself, she was strangled.
Q - Is this death a reportable event?
A - Yes. Since the electric hospital bed (a medical device) might have caused or contributed to the patient's death, the event is reportable by the home care agency (the user facility) to FDA and the manufacturer within 10 working days of becoming aware of the event.

TABLE 1

CAUSED OR CONTRIBUTED

"Caused or contributed" means that an incident was or may be attributable to a medical device. The medical device may have been a factor in a death or serious injury, including events which occurred as a result of:

Device failure
Manufacturer defect
Malfunction
Improper/inadequate design
Improper/inadequate labeling
User error

TABLE 2

DEVICE-RELATED SERIOUS ILLNESS/INJURY

FDA defines a device-related serious injury as an injury or illness that:

- Is life-threatening;
- Results in permanent impairment/ damage to body function or structure; or
- Necessitates medical/surgical intervention to prevent permanent impairment/damage of body function/structure

Serious illness/injury: Must be reported by the user facility to the device manufacturer within 10 working days of the facility becoming aware of the event. (If the manufacturer is unknown, the report should be sent to the FDA.)

FDA encourages **user facilities** to submit reports of device malfunctions that **do not result in death or serious injury** directly to the **manufacturer** using the mandatory reporting form (FDA 3500A). Although these reports are not mandatory under the law, they provide important information that can result in product recalls and other types of corrective action.

CASE EXAMPLE: A 56 year old male entered an outpatient treatment facility to receive radiation therapy for throat cancer. He subsequently sustained burns central to and bordering the treatment area. Upon further investigation by the facility, it was discovered that the Radiation Treatment Planning System (RTP) had a software problem which included an algorithmic error resulting in irregular field settings. Due to this error, the patient received a 22% overdose of radiation to areas outside of the central beam axis during the course of his linear accelerator-based therapy. His radiation therapy was suspended, and he received treatment for his burns.
Q - Is this injury a reportable event? A - Yes. A software problem with the RTP (medical device) resulted in a serious burn injury to the patient, which required medical intervention to prevent permanent damage to body structure. The outpatient treatment facility (the user facility) should report this event to the manufacturer within 10 working days of becoming aware of the event.

CASE EXAMPLE: During a routine angioplasty procedure in a hospital, the tip of apercutaneous transluminal angioplasty catheter detached. The patient experienced no electrocardio -graphic changes or chest pain and was transferred to the medical intensive care unit. He ultimately underwent surgery to remove the wire tip of the catheter.
Q - Is this a reportable event?
A - Yes. Medical intervention was necessary (one of the definitions of "serious"), after the device (catheter) malfunctioned, to prevent permanent impairment to body function. The hospital (the user facility) should report this event to the manufacturer of the device (within the 10 working day limit).

CASE EXAMPLE: A 40 year old female undergoing a laminectomy was administered what the anesthesiologist thought to be 100% oxygen (to bring her out of anesthesia).When the patient became cyanotic, the anesthesiologist immediately removed her from the ventilator, believing it was malfunctioning. The patient was manually resuscitated. Three hours later, in the same operating room, a four month old premature infant was in surgery for a ventriculoperitoneal shunt. When the same ventilator was used, and oxygenation had been initiated, the infant became cyanotic and CPR had to be administered. Upon investigation by the hospital, it was found that the oxygen hose was inappropriately assembled into the nitrous oxide inlet and the nitrous oxide hose was inappropriately assembled into the oxygen inlet. The biomedical engineering department documented that the manufacturing firm had delivered and set up the device for use. Subsequently, no one had checked the ventilator connections prior to use of the device. *Q - Is this a reportable event? A - Yes. The incorrect assembly of the ventilator connections (medical device) resulted in a life-threatening event (one of the definitions of "serious"). This event should be reported by the hospital (the user facility) to the manufacturer (within the 10 working day limit).*

CASE EXAMPLE: A flash fire occurred during a blepharoplasty procedure being performed on a 40 year old male in an outpatient surgical facility. The patient was receiving oxygen via nasal cannula. The surgeon was cauterizing with an electrosurgical cutting and coagulation device when a " golf ball-sized" flash occurred. The patient's eyelashes, face, and cornea were burned. The burns were treated by debridement and ointment, and the patient ultimately required treatment by an ophthalmologist. The electrosurgical device was evaluated by the manufacturing firm and found to be functioning properly. The instruction manual contained warnings regarding fire hazards specifically with the use of electrosurgery in an oxygen enriched environment. *Q - Is this event reportable even though the labeling warns of potential fires? A - Yes. The patient required medical intervention to prevent permanent impairment after receiving an injury attributed to the use of the device. The outpatient surgical facility (the user facility) should report this event to the manufacturer within 10 working days of becoming aware of the event.*

CASE EXAMPLE: A 34 year old female with a nonpalpable breast lesion discovered by mammography entered an outpatient diagnostic facility for a large core needle biopsy under stereotactic guidance. The patient experienced no discomfort after the procedure, but a subsequent mammogram revealed that metal shavings and fragments from the 14 gauge needle had remained in the breast tissue after the biopsy was performed. This was due to multiple firings of the biopsy gun into the tissue that resulted in the needle hitting the cannula, causing the burring. *Q - Is this event reportable under the law by the user facility? A - No. This is a device malfunction which did not meet the definition of a serious illness / i n j u ry. However, F DA strongly encourages user facilities to report device malfunctions to the manufacturer and/or MedWatch so that they can take appropriate action if needed.*

CASE EXAMPLE: A nurse in a hospital was preparing to draw up a medication into a 5 cc syringe. In the process, he noticed the markings on the syringe were at an angle that made it impossible to draw up the medication accurately. He then checked the drawer where the syringes were stored and noticed at least 10 other syringes that were mismarked. Upon opening a new box of syringes, he discovered all the syringes were correctly marked. *Q - Is this event reportable under the law by the user facility? A - No. Although this device problem is not reportable under the law, FDA would encourage the user facility to report it to the manufacturer and/or MedWatch*

Of special note:

• Health professionals need to be aware that if a patient brings his/her own medical device (i.e.,a wheelchair) into a user facility for personal use and the device causes or contributes to the patient's injury or death, the event is reportable under MDR (even though the device is not owned or leased by the user facility) because it occurred in a user facility (14)

. • Healthcare professionals who work in user facilities and sustain a device-related illness/injury (or death) are considered "patients" of that user facility and any serious adverse event reportable under the law would be reported as if it had happened to a patient in that facility.

The role of the healthcare professional in user facility reporting:

It is critical that health professionals working in user facilities monitor and report all device problems in accordance with the procedures established by their facility.

These procedures will probably include:
• Removing the defective device from the patient area;
• Labeling the device with a description of the problem and the date;
• Recording the name, model number, and manufacturer of the device;
• Notifying the appropriate personnel;
• Filling out an incident report, and submitting all the evidence with the written report.

CASE EXAMPLE: A 2 year old female was admitted to the hospital with a fever of unknown origin and diagnosed with sickle cell anemia. The child was receiving D5W with potassium IV at 20 cc/hr per a large volume infusion pump. The mother, who was in the room with the child, heard the pump alarm and turned on the nurse call light. The nurse heard the pump alarming upon entering the room. The child was coughing and having difficulty breathing. When the nurse attempted to better open the patient's airway, the child became limp and unresponsive. A code was called and CPR was initiated. The patient was removed from the pump and transferred to the ICU, where she died several hours later. *Q - What would be some of the device-related actions which should be taken? A - A health professional witnessing this event needs to identify that the infusion pump might have contributed to the death of the pat i e n t . Established procedures within that facility must be followed. These procedures may include that the pump be labeled, removed from the clinical area , a n d checked to evaluate why it was alarming (whether it was programmed correctly, whether there appeared to be over/under infusion, whether the tubing was properly i n s t a l l e d, e t c.). The healthcare professional should also notify the appropriate personnel within his/her facility (such as the risk manage r) , and complete the necessary written report.*

Although the healthcare professional might be the one to discover the problem, the ultimate responsibility for reporting device-related events to the manufacturer and/or FDA rests with the user facility. The healthcare professional does not need to determine if a device-related incident is reportable to FDA or the manufacturer. The user facility investigating team will make this determination within the requirements of MDR.

Above and beyond following internal reporting policies in their user facility, healthcare professionals are encouraged to take an active role in developing the mandatory device monitoring system which will provide an effective mechanism for data collection, documentation, and evaluation.

The MDR regulation specifies that the following be done in all user facilities :

• Obtain copies of the MDR regulation, reporting forms and instructions, and coding manual.

• Designate an MDR contact person (e.g., the facility administrator, risk manager, or biomedical/clinical engineer). The contact person can rely on a committee to determine reportablility of events.

• Develop written procedures explaining how the user facility intends to comply with MDR requirements (usually these procedures have been added to the monitoring systems already present in the facility)

.

• Start a file of reports and information that is sent to FDA and the manufacturer. Files must be kept not only for events which were reported, but for those not reported, and must be maintained for two years.

• Develop internal systems to identify device-related events, determine which events must be reported, provide documentation of decisions, and ensure that forms are properly completed and submitted within the required time frame.

N o t e : The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be reviewing compliance with MDR during their site visits. User facilities can also be visited by FDA investigators to determine whether they are in compliance with MDR.

VOLUNTARY REPORTING BY HEALTH CARE PROFESSIONALS

The second reporting mechanism , voluntary reporting by healthcare professionals, is just as vital as mandatory MDR in protecting the safety of patients and device operators.

Under MEDWATCH, FDA's Medical Products Reporting Program, health professionals are encouraged to report serious adverse events and product problems with all medical products (i.e., drugs, biologics, medical devices, and special nutritional pro d u c t s , including dietary supplements , infant formulas , and medical foods) to FDA and/or the manufacturer. Health professionals use the voluntary reporting form (FDA 3500). Whenever a device fails to perform as expected, it should be kept, as well as any other material evidence that could be used if an investigation of the product is made (15)

Medical devices should not be sent to FDA.

The definition of a serious adverse event is broadly defined within voluntary reporting to include any patient outcome that results in death, a life-threatening eve n t , hospitalization (initial or prolonged), disability, a congenital anomaly, or if medical or surgical intervention was required to prevent permanent damage. Health professionals do not need to prove causality; a suspected possible association between a product and an adverse patient outcome is sufficient reason to report.

FDA is also interested in reports of product problems such as inaccurate or unreadable labeling, packaging or product mix-up, contamination or stability problems, defective devices, or product confusion (caused by name, labeling, design, or packaging).

When can the voluntary system be used to report problems with medical devices?

1. To report medical device events occurring in clinical settings which are **exempt** from user facility reporting (such as the office of a physician, nurse practitioner, or dentist). Events that are particularly important to report are serious device malfunctions that result in a death or injury, or when a device-related condition is created that may be unsafe, hazardous, or otherwise presents a public health concern. FDA is not interested in reports from health professionals if personal preference is at issue rather than device performance.

2. To report some medical device events occurring within a user facility (it is usually the user facility that makes the decision to file a voluntary device report). User facilities are encouraged to use the mandatory version of the form , **F DA 3500A**, even though the reporting is voluntary, because the 3500A requests additional necessary information about the device incident.

• Voluntary reporting is appropriate for a "near miss" (i.e., under slightly different circumstances, a serious injury or death might have occurred) When a potential hazard is recognized, corrective action should always be taken. FDA encourages the voluntary reporting of "near misses" to the device manufacturer (16)

• The voluntary reporting mechanism can also be used for reporting user error not resulting in death or serious illness/injury, because such events may indicate that the labeling for a device does not provide adequate directions for use or adequate warnings (17)

• Finally, voluntary reporting of device-related problems in a user facility is appropriate for device-related events not reportable under the law (i.e., not causing or contributing to serious illness/injury or death) which affect product quality such as defective devices, inaccurate or unreadable product labeling, packaging or product mix-up, contamination, or stability problems.

It is important to note that voluntary reporting on the FDA 3500 by health professionals does not satisfy their user facility's medical device reporting requirements under MDR. Health professionals should follow the intern a l incident reporting procedures within their facilities for all device - related events. However, health professionals can file an individual report using the FDA 3500 form.

WHAT HAPPENS TO YOUR REPORT?

Reports sent to the device manufacturers:

Upon receiving a report from a user facility or an individual healthcare professional, a manufacturer must investigate, evaluate, and identify the underlying causes of any adverse event reported to them. (The manufacturer usually contacts the reporter to obtain as much information as possible so that the manufacturer can investigate the event and complete their report to FDA.) FDA periodically inspects manufacturers for compliance with manufacturing and reporting requirements. In addition , device distributors must also report device-related deaths, serious injuries , serious illnesses, a n d malfunctions to FDA with a copy to the manufacturer .
(18) In some cases the problem might be resolved by means of relabeling or a recall. For example, MedWatch received a call from a dental office reporting that an employee had been momentarily unable to release her hand from an ultrasonic cleaning device. FDA's investigation revealed that there was electrical leakage from the lid even though the unit was turned off. In another incident, an electrical fire started in an ultrasonic device that had been turned off prior to cleaning. The manufacturer identified the cause of the problem and initiated a recall. (1)

Reports Sent to FDA:

When FDA receives a report from a user facility or an individual health professional, it is entered in the medical device postmarket surveillance database, and subsequently compared to other information. Part of this review is to evaluate any past problems with the device, particularly those which may present an immediate risk to the public health. All voluntary reports that are received by MedWatch are sent to the manufacturer for follow-up. FDA staff also look at actual or potential risk, and ensure that appropriate corrective action is initiated. Not all reports involve problems that re q u i re immediate resolution. FDA continually reviews the database to detect problems, trends, and potential hazards.

As a result of such trend analysis, FDA staff noticed a gradual increase in the number of deaths associated with the use of hospital bed side rails (19)

Between January 1990 and June 1995, F DA received 102 reports of head and body entrapment incidents involving hospital bed side rails. Although one entrapment occurred with a 2 year old patient, the majority of deaths and injuries involved elderly patients. This prompted FDA to mail a Safety Alert entitled *Entrapment Hazards with Hospital Bed Side Rails* on August 23, 1995 to over 94,000 hospitals, nursing homes, hospices, nursing associations, and home healthcare agencies.

E ach ye a r, F DA receives approximately 100,000 reports through the MDR route and 5,000 device reports through the voluntary MedWatch route. Nurses are active device reporters, submitting about 25% of the voluntary device reports (biomedical engineers and other technicians/ technologists submit about 21%, risk managers about 13%, and physicians about 8%). The remainder of the voluntary reports are submitted by pharmacists and dentists, with about 17% from non-health professionals.

Confidentiality and Public Availability of Reports

FDA is aware that health professionals are concerned about the issue of confidentiality and public availability of reports.

Voluntary Reports (reported on FDA 3500) from health professionals:

The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. FDA will not release any patient identifiers to the public. Healthcare professionals can assist in this process by not using the patient's name, initials, or other identifying information in block A1 (patient identifier) on the reporting form (i.e., leave it blank).

The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise (there is a check-off box on the form). However, FDA will not disclose the reporter's identity in response to a request from the public, pursuant to the Freedom of Information Act.

On July 3, 1995, FDA published a regulation that extends this protection by preempting state discovery laws for voluntary reports held by drug, biologic, and medical device manufacturers (20)

Mandatory Reports (reported on FDA 3500A) from user facilities:

Certain information from user facility reports is available for public disclosure. Prior to public disclosure, F DA will delete:

- Any information that constitutes trade secret or confidential commercial or financial information;

- Any personal, medical, and similar information (including the serial number of implanted devices) which would constitute an unwarranted invasion of privacy; and

- Any names and other identifying information of a third party voluntarily submitting an MDR report. This includes physicians, nurses, other healthcare professionals, or other hospital employees, unless they are the designated MDR contact person.

PROVIDING FEEDBACK TO HEALTH CARE PROFESSIONALS

Reports from health professionals and other sources provide valuable information about device problems. When risks or potential risks associated with the use of medical devices are identified by FDA, the agency issues a Notice (or letter), a Public Health Advisory, or a Safety Alert. This information is then mailed to hospital administrators, risk managers, biomedical engineers, pharmacists, and other agencies. It is also sent (via email or fax) to the M e d Watch Partners , rep resenting more than 130 health professional specialty organizations.

A Notice is usually a letter to healthcare professionals or healthcare organizations from FDA. Two recent examples are the April 17, 1997 Notice alerting health professionals to a potential infection problem with medical devices that are rented or leased by healthcare facilities, and the June 13, 1997 Notice entitled *Radioactivity in Radiation Protection Devices.*

A Public Health Advisory is generally issued when there has been a problem identified with a device and describes potential risk. For example, FDA issued a Public Health Advisory on March 21, 1994 entitled *Avoiding Injuries fro m Rapid Drug or IV Fluid Administration*.identified with a device and describes potential risk.

HOW TO OBTAIN FORMS AND INSTRUCTIONS

Voluntary (FDA 3500) form for reporting by **health professionals :**

- By mail or fax : call 1-800-FDA-1088 (fol low instructions for health professional or press "0" during the initial message)

- By intern e t : www. f da.gov / medwatch (cl i ck on "How to Report " , then "Reporting by Health Professionals"). Print the form or download as a PDF file. There is also form software which can be downloaded and used to complete the forms using a personal computer. After the initial entries are m a d e, the completed form can be printed and mailed to FDA and/or the manufacture r. This software does not permit electronic submission of reports. If you prefer a copy of the free software on disk, call 1 - 8 0 0 - F DA-1088 (press 0), or e-mail MedWatch (medwatch @ bangate.fda.gov). Note: the form software contains both the FDA 3500 and the FDA 3500A forms.

Mandatory (F DA 3500A) form for reporting by **user facilities :**
- By mail or fa x : call 1-800-FDA-1088 (press "0" during the initial message)
- By intern e t : www.f da.gov (cl i ck on “Medical Dev i c e s / Radiological Health,” “ Program Are a s ,” “Medical Device Reporting,” and "Forms and Instructions." Print the form or download as a PDF file. There is also form software which can be downloaded and used to complete the forms using a personal c o m p u t e r. After the initial entries are made, the completed form can be printed and mailed to FDA and/ or the manufacturer. This software does not permit electronic submission of reports. If you prefer a copy of the free software on disk, call 1-800-FDA-1088 (press 0), or e-mail MedWatch (medwatch @ b a n gat e. f d a . gov). Note: the form software contains both the FDA 3500 and the F DA 3500A forms .

HOW TO REPORT TO FDA

Voluntary (3500):

- By mail (postage-paid form)
  Med Watch
  The FDA Medical Products Reporting Program
  Food and Drug Administration
  5600 Fishers Lane
  Rockville, MD 20852-9787
- By phone: 1-800-FDA-1088
- By fax: 1-800-FDA-0178
- By internet: available late 1997

Mandatory (3500A):

- By mail:
  FDA Center for Devices & Radiological Health
  MDR Reporting
  PO Box 3002
  Rockville, MD 20847-3002

  Mark the envelope:
  "User Facility Report"

QUESTIONS ABOUT REPORTING?

Voluntary:

Contact the MedWatch office
Phone: 1-800-FDA-1088 (press 0) or (301) 443-0117 (local)
Fax: 1-800-FDA-0178 or (301) 443-5776 (local)
E-mail: medwatch@bangate.fda.gov
Mail: MedWatch
FDA, HF-2
5600 Fishers Lane, Room 9-57
Rockville, MD 20857

Mandatory:

Reporting Systems & Monitoring Branch (HFZ-533)
FDA, CDRH
1350 Piccard Drive
Rockville, MD 20850

Phone numbers for specific questions (Please use fax numbers except for emergencies): Interpretation of policy
(301) 827-0038 (fax) (301) 594-2735 (voice)

Individual 3500A or semi-annual reports
(301) 827-0038 (fax) (301) 594-2731 (voice)

Emergencies outside of normal East Coast business hours
(301) 443-1240 (fax) (301) 443-3757 (voice - 24 hours/day)

SELF-ASSSESSMENT QUESTIONS

1. Which of the following products *ARE FDA* - regulated medical devices?

A. Examination gloves

B. Software to run an MRI machine

C. Home pregnancy kit

D. All of the above

2. Which of the following is *NOT* true about the premarket review of medical devices?

A. Clinical studies must be conducted if the manufacturer files a premarket approval application to market a device.

B. The premarket review process guarantees the safety and effectiveness of medical devices.

C. The manufacturer must develop good testing and manufacturing practices prior to marketing a device.

D. A premarket notification can be filed by a manufacturer who can demonstrate the similarity of the new device with those already on the market.

3. Which of the following statements emphasizes the importance of post market surveillance by healthcare professionals?

A. Problems related to durability of a device will only be seen upon actual use in patients.

B. The majority of medical devices do not undergo clinical trials.

C. Premarket testing cannot detect problems with devices that may occur in certain clinical situations.

D. All the above statements are true.

4. Which of the following is *NOT* considered one of the three broad categories of medical device adverse events?

A. Use Problems

B. Clinical Problems

C. Labeling Problems

D. Device Problems

5. Which of the following is *NOT* a device user facility?

A. An oral surgeon's office

B. A home healthcare agency

C. A diagnostic laboratory

D. A nursing home

6. Which of the following is *NOT* a reportable event under MDR?

A. Device user error resulting in the death of a hospital patient

B. A life-threatening device-related event which occurred in an a ambulance

C. Death of a patient due to a medical device which occurred in a physician's office

D. A serious injury to a patient which occurred in an outpatient mammography unit.

7. Which of the following IS true for healthcare professionals working in a device user facility?

A. Health professionals are responsible for determining if a device-related event is reportable under MDR.

B. Health professionals must report device-related events according to their facility's procedures.

C. The responsibility for reporting device-related death or serious injury events rests ultimately with the health professional.

D. Healthcare professionals should not play any role in helping their facilities identify device-related events.

8. Which of the following incidents must be reported by the user facility under MDR?

A. The serious illness of a patient in a hospital which might have been caused by a drug

B. Confusing instructions about the operation of a medical device

C. Serious injury to a patient possibly caused by a medical device in a nurse practitioner's office

D. A device malfunction in a same-day surgical facility which results in the death of a patient.

9. Which of the following device reports would NOT be of interest to FDA?

A. Problems noted during the maintenance or servicing of a device which could affect the safe use of the device

B. Serious injury as a result of a rented hospital bed to a patient under the care of a home health agency

C. A health professional's individual preference for a particular device.

D. User error caused by confusing device instructions

10. Which of the following statements is NOT true?

A. Reports from health professionals and other sources provide valuable information about device problems.

B. To ensure the safety of medical devices, FDA can utilize mechanisms such as relabeling, Public Health Advisories, Safety Alerts, and recalls.

C. Manufacturers are not required to investigate, evaluate, and identify the underlying causes of device adverse events reported to them.

D. If a product is not a medication (drug or biologic) and it is used for treatment or diagnosis, it is probably a medical device.

Department of Health & Human Resources

Public Health Services

Food and Drug Administration, HF-2

Rockville, MD 20857 USA

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HIV Infection In services education

Objectives

After completing this program, the home health aide will be able to:

» Name two early symptoms of initial HIV infection

» List three methods by which HIV is transmitted

» Note that there are many people with HIV infection who are unaware they are infected, and

» Recognize that standard precautions offer the best protection for preventing transmission of HIV in the workplace.

Overview

The number of persons in the United States infected with the human immunodeficiency virus (HIV) continues to increase. According to 2003 statistics, the Centers for Disease Control and Prevention (CDC) estimated there were 850,000-950,000 Americans living with HIV. Twenty-five percent were estimated to be unaware of their serostatus. Additionally, most HIV infected individuals are living much longer before developing acquired immunodeficiency syndrome (AIDS). In light of those statistics, home health aides are currently very likely to care for HIV-infected patients without being aware of the patient's HIV serostatus.

The purpose of this in-service is to provide information about HIV infection and dispel some common misunderstandings home health aides may have about the condition.

Content

Read the Fact Sheet	15 minutes
Read the Case Study	10 minutes
Complete "Think About It"	10 minutes
Complete the Post-test	15 minutes
Feedback Session	10 minutes

Supplemental learning activities

* Obtain Fact Sheets from the CDC. Distribute the Fact Sheets and discuss with participants, **http://www.cdc.gov.**

» Obtain additional information from the National Institutes of Health (NIH) and distribute to participants. **http://aidsinfo.nih.gov.**

»Arrange for a registered nurse to speak to participants. Have the nurse present information about your agency's infection control plan and the importance of using standard precautions with every patient. Ask the nurse to emphasize the vital importance of immediately reporting any potential exposures to bloodborne pathogens.

»Arrange for a social worker to speak to participants and encourage a group discussion about how the participants feel about caring for patients with HIV infections.

»Ask a member of the administrative staff to speak to participants about State laws regarding disclosures about a patient's HIV serostatus.

POST-TEST ANSWERS

1.	d	They are similar to a mild case of flu.
2.	a	Casual contact with an HIV-infected person
3.	b	False
4.	c	The 1980s
5.	d	No, about one-fourth of the HIV-infected patients themselves don't know they are infected.
6.	a	A virus causes it.
7.	a	True
8.	b	Headache and tired feeling
9.	a	It is transmitted through contact with HIV-contaminated body fluids.
10.	d	There is a vaccine that will prevent HIV infection.

INSTRUCTOR'S LOG

DATE / TIME / PLACE

Attachments

☐ Participation Record ☐ Post-test ☐Handouts ☐ Other _____ RN

ATTENDANCE LOG

DATE	AIDE PARTICIPANT	TEST SCORE	FEEDBACK	RN SIGNATURE

Facts about hiv Infection

During the summer of 1981, a high incidence of a relatively rare form of cancer in otherwise healthy young men was reported in the United States, especially in New York City and San Francisco. The cancer had previously been found only in patients with severely impaired immune systems. Those cancer patients turned out to be among the earliest U.S. cases of what we now call acquired immunodeficiency syndrome (AIDS).

In 1982, the transmission of AIDS was linked to blood and body fluids, and in 1984 the virus causing AIDS was identified. That virus is now known as human immunodeficiency virus (HIV). The following year, antibody testing became available.

In the years following its discovery in the U.S., HIV infection progressed rapidly to symptomatic AIDS and almost all patients died within a few years of diagnosis. In 1987, the first drug specifically for patients with AIDS was approved and, since that time, newer and better drugs have been found to delay the onset of AIDS following HIV infection.

In some parts of Africa, almost a third of the entire population (between the ages of 15 and 45) is infected with HIV. In the U.S., increasing numbers of Americans have HIV infection and, unfortunately, about 25% of them do not even know they are infected.

Overall, home health aides are increasingly less likely to know which of their patients have HIV infections. Therefore it is essential that all patients be treated as if they are infected. Home health aides should strictly follow standard precautions with every single patient, every single day.

HIV INFECTION

Cause

Two types of the HIV virus have been identified. They are called HIV-1 and HIV-2. The types are very similar although AIDS seems to develop more slowly in people infected with HIV-2. HIV-1 is by far the more common type in the United States while HIV-2 is common in West Africa. HIV is a virus that infects the cells of the body and substitutes its own genetic structure for the genetic structure within the cells. Each time the cells divide, new copies of the virus are produced. These new viruses are released from the infected cells to invade other cells.

Symptoms

Some individuals do not have any symptoms when they first become infected with HIV. However, it is more common for people to develop a brief illness similar to a mild case of influenza. Symptoms may include a low-grade fever, headache, sore throat, or a tired feeling. The symptoms usually occur between two and six weeks of initial infection. However, since the symptoms are so similar to other viral illnesses, and usually do not last very long, many people are not aware they have been infected. It is important to note that once the person has become infected with HIV, he or she can transmit the infection.

Transmission from person to person

HIV is a bloodborne virus and is transmitted only through contact with body fluids containing the virus or infected cells. The virus can appear in almost any body fluid, but is more concentrated in blood, semen, vaginal secretions, and breast milk. Transmission is much more likely through contact with more concentrated body fluids. HIV is transmitted in the following ways:

»Injection or infusion of contaminated blood

- Because the American supply of blood and blood products is tested for HIV, infection resulting from transfusions is extremely small.
- Sharing of needles among injecting drug users remains a problem. If a person injects drugs with a needle previously used by an HIV-infected person, there is a great likelihood of infection.

• Accidental needle pricks from HIV-contaminated needles is a risk among healthcare workers and caregivers. A healthcare worker who is accidentally pricked with an HIV-contaminated needle has about a 1 in 300 chance of becoming infected with HIV. Taking a combination of drugs soon after exposure reduces the person's risk.
• Contaminated tattoo needles can transmit HIV to a person obtaining a tattoo.

» Sexual activity with an HIV-infected person in which the mucous membranes of the mouth, vagina, penis, or rectum are exposed to body fluids

• Unprotected sexual intercourse is the primary method by which HIV is transmitted from one person to another. While less common, HIV can also be transmitted during oral sex.

» Contact with contaminated body fluids through broken skin

• HIV transmission can occur when there is a rash, cut, abrasion, or any open area on the skin (especially the hands) if there is contact with contaminated body fluids of an HIV-infected person.

» Transfer of the virus from an HIV-infected mother to a baby before or during birth or after birth through breast milk

» Splashing of contaminated fluids into the mouth or eyes

• The risk of transmission by splashing of contaminated body fluids is much less than the risk of transmission following a needlestick. There is less than a 1 in 1,000 chance of transmission.

» Organ or tissue transplants

• This is very rare in the United States since all donated organs and tissue are now tested for HIV prior to transplanting them.

Hospitals, clinics, and other health care facilities do not isolate patients who have HIV infection. HIV is not transmitted through the air or by casual contact. The virus does not survive outside the body, and contaminated equipment can easily be disinfected.

However, all health care workers who may come in contact with blood or other body fluids must strictly follow standard precautions. The precautions apply to every single patient, not just those patients known to have HIV infection, because 1.) many HIV-infected people do not know they are infected, 2.) some of them may know but do not disclose the information, and 3.) there are other viruses that can be transmitted by blood and body fluids.

HIV is not known to be transmitted:

- by casual contact at work, school, or home, or even close, non-sexual contact such as hugging and light kissing
- by mosquito or other insect bites
- by the coughing or sneezing of an infected person, or
- by contact with tears of an infected person.

Treatment for HIV infection

There is no known cure for HIV infection, and no vaccine available to prevent it. However, there are about 20 medications now available that may help keep an HIV-infected person healthy by suppressing the virus. Not every person with HIV infection will be taking the medications. The person and physician may decide not to start treatment if the person's overall health is good, the person's immune system is working, and the person has a relatively low amount of virus in his or her blood. There are several other reasons why an infected person and his or her physician may decide to delay starting the treatment. Those reasons include:

» The medications are very expensive.

» Most individuals will need to take a combination of three or more of the medications. Compliance with the treatment usually means the person must make significant adjustments to his or her lifestyle.

» Some of the medications must be taken several times during the day and night at very specific times in order to be effective. Some are taken with food and others are taken on an empty stomach, so the person may have to significantly change meals and mealtimes.

» The medications all have negative side effects, some of which may be very serious.

» Once the person decides to begin treatment, he or she will need to take the medications for the rest of his or her life.

» If the virus is not fully suppressed, drug resistance can develop. This may result in an HIV infection that cannot be controlled with certain medications.

HIV INFECTION AND AIDS

AIDS is the most severe form of HIV infection and occurs when the virus increasingly attacks the immune system to the point that it can no longer protect against many types of infection. AIDS is diagnosed when an HIV-infected person has at least one complicating illness because of a weakened immune system and by a critical drop in the number of certain blood cells.

No one is certain why some people develop AIDS much more quickly than others do. Within 10 to 11 years of becoming infected, half the people with HIV who have not received treatment will develop AIDS. A few people have stayed well without treatment for as long as 15 years.

With effective treatment, HIV-infected people are living longer and longer without developing AIDS. In some cases the virus is so well suppressed it cannot be detected with current tests. However, the virus is still present and can be transmitted to other people.

STRATEGIES TO PREVENT HIV TRANSMISSION IN HOMECARE

1. Assume that the blood and body fluids of every patient can possibly be infected with HIV. 2 Use personal protective equipment (PPE) when you anticipate possible contact with blood and body fluids. 3-Remove gloves carefully, and thoroughly wash your hands immediately after removing the gloves.

5. Use caution when handling and disposing of sharp instruments or needles used by patients.

6. Attend your agency's annual bloodborne pathogens in-service program.

7. Learnand follow your agency's infection control policies.

7.1mmediately inform the appropriate person at your agency if you are directly exposed to a patient's blood or body fluids.

KEY POINTS FOR HOME HEALTH AIDES

» About a fourth of the people with HIV infections do not know they are infected. Many of the people who do know do not tell the homecare nurse or home health aide.

» Most HIV-infected patients are receiving homecare for reasons other than the HIV infection except for patients with AIDS, or HIV-infected patients requiring medication assistance.

» It is always important to follow the instructions carefully when you are assigned to assist patients with medications. Timing is especially critical for HIV-infected patients.

» Not every person known to be HIV infected will be taking anti-HIV medications.

» Following standard precautions with every patient during every visit is the best protection against becoming HIV infected in the workplace.

Case study

Roxanne is a home health aide who makes intermittent visits and also does private duty. She's been working at the same agency since 1980. Because of her experience, she is often asked to take newly hired aides on joint visits during their orientation. Today Juan is accompanying Roxanne. Juan has never worked in health care.

The first visit is to Mr. Sinclair who lives in an exclusive gated community. As they are driving to the visit, Roxanne tells Juan about Mr. Sinclair, a widower who lives alone in a very large home. "He's loaded," says Roxanne, "but he's very nice." When they reach the house, Juan reaches for Roxanne's supply bag. Roxanne tells him there's no need to bring it in because Mr. Sinclair has soap and paper towels for her. When Juan asks about gloves, Roxanne replies, "Oh, he hates for me to wear gloves. He says it makes him feel dirty."

"We just learned about bloodborne pathogens like HIV," says Juan. "Aren't you concerned about them?" Roxanne responds, "Juan, when you've been around as long as I have, you will learn that the rules don't always apply. Mr. Sinclair is rich and even has a maid and a cook. There's no way he could have HIV or any of those other things."

Juan is rather surprised by Roxanne's statement. He asks, "But how can you tell? Aren't you always supposed to use proper protective equipment?"

"Oh, that's what they tell you in class," says Roxanne. "This is the real world. Now, if I were going to the inner city, you can bet I'd wear gloves. But these rich folks don't want you to wear them. I'm not going to give up a good case over something like that."

Roxanne continued, "They also tell you not to do anything that's not on the assignment sheet, too. But what you really need to do is follow what the patient wants. And don't even think of calling the nurse if the patient refuses something on the assignment. That will get you in trouble with the patient every time."

THINK ABOUT IT

- Does living in a grand home mean a person doesn't have an HIV infection?
- Do you think that Roxanne may be putting herself at risk by not using appropriate personal protective equipment on all of her patients?
- Have you ever failed to wear gloves when you really should have? What were the circumstances? Is there anything different you might have done?
- How do you respond to patients who don't want you to wear gloves?
- What are some very wrong things Juan might learn from Roxanne?

DIRECTIONS: READ EACH QUESTION CAREFULLY. THEN, DETERMINE THE BEST ANSWER. CHECK THE CORRESPONDING BOX ON YOUR ANSWER SHEET. DO NOT WRITE ON THIS POST-TEST.

1. Which of the following statements best describes the early symptoms of HIV infection?
    a. They are similar to symptoms of multiple sclerosis.
    b. They are similar to symptoms of severe arthritis.
    c. They are similar to symptoms of food poisoning.
    d. They are similar to a mild case of flu.

2. Which of the following is not known to be a method of HIV transmission?
    a. Casual contact with an HIV-infected person
    b. Needle pricks from an HIV-contaminated needle
    c. Sexual intercourse with an HIV-infected person
    d. Contact with HIV-infected body fluids though open skin

3. The early symptoms of HIV infection are so severe that people who have HIV infections will know they have it.
    a. True
    b. False

4. When was HIV infection first recognized in the United States?
    a. The 1940s
    b. The 1990s
    c. The 1980s
    d. The 1970s

5. Will home health aides always know which patients are infected with HIV?
    a. Yes, it will always be on the assignment sheet.
    b. Yes, patients with HIV infection will always take lots of pills frequently.
    c. No, it's against HIPAA regulations for home health aides to know.
    d. No, about one-fourth of the HIV-infected patients themselves don't know they are infected.

6. Which of the following is true about HIV infection?
    a. A virus causes it.
    b. It is a bacterial infection.
    c. It is transmitted through the air.
    d. The cause is unknown.

7. Following standard precautions with every patient during every visit is the best protection against becoming HIV infected in the workplace.
    a. True
    b. False

8. Early symptoms of HIV infection commonly include:
    a. Nausea and vomiting
    b. Headache and tired feeling
    c. Bruising and bleeding
    d. Numbness and tingling

9. Which of the following is true about HIV transmission?
    a. It is transmitted through contact with HIV-contaminated body fluids.
    b. It is transmitted by mosquitoes.
    c. It is transmitted by coughing and sneezing.
    d. It is transmitted by South African birds.

10. Which of the following is not a true statement about HIV infection?
    a. AIDS is the most severe form of HIV infection.
    b. There is no known cure for HIV infection.
    c. Not every patient with HIV infection will be taking medications to suppress the HIV.
    d. There is a vaccine that will prevent HIV infection.

NAME_____ DATE _____

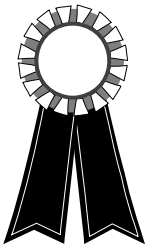
DIRECTIONS: READ EACH QUESTION IN THE POST-TEST CAREFULLY. THEN, DETERMINE THE BEST ANSWER. CHECK THE CORRESPONDING BOX ON THIS ANSWER SHEET.
DO NOT WRITE ON THE POST-TEST.

MULTIPLE CHOICE ANSWER SHEET

1.	☐	a	☐	b	☐	c	☐	d
2.	☐	a	☐	b	☐	c	☐	d
3.	☐	a	☐	b				
4.	☐	a	☐	b	☐	c	☐	d
5.	☐	a	☐	b	☐	c	☐	d
6.	☐	a	☐	b	☐	c	☐	d
7.	☐	a	☐	b				
8.	☐	a	☐	b	☐	c	☐	d
9.	☐	a	☐	b	☐	c	☐	d
10.	☐	a	☐	b	☐	c	☐	d

INSTRUCTOR'S COMMENTS/SIGNATURE

Signature _____ RN Date _____



Certificate of Achievement

Awarded to: _____

For Completing the One-Hour Course Entitled
"HIV Infection Control:Standard and Additional Precautions"

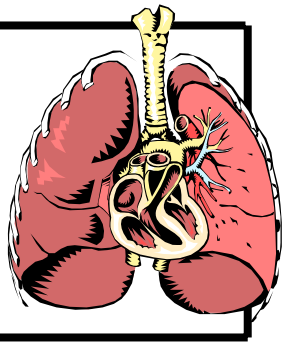
Date of Course: _____

Facility: _____

Presented by: _____

(Signature of presenter, or write “self-study”)

OXYGEN THERAPY



Teaching plan

To use this lesson for self-study, the learner should read the material, do the activity, and take the test. For group study, the leader may give each learner a copy of the Learning Guide and follow this Teaching Plan to conduct the lesson. The lesson should take approximately one hour.

Note: This lesson contains information about oxygen therapy. Most state regulatory bodies allow aides or personal care attendants to assist with oxygen therapy, although a few do not permit it. Use this material according to the rules in your state. Even if your workers do not assist with oxygen, they may assist a resident who is able to set liter flow or use oxygen independently, making this knowledge useful.

Objectives

At the conclusion of this lesson, a participant will be able to:

- Explain the body's normal mechanism for processing oxygen
- Describe conditions for which supplemental oxygen is used
- Recognize the different types of delivery systems for oxygen therapy
- Explain safety considerations for the use of oxygen

The lesson

Print a learning guide, test, and certificate for each participant. Using the learning guide, deliver a brief lecture on the body's normal mechanism for processing oxygen within the body, explaining what happens when oxygenation is poor and supplemental oxygen therapy must be used. Define the italicized words in the learning guide to be sure participants understand them.

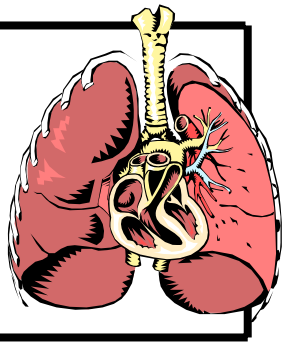
Review the different delivery systems generally used for the delivery of oxygen therapy (oxygen concentrators, portable tanks, liquid oxygen). If possible, ask a local oxygen or medical equipment supplier to bring different types of equipment to teach participants how to turn on the supply and set liter flow, allowing time for practice.

The Test

Have participants take the test. Review the answers together. Give certificates to those who answer at least 70% of the test questions correctly.

Test answers: 1. Oxygen; 2. Carbon dioxide; 3. Asthma, pneumonia, bronchitis, severe allergies; 4. False; 5. Compressed gas, liquid oxygen, oxygen concentrator; 6. True; 7. True; 8. Headaches, slurred speech, sleepiness, or shallow, slow breathing; 9. Difficult, irregular breathing; restlessness or anxiety; tiredness or drowsiness; blue fingernail beds or lips; confusion; being easily distracted; 10. True; 11. False; 12. Water; 13. Sterile or distilled water; 14. False; 15. True.

OXYGEN THERAPY



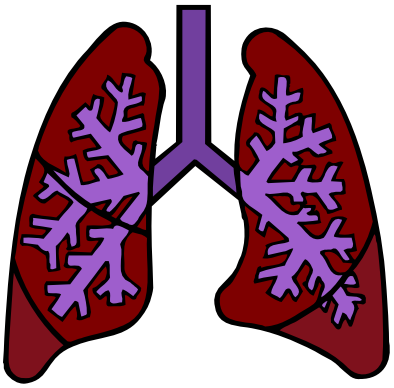
Learning guide

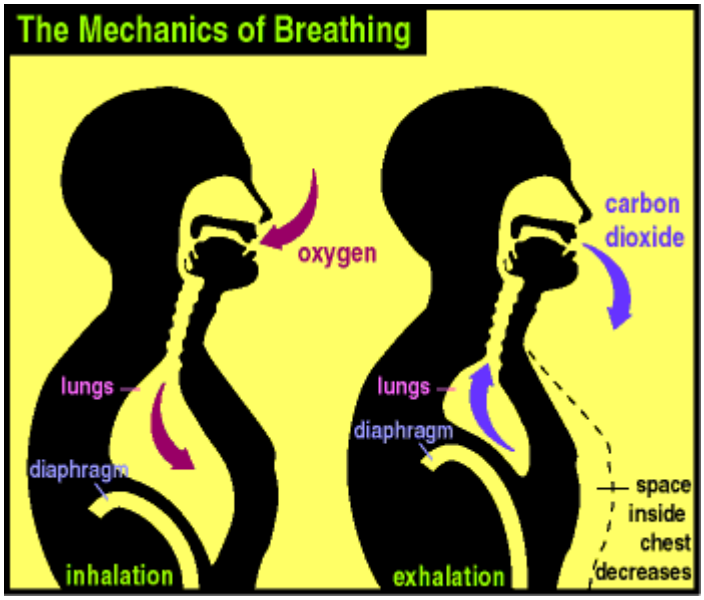
OXYGEN is one component of the air that is all around us. It is a colorless, odorless, tasteless gas that forms 21% of our atmosphere. About two-thirds of the human body is composed of oxygen. About nine-tenths of all water is oxygen. It is absolutely essential to life on this planet. The human body must constantly take in fresh oxygen. We cannot survive longer than a few minutes without it.

How a healthy person processes oxygen

When we breathe in, or ***inhale***, our ***respiratory system*** takes oxygen in through the nose, warming it as it moves down the ***trachea*** (windpipe), through the ***bronchial tree,*** and into the ***lungs*****.** Once in the lungs, the oxygen moves into the blood through special cells called ***alveoli*****.** In the blood, ***red blood cells*** trade waste products (***carbon dioxide***) for oxygen and carry the fresh oxygen to the cells.

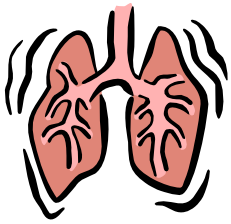
When everything is working properly, the oxygen goes into the blood and to every cell in our body, providing oxygen for energy, growth, and cell reproduction. When the demand for oxygen increases, as when we exercise, we take more air into the body to meet the needs of the cells. The body also uses the mechanism of breathing to release carbon dioxide, a waste product, from the body. As we breathe out, or ***exhale***, the carbon dioxide leaves the body. Look closely at the diagram and drawing below.



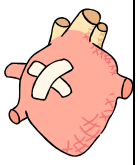


When things don't work right

When something goes wrong with the body's normal method for processing oxygen, medications and supplemental oxygen are used to help make sure the body gets the oxygen it needs.



If a resident has ***heart failure***, he or she may have difficulty breathing. In this case, oxygen is often given along with special medications to make sure tissues in the heart and throughout the body receive needed oxygen.



If a resident has ***emphysema*** or ***COPD*** (chronic obstructive pulmonary disease), the alveoli become ineffective in exchanging oxygen for carbon dioxide. Supplemental oxygen therapy helps meet the resident's need for oxygen.

Residents with sleep disorders such as ***sleep apnea*** may also need oxygen therapy.

Other conditions, such as ***asthma, pneumonia, bronchitis,*** and ***severe allergies***, may require short-term use of oxygen therapy. Usually people with these conditions use extra oxygen for only a short time, until they are well.

Oxygen Therapy

Some people use oxygen only while exercising, others only need it while sleeping, and still others need oxygen continuously. A person's physician can do blood tests to help determine how much oxygen is needed and when. Oxygen therapy is a plan of oxygen supplementation prescribed by a doctor.

For people who do not get enough oxygen naturally, supplements of oxygen can have several benefits. Supplemental oxygen can improve their sleep and mood, increase their mental alertness and stamina, and allow their bodies to carry out normal functions. It also prevents heart failure in people with severe lung disease.

Oxygen at very high levels over a long period of time can be toxic and very harmful to one's health; therefore, a doctor's prescription is required. Oxygen used to treat medical conditions is a drug. We administer and document oxygen therapy according to the rules that govern medication administration.

The doctor's prescription will spell out the flow rate in liters per minute (LPM or L/M). This is how much oxygen the person needs per minute, and it should not be changed without a doctor's order.

Obtaining oxygen equipment

Medical equipment suppliers provide oxygen and an oxygen delivery system as ordered by a physician. When a resident obtains an oxygen system from the medical equipment supplier, you'll learn how to assist the resident to set it up, check for problems, and clean it. ***Keep the supplier's phone number handy in case of problems.***

Types of oxygen delivery systems

The purpose of oxygen delivery systems is to get extra oxygen into the person's respiratory system and blood. Oxygen is available from three different delivery systems. Each system of delivery has advantages and disadvantages.

The three systems are:

Compressed gas

Oxygen gas can be compressed and stored in tanks or cylinders of steel or aluminum. These tanks come in many sizes; larger ones usually stay in one place, and people take the smaller ones with them when they want to move around. The tanks must be refilled with oxygen when the oxygen in them is gone.

PORTABLE LIQUID OXYGEN

Liquid oxygen

When oxygen gas is cooled, it changes to a liquid form. People who are more active often use liquid oxygen because larger amounts of it can be stored in smaller, more convenient containers than compressed oxygen. The disadvantage is that liquid oxygen cannot be kept for a long time because it will evaporate. The containers must be refilled with liquid oxygen.

Oxygen concentrators

Oxygen concentrators deliver higher concentrations of oxygen from the air. An oxygen concentrator is an electric device about the size of an end table. It produces oxygen by concentrating the oxygen that is already in the air and eliminating other gases. This method is less expensive, easier to maintain, and doesn't require refilling, but it is not portable. Some oxygen concentrators give off heat and are noisy. Back-up methods are necessary in case of a power failure, and the electric bill may rise. Oxygen concentrators may not deliver enough oxygen for some people. An oxygen concentrator will usually include a humidifier to warm and add moisture to the prescribed oxygen.

ELECTRICAL OXYGEN CONCENTRATOR

Large tanks and portable tanks

Skilled care facilities sometimes have a system for delivering oxygen directly into the person's room or apartment. Individuals living in any setting may have large tanks to store large amounts of liquid oxygen or compressed oxygen gas.

In either case, the resident may need small, portable tanks of liquid or compressed oxygen for brief periods—a few hours—outside his or her room or apartment. Portable tanks are a backup system suitable to use in an emergency or when the resident leaves the room or apartment for meals or outings.

Oxygen administration

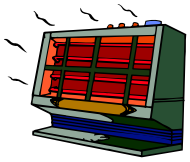
Oxygen is usually administered with continuous flow through a two-pronged nasal tube called a ***nasal cannula***, even though this system wastes oxygen. To improve efficiency and increase the person's ability to move around, there are other devices. These include face masks, reservoir cannulas, and demand-type systems. Usually, a respiratory therapist, medical equipment specialist, nurse, or physician instructs the person about proper oxygen use.

General Guidelines

When assisting with an oxygen tank, an oxygen concentrator, or liquid oxygen, follow these important guidelines:

- Always stabilize the oxygen tank (using a special stand) and store it in an area that is out of the way so it will not fall.
- Close the oxygen tank tightly when not in use.

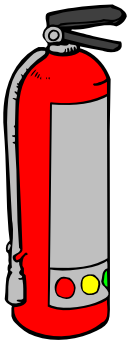
- **Because oxygen can cause an explosion, keep the oxygen tank away from any flammable source, such as matches, heaters, or hair dryers.**

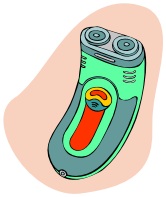


- Check the water level in the humidifier bottle (if one is provided) often. If it is near or below the refill line, pour out any remaining water and refill it with sterile or distilled water.

- If the resident complains of his or her nose "drying out," ask your supervisor about obtaining a water-soluble lubricant like K-Y Jelly to help keep nasal passages moist. Do not use petroleum-based products.
- If the oxygen tubing irritates the resident's skin (on sides of face or behind ears), ask your supervisor about using cotton balls or getting special moleskin protectors to protect skin from the tubing.
- If the resident's supply of oxygen is getting low (for portable tanks), advise him or her to re-order, or check with your supervisor about reordering. Oxygen should be ordered at least two or three days in advance to allow time for delivery.
- Maintain the oxygen flow at the prescribed rate. If you're not sure whether oxygen is flowing, check the tubing for kinks, blockages, or disconnection. Then make sure the system is on. If you're still unsure, submerge the nasal cannula in a glass of water, with the prongs pointing down. If bubbles appear, oxygen is flowing through the system. Shake off extra water before reinserting the cannula in the resident's nose.

Safety tips





- Oxygen is highly combustible and may explode. It should not be used near electrical equipment or while using an electric appliance, such as an electric razor.
- A sign is usually placed on or near the apartment or room door to alert visitors that oxygen is in use. In a care facility, your supervisor will notify the local fire department that oxygen is in use in the building.
- Familiarize yourself with the location of fire extinguishers in the resident's home or in the care facility. If a fire does occur, turn off the oxygen immediately.

- Don't smoke—and don't allow others to smoke— near the oxygen system. Keep the system away from direct sunlight, space heaters and other sources of heat, and open flames, such as in a gas stove.
- Don't run oxygen tubing under clothing, bed covers, furniture, or carpets.
- Keep the oxygen system upright.
- Make sure the oxygen is turned off when not in use.
- Keep oxygen concentrators away from the wall to allow air to circulate.

When to call your supervisor

The resident **may not be getting enough oxygen** if you notice these signs:

- difficult, irregular breathing
- restlessness or anxiety
- tiredness or drowsiness
- blue fingernail beds or lips
- confusion
- the resident is easily distracted

The resident may be getting **too much oxygen** if you notice these signs:

- headaches
- slurred speech
- sleepiness or difficulty waking up
- shallow, slow breathing

If any of these signs develop, call your supervisor or a nurse or doctor immediately. And—above all—***never change the oxygen flow rate*** unless a licensed medical professional tells you to do so.

Oxygen therapy test

Name _____ Date _____ Score _____
(10 correct answers required to pass.)

1. When breathing is normal, inhaling causes _____ to be drawn into the lungs.
2. Exhaling releases _____ _____from the lungs.
3. People may need short-term oxygen therapy for _____,
   _____, _____, and _____.
4. It is safe to use electric razors and hair dryers in areas where oxygen is in use.
   True or False
5. Three types of oxygen delivery systems are used. They are:
   _____, _____, and _____.
6. You should not adjust the rate of oxygen flow unless the nurse or doctor directs you to do so. True or False
7. If a fire occurs, oxygen should be turned off immediately. True or False
8. If a resident is getting too much oxygen, these signs may be noticed (name three):
   _____, _____, and _____.
9. If a resident is not getting enough oxygen, these signs may be noticed (name three):
   _____, _____, and _____.
10. You should report signs or symptoms of too little or too much oxygen immediately.
    True or False
11. Portable tanks should not leave the building. True or False.
12. Invert the nasal cannula in _____ to check if oxygen is flowing.
13. If water in the humidifier bottle is below the fill line, refill it to the line with
    _____ _____.
14. If oxygen tank supplies are low, oxygen can usually be delivered within an hour or two of re-ordering. True or False
15. A sign is usually placed on or near the door of a room or apartment to alert visitors that oxygen is in use. True or False

Certificate of Achievement

Awarded to _____
(Name of Participant)

For Completing the One-Hour Course Entitled

OXYGEN THERAPY

Date of Course: _____

Facility or Agency: _____

Presented by: _____
(Signature of presenter, or write “self-study”)

Understanding pain

Teaching plan: Guidelines for teaching this lesson

Lesson overview

This one-hour lesson plan is about pain and how your workers should respond to and care for patients with pain. You may use it in a group setting or for individual self-study. Every learner should read the packet, do the Activity, and make at least a 70% score on the test before receiving the certificate of achievement. Copy the learner guide, test, and certificate for each learner.

Learning objectives:

At the conclusion of this session, participants will:

1. Recognize the right to pain management
2. Understand pain as the fifth vital sign
3. Pay attention to patients' reports of pain and recognize nonverbal signs
4. Know about different kinds of pain
5. Know basic pain management concepts.

Introductory activity: What's wrong here?

Ask your learners to read each of the conversations from "What's wrong here?" As each one is read aloud, ask the group if anyone can tell you what is wrong with the conversation. See if they have any ideas about how the conversation should be handled. Don't give them any answers or clarifications at this time; just have them share their ideas. Explain that we will learn more about pain in this lesson.

Lesson activities

1. Explain to your workers that many people misunderstand pain and how we should respond to it. Ask them to look at the list of common misconceptions. Tell them that all of these things are incorrect. Refer them back to the conversations in "What's wrong here?" and ask them to identify the misconceptions in those conversations. Discuss this and allow for questions. The answers are on the test key.
2. Ask whether any of your workers have ever experienced an illness that caused them pain. Did they find out that sometimes people or doctors didn't believe they were having pain, or didn't think there was anything wrong? Emphasize that all complaints of pain should be investigated, and that only the patient knows the type and amount of pain he or she has. Review the material in the learning guide, "Pain: The Fifth Vital Sign." Review the nonverbal symptoms of pain and the importance of reporting a patient's pain to a supervisor.
3. Help your workers review the types of pain. You may want to have them read it aloud. Discuss any policies and procedures you have in your agency about reporting pain, applying warm or cold compresses, exercise, or massage. Emphasize the importance of support, which is something all caregivers can give. Allow time for discussion and questions.

Evaluation and feedback

Have the learners take the test. You may grade it together and discuss any wrong answers. They should receive at least nine correct answers to pass. Hand out the certificates to learners who pass the test. Be sure the attendees sign your attendance roster.

Understanding pain: Learning guide

What's wrong here?

Here are four conversations that were overheard in an assisted living facility. Each one demonstrates a misunderstanding about pain. Can you identify the problem or suggest a better way to think and talk about pain? Don't worry if you don't recognize the problem, because in this lesson you will learn about pain and how to deal with it in your work.

Mrs. Flynn: "My hands are really hurting today. That medicine the doctor gave me doesn't help very much."

Attendant: "I know how you feel. I have arthritis in my knees and they really hurt sometimes with all the walking I have to do. I guess it just gets worse the older you get, so we might as well get used to it and not complain about it."

Attendant Mary: "That Mrs. Garrett is always complaining about her pain. She takes way too much of her pain medicine if you ask me. I think she's addicted to it."

Attendant Alex: "You're probably right. Anyway, I don't think she really hurts all that bad. She's just lonely and wants some attention."

Attendant Joan: "Poor Mr. Howard. He's so confused, he doesn't even recognize his own daughter sometimes."

Attendant Jerry: "Well, one good thing, at least he doesn't complain about anything. Even when he fell and hurt his leg, he didn't ever say it bothered him. I heard that when your mind goes, you don't feel pain."

Attendant: "Good morning, Mrs. Moore. How are you feeling today?"

Mrs. Moore: "I don't like to complain."

Attendant: "Is something wrong?"

Mrs. Moore: "Yes, my back is killing me and it hurts to walk, but please don't tell anyone. If my daughter or my doctor hear about it, they'll start doing a lot of painful tests on me and put me in a nursing home. Just help me get up, and I'll be okay."

Common misconceptions about pain

Patients and workers may think that:

1. Pain is a sign of aging.
2. Nothing can be done about some kinds of pain.
3. Pain is a punishment for past actions.
4. Pain is a sign of serious illness or impending death.
5. Complaining of pain is a sign of weakness.
6. Complaining of pain will lead to unpleasant medical tests.
7. Complaining of pain will result in losing one's independence.
8. Elderly and disabled people have a higher pain tolerance.
9. Confused people have a higher pain tolerance.
10. People who complain of pain are just trying to get attention.
11. Elderly and disabled people are likely to get addicted to painkillers.

In the conversations you read, which of these misconceptions about pain can you find? Write the number of the matching misconception(s) beside the conversations on the preceding page.

All of these ideas are wrong. Pain is a sign that something is wrong with our bodies, and it doesn't occur just because we get older. Healthy older people should not have pain. If something hurts, a physician should investigate to see if the pain is caused by a treatable condition. If the pain is caused by a condition that cannot be improved with treatment, then the doctor should prescribe medications that will allow the person to live without constant pain.

Everyone has the right to try to live without pain if it is possible to do so and the right to receive appropriate pain management when necessary. No one should suffer unnecessarily when treatment or relief is available.

Pain: The fifth vital sign

To find out whether a person is healthy or not, we often check the four major vital signs: blood pressure, temperature, pulse, and respirations. In addition, we should check to see if the person is experiencing any pain. This is now being called "the fifth vital sign" because we know that the presence of pain is an indication of a health problem that should be investigated. When residents tell you they are having pain, or you see nonverbal signs of pain, always report it to your supervisor.

In addition, we must remember that only the patient really knows how he or she is feeling or how much pain he or she is experiencing. The person having pain is the ***only*** expert on this subject, and no one else has the right to make a judgment about the type or amount of pain an individual has. We must always believe a person's self-report of pain.

How do you know if someone is in pain and can't or won't tell you?

Watch for these nonverbal signs of pain:

Guarded movements
Facial grimacing
Rapid heartbeat
Rapid breathing
Sadness or depression
Elevated blood pressure
Restlessness or sleeplessness
Moaning, groaning, or sighing
Bracing or tensing the muscles

Any of these symptoms should be reported to your supervisor.

Types of pain

Acute pain

Acute pain is severe and usually signals an injury or illness that must be treated. Kidney stones and heart attacks cause acute pain. When the cause of the pain is cured, the pain goes away. Acute pain can be a symptom of serious problems that require emergency treatment. Acute pain is generally too intense to ignore and will often cause people to clutch the part of the body that hurts. This type of pain indicates that medical attention is needed.

Chronic pain

Chronic pain is a persistent, ongoing pain that lasts for weeks, months, or years. Sometimes the pain was originally caused by an injury or illness that was cured, but for unknown reasons the pain continues. There may be an incurable disease causing the pain, such as cancer. Chronic pain can even occur without any known injury or illness causing it. The best that can be done in these situations is to treat the pain, without curing the underlying disease.

Chronic pain is not always constant and continuous, but it can come and go. Sometimes chronic pain becomes very sharp or severe for a time, and then subsides. It can be very disabling to live with chronic pain because the pain makes it too painful or tiring to perform everyday activities.

Chronic pain is caused when the nervous system keeps sending out pain signals repeatedly. It can cause loss of appetite, depression, irritability, and sleeplessness. Chronic pain sufferers get caught in a vicious cycle of exhaustion and depression that can make the pain worse.

New medicines and treatments make it possible to relieve even the most severe pain. No one today should have to live with untreated chronic pain.

Major types of chronic pain

These are some of the common kinds of chronic pain. Each has a variety of causes.

Headache
Low back pain
Cancer pain
Arthritis pain

Angina—the chest pain caused by restricted blood flow to the heart

Neurogenic pain—this kind of pain comes from the nerve tissues and includes such painful conditions as ***trigeminal neuralgia***, a disease that causes severe pain in the face.

Psychogenic pain—this kind of pain is not due to any known disease or injury but seems to come from the brain or mind.

Major types of pain management

Medication prescribed by a doctor is the best treatment for pain. There are also nondrug treatments that caregivers can use.

Mild exercise

Exercise helps to increase flexibility and strength, relieving muscle stress that can cause backaches, headaches, and fatigue. Exercising in warm water is particularly good for arthritis sufferers, because the water relaxes and supports the muscles, making exercises easier to perform.

Heat or cold applications

Warm or cool compresses applied to a painful area can bring temporary relief for headache, backache, and arthritis.

Massage

Massage is useful for back pain, but any painful area that is red or swollen should not be massaged until a doctor has evaluated the problem.

Support

Sometimes a sympathetic listening ear and a caring attitude are the best medicine for people with chronic pain.

Understanding pain: Test

Name: _____ Score: _____ (9 correct answers required)

Match the question on the left with the answer on the right by putting the correct letter in the blank by each numbered question.

1. This kind of pain is severe and goes away when the underlying problem is cured. _____
2. This is a nonverbal sign of pain that should be reported to a nurse or doctor. _____
3. This is a common type of chronic pain. _____
4. This can be a helpful treatment for back pain, headaches, and arthritis. _____
5. This kind of pain is persistent and ongoing and sometimes occurs without a known cause. _____

a. Mild exercise
b. Guarded movements
c. Chronic pain
d. Acute pain
e. Arthritis

Answer the following questions by circling "T" for true or "F" for false.

6. We should always believe what a resident tells us about his or her pain. T or F

7. Warm or cold compresses aren't helpful in relieving pain. T or F

8. Confused people and the elderly have a higher pain tolerance. T or F

9. Nothing can be done to relieve certain types of pain. T or F

10. Elderly and disabled people are likely to get addicted to painkillers. T or F

11. You should never massage a painful body part that is red or swollen. T or F

12. Any time a resident complains of pain, it should be reported to your supervisor. T or F

Fill in the blank in the question below:

13. Pain is called the _____ vital sign because we should ask about pain when we are checking people's health status. It should be part of checking the other four vital signs.

Understanding pain: Test answer key

Test answers:

1. This kind of pain is severe and goes away when the underlying problem is cured. ____**d.**____
2. This is a nonverbal sign of pain that should be reported to a nurse or doctor. ____**b.**____
3. This is a common type of chronic pain. ____**e.**____
4. This can be a helpful treatment for back pain, headaches, and arthritis. ____**a.**____
5. This kind of pain is persistent and ongoing and sometimes occurs without a known cause. ____**c.**____

a. Mild exercise
b. Guarded movements
c. Chronic pain
d. Acute pain
e. Arthritis

6. We should always believe what a resident tells us about his or her pain. (T) or F
7. Warm or cold compresses aren't helpful in relieving pain. T or (F)
8. Confused people and the elderly have a higher pain tolerance. T or (F)
9. Nothing can be done to relieve certain types of pain. T or (F)
10. Elderly and disabled people are likely to get addicted to painkillers. T or (F)
11. You should never massage a painful body part that is red or swollen. (T) or F
12. Any time a resident complains of pain, it should be reported to your supervisor. (T) or F
13. Pain is called the ____**fifth**____ vital sign because we should ask about pain when we are checking people's health status. It should be part of checking the other four vital signs.

Answers to matching common misconceptions to conversations in "What's wrong here?"

Mrs. Flynn's attendant's misconceptions: #1, #2, and #5.

Attendants Mary and Alex: #10 and #11.

Attendants Joan and Jerry: #9.

Mrs. Moore: #6 and #7.

Certificate of Achievement

Awarded to: _____

For Completing the One-Hour Course Entitled "Understanding Pain"

Date of Course: _____

Facility: _____

Presented by: _____

(Signature of presenter, or write “self-study”)

Psychosocial care

To use this lesson for self-study, the learner should read the material, do the activity, and take the test. For group study, the leader may give each participant a copy of the learning guide and follow this teaching plan to conduct the session. Certificates may be copied for everyone who completes the lesson.

Objectives

Persons completing this lesson will be able to

- Define psychosocial care and recognize opportunities to provide it.
- Practice good communication skills with clients.
- Assist clients in fulfilling psychosocial needs.

The lesson

Ask your participants to make a list of all the important people in their lives, such as family members, friends, and coworkers. Now ask them to look at the list and try to imagine what their lives would be like if they couldn't see some or all of those people anymore. Remind them that many of the clients we care for are lonely or have limited numbers of social interactions. Often, caregivers are the only people they interact with on a regular basis, so we are very important people in their lives.

Divide your participants into small groups of two or three. Assign each group one of the sections in the learning guide: self-esteem, adjustment to age or disability, coping mechanisms, communication, social relationships, intellectual stimulation, and sexuality. Give each group more than one topic if necessary, or make your groups larger to accommodate the number of participants. Ask each group to read the material on their topic in the learning guide and prepare to explain it to the rest of the participants.

After allowing enough time for the group work, bring everyone together and ask each group to present their material. Allow time for discussion and questions.

Discuss things the participants can do to meet the psychosocial needs of their clients. Ask each of the participants to look for opportunities to do these things. Plan to review their progress at some future date, and reward those who excel at good communication or other psychosocial care. Review the Medication of the Month.

Conclusion:

Have participants take the test. Review the answers together. Give certificates to participants who score eight or more correct answers.

Test Answers: 1F 2T 3d 4T 5F 6b 7F 8T 9F 10T 11T

Psychosocial care Learning guide

Psychosocial care is care that enhances the mental, social, spiritual, and emotional well-being of clients, families, and caregivers.

What does psychosocial care involve?

- Issues of self-esteem
- Adjustment to illness or disability
- Intellectual stimulation
- Social functioning and relationships
- Communication
- Sexuality

ISSUES OF SELF-ESTEEM

Anyone having contact with clients and their families provides psychosocial care. You can do your job in a way that helps your clients feel good about themselves, enhancing their self-esteem.

It is important to meet every client's basic needs for acceptance, social opportunities, food, clothing, rest, activity, comfort, and safety. The way routine care is carried out affects a client's mood, self-esteem, dignity, self-respect, and feelings of independence.

Encourage and praise clients whenever possible.

All physical care is an opportunity to provide good psychosocial care.

Physical care includes helping with daily activities. Paying attention to a client's appearance, such as by shaving a man or fixing a woman's hair, is a practical way to enhance self-esteem. Look for small ways to make a difference.

Clients who are confined to bed or dealing with illness often experience tremendous emotional upset brought on by inactivity and dependence. Help the person express his or her feelings. High levels of emotional distress can make illness worse and slow recovery.

Everyone should be encouraged to do as much of his or her personal care as possible. This gives many clients a real sense of dignity and accomplishment. Of course, always follow the plan of care.

ADJUSTMENT TO ILLNESS, DISABILITY, AND/OR AGE AND ITS CONSEQUENCES

Whether it happens suddenly or gradually, losing one's independence and finding it necessary to rely on others is a big adjustment that can create great emotional distress. Clients may feel the loss of friends and family as they become more dependent or isolated from their social network. In addition, family members often feel the stress of caregiving. Both clients and families may experience anxiety and/or depression.

Anxiety and depression

When a client exhibits signs of anxiety or depression or says he or she feels anxious or depressed, pay attention. Anxiety and depression can be caused by some medicines, by withdrawal from medicines, or by a mental illness. Medications may be used to treat both conditions.

Cognitive loss or dementia can cause anxiety or depression, or can be made worse by either condition. Anxiety and depression that go untreated may lead to physical problems or an increased risk of accidental injuries. Treatment can improve the person's quality of life.

Anxiety or depression may cause a decrease in daily functioning, behavior problems, or lapses in judgment.

The dying client

Supporting a client and family through death is important. Sometimes a dying person feels lonely and depressed. He or she may feel abandoned or hopeless and become resentful or withdrawn.

Many people are uncomfortable with the thought of death and prefer to withdraw and leave a dying person alone. Usually the sick and the dying need company. Sometimes there is nothing to do but hold the person's hand. If the dying person wants to talk about dying, listen and respond appropriately and honestly. If you do not know how to respond, simply assure them that you care and encourage them to talk about their feelings while you listen.

When you see that a client is in pain or is uncomfortable, tell your supervisor. If appropriate, bring fresh pillows or sheets, remove wrinkles from the bed, or help the client change position. Restlessness, tension, and discomfort may be relieved by a change in position. See if the client is thirsty or hungry, and ask if the temperature in the room is all right. Encourage the person to tell you what is causing his or her distress. Excitement, anxiety, and depression can contribute to pain—not all pain is physical.

When in a client's presence, always speak directly to him, not about him or around him. Because hearing is thought to be the last of the senses to fade, an unconscious person may hear and be hurt by careless conversations.

Coping mechanisms

Faith

There is a difference in religion and spirituality. Religion may be based on traditional activities at a place of worship. Spirituality involves personal thoughts, feelings, characteristics, and experiences of a supreme being. People may think of themselves as spiritual even when they are not involved with a place or worship.

A hopeful, positive attitude about life and illness improves physical and mental health outcomes. People who use religious coping skills (praying, reading a sacred book, etc.) are less likely to develop depression and anxiety. Persons with a strong personal faith and many social contacts are better able to cope with health problems and remain more motivated to recover and to stay well. Caregivers who maintain social contacts and faith are better able to cope with the stresses of caregiving.

Workers can enhance the coping skills of both the client and the family. Interventions include praying with clients, reading sacred books to them, and seeing that they have the religious materials they need, such as audiotapes and large-print books. Spiritual health should be included as part of the physical, mental, emotional, and social needs addressed in psychosocial care.

Stress management and relaxation techniques

Help clients use these techniques when they are feeling anxious or depressed. As simple as they are, they can be very calming and cheering.

Imaging

- Get comfortable.
- Imagine a favorite scene (beach, mountain, etc).
- Feel the body relax and enjoy the warmth of the sun, the smells of the beach, or the gentle breeze and cool crisp air in the mountains.
- Continue until the body feels totally relaxed.

Abdominal Breathing

- Relax (either sitting or lying).
- Place right hand on chest and left hand on abdomen.
- Breathe in slowly through the nose.
- Hold breath and slowly count to five.
- Purse lips and exhale slowly.
- Relax.
- Repeat.

Change of scenery

Everyone needs a change of scenery from time to time. Clients that are able should be assisted to go on outings with friends and family. Those who cannot go out need visits from friends and family, or from staff and volunteers if others don't come. Room decorations can be changed, plants or flowers added, pictures hung, or new curtains put in place. Sometimes a simple rearrangement of the furniture, if safe and possible, can improve a person's emotional outlook.

COMMUNICATION

Good communication between workers, clients, and families is essential. Workers should be able to recognize the difference between a client who just needs a listening ear and a client who should be referred for formal counseling.

Communication takes place on two levels—verbal and nonverbal. Verbal is what is said. Nonverbal is expressed through body movements, gestures, facial expressions, posture, tone of voice, or touch.

Communication includes both speaking and listening. Ask yourself how the client is thinking and feeling. Listen to both the verbal and the nonverbal messages. Pay attention to your verbal and nonverbal messages.

Listening means to both understand and accept what a person says about his or her situation and feelings. Empathy means understanding what he or she says so well that you can identify with him. When you show you care, clients feel safe and will share concerns with you. This is therapeutic communication.

Active listening tells the client that you respect him. When you look into the eyes of the person speaking, you show him or her by your facial expressions that you are following what he is saying. This encourages him or her to continue with the train of thought. A person can tell if you are distracted and not listening.

Ask questions to clarify what the client is saying. This will encourage him or her to talk more. Avoid questions that require only a “yes” or “no” answer. Use open-ended questions like, “Can you tell me about the problems you are having?” Don’t ask questions that might steer the conversation in another direction.

Don’t brush off the client’s concerns by saying “Don’t worry about it; it will be okay.” This makes the client’s concerns seem trivial.

Try not to either agree or disagree with a client’s statements. You should not judge the things he or she says. You must leave room for the client to change his or her mind. Don’t give advice. If the client asks for advice, reply, “What do you think you should do?”

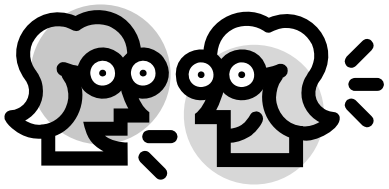
While listening:

- Don’t plan your reply.
- Don’t daydream or think about your next task.
- Don’t change the subject.
- Don’t laugh if the client is serious.
- Don’t interrupt.

Say back to the client what you hear him or her say. Don’t use his or her exact words, but briefly rephrase or paraphrase her statements. This gives the client a chance to restate what he or she meant, or to clarify his or her thoughts. It is important to make comments that indicate that you understand what has been said. If you don’t comment for a few minutes, the client may think you have lost interest, you don’t understand, or you disapprove. Short silences are good, however, to give the client time to think.

Sometimes a good listener may understand what the client is feeling before the client has recognized or expressed his or her own emotion. If you ask the client if he or she might be feeling a certain way, he or she might recognize an underlying emotion. A listener might say, “I wonder if . . .” or “Could it be that . . .”

SOCIAL FUNCTIONING AND RELATIONSHIPS



Social contact is a basic human need. People who are isolated from others have a higher risk of depression, anxiety, low self-esteem, mental disorders, and physical illnesses. Giving clients opportunities to maintain existing social relationships and develop new ones may be the most important thing we can do to meet psychosocial needs. It is our responsibility to provide social activities and to encourage clients to participate.

Here are some suggestions for encouraging social relationships:

- Find out if the client has a hobby or activity he or she enjoys or used to enjoy. If so, help the client obtain whatever is needed to be involved in that hobby or interest. Assistive devices or special accommodations may be necessary, so work with an occupational therapist to find ways the client can do this activity.
- Help clients get to know others who like the same activities.
- Provide ample time and opportunity for social visits with family and friends. Do not let your routines or schedules interfere with social interactions.
- Find ways for clients to communicate with others. Make sure that they have easy access to a telephone that is equipped for their use. They may need a volume booster on the phone so they can hear, or they might want help dialing. If possible, program numbers into a phone so they can speed-dial friends and family. Another good form of communication is electronic mail (e-mail). Clients will need a computer, a phone line, and an Internet service provider (ISP) to use e-mail. If the client cannot type, he or she could use a voice recognition program that listens to spoken words and produces e-mail or letters without typing.
- If the client builds, makes, cooks, or otherwise creates something, be sure to praise the effort and admire the product. Provide the client with books or videos that might be of interest on the subject. Encourage additional projects.
- Involving clients with younger people can make the clients feel valued, useful, and important. Give clients an opportunity to share knowledge and skills with others with similar interests or with students and young people.
- People like to feel successful. Everyone enjoys being recognized by others. Make every effort to recognize and validate clients. Encourage families to display pictures, awards, and diplomas. Be generous with praise and verbal rewards.

INTELLECTUAL STIMULATION

People also enjoy solitary pursuits that engage their minds. Audio books on tape, books with large print, videotapes, television programs, movies, music, and the Internet are all good sources of intellectual stimulation. Talk to clients about setting new learning goals for themselves and working to achieve them. People who are always learning new things strengthen their mental abilities and may slow or halt cognitive decline.

SEXUALITY

The fact that a client is ill, disabled, or elderly does not necessarily mean that he or she no longer has a need for sexual expression. Adults have the right to determine their sexual activities within the limits of polite behavior. Adults of any age or physical condition that choose to be in a consensual sexual relationship must be given appropriate privacy, protection, and support to fulfill this need.



Methods of meeting psychosocial needs of clients and families

Education

Group education and discussion, social interaction, activity programs, support groups, and training classes for both family members and clients can improve client/family relationships and attitudes. These programs enhance quality of life for both clients and families.

Accurate information about the aging process, illnesses, disabilities, and the specific problems of the client can help caregivers understand their own reactions and feelings. They can be taught how to take better care of themselves and their loved ones.

Activities

Regular physical activity and social interactions must be encouraged. Programs should promote well-being and enjoyment and must be tailored to the abilities of the participants.

Use of pets

Having animals around for companionship has proven to improve people's quality of life. Encourage clients to have pets only if someone is capable of caring for the animal.

Social worker

Social workers help clients deal with illness, loss, and end-of-life issues. They may work with clients and/or families to help them cope with the psychosocial effects of these events.

Education of healthcare workers

Healthcare workers must be educated in order to provide the necessary care and services to attain or maintain the highest possible physical, mental and psychosocial well being of clients. Everyone should be aware of cultural diversity and be committed to anti-discriminatory practices.

Psychosocial care test

Name _____ Date _____ Score _____

(Must score at least 8 correct answers to pass)

Directions: Circle the correct answer.

1. Assisting someone with personal care or giving physical care is not the time to worry about giving psychosocial care. True or False

2. High levels of emotional distress can make illness worse and slow recovery. True or False

3. Untreated anxiety or depression may cause which of the following effects?
    a. Decrease in daily functioning
    b. Increased risk of accidents
    c. Behavior problems
    d. All of the above

4. Some medications can induce anxiety or depression. True or False

5. An unconscious client cannot hear, so you may talk about him or her freely with others in the room. True or False

6. Which of these statements gives a good example of active listening?
    a. The worker stands in the doorway with one foot out the door while the client talks.
    b. The worker sits down and looks at the client while he or she talks.
    c. The worker tells the client not to worry about it, that everything will be okay.
    d. The worker listens and then says, “Now, here’s what you should do . . .”

7. Animals should not be kept around elderly, sick, or disabled people. True or False

8. Persons with a strong personal faith and many social contacts are better able to cope with health problems and more motivated to recover. True or False

9. Elderly, disabled, or sick people should not be allowed to have sexual relationships. True or False

10. Social contact is a basic human need. True or False

11. People who are always learning new things may slow or halt cognitive decline. True or False

Certificate of Achievement

presented to

_____

(Name of Participant)

for completing the 1-hour course

Psychosocial Care

Date _____

Facility/Agency _____

Presented by _____
(Signature of presenter or write “self study”)

Respiratory disorders

Teaching plan

To use this lesson for self-study, the learner should read the material, do the activity, and take the test. For group study, the leader may give each learner a copy of the learning guide and follow this teaching plan to conduct the lesson. Certificates may be copied for everyone who completes the lesson.

Learning Objectives

Participants in this activity should be able to:

- Explain the breathing process.
- Recognize and report symptoms of respiratory disease.
- Use knowledge of respiratory disorders to provide care for affected individuals.

Lesson Preparation

- Before class, tape a piece of paper under each chair participants will sit in. Write one of these words on some of the pieces of paper: nose, sinuses, pharynx, epiglottis, larynx, trachea, bronchi, bronchioles, lungs, alveoli, pleura, diaphragm. Use each word once.

Suggested Activities

1. Ask participants to find the piece of paper taped to their chairs. Ask those who have a word to look in the first two pages of the learning guide and prepare to explain what the word means and what role it plays in respiration. Give participants time to look up the words, and then ask them to tell the group what they know. Participants without words should spend the time reading the first two pages of the learning guide.
2. Go over the material about different respiratory disorders in the learning guide with the participants. If any of them care for clients with a respiratory disorder, ask them to share what they know. Remind workers that they should not wear perfume because it irritates sensitive lungs. Discuss care measures such as quick showers to reduce humidity, fans to circulate air, and techniques to conserve a client's energy.
3. Have the participants practice each of the techniques on the last page of the learning guide: pursed-lip breathing, controlled coughing, the orthopneic position, and the relaxation and visualization exercise.
4. Discuss the behavior problems that sometimes occur with clients with respiratory disorders. Emphasize that these clients often feel very uncomfortable and unhappy and need lots of compliments, support, encouragement, and understanding.
5. Have the learners take the test, and then grade the test together. **Test Answers: 1. 12–20. 2. True. 3. True. 4. False. 5. Handwashing. 6. False. 7. a. 8. b. 9. d. 10. c.**
6. Hand out certificates to those who achieve 70% or above on the test.

Respiratory disorders

Learning guide

***Respiration* means *breathing*. In this lesson you will learn about the *respiratory tract,* also called the *respiratory system*. This is the passage that air goes through as we breathe in and out. The respiratory tract contains these important parts:**

The upper respiratory tract

→ Nose—warms the air breathed and filters out bacteria and debris. Nasal breathing is important for best lung function.

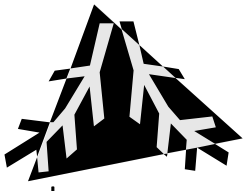
→ Sinuses—cavities (holes) in the skull. They connect to the nasal passage and are lined with nasal tissue.

↓ Pharynx—passageway that conducts air from the nose to the voice box. The pharynx also conducts food from the mouth to the esophagus, the tube that leads to the stomach.

↓ Epiglottis—flap that covers the entrance to the voice box when we swallow. It prevents food and liquids from getting into the lungs.

↓ Larynx—the voice box, located between the pharynx and the windpipe (trachea).

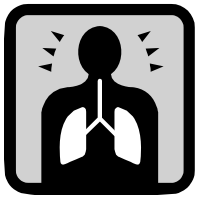
↓ Trachea—windpipe. This is the airway connecting the larynx to the tubes leading to the lungs (bronchi).

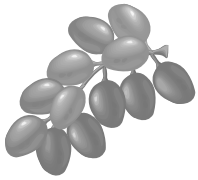


The lower respiratory tract

↓ Bronchi—two tubes that lead from the trachea to the lungs. The bronchi divide into many smaller airways, called *bronchioles*.

↓ Lungs—pair of large spongy organs that take oxygen out of the air we breathe and exchange it for carbon dioxide in our blood.





↓ Alveoli—millions of tiny air sacs in the lungs, surrounded by tiny blood vessels called *capillaries*. This is where the exchange of oxygen and carbon dioxide takes place. These sacs look like bunches of grapes.

→ Pleura—a membrane that covers the lungs and helps them move freely.

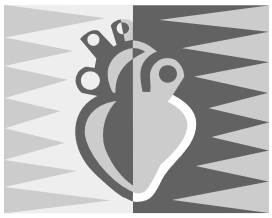
How the Respiratory System Works

The respiratory tract inhales oxygen into the lungs, transfers the oxygen to the blood, and exhales carbon dioxide. Breathing is usually automatic, controlled subconsciously by the respiratory center at the base of the brain. The brain senses when oxygen levels are too low or carbon dioxide levels are too high and increases the speed and depth of breathing. Normal respiration occurs 12–20 times a minute.

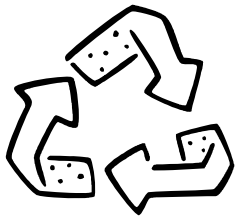
All cells in the body need oxygen. They get oxygen when the body breathes in air that the blood can circulate to all parts of the body. Breathing is accomplished with the help of the *diaphragm*, a set of muscles lying across the bottom of the chest cavity. Oxygen is pulled into the lungs when the diaphragm contracts. Carbon dioxide is pumped out when the diaphragm relaxes.

Air inhaled through the nose is filtered, moistened and warmed in the nasal passages. Air goes down the pharynx, into the trachea, through the larynx and into the two large bronchi. The bronchi branch into smaller airways that conduct the air into the lungs. The inhaled oxygen diffuses into the blood through the many capillaries. The blood exchanges carbon dioxide for oxygen. The carbon dioxide is then exhaled.

Oxygenated blood travels from the lungs through the pulmonary veins and into the left side of the heart, which pumps the blood to the rest of the body.



The blood delivers its oxygen to the tissues and picks up and distributes nutrients and waste products, then returns to the heart and gets pumped back to the lungs to pick up oxygen and get rid of carbon dioxide.



Elimination of carbon dioxide is just as important as getting oxygen. A buildup of carbon dioxide leads to headaches, drowsiness, and even death.

Fast facts:

Chronic Obstructive Pulmonary Disease (COPD) accounts for more than 100,000 deaths every year. It is the fourth most common cause of death in the U.S.

People with asthma are almost 60% more likely to develop lung cancer.

Each year more than 25,000 people in the U.S. get tuberculosis (TB).

Problems that develop in the respiratory tract

There are many disorders and infections of the respiratory system. Infections occur more frequently in the respiratory tract than in any other organ in the body. Examples of upper respiratory infections include the common cold, sinusitis, and influenza (flu). Lower respiratory problems include infections such as bronchitis and pneumonia and disorders like emphysema and asthma. Some of the more serious ones are described in the following pages.

Upper respiratory infections

Influenza (Flu)

Influenza is a ***highly contagious*** infection of the upper respiratory tract. It is caused by a virus and spreads easily through coughing and sneezing. Influenza can lead to pneumonia and death and is responsible for epidemics that occur almost every winter. Flu vaccine can prevent influenza.

Influenza virus is generally passed from person to person by airborne transmission. However, the virus can live for a short time on objects such as pens, pencils, keyboards, and telephone receivers. Touching those objects can transmit the virus.

Symptoms of influenza include high fever, headache, sneezing, coughing, sore throat, severe aches and pain, and fatigue. The most *common* complications of flu are respiratory disorders, especially bronchitis. Pneumonia is the most *serious* complication.

Treatment includes bed rest and increased fluids, antiviral drugs, and medication to relieve aches and fever. Most people recover in a week, but many flu victims feel exhausted for 3–4 weeks. Getting the annual flu shot, washing hands frequently, and avoiding contact with infected persons can prevent influenza.

Lower respiratory infections

Pneumonia

Pneumonia is the most common and most serious type of lung infection. It can be caused by a virus that is inhaled or by bacteria that gets in through the mouth. Pneumonia causes the alveoli to fill with liquid that blocks the exchange of oxygen in the lungs. The lack of oxygen combined with the spread of infection can cause death.

Pneumonia caused by bacteria is spread from person to person through secretions from the nose, mouth, and throat. Symptoms may include high fever, chills, severe chest pain, and a cough that produces mucus. Bacterial pneumonia can come on gradually or suddenly. It often follows what appears to be an ordinary respiratory infection.

Bacterial pneumonia can develop 4–14 days after an apparent recovery from the flu, especially in people with heart disease. Fever returns, along with a cough that produces mucus. This disease can progress rapidly from flu to serious pneumonia, and it often causes death.

Pneumococcal pneumonia is the most common type of bacterial pneumonia. It can be prevented with immunization and hand washing.

Pneumonia caused by a virus resembles the flu at first, with fever, dry cough, headache, muscle pain, weakness, and shortness of breath. Careful hand washing can help prevent its spread.

Tuberculosis (TB)

Tuberculosis is a chronic bacterial infection that affects the lungs. TB germs are airborne, causing illness when they are inhaled.

TB is usually passed to those who share breathing space for a prolonged time with someone with contagious TB disease. The most common places for becoming infected are the home and workplace. TB usually does not result from brief casual contact. Adequate ventilation is the best way to prevent transmission. Those who care for people with TB may have to wear special masks to protect themselves by filtering out the TB bacteria from the air they breathe.

A skin test called a PPD is recommended for people who are at risk for TB. This includes healthcare workers, the elderly, people in group settings such as long-term care facilities, people who work or live with a person with active TB disease, people with AIDS or impaired immune systems, the homeless, and those who abuse alcohol or drugs.

A positive PPD means that the immune system is reacting to TB germs located somewhere in the body, so that person is at increased risk for developing TB disease unless preventative treatment is given. A positive PPD does *not* mean that one has TB disease or is contagious to others. Most people who become infected never develop active TB. A person with TB usually is not contagious once treatment has begun. To treat the disease, medications are given for 6–9 months. The entire treatment must be given or the person can become ill again.

A cough that won't go away is usually the first symptom of TB. This table shows what happens with exposure to tuberculosis, TB infection, and active disease.

	PPD	Chest x-ray	Symptoms	Contagious	Medication for treatment
Stage 1: Exposure	Negative	Normal	None	No	No
Stage 2: TB infection	Positive	Normal	None	No	Special antibiotic might be given for prevention of active TB
Stage 3: Active disease	Positive	Abnormal	Cough, wt. loss, fever, fatigue, loss of appetite, night sweats, coughing up blood	Yes	Curable in most cases by treatment with several medications taken by mouth for 6–9 months

Lung disorders

Asthma

Asthma is a long-term chronic breathing problem that can affect people of any age. It may be inherited, or may be caused by allergies to pollen, pets, dust, or medications. Smoking increases the risk of developing asthma, and stress may make it worse. Persons with asthma can live normal lives with medication and proper care.

A person with asthma has sensitive bronchi that react to triggers such as smoke, air pollution, cold weather, exercise, or allergies. The bronchi may tighten or narrow, becoming inflamed and swollen, making it harder to breathe fresh air in and exhale the stale air. Sometimes it is harder to exhale than inhale. Symptoms of asthma are wheezing, dry cough, or sometimes a cough with mucus, shortness of breath, and chest tightness.

Medications may include an inhaler, puffer, or pills. Some medicines reduce the swelling and inflammation in the bronchi, helping to prevent asthma attacks from starting, but they do not stop an attack once it has started. Inhalers work quickly, opening the narrowed airways. They help stop an attack once it has begun and are used as needed. Some asthma drugs may cause irregular heartbeats.

Blood pressure medicines, sleeping pills, tranquilizers, sedatives, or aspirin may cause a problem in older people with asthma. These drugs make one breathe more slowly and less deeply, which can be dangerous if one has asthma.

Common symptoms of respiratory problems

These symptoms should be reported to your supervisor:

- *Cough*—varies with type of problem. Take notice of these things:
  - Is the cough dry, without sputum?
  - If there is sputum with the cough, what color is it? Is there any blood in the sputum? Is the sputum thick or thin?
  - What factors affect the cough, such as walking, talking, eating, etc.?

  Two kinds of medicines are used to treat coughs. *Antitussives* suppress the cough, and *expectorants* help loosen mucus so it can be coughed up.
- *Shortness of breath* (SOB, dyspnea) is the unpleasant sensation of breathlessness or difficulty in breathing. Shortness of breath may happen mostly during activity, when it is often called *distress on exertion*, or DOE. Some people feel short of breath all the time because of narrowed airways. Sometimes shortness of breath occurs when lying down. This is usually due to heart failure and is relieved by sitting up.
- Breathing that is *abnormal*—too fast, too slow, irregular, shallow, or gasping.
- *Pleurisy* is a sharp pain caused by an irritation in the lining of the lungs. It is made worse by deep breathing and coughing. Sometimes the area is sore to the touch.
- *Cyanosis* is a bluish color of the lips, nails, and skin caused by lack of oxygen.

Chronic Obstructive Pulmonary Disease (COPD)

COPD is the name for reduced airflow in to and out of the lungs. It is associated with diseases such as **emphysema** and **chronic bronchitis**. Smoking is the cause of 80%–90% of COPD. Other causes include heredity, second-hand smoke, and air pollution. There is no cure.

Bronchitis is an inflammation of the bronchi. In chronic bronchitis the airways become narrow, scarred, and partly clogged with mucus, making it difficult to breathe. There may be a cough that lasts for months and returns often, lasting longer each time.

Emphysema occurs when some of the air sacs deep in the lungs are damaged, often because of long-term infection and irritation. When lung tissue is damaged, the airways collapse, trapping stale air and blocking intake of fresh air. The lungs try to take in more air and become over-inflated and stretched out, gradually getting so big they completely fill the chest cavity. Many with severe emphysema develop a barrel-shaped chest because of this.

The stretched-out lungs cannot effectively exhale, creating the feeling that something is blocking the airway. Stale air is never completely replaced with fresh air, and less oxygen gets into the blood. Emphysema makes the heart work harder, eventually leading to heart failure.

Many people with emphysema lose 50–70% of their lung tissue before they are aware of symptoms. A daily morning cough with clear sputum is the earliest symptom. Gradually the morning cough becomes an all-day cough. Sometimes the first symptom people notice is breathlessness, especially with activity. Other symptoms of COPD include chest tightness and increased mucus.

Care measures for COPD:

→ Medications.

→ Oxygen therapy.

→ Good nutrition and correct body weight.

→ Good ventilation. People with COPD often like to have a fan blowing air toward them.

→ Rooms should be at a comfortable, moderate temperature, not too hot, too cold, or too humid. Showers and baths should be quick if moisture in the air makes breathing difficult.

→ Loose-fitting clothes are best.

→ Avoid dust, allergens, air pollution, smoke, and other irritants. Animal hair, scented soaps, colognes, perfumes, powders, cleaners, aerosol sprays, glues, and paints can all cause problems with breathing.

→ Exercise can strengthen, improve well being, and reduce shortness of breath.

→ Drinking lots of water will keep secretions thin and easy to bring up.

→ Tasks should be broken into short segments with frequent rest periods of at least 5–15 minutes.

→ Sit when performing tasks if possible.

→ Relaxation exercises and special breathing techniques can help the COPD client feel better.

→ Caregivers must give frequent support, encouragement, and reassurance.

→ Be patient, be complimentary, and keep a positive attitude with COPD clients. They often feel anxious and irritable. Lack of oxygen in the blood can cause fatigue, forgetfulness, depression, confusion, poor appetite, moodiness, agitation, frustration, and sleeplessness.

Breathing techniques and relaxation exercises that help those who feel breathless

Pursed-lip breathing is helpful in many cases of shortness of breath. It improves ventilation, reduces air trapped in the lungs, relaxes the client, and eases the effort of breathing. This is especially good to do while exercising or performing any physical activity:

→ An erect, upright posture is best for full lung and chest expansion.

→ Breathe in slowly through the nose for 1 count. Feel lungs fill with air.

→ Purse lips slightly as if to whistle.

→ Breathe out gently and slowly through pursed lips for 2 slow counts.

→ Do not force the air out; let it escape naturally.

→ Keep doing this until breathing eases.

Clients can learn ***controlled coughing*** techniques to help clear the breathing passages:

→ Take a slow, deep breath and hold for 2 seconds.

→ Cough twice, with mouth slightly open. The first cough should loosen mucus, and the second should push it out of the lungs.

→ Pause. Sniff gently. Do not take a deep breath, as this may push mucus back to the lungs.

The ***orthopneic position*** can help clients with enlarged lungs breathe better by stabilizing the chest and shoulders and helping the client use other muscles to support breathing:

→ Sit leaning forward. Support the arms on a surface in front. An overbed table provides good support and can be adjusted to the right height. Arms can also be supported on the knees.

Relaxation and visualization exercises can calm anxiety and agitation:

→ Sit in a chair with eyes closed and do pursed lip breathing for a minute or two.

→ Frown, tightening the muscles in the forehead. Hold for 3 seconds and then relax.

→ Clench jaw by tightening the muscles in the lower jaw. Hold for 3 seconds and relax.

→ Tighten and relax arms and hands, then buttocks, then legs and feet.

→ Let the body go limp.

→ Imagine the most peaceful scene you can think of.

→ Visualize the scene with you in it. Think of as much detail as possible.

→ Think about how relaxing it is to be in that place and how easily you can breathe there.

Energy conservation measures can help clients accomplish tasks with less effort:

→ Push or slide objects instead of lifting them. Wheeled carts are helpful.

→ To stand, take several slow, deep breaths, then stand while breathing out through pursed lips.

→ Always exhale when lifting or pushing heavy objects or when doing an action or exercise.

→ When climbing stairs, use pursed-lip breathing, stop often to rest, and use the rail for support.

Respiratory disorders test

Name _____ **Date** _____ **Score** _____
(Must have at least 7 correct answers)

1. The normal rate of respiration is _____ to _____ breaths per minute.

2. The main function of the respiratory system is to inhale oxygen into the lungs, transfer the oxygen to the blood, and exhale carbon dioxide. True or False

3. Asthma can affect people of any age. True or False

4. A positive tuberculin test (PPD) means a person has TB disease and is contagious. True or False

5. Two things that will help prevent the spread of pneumonia and flu are: _____ and immunization.

6. Clients with COPD should not exercise. True or False

7. Which of the following symptoms should be reported to a supervisor?
    a. Cough, shortness of breath, cyanosis
    b. Respiratory rate of 16 and regular
    c. Relaxing and visualizing

8. A client who has difficulty with ADLs because of shortness of breath might be advised to:
    a. Drink less water.
    b. Use pursed-lip breathing and take frequent breaks.
    c. Let someone else do everything for them.

9. Which of the following can cause breathing problems for a client with a lung disorder?
    a. Perfume.
    b. Dust.
    c. Humidity.
    d. All of the above.

10. Clients with COPD often suffer from depression, anxiety, or forgetfulness due to:
    a. Old age.
    b. Personality disorder.
    c. Lack of oxygen.

Certificate of Achievement
Awarded to

_____

(Name of participant)

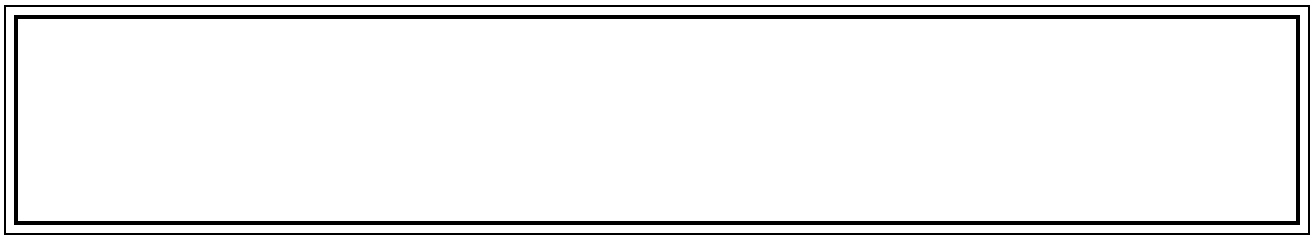
For Completing the One-Hour Course Entitled

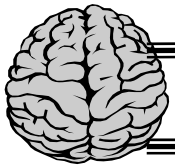
Respiratory Disorder

Date of Course _____

Facility or Agency _____

Presented by _____
(Signature of presenter, or write "self study")





Seizures and strokes: Teaching plan

To use this lesson for self-study, the learner should read the material, do the activity, and take the test. For group study, the leader may give each learner a copy of the learning guide and follow this teaching plan to conduct the lesson.

Learning objectives

Participants in this lesson will be able to

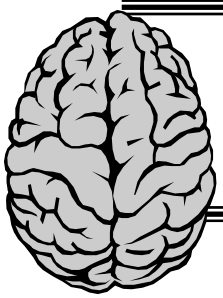
- Define seizure, seizure disorder, and epilepsy.
- Recognize when someone is having a seizure and respond appropriately.
- List care measures for people on anticonvulsant medications.
- List risk factors for strokes.
- State the most common symptoms of stroke.
- Recognize the symptoms of stroke and respond appropriately.

Introductory activity

Distribute a copy of the learning activity to each participant. Ask them to read the stories and write or say how they would respond. This can be done as a group discussion or as an individual activity. It is likely that many of the learners will not know the answers. Reassure them that they will learn how to respond to these important situations in today's lesson. The answers are given on the separate learning activity answer key.

The lesson

1. Give a copy of the learning guide to each participant. Instruct participants to listen to your lecture and follow along in the learning guide. Ask them to listen especially for the correct way to respond to the scenarios given to them in the learning activity and to write down answers they didn't know before.
2. Use lecture and discussion to cover the content in the learning guide. Participants can take turns reading and discussing different sections in the guide.
3. Encourage participants to memorize the five most common symptoms of stroke. Allow time for practice if possible.
4. At the conclusion of the lesson, look at the learning activity again and see whether the participants are able to write or say the correct way to respond in each case. Rapid response to both seizures and strokes is essential, so each participant should leave the session knowing exactly what to do in both situations.
5. Have participants complete the test and receive a certificate for at least nine correct answers. Test answers: 1c; 2T; 3T; 4b&d; 5d; 6: numbness/weakness, confusion/trouble speaking, trouble seeing, dizziness/trouble walking, severe headache; 7b; 8F; 9F



Seizures and strokes Learning guide

Seizure disorder

About 2.3 million people in the United States have some form of epilepsy, also called seizure disorder. For the vast majority of cases, no single cause has been determined. People with epilepsy often struggle to overcome low self-esteem and the stigma that is attached to having seizures. Some people mistakenly believe that epilepsy is a form of mental illness or mental retardation. The truth is that many people with seizure disorders lead productive and outwardly normal lives.

What is a seizure?

A seizure is rhythmic jerking of the body or an involuntary change in body movement, sensation, awareness, or behavior. It can last from a few seconds to a few minutes. Seizures are sometimes called convulsions.

What is epilepsy?

The word epilepsy is used when more than one seizure in a row has occurred. If someone has a single seizure they are not usually said to have epilepsy. The terms epilepsy and seizure disorder are often used interchangeably. The onset of epilepsy is most common in children and the elderly.

When is a seizure not epilepsy?

- First seizures
- Febrile (caused by high fever) seizures
- Eclampsia seizures (in pregnancy)

Symptoms experienced by a person during a seizure depend on where in the brain the disturbance in electrical activity occurs.

Why are seizures harmful?

A person can be injured during a convulsion, because the body is moving uncontrollably. Also, the brain can be starved of oxygen during long seizures. This can lead to brain damage. Repeated seizures or seizures that last longer than 20–30 minutes can damage the brain's neurons (nerve cells).

What causes seizures/epilepsy?

A seizure occurs when neurons generate uncoordinated electrical discharges that spread throughout the brain. Anything that disturbs the normal pattern of nerve cell activity can lead to seizures. Neurons are very sensitive to abnormal electrical impulses. Illness, injury, an imbalance of the chemicals in the brain that carry messages between nerve cells, and brain abnormalities can be responsible for seizure. Some examples:

- Heart attacks and strokes, or any condition that deprives the brain of oxygen. Proper treatment of heart disease and high blood pressure can prevent some cases of epilepsy.
- Metabolic disturbances: alcohol withdrawal, severe liver disease, kidney disease.
- Infections such as meningitis and AIDS. Good treatment may prevent seizures.
- Brain tumors or head injury. Wearing seat belts and cycle helmets and using child car seats can prevent brain injury and therefore prevent this type of seizure.
- Presence of certain drugs or stopping certain drugs suddenly (such as narcotics).
- Illicit drug use, like cocaine, heroine, or PCP.
- Alzheimer's disease.
- Neurodegenerative disorders, such as multiple sclerosis.
- Inherited disorders and genetic factors.

What are some types of seizures?

There are many different kinds of seizures. Following are four types:

- A grand mal, or tonic-clonic seizure, involves the entire body in a convulsion. When a person has this type of seizure he or she may cry out, fall to the floor unconscious, twitch or move uncontrollably, drool, or even lose bladder control. It usually lasts for 5–20 minutes. When the seizure is over and the person regains consciousness, he or she feels exhausted and dazed. This is the image most people have when they hear the word epilepsy. Sometimes people experience warning signs beforehand, such as unusual smells, visual changes, or feelings. This warning is called an ***aura***.
- A complex partial seizure causes a person to appear confused or dazed. He will not be able to respond to questions or direction.
- A petit mal (pet-ee mal), or absence seizure, causes a brief loss of consciousness without other symptoms. There is no warning. This type of seizure is not noticeable in some people. The person may briefly stop what he or she is doing, stare for 5–10 seconds or blink rapidly, then continue his or her activity. The person becomes unresponsive, appears to be daydreaming, and cannot be aroused during this time.
- Status epilepticus is prolonged, repetitive seizure activity that last more than 20–30 minutes while the person is unconscious. It is a medical emergency and can result in death if not treated aggressively. It is caused by certain medications, stroke, infection, trauma, cardiac arrest, drug overdose, and brain tumor.

How is epilepsy treated?

There are several ways to treat epilepsy. Treatments can control seizures some of the time in about 80% of people with epilepsy. Once epilepsy is diagnosed, it is crucial that treatment begin as soon as possible.

There are many different medications and a variety of surgical procedures that may provide good control of seizures. Some people are helped with special diets.

People with seizure disorders should carry an ID card or wear a bracelet that tells about their condition, their medications, and their doctor's name and phone number.

Medications to control seizures are called anticonvulsants. These must be taken regularly as directed, without missing doses. Missed doses may cause a single seizure, several seizures, or death.

People with severe seizures who don't take their medications have a shorter life expectancy and more risk of cognitive impairment.

Common anticonvulsants are Dilantin (phenytoin), Tegretol (carbamazepine), Depakene (valproate), and phenobarbital. These medications should be taken with food or milk to prevent stomach problems.

Anticonvulsant medications can cause changes in a person's mental status, including mood and behavior. They can also affect speech, balance, the eyes, the stomach, and the gum tissue in the mouth. Changes in any of these areas must be reported. Good oral hygiene will help prevent gum problems.

What should you do if you see someone having a seizure?

1. Roll the person on his or her side to prevent choking on any fluids or vomit.
2. Loosen any tight clothing around the neck.
3. Keep the person's airway open. If necessary, grip the person's jaw gently and tilt his or her head back.
4. DO NOT restrict the person from moving unless he or she is in danger.
5. DO NOT put anything into the person's mouth, not even medicine or liquid. These can cause choking or damage to the person's jaw, tongue, or teeth. Contrary to widespread belief, people cannot swallow their tongues during a seizure or at any other time.
6. Remove any sharp or solid objects that the person might hit during the seizure.
7. Note how long the seizure lasts and what symptoms occurred so you can report it as soon as possible to your supervisor, or to emergency personnel if needed.
8. Stay with the person until the seizure ends. After a seizure ends, the person may be sleepy and tired. He or she may have a headache and be confused or embarrassed. Be patient with the person. You may need to help him or her clean up.

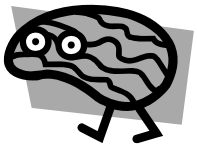
When is a seizure an emergency situation? Call for help if

- the person does not begin breathing again and return to consciousness after the seizure stops.
- another seizure begins before the person regains consciousness.
- the person injures himself or herself during the seizure.

Stroke

About 600,000 Americans will have a stroke this year. More than 160,000 will die from it. Two-thirds of all strokes happen to people over age 65. Stroke risk doubles every ten years past age 55. Many of the causes of stroke can be controlled, and rapid treatment when stroke occurs can save lives and prevent permanent damage. May is American Stroke Month.

What is a stroke?



A stroke is a “brain attack,” meaning it occurs in the same way a heart attack does, only it affects the brain instead of the heart. A stroke occurs when the blood supply to part of the brain is suddenly cut off. This can happen when a blood clot blocks a blood vessel or when a blood vessel breaks and spills blood into the brain. As a result, brain cells in the affected area die. The cells usually die within minutes to a few hours after the attack starts. When brain cells die, they release chemicals that start a chain reaction, killing even more brain cells in a bigger area.

When brain cells die, the abilities that are controlled by that area of the brain are lost. This can include speech, movement, and memory, depending on where in the brain the stroke occurs and how many brain cells are killed. A small stroke might cause weakness of an arm or leg. A large stroke might cause paralysis on one side of the body or loss of the ability to speak and understand language. People can sometimes recover completely from minor strokes, but a severe stroke can be fatal. Rapid treatment is the key to preventing death and paralysis. Stroke is an emergency!

What are the symptoms of stroke?

The five most common stroke symptoms include:

1. Sudden numbness or weakness of face, arm, or leg, especially on one side of the body.
2. Sudden confusion, trouble speaking, or trouble understanding.
3. Sudden trouble seeing in one or both eyes.
4. Sudden dizziness, trouble walking, or loss of balance or coordination.
5. Sudden severe headache with no known cause.

Call 911 if you see any of these symptoms in someone.
Treatment is much more effective if given soon after the attack.
Every minute can make a difference in preventing serious damage or death.
Get emergency help even if the symptoms are painless or go away quickly.

Some other less common stroke symptoms include:

1. Sudden nausea, fever, and vomiting. This is different from a viral illness because it comes on very quickly, in minutes or hours instead of over several days.
2. Brief loss of consciousness or a period of decreased consciousness, such as fainting, confusion, convulsions, or coma.

These symptoms should be reported to medical personnel immediately.

What is transient ischemic attack?

A transient ischemic attack (TIA) is a stroke that lasts only a few minutes and goes away quickly. A TIA occurs when the blood supply to part of the brain is briefly interrupted. The symptoms are similar to those of stroke, but they usually disappear within an hour.

Only a doctor can tell whether stroke symptoms are from a TIA or a serious stroke. You should assume that all stroke-like symptoms require emergency help. Don't wait to see if they go away. TIAs are often warning signs that a person is at risk for a more serious stroke.

Who is at risk for stroke?

People over age 65, African-Americans, people with diabetes, men, and people with a family history of stroke are at greater risk of brain attack than the rest of the population. These things cannot be controlled. People with diabetes, however, can lower their risk of stroke with treatment.

Many things that increase the risk of stroke can be controlled or treated, such as:

- High blood pressure—untreated high blood pressure increases stroke risk four to six times. Blood pressure is too high if it is usually more than 140/90.
- Heart disease—some heart conditions increase stroke risk by up to six times.
- High cholesterol—this increases the risk of stroke by clogging blood vessels.
- Personal history of stroke or TIA—people who have had a stroke or TIA are at risk for having another stroke. 35% of those who experience TIAs have a stroke within 5 years.
- Sleep apnea—people who do not breathe for periods of time while they are sleeping develop low levels of oxygen in the blood, possibly leading to blood clots and stroke.

- Smoking—cigarette or cigar use doubles the risk of stroke by damaging blood vessels.
- Alcohol—excessive alcohol consumption is associated with stroke in some studies.
- Weight—excess weight puts a strain on the blood vessels and is often linked to high blood pressure, high cholesterol, and diabetes.

What should you do if you see someone having a stroke? Call 911!

52% of the stroke patients in one study were not aware they were experiencing a stroke. Most strokes are recognized by someone other than the victim.

The National Stroke Association urges everyone to know the 3 Rs of stroke:

Reduce risk.
Stop smoking, control weight and cholesterol, avoid excessive alcohol, and treat high blood pressure, heart disease, and sleep apnea.

Recognize symptoms.
Memorize the 5 most common symptoms of stroke and be alert for them in people around you.

Respond by calling for emergency medical help.

Seizures and strokes learning activity

Read the stories below, and then decide how you would respond in each situation.

1. You find a client on the floor. Her arms and legs are jerking and thrashing around, and it appears that she has wet herself. She does not respond when you call her name. What is the first thing you should do? List five or six things you should do to respond to this client's seizure.

    a. _____
    b. _____
    c. _____
    d. _____
    e. _____
    f. _____

2. After the client in the first scenario has stopped convulsing, she does not open her eyes or respond when you call her name. After a minute or two she begins convulsing again. How should you respond now?

    _____

3. You are helping a client with a shower. Suddenly the client begins acting strangely. He doesn't seem to understand what you are saying to him, and he appears confused. This is not normal behavior for this client.

    What is this a possible symptom of? _____

    How should you respond to this problem? _____

4. You notice that your client is not using his right arm like he usually does. He is letting the arm hang at his side while he uses his left hand to do things. When you ask him about it, he says his arm is feeling weak today, but he's sure it will pass. What, if anything, should you do about this?

    _____

Seizures and strokes learning activity answer key

Read the stories below, and then decide how you would respond in each situation.

1. You find a client on the floor. Her arms and legs are jerking and thrashing around, and it appears that she has wet herself. She does not respond when you call her name. What is the first thing you should do? List five or six things you should do to respond to this client's seizure.

    a. Roll her on her side to prevent choking.
    b. Loosen any tight clothing around her neck.
    c. Keep her airway open.
    d. Remove anything sharp or solid that she might hit.
    e. Report what is happening to a supervisor or medical personnel as soon as possible.
    f. Stay with the client until she is fully conscious and calm.

2. After the client in the first scenario has stopped convulsing, she does not open her eyes or respond when you call her name. After a minute or two she begins convulsing again. How should you respond now?

    Call for emergency medical help.
    Status epilepticus, or repetitive seizure activity, is life-threatening.

3. You are helping a client with a shower. Suddenly the client begins acting strangely. He doesn't seem to understand what you are saying to him, and he appears confused. This is not normal behavior for this client.

    What is this a possible symptom of? It could be a stroke.

    How should you respond to this problem? Call for emergency medical help.

4. You notice that your client is not using his right arm like he usually does. He is letting the arm hang at his side while he uses his left hand to do things. When you ask him about it, he says his arm is feeling weak today, but he's sure it will pass. What, if anything, should you do about this?

    This is a symptom of possible stroke. Call for emergency medical help.

Seizures and strokes test

Name _____ Date _____ Score _____
Circle or write the correct answer(s). (Must have 9 correct answers)

1. A seizure is
   a. a heart attack.
   b. a voluntary change in body movement, sensation, awareness, or behavior.
   c. an involuntary change in body movement, sensation, awareness, or behavior.
   d. the same thing as epilepsy.

2. There are many different types of seizures. True or False

3. People who take anticonvulsant medications may be prone to gum problems and need good oral hygiene. True or False

4. How can you help someone who is having a seizure? (More than one answer.)
   a. Put a tongue blade in their mouth to keep them from swallowing their tongue.
   b. Remove any sharp or solid objects they might hit during the seizure.
   c. Try to hold their body still.
   d. Stay with them until the seizure ends.

5. When is a seizure a medical emergency?
   a. Another seizure begins before the person regains consciousness.
   b. The person injures himself/herself during the seizure.
   c. The person does not return to consciousness after the seizure stops.
   d. All of the above.

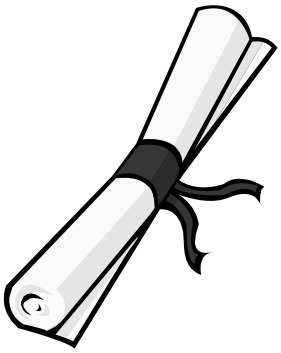
6. List the five most common symptoms of stroke (five points).
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

7. Some risk factors for stroke that <u>can</u> be controlled include:
   a. Age, gender, race, diabetes.
   b. High blood pressure, heart disease, high cholesterol, smoking, weight.
   c. Occupation, allergies, finances, education.
   d. There is nothing anyone can do to lower their risk of having a stroke.

8. Stroke cannot be treated. True or False

9. There is no hurry in getting treatment for stroke, because the damage is already done. True or False

Certificate of Achievement



Awarded to

_____

(Name of participant)

For Completing the One-Hour Course "Seizures and Strokes"

Date of course _____

Facility/Agency_____

Presented by: _____

(Signature of presenter, or write "self study")

TB INSERVICE

TEACHING PLAN

Define TB

Tuberculosis (TB) is an airborne infectious disease that is caused by a germ that gets into the lungs. TB is spread through casual contract. It is spread when the contact takes place in confined spaces and in poorly ventilated areas that increase the risk of exposure. It can also be spread on mucous droplets of an infected person through talking, laughing, singing, yellow breathing or coughing.

Symptoms of TB may also be present in people who are not infected. These people may be a "carrier" but not be infectious. A carrier will not show signs and symptoms but will test positive on a TB skin test.

Let's Talk about TB

Before the 1940's TB was a common disease. TB was the leading cause of death in the United States. It has been estimated that one in seven deaths were caused by TB. Unfortunately, a cure was found and TB was significantly reduced in the United States when it seemed we had won the war against tuberculosis, it is now becoming a serious health threat again. During the mid 1980's, cases of TB began to increase, especially among the HIV positive population. New, drug resistant strains of TB have also been found. The World Health Organization estimates 1.7 billion people are infected with tuberculosis.

Healthcare workers are often exposed to diseases without their knowledge. This is important for everyone who works in healthcare to understand TB. Understanding symptoms and precautions is the only way to prevent getting or giving the disease. Knowledge takes the fear out of the unknown. TB is more common among older people, especially males, foreign borne individuals and individuals who are also infected with HIV. Anyone with a compromised immune system is at a greater risk of contracting TB.

In 2001, 1,145 cases of TB were reported in Florida, which made FL the 4th highest TB in the United States. 43% of the TB cases were reported in 2001 were from people outside the United States. In 1995, it was only 15%. 23% of the reported Florida TB cases in 2001 were HIV positive.

A simple TB skin test can identify those people who are either currently infected with the disease or have been exposed to it. A chest x-ray can then determine if the disease is present.

The CDC considers the following individuals at high risk for TB and recommends a TB skin test.

- Persons with signs or symptoms of tuberculosis
- Persons who have had contact with a person with active TB
- Persons with an abnormal chest X-Ray suggestive of TB

- Persons who inject drugs
- Persons with poor or compromised immune systems
- Groups at high risk of recent infection of TB (recent immigration from other countries, employees and residents of nursing homes, hospitals, prisons, and mental institutions)

The tuberculin test that gives the most accurate result is the Mantoux test, often call "PPD" named for the serum that is used. (Purified Protein Derivative). The serum is injected just below the skin, usually on the forearm, and then checked in 48-72 hours for results. If the area is red and raised, (6-10mm) it could be an indication of exposure to TB or active TB. The PPD is not 100% accurate. False positives and false negatives may occur. However, there is no better diagnostic test available. This skin test is a screening tool and is the traditional method of diagnosing individuals infected with mycobacterium tuberculosis.

Foreign Countries

People born in foreign countries may have been vaccinated with BCG. BCG is a vaccination for TB. This vaccination is not widely used in the United States, but is given to infants and small children in foreign countries where TB is high. BCG does not always protect the individual from TB.

A PPD test should not be given to people who have been vaccinated with BCG. BCG causes a false positive result. These individuals need to have a chest x-ray to determine their TB status.

(Just in case you're interested … BCG vaccine was named after the French scientists named Calmette and Guerin. The "B" stands for Bacillus.)

Symptoms of Tuberculosis

Just because a person has a cough or is tired, does not mean they have TB. TB is suspected when the symptoms last longer than three weeks, if the person has had a "positive" PPD, or if they have had a recent exposure to TB. Many other diseases, including HIV, have some of the same symptoms, so a visit to the doctor is always recommended for accurate diagnosing.

So, what are the symptoms of TB?

Respiratory symptoms lasting more than three weeks should be evaluated, especially if they are accompanied by one or more of the following:

- Fatigue (tired all the time)
- Malaise (generally "feeling bad")
- Loss of appetite
- Weight Loss (not planned)
- Fever
- Night Sweats

- Prolonged Coughing
- Coughing Up Blood
- Chest Pain

The Difference between TB Infection and TB Disease

There are two kinds of TB exposures.

1. TB Infection- also called latent TB, or inactive TB
2. TB Disease- also called active TB

TB Infection (inactive TB) – This means that the person has the TB germ, but doesn't look or feel sick. They cannot give another person TB. A TB skin test, given to someone who has inactive TB, will test positive. Sometimes, a doctor will prescribe preventative treatment. A single medication is given, usually for 6 months, but can be given for up to one year. Only about 5- 10% of inactive TB cases become active TB.

TB Disease- (active TB)- With active TB, the person usually feels sick. The person will have a cough for 3 weeks or more, feel weak, have a fever, have weight loss, and low appetite. They may have night sweats, or cough up blood. Sometimes, they have chest pains while coughing. This person IS contagious unless he or she is taking TB medications as directed by a physician. Treatment for active TB requires more than medication. The therapy usually lasts between six months and a year. After one to two weeks, the person is no longer contagious. TB patients who are prescribed medication (but stop taking them before they should, are at very high risk for a stronger form of TB). This form is resistant to the normally prescribed medications. Stronger drugs are taken for a longer period of time required to kill this type of TB. Without treatment, the disease will become worse. If TB is in the lungs, it may produce phlegm, mucous, and or blood. TB can get into other parts of the body as well, including the liver, kidneys, spine, bones and abdominal cavity. TB disease in other parts of the body has different symptoms than with TB in the lungs. Symptoms depend upon the part of the body that is infected.

A positive PPD requires a chest x-ray for complete diagnosis. The chest x-ray will show any damage to the lungs. Phlegm from a persistent cough can also be tested for TB. The test requires 3 different specimens. They must be obtained first thing in the morning after the patient has brushed their teeth and rinsed their mouth. A deep cough is needed to produce the phlegm, which is put into a sterile container and tested.

If TB bacilli are present in the lungs or throat, they can be exhaled into the air by breathing or coughing. Others can breathe in the bacilli and become infected. This is the reason that TB patients are isolated and visitors are required to wear masks.

How a Person Becomes Infected with TB

The organism, mycobacterium tuberculosis, is a bacterium. It is carrier on drops of moisture in the air. When the droplets are inhaled, they travel inside the lungs where they start to multiply. Once the TB germ has entered the body, the person now has TB INFECTION (inactive TB).

You cannot get TB by touching the person with TB or from their drinking glasses, clothing, shaking their hand or sitting on the same toilet seat.

The immune system traps TB with its white blood cells. The white blood cells try to destroy the bacteria to help keep the person from getting sick. These germs go into a "sleeping state". The infected person usually feels fine at this point. But often, when person is tired, run down, or the immune system is compromised by other diseases such as HIV, pneumonia, cancer, or diabetes, the germ breaks out of the capsules and begins to multiply. At his point, the person has TB DISEASE (active TB).

Medication Treatment

The type of treatment the individual will receive will depend on whether they have TB infection of TB disease. TB infection (Inactive TB) is usually treated with a drug called "INH", also known as Isoniazid. INH kills the TB bacteria that are in the body. If the person takes this medication as prescribed, it will usually keep them from getting the TB disease. Treatment is 6-12 months. Side effects include loss of appetite, nausea, vomiting, yellowish eyes skin, fever, abdominal pain, and tingling in hands or feet. Alcohol can increase the side effects and can contribute, to liver problems with these drugs, so while taking this medication, drinking alcohol not allowed.

Multi-drug therapy is required for TB Disease (active TB) and can include the use of Rifampin. Rifampin can turn urine orange. It may even turn tears or saliva orange. Rifampin will stain contact lenses, so persons taking this drug must wear their glasses until the treatment is over. Rifampin also causes sensitivity to the skin so a good sunscreen should be used. Rifampin may interfere with birth control pills. Alternate birth control methods must be used during the treatment. Alcohol should not be used while taking this drug.

Other drugs used include Pyrazinamide and Ethembutel. Streptomycin may also be given by injection. TB does not normally require hospitalization. Treatment can usually be given on an out-patient basis through a doctor's office.

Why Health Care Workers Need to be Concerned

At one time, TB in the United States had almost been eliminated. Unfortunately, because of HIV and other immune compromising diseases, it is on the rise. Prevention is the way to control this disease. As a healthcare provider, you have an increased risk of coming in contact with someone who has the disease. The greater your exposure to a person with the disease the greater your risk is of becoming infected.

In order to protect yourself you must understood all of the following:

- How TB is transmitted

- Testing for TB infection
- Wearing personal protective equipment (PPE) when in contact with people who have TB or have been exposed to TB
- Reporting to your supervisor any possible exposure to TB
- Participating in annual PPD screening tests.

PPE and Isolation Precautions

When working in a facility with patients who have TB, PPE (personal protective equipment) should be worn according to that facility's specific policy. The policy and procedures should cover the use glove, gowns, masks, as well as the proper disposal of these items.

The mask you will be required to use for an individual with TB is different from the general type of masks used: A TB mask is called a respirator mask. It's a special fitting respirator that will not allow the tiny TB particles to enter. It has a specially designee filter and is referred to as an N95 mask.

Isolation procedures include

An acid fast bacillus (AFB) isolation card should be present, instructing the health care worker to wear a mask, wear a gown, and to use gloves for touching the patient and/or all infected article. Good hand washing is very important. Any item in the isolation room should be treated as if it is contaminated. There should be an isolation cart outside the room with proper PPE available for immediate use.

Keep in mind that the air we breathe is a positive air pressure environment. A person with TB needs to be placed in a negative air pressurized room. Negative air pressure means air flows INTO the room from the outside. The air is also filtered back to the outside, passing through specially designed filters. The air is cycled through at least six times an hour. Remember to open doors SLOWLY to prevent air from flowing back into the building. The door must always remain closed. Wear a respirator mask when in a room that has known or suspected TB. You must be fitted for a respirator mask.

*** IMPORTANT TO REMEMBER ***

It very important that the mask fits your face without leaking. TB particles are very small and can get inside a mask that doesn't fit properly.

It you must take the patient out of the room for any reason, the patient is to wear a REGULAR SURGICAL MASK, NOT A RESPIRATOR TYPE N95, LIKE YOU WEAR TO ENTER THE ROOM!!! This is because the respirator N95 mask ONLY filters INHALED air NOT EXHALED AIR.

Home Care

Patients with newly diagnosed TB are placed on medication and when they are sent home, they are put on home isolation. This means they cannot go to any public places such as work, school, church or stores.

How infectious a patient is, is determined by a number of repeated tests. The tests must be negative for three days in a row before a patient is free to leave the home.

As treatment continues the patient feels much better. This means the medication is working. If the patient does not feel better after 3 weeks of medication, the medication may not be working. You should report this to your supervisor.

The local public health department tests everyone living in the home for TB. If anyone tests positive for the infection or disease they are treated with medication. The public health department does not recommend uninfected persons leave the home unless they are very young.

If the patient has active lung disease, with positive tests, the home care staff should wear a N9S fit-tested mask.

Home care staffs do not need to take any special precautions with their bags, equipment or clothing. These items do not present any TB risk to themselves or other patients.

Patients with active TB should be taught respiratory hygiene and cough precautions.

- Always cover the mouth when coughing or sneezing
- Use two Kleenex to cover the mouth
- Practice good hand washing including, after coughing, sneezing or contact with respiratory secretions
- Avoid singing of yelling
- Family members can decrease the possibility of becoming infected by sleeping in a different room than the patient while they are contagious.

Summary

TB is a disease that is spread from person to person through the air. It is particularly dangerous to those with a weakened immune system. TB is the leading cause of death among HIV infected people, accounting for about one in every three people infected with HIV.

TB is preventable. An annual TB skin test is necessary to identify exposure and begin proper treatment quickly to prevent transmission and even death.

It is important for the healthcare worker to understand how TB is spread and take all necessary precautions to prevent transmission and even death.

TEST

1. Tuberculosis is an airborne disease carried on mucous droplets.
2. Tuberculosis is spread through casual contact such as hand shaking.
3. Tuberculosis Is the leading cause of death in the United States.
4. Your age, sex, or where you were born does not affect your risk for TB
5. When a patient goes home after being diagnosed with active TB and put on medication, they can go with the family grocery shopping.
6. The Mantoux, or PPO skin test is done on the upper arm muscle.
7. A positive PPD test means you have active TB. There is no need for further testing to confirm the results.
8. BCG may affect the results of a PPD skin test
9. Signs and symptoms of TB include long-term cough, chest pains, shortness of breath, and coughing up blood.
10. TB infection and TB disease is the same thing.
11. People with HIV or compromised Immune systems, are already sick so they cannot Get TB.
12. An individual with Inactive T8 will have a positive skin test but no symptoms.
13. TB can be diagnosed from a deep cough sputum specimen taken before bedtime.
14. Home Care Staff do not need to take any special precautions with their bags, equipment or clothing.
15. In a facility, when leaving the isolation room, a regular surgical mask should be worn by the person with active TB.

Multiple Choice

16. Which of the following drugs are not used for treatment of:

a. Isoniazid

b. Ethambutol

c. Rlfampln

d. They are all used for treatment of TB

17. Signs and symptoms of TB include:

a. coughing up blood, chest pain, sneezing

b. Long term cough, chest pain, coughing up blood

c. Chest pain, shortness of breath, migraine headaches

d. long term coughing, coughing up blood, increased appetite

18. The side effects of medication taken for TB include:

a. yellowish eyes or skin

b. abdominal pain

c. Increased symptoms with alcohol use

d. All of the above

19. It is important to use alternate birth control methods when

a. Inactive 18 IS present

b. exposed to TB

c. Taking Rifampin to treat TB

d. None of the above

20. TB is:

a. preventable

b. treatable

c. dangerous to those with a weakened immune system

d. all of the above

ANSWER SHEET

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
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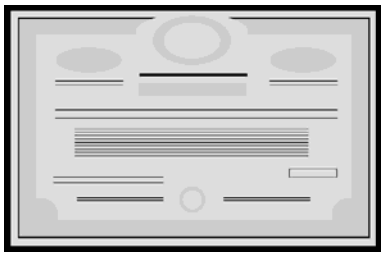

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TB INSERVICE

Date of course: _____

Agency: _____

Presented by: _____
(Signature of presenter, or write “self-study”)

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HOME HEALTH

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At Wellspring Home Health Center, you're cared for like a family.

Team Wellspring,

With the coronavirus outbreak, please let us all take the necessary measures to protect ourselves, families, patients and the community around us.

Guidelines for treating or suspecting someone with COVID 19

Please when making a home visit make sure to use the following questions to identify the risk for having COVID19 infection: Asked the following questions before visiting your patients:

For Patients:

1. Have they travel out of the country in the last 14 days?

2. Do they have any signs and symptoms of a respiratory infection, such as fever, cough and sore throat?

3. In the last 14 days have they contacted or have contact with anyone under investigation for COVID19 or respiratory illness?

If they answer YES to any of this question, they must wear face mask and report to your clinical director immediately, local and Department of Health.

The Washington State Department of Health has established a call center to address questions from the public. If you have questions about what is happening in Washington State, how the virus is spread, and what to do if you have symptoms, please call 1-800-525-0127 and press #.

Washington State Department of Health (DOH) and Centers for Disease Control (CDC) share information about COVID-19 at:

- https://www.doh.wa.gov/Emergencies/Coronavirus#beprepared
- https://www.cdc.gov/coronavirus/2019-ncov/index.html
- https://www.cdc.gov/coronavirus/2019-ncov/faq.html

A Washington State DOH phone line is also available for any questions. Call 1-800-525-0127 and press #.

FOR Employee's:

Please if you have any signs and symptoms of a respiratory infection, please stay home or if you develop signs and symptoms of a respiratory infection while on the job stop working immediately and put a facemask. and make sure to use CLOROX wipes and wipe down all equipment that you touch or work with to prevent the spread or the virus and to keep us all Safe.

Thank you

Management Staff

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An Infection Control Module: **Standard Precautions**

INSTRUCTIONS FOR THE SUPERVISOR

Step One:

- Make a copy of the Instructions for the Learner page. Return your original to the sheet protector. Add the following information to the copy:
    1. The name (or position) of the person to whom the aides should direct questions.
    2. The name (or position) of the person to whom the aides should turn in their quizzes.
    3. The date by which the quiz page should be turned in.
    4. The name (or position) of the person who will initial the aides' Inservice Club Membership Cards.
- Use this copy as your "master" as you make up the inservice packets.

Step Two:

- Have the following copied for each learner:
    1. The **Instructions for the Learner** page.
    2. The **11 Page** Inservice newsletter.
    3. OPTIONAL: Your workplace policy on handwashing and handling exposures to bodily fluids.
    4. The **Quiz** page.

Step Three:

For Self-Study Use

- Distribute as desired—in employee mailboxes; folded in paychecks, etc.
- You may want to post the Quiz Answer Sheet in a prominent spot.

For Group Use

- Read over the Suggested Participatory Activities, the Suggested Teaching Tips and the Suggested Discussion Questions.
- Select the activities you want to use during your inservice hour.

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SUGGESTED PARTICIPATORY ACTIVITIES

ACTIVITY # 1: THE DO OR DON'T QUIZ

- Make copies of the Do or Don't Quiz included in this inservice and hand out to participants.
- Have them mark their answers then review it with the answer key.
- Discuss any items which were answered incorrectly.

ACTIVITY #2: PROTECTIVE EQUIPMENT RELAY RACE

- Divide your group into teams of 4 people each. Or, if your group is large, ask for volunteers to make up at least *two teams* of 4 people each.
- Set up a "station" across the room for each team that contains a supply of gloves, gowns, masks, etc.
- Line up your teams and give them the following instructions:

  Player One: Prepare yourself for giving a bath to a patient with chickenpox/shingles.

  Player Two: Prepare yourself for helping a nurse suction a patient with pneumonia.

  Player Three: Prepare yourself to empty a bedpan.

  Player Four: Prepare yourself to transfer a patient with scabies from the bed to a wheelchair.
- Have the teams race. The first team to finish correctly wins.
- Have each player of the winning team explain how she/he decided what to put on.
- Now, have each player take off the gloves, gown, mask, etc. the proper way!

ACTIVITY #3: INFECTION CONTROL DETECTIVES—A TEAMBUILDING ACTIVITY!

Explain to the group that it takes a whole team, working together with the common goal of complete "infection control" to break the chain of infection. Use this activity to reinforce the concepts learned in this inservice, and to enhance collaboration, cooperation and communication among your team.

- Have everyone work as a group or break larger groups into teams. Announce that everyone is now an official epidemiologist, or "infection control detective"!
- Give each group a copy of the "Memo" included in this packet. This outlines the problem.
- Now, challenge the group (or groups) to come up with some solutions.
- Solutions to the problem may vary. So, be sure to explain that this is a real world problem that doesn't have a single "right" solution. The most logical conclusion will be if your team recognizes that the infections are all "contact" transmissions and that handwashing education is probably needed.
- The point of the exercise is to get the group thinking about infection control from the "big picture" view and to help them understand that they each have an important role to play.

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SUGGESTED TEACHING TIPS

TEACHING TIPS

- Make an overhead of the Quiz Answer Sheet, and the Do and Don't Quiz answer sheet.
- Take advantage of this inservice time to go over your workplace policies on handwashing and handling exposure to bodily fluids.
- Take some time to allow participants to discuss their reaction to:
  - The "Get Out" box on page 6.
  - The "Connect It Now" box on page 7.
  - The "Next Step" box on page 9.
- Create a display table with various infection control items like gowns, gloves, masks, biohazard bags, etc. Make sure everyone on your staff knows how to find these items when needed.
- The CDC has facilities in Alaska, Georgia, Ohio, Colorado, West Virginia, Pennsylvania, North Carolina, Washington and Washington, DC. If there is a facility near you, you may be able to get a CDC employee to come and do a follow-up inservice with your staff. The address for the main headquarters of the CDC is 1600 Clifton Road NE, Atlanta, GA 30333.

RESOURCES

The following resources were used in developing this inservice. You might want to check them out for further information:

- www.cdc.gov
- www.osha.gov
- www.icna.co.uk/default.asp
- info.med.yale.edu/ynhh/infection/welcome.html
- Basic Infection Control for the Health Care Professional by Michael Kennamer
- Mosby's Essentials for Nursing Assistants by Sheila A. Sorrentino, et al

PLEASE NOTE:

Your staff may enjoy the following related In the Know inservices:

- Client Safety Tips
- Home Care Safety Tips
- Infection Control in the Home
- A Tuberculosis Update
- And Infection Control Update
- Handwashing
- Understanding Drug Resistant Bacteria
- Understanding MRSA
- Protecting Your Clients During Flu Season

If your In the Know library doesn't include these titles, they are available for purchase by calling our toll-free number:

877-809-5515

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SUGGESTED DISCUSSION QUESTIONS

DISCUSSION QUESTION #1

Handwashing is the single most important thing you can do to prevent the spread of infections. Can you think of *at least* six times during your day when your should wash your hands? (Have participants call out answers and write them on an overhead or flipchart to keep track).

Possible answers include:

1. When visibly contaminated.
2. Before and after every client contact.
3. After removing gloves.
4. Before eating, drinking or applying makeup.
5. After using the bathroom.
6. Just before leaving work to go home.

DISCUSSION QUESTION #2

Study after study reveals that healthcare workers in general, and nurses and nursing assistants in particular, have a very high rate of non-compliance with standard precautions guidelines. This means that in spite of all the teaching and preaching about the dangers of spreading infections, nurses and nursing assistants continue to ignore handwashing guidelines and fail to use personal protective equipment properly. Why do you think this is the case? And, what do you think can be done to change the situation?

HERE ARE MORE QUESTIONS THAT MAY SPUR SOME INTERESTING DISCUSSION:

- In this inservice you learned that following Standard Precautions is regulated under federal law and mandated in all US healthcare settings. However, there is no direct enforcement or consequence for failing to follow these guidelines. Do you think more strict enforcement of the guidelines would make healthcare settings safer places for clients? How would you feel if you could be charged with a federal offense for failing to wash your hands properly at work? What if you could lose your job for ignoring contact precautions?
- If you noticed that a co-worker never washed his or her hands between clients, what would you do—and why?

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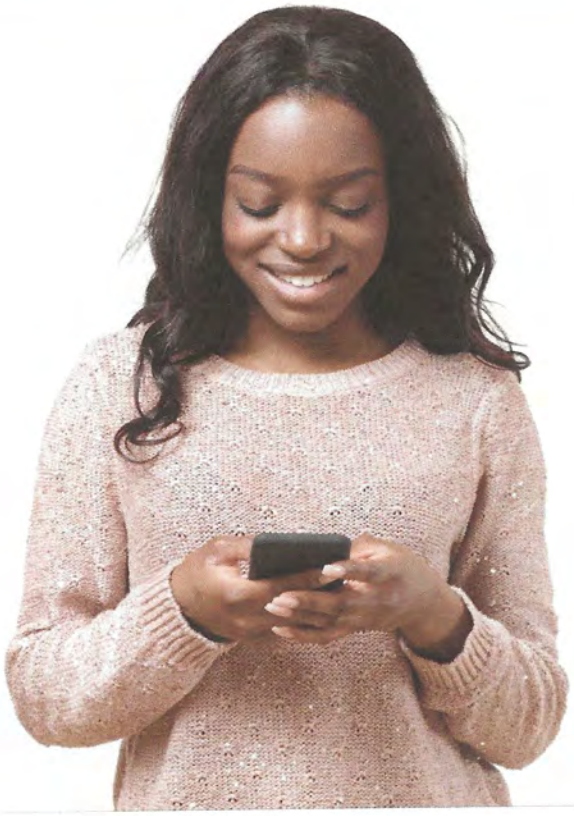

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KEYWORD SEARCHABLE WIKI: Whether on the job or on the run, give caregivers ***instant access to important resources*** right from their smartphone!

TRACK PROGRESS AND RUN REPORTS: Easily monitor your team's progress in courses, keep certificates all in one place, and generate reports that satisfy surveyors.

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QUIZ ANSWER KEY

1. **Standard Precautions protect:**
   D. All of the Above.

2. **The Chain of Infection starts with:**
   A. An infectious agent. Remember, you can break this part of the chain by CLEANING! Cleaning the environment removes infectious agents. Without infectious agents . . . there is no chain of infection!

3. **A client is on contact precautions for MRSA. What personal protective equipment will you need to care for this client?**
   B. Gown and gloves. Contact precautions are used when the person has an infection that is transmitted though direct or indirect contact. Gown and gloves should be put on before entering the care area and removed prior to leaving the area. Hands must be washed after removing the gown and gloves.

4. **A client with the flu should be placed on:**
   B. Droplet precautions. Droplet precautions require you to wear a mask whenever you are within 3 feet of the clients.

5. **False**
   Wearing gloves should never take the place of washing hands!

6. **True**
   Sadly, most healthcare workers do not wash their hands as often as they should. There are many reasons for this. And, the reasons should be addressed so a suitable solution can be found.

7. **True**
   Standard precautions are regulated by OSHA. OSHA regulations are federal laws. So, following standard precautions is federally mandated in all US healthcare settings.

8. **False**
   It's **NEVER** okay to share equipment between two clients on contact precautions—ESPECIALLY if they have different infections.

9. **False**
   Bodily fluids like urine and vomit should be **FLUSHED DOWN THE TOILET**.

10. **Fill in the Blank**
    The most common way infections are spread in the healthcare setting is by the **HANDS** of healthcare workers.

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THE DO OR DON'T QUIZ

DIRECTIONS: For each question below, mark "Do" or "Don't".

	DO	DON'T
1. Wash your hands between every client.	_____	_____
2. Use the same pair of gloves on more than one client as long as you rinse them off between clients.	_____	_____
3. Use Standard Precautions on all clients where you have contact with body fluids or broken skin.	_____	_____
4. Wear gloves in place of handwashing.	_____	_____
5. Use the same pair of gloves when performing tasks on different body sites on the same client.	_____	_____
6. Use a dirty gown again as long as you have washed your hands.	_____	_____
7. Wear eye protection and gown if you may be splashed with body fluids	_____	_____
8. Put a mask on clients on airborne or droplet precautions if they have to be around uninfected people for a short period of time.	_____	_____
9. Move a client on airborne or droplet precautions from the room if it isn't absolutely necessary.	_____	_____
10. Put clients on additional precautions in the same room with people who have the same disease.	_____	_____
11. Recap a used needle if you find it.	_____	_____
12. Put used needles only in puncture-resistant containers.	_____	_____
13. Change gloves immediately if they are torn.	_____	_____
14. Remind your coworkers to use Standard Precautions.	_____	_____
15. Multi-task and take shortcuts in your work whenever possible.	_____	_____

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THE DO OR DON'T QUIZ—ANSWER KEY

DIRECTIONS: For each question below, mark "Do" or "Don't".

	DO	DON'T
1. Wash your hands between every client.	X	
2. Use the same pair of gloves on more than one client as long as you rinse them off between clients.		X
3. Use Standard Precautions on all clients where you have contact with body fluids or broken skin.	X	
4. Wear gloves in place of handwashing.		X
5. Use the same pair of gloves when performing tasks on different body sites on the same client.		X
6. Use a dirty gown again as long as you have washed your hands.		X
7. Wear eye protection and gown if you may be splashed with body fluids	X	
8. Put a mask on clients on airborne or droplet precautions if they have to be around uninfected people for a short period of time.	X	
9. Move a client on airborne or droplet precautions from the room if it isn't absolutely necessary.		X
10. Put clients on additional precautions in the same room with people who have the same disease.	X	
11. Recap a used needle if you find it.		X
12. Put used needles only in puncture-resistant containers.	X	
13. Change gloves immediately if they are torn.	X	
14. Remind your coworkers to use Standard Precautions.	X	
15. Multi-task and take shortcuts in your work whenever possible.		X

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INFECTION CONTROL DETECTIVES: MEMO

SUNSHINE CENTER HAPPY HOME FOR SENIORS

To: The Infection Control Detectives
From: Candy Barr RN, Nurse Manager
Date: August 23, 2011
Re: Increase in Healthcare Associated Infections for the past quarter

The healthcare associated infection rates of our residents for the past quarter have more than *doubled* from the usual 10 percent to 25 percent. It is clear that we have a breach in infection control. I have listed the infections and their rates below.

Having all these infections causes many problems. Our residents are not receiving the care they deserve, the length of stay has increased and we could lose our accreditation.

By the end of the day today, I expect you to have had meetings with all of the employees to discuss this crisis and report back to me with solutions. We will meet in my office at 4pm today.

Please contact me if you have any questions at (212) 555-7111. Thank you in advance for responding to this most urgent matter.

HEALTHCARE ASSOCIATED INFECTION RATES FOR 2ND QUARTER:

- E. coli—3% increase (10 residents)
- Surgical wound infections—3% increase (8 residents)
- MRSA—6% increase (20 residents)
- Hepatitis A—2% increase (2 residents)

DECIDE WITH YOUR TEAM:

- You've been asked to interview the staff. What exactly do you want to ask them, and why?
- Look at the infections and decide how each is transmitted. Based on this information—what infection control measure is most likely being ignored?
- Do you need to see the charts to find out exactly which members of the healthcare team cared for each client with a new infection? Why or why not?
- What solution do you propose to prevent further outbreaks?
- How will you present or "teach" your solution to the staff?

inthe**know**
CAREGIVER TRAINING

An Infection Control Module: **Standard Precautions**

EVALUATION

Employee Name_____

Date_____ ❑ **Self-Study Inservice** ❑ **Group-Study Inservice**

1. Put a checkmark in the box that best describes how you feel about each learning objective.

LEARNING OBJECTIVE	I am able to do this.	I might be able to do this.	I can't do this.	I'm not sure.
Describe standard precautions and discuss why they are so important in the healthcare setting.				
List at least five of the "Top Ten" standard precaution guidelines.				
Discuss the difference between standard precautions and transmission-based precautions.				
Explain how healthcare workers can break the chain of infection.				
Demonstrate proper infection control precautions in your daily work.				

2. Did you learn anything new that will help you in your job? ❑ **Yes** ❑ **No**

If yes, please explain:_____

_____

_____

3. If you have questions about the inservice information that did not get answered, note them here:

_____

_____

4. Other comments? _____

_____

_____

_____

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CAREGIVER TRAINING

Certificate of Completion

This certifies that

has successfully completed one hour of continuing education on the topic of

Standard Precautions

on this day

Every In the Know course is approved for all caregivers (CNA, HHA, PCA, CHHA, etc.) in all states.
Courses are written especially for caregivers by registered nurses. The learner had the opportunity to contact In the Know at 877-808-5515 to speak to a registered nurse regarding any questions about the content.

Washington DSHS CE Code: CE121868

Florida Board of Nursing CE Provider #: 50-16953, **Topic Approval Code:** 20-511075

California Dept. of Public Health Approval: NAC# 7036

Exhibit 13.

Wellspring Quality Improvement Program Policy

WAC 246-335-555
QUALITY IMPROVEMENT PROGRAM

In compliance with Conditions of Participation under WAC 246-335-555, personnel, contractor, and volunteer records, Wellspring Home Health Center, LLC **develops and operationalize policies and procedures that describe:**

Quality Assessment and Performance Improvement (QAPI) Program

1. Wellspring Home Health Center, LLC has a QAPI Program that is implemented by a QAPI Committee. The QAPI Program must be ongoing, focused on patient outcomes that are measurable, and have a written plan of implementation. The QAPI Committee must review and update or revise the plan of implementation at least once within a calendar year, or more often if needed.
2. The QAPI program will ensure mechanisms to:
    a. Identify problems;
    b. Recommend appropriate action; and
    c. Implement recommendations.
3. The QAPI Program must include:
    a. A system that measures significant outcomes for optimal care.
    The QAPI Committee uses the measures in the care planning and coordination of services and events. The measures include the following as appropriate for the scope of services provided by Wellspring HHA: an analysis of a representative sample of services furnished to patients contained in both active and closed records.
    b. A review of:
        1. negative patient care outcomes;
        2. complaints and incidents of unprofessional conduct by a licensed staff and misconduct by unlicensed staff;
        3. infection control activities;
        4. medication administration and errors; and
        5. effectiveness and safety of all services provided, including:
        6. the competency of Wellspring clinical staff;
        7. the promptness of service delivery; and
        8. the appropriateness of Wellspring responses to patient complaints and incidents;
        9. a determination that services have been performed as outlined in the individualized service plan, care plan, or plan of care; and
        10. an analysis of patient complaint and satisfaction survey data; and
        11. An annual evaluation of the total operation, including services provided under contract or arrangement.

1. Wellspring uses the evaluation to correct identified problems and, if necessary, to revise policies.
    1. Wellspring must document corrective action to ensure that improvements are sustained over time.
    2. Wellspring must immediately correct identified problems that directly or potentially threaten the patient care and safety.

2. QAPI documents must be kept confidential and be made available to Washington state regulatory personnel upon request.

QAPI Committee Membership:

At a minimum, the QAPI Committee must consist of:

a. The administrator;
b. The director, supervising nurse or therapist or the supervisor of Wellspring licensed to provide personal assistance services and
c. An individual representing the scope of each service provided by Wellspring.

Frequency of QAPI Committee meeting:
The QAPI Committee must meet quarterly as per Wellspring requirements and reports to the Governing Body through the PAC committee at least two times per year.

QAPI Policy:

It is the policy of Wellspring to implement and maintain a Quality Assessment and Performance Improvement (QAPI) Program. This program is designed to have a method of objectivity and systematically monitor and evaluate the quality and appropriateness of patient care.
It also demonstrates Wellspring's commitment to continually provide quality health care.
The committee members consisting of the Administrator, Director of Clinical Services, community representative, and, a member from each service discipline Wellspring offers.
The term is three years. This term may be renewed for an additional three years by the Administrator.
None of the information, interviews, reports, statements, memoranda and recommendations produced during or resulting from Wellspring's quality improvement program may be admissible as neither evidenced nor be discoverable in any action of any kind in any court, as provided in Article VIII, Part 21 of the Code of Civil Procedure (Medical Studies).
Wellspring Home Health Center, LLC is a private, for-profit, certified and licensed home health Agency providing service to all patients without regard to racial ethnicity, religion, age, gender, sexual orientation, or handicap.
The goal of Wellspring Home Health Center, LLC is to continuously improve the quality of services rendered.
The responsibility of the QAPI Committee will be to assist in carrying out the objectives and activities of monitoring and evaluating as identified in the QAPI Plan.

Wellspring Home Health Center, LLC QAPI program consists of but is not limited to the following:

1. Program/staff performance assessment activities.
2. Staff recruitment, training, orientation and continuing education programs.
3. Case conferences.
4. Management meetings.
5. Ongoing review of clinical records.
6. Clinical staff peer review activities.
7. Review of records requested by utilization/record review.
8. High volume services, conditions, or diagnoses.

9. Evaluation of systems designed to support clinical operations.
10. Compliance with clinical practice standards and recognized professional standards.
11. Program evaluations based upon measurable objectives, patient outcomes and cost effectiveness.
12. Management systems that support infection control functions.
13. Patient/physician satisfaction assessment.
14. Quality control activities.
15. Annual program evaluation.
16. Orientation/training program.
17. Continuing education.
18. Performance appraisals
19. Re-prioritization of performance activity.

Exhibit 14.

Key Personnel Information

United States Army

Chaplain (Lieutenant Colonel) Ernest M. Ibanga

Pastoral Care Coordinator
Joint Base Lewis-McChord, Washington
President – Wellspring Home Health Center, LLC

SOURCE OF COMMISSIONED SERVICE
Direct Appointment

EDUCATIONAL DEGREES
Biola University: Bachelor of Arts in Biblical Studies
Biola University: Master of Arts in Theological Studies
Lincoln Christian University: Master of Divinity
Texas A&M University: Master of Science in Counseling Psychology
Dallas Theological Seminary: Doctor of Ministry

MILITARY SCHOOLS ATTENDED
United States Navy Hospital Corpsman Basic Course
United States Navy Chaplain Basic Officer Course
United States Army Chaplain Basic Officer Course
United States Army Family Life Chaplain Training
United States Army Clinical Pastoral Education
United States Army Command General Staff College
United States Army Chaplain COL/LTC Course

PROMOTIONS	DATES OF APPOINTMENT
Ensign	20 April 1999
1LT	30 December 2000
CPT	2 August 2001
MAJ	4 March 2009
LTC	2 May 2016

FROM	TO	ASSIGNMENT
Apr 97	Apr 99	Hospital Corpsman, United States Naval Hospital, Great Lakes, Illinois
Apr 99	Dec 01	Staff Chaplain, US Naval Training Center, Great Lakes, Illinois
Jan 01	Mar 01	Staff Chaplain, US Coast Guard Support Center, Elizabeth City, NC
Apr 01	Apr 03	Battalion Chaplain, 57th Signal Battalion, Fort Hood, TX
May 03	Dec 03	Brigade Chaplain, 3rd Signal Brigade, Fort Hood, TX
Jan 04	Dec 04	Brigade Chaplain, Joint Task Force Phantom, Baghdad, Iraq

Jun 05	Oct 05	Battalion Chaplain, 551st Signal Battalion, Fort Gordon, Georgia
Oct 05	Jun 07	Battalion Chaplain, 369th Signal Battalion, Fort Gordon, Georgia
Jul 07	Oct 08	Battalion Chaplain, 63rd Expeditionary Signal Battalion, Balad, Iraq
Nov 08	Aug 10	Battalion Chaplain, 63rd Expeditionary Signal Battalion, Fort Gordon, Georgia
Aug 10	Jan 12	Brigade Chaplain/Family Life Chaplain, 4th Sustainment Brigade, Fort Hood, Texas
Jan 12	May 13	Deputy Command Chaplain/Family Life Chaplain, 13th Expeditionary Sustainment Command, Fort Hood, Texas
Sep 13	May 14	Brigade Chaplain, 2nd Engineer Brigade, Joint Base Elmendorf-Richardson, Alaska
May 14	Aug 14	Brigade Chaplain, Joint Task Force Trailblazer, Bagram, Afghanistan
Aug 14	Aug 15	Pastoral Coordinator, Joint Base Elmendorf-Richardson, Alaska
Aug 15	Jun 18	Garrison Chaplain, United States Army Garrison, Fort Greely, Alaska
Jun 18	Present	Pastoral Coordinator, Joint Base Lewis-McChord, Washington

SUMMARY OF JOINT ASSIGNMENTS	**DATE**	**GRADE**
Brigade Chaplain, Joint Task Force Phantom, Baghdad, Iraq	Jan 04 - Dec 05	CPT
Brigade Chaplain, Joint Task Force Trailblazer, Bagram, Afghanistan	May 14 - Aug14	MAJ
Pastoral Coordinator, Joint Base Elmendorf-Richardson, Alaska	Aug 14 - Aug 15	MAJ
Pastoral Coordinator, Joint Base Lewis–McChord, Washington	Jun 18 – Present	LTC

SUMMARY OF COMBAT DEPLOYMENTS	**DATE**	**GRADE**
Brigade Chaplain, Joint Task Force Phantom, Baghdad, Iraq	Jan 04 - Dec 05	CPT
Battalion Chaplain, 63rd Expeditionary Signal Battalion, Balad, Iraq	Jul 07 - Oct 08	CPT
Brigade Chaplain, Joint Task Force Trailblazer, Bagram, Afghanistan	May 14 - Aug 14	MAJ

US DECORATIONS AND BADGES

Bronze Star Medal
Meritorious Service Medal (with 4 Oak Leaf Clusters)
Army Commendation Medal (with 1 Oak Leaf Cluster)
Army Achievement Medal
Meritorious Unit Commendation
National Defense Service Medal
Afghanistan Campaign Medal(with one bronze Service Star)
Iraq Campaign Medal (with three bronze Service Stars)
Global War on Terrorism Expeditionary Service Medal
Global War on Terrorism Service Medal
Army Service Ribbon
Army Overseas Service Ribbon (with award numeral "2")
NATO Medal
Navy Unit Commendation
Navy Pistol Sharpshooter Ribbon

Joyce Ibanga 706-833-7205/706-833-9917

261 W. RIVERDANCE CIRCLE *WASILLA, AK 99654*

Jeibanga@aol.com

OBJECTIVE: To secure a position as a Home Health Care Agency Administrator

EDUCATION

Grand Canyon University
3300 W Camelback Road, Phoenix, AZ 85017
Master of Science in Health Care Administration – IN PROCESS
Graduation Date: July 2021

Grand Canyon University
3300 W. Camelback Road, Phoenix, AZ 85017
Bachelor of Science: Health Science in Professional Development & Advanced Patient Care
Graduation Date: November 30, 2014

Temple College
2600 S First Street, Temple, TX 76504
Associate of Applied Science Advanced Respiratory Care
Graduation Date: May 12, 2012

HIGHLIGHTS OF CERTIFICATIONS

- Bachelor of Science: Health Science in Professional Development & Advanced Patient Care
- Associate Degree in Registered Respiratory Therapist
- Texas Respiratory Therapist License
- BSL Certified

WORK EXPIERENCE

Wellspring Home Health Center, LLC
201 E Swanson Avenue., Suite 7
Wasilla, AK 9965 &
5700 Old Seward HWY, Suite 102
Anchorage, AK 99508
Job Title: Administrator/CO-CEO
July 2015 to Present

- Responsible for the overall management of the Home Health Agency program.
- Responsible for hiring, training, supervising, managing performance and discipline of all administrative and direct care employees and contract staff.

- Responsible for requesting, recording/tracking, and storage of all required proof of training and certifications for employees and contract staff.
- Ensures compliance with all Alaska & Washington state and federal laws and maintain proper licensure for the Alaska & Washington State Home Health Agency.
- Maintains agency documents for each employee and contractor to ensure proper retention requirements.
- Required to maintain processes and procedures to ensure that the selection, documentation, screening and verification of credentials for all contractors referred by the agency to meet Florida state requirements.
- Prepares for and responds to Alaska & Washington Agency for Health Care Administration communication and audits in a timely manner.
- Make sure the alternate administrator, must be available to the public for any eight consecutive hours between 9 a.m. and 5 p.m., Monday through Friday of each week, excluding legal and religious holidays. Available to the public means being readily available on the premises or by telecommunications.
- Make sure the alternate administrator or our On-Call Registered Nurse (RN), is available 24 hours per day, 7 days per week for emergency phone calls, transportation of customers who are discharged from the hospital on weekends, to address caregiver or client concerns, to appropriately manage staffing, and to respond to calls from CHAP if necessary.
- Responsible to partner with the compliance department in maintenance and updating of the emergency management plan and registration of the emergency management plan with the county.
- Coordinates patient care services and oversee scheduling procedure
- Sets or adopts policies for and keep records of criteria for admission to service, case assignments and case management
- Manages client´s records accessibility to ensure employees and contract staff has necessary access.
- Notifies families of needs or problems.
- Keeps accurate records for emergencies on file regarding health condition.
- Completes incident reports and ensure proper safety processes are being followed.
- Ensures timely and appropriate response to customer/family concerns.
- Maintains privacy and confidentiality of records, conditions, and other information relating to clients, employees and facility.
- Assures quality client care is provided consistent with company policies and budget objectives.
- Attends all mandatory meetings and in-service training sessions & Conferences to keep up with both Federal & States regulations.
- Pursues record keeping, filing and extensive usage of DATASOFT Logic Software System for the entire agency´s administration process.
- Has ability to travel as needed to a fourth our Alaska and Washington locations.
- Use my own vehicle for travel & maintain a valid driver’s license and automobile insurance coverage in limits that meets or exceeds Company standards.

Providence Alaska Medical Center
3200 Providence Dr., Anchorage, AK 99508
December 13, 2014 to present
Job Title: Registered Respiratory Therapist

- Responsible for assessing the patient's respiratory status and recommending appropriate therapies.
- Implement therapies and evaluate patient response to therapeutic interventions.
- Access, analyze, customize, coordinate and communicate the patient's plan of care and actively collaborate with other members of the health care team.
- Perform mechanical ventilation set-ups, High flow and Noninvasive ventilation/Cpap set ups, monitoring, assessment of equipment/patient interfaces, and makes appropriate changes based on ABGs for both pediatric and adult ventilators.
- Communicate patient's status to health care team.
- Dispense prescribed Respiratory Therapy medications and consult with staff physicians regarding orders related to Respiratory Therapy services

Providence Transitional Care Center
910 Compassion Circle, Anchorage, AK 99503
February 3, 2014 – to Present
Job Title: Registered Respiratory Therapist Supervisor

- Provides life-saving therapies by responding to code alerts, participating as a member of the profession, educate the community by participating in health education projects.
- Maintain safe, secure, and healthy work environment by establishing, following, and enforcing standards and procedures, complying with legal regulations.
- Accomplishes Respiratory Therapist human resources objectives by orienting and training new employees; communicating job expectations to adhere to policies and procedures.
- Help comply with Respiratory Therapist operational standard by contributing skills to strategic plans and implementing quality and customer service standards.
- Keep health care team members informed of patient's conditions by presenting Respiratory treatment plans to physicians, getting approvals, giving treatments, and evaluating results.
- Responsible for the assessing the patient's respiratory status and recommending appropriate therapies.
- Implement therapies and evaluate patient response to therapeutic interventions.
- Accept, analyze, customize, coordinate and communicate the patient's plan of care and actively collaborate with other members of the health care team.
- Maintains safe operation of respiratory care services equipment by adhering to governmental and hospital safety regulations, evaluating new equipment and techniques, maintaining inventory of equipment, providing preventative maintenance, troubleshooting malfunctions and arranging for repairs.
- Enhances respiratory therapy department and organizational reputation promoting pride in departmental accomplishments and exploring new opportunities to add values to individual accomplishments.

Scott and White Memorial Hospital

2401 S 31st Street, Temple, TX 76508
June 10, 2012 – August 17, 2013
Job Title: Respiratory Care Practitioner II

- Observes and assesses critically ill patients using physical examination, verbal and written
- Communication from patients, family, and other healthcare team members, critical care monitoring devices, lab and test results, and other data as relevant to patient care.
- Administering/implements therapeutic measures as ordered, including mechanical ventilation, BIPAP, CPAP, artificial airway evaluation and care, suctioning, sputum collection, administration of nebulized medications obtains and performs ABGs using I-STAT lab system, percussion and postural drainage, equipment/supply changes per hospital and department policies, and pertinent x-ray interpretation endotracheal tube placement, pneumothorax recognition, atelectasis recognition etc..
- Identifies and responds to both existing and potential emergency situations by initiating corrective treatment, medications, and emergency and resuscitative measures based on appropriate utilization and physician orders unit and hospital guidelines and ACLS protocol
- Read prescription, measure arterial blood gases, and review patient information to assess patient condition.
- Monitor patient's physiological responses to therapy, such as vital signs, arterial blood gases, or blood chemistry changes, and consult with physician if adverse reactions occur.
- Set up and operate devices such as mechanical ventilators, therapeutic gas administration apparatus, environmental control systems, or aerosol generators, following specified parameters of treatment.
- Enforce safety rules and ensure careful adherence to physicians' orders.
- Explain treatment procedures to patients to gain cooperation and allay fears.
- Relay blood analysis results to a physician.
- Maintain charts that contain patients' pertinent identification and therapy information.
- Work as part of a team of physicians, nurses, or other healthcare professionals to manage patient care by assisting with medical procedures or related duties.
- Inspect, clean, test, and maintain respiratory therapy equipment to ensure equipment is functioning safely and efficiently, ordering repairs when necessary.

Metroplex Health System
2201 S. Clear Creek Road, Killeen, TX 76549
July 5, 2012 – August 27, 2013
Job Title: Registered Respiratory Therapist

- Patient Assessment/Plan of Care Obtains/verifies physician order for therapy and validate for appropriateness. Reviews available medical records and obtain pertinent medical history from patient or family.

- Evaluates each patient using age and diagnosis appropriate assessment tests and measurements. Applies appropriate patient care interventions according to protocol guidelines and priority of care.
- Demonstrates competence in the performance of age appropriate patient assessment and individualizes care based on age specific needs Patient Treatment Uses therapeutic treatment techniques appropriate to patient age and desire for treatment.
- Performs treatment procedures that are within the scope of the professional license.
- Performs/delegates technical procedures appropriately and safely. Determine patient response to treatment and evaluate progress (reassessment).
- Educates patient and family through instruction, demonstration, or appropriate handouts in treatment plan, safety issues, and home programs/self-management.
- Maintain bedside and ventilator alarms in audible position.
- Maintains patient safety throughout treatment.
- Communicates with physicians and other healthcare personnel as appropriate regarding patient care issues.
- Demonstrates competence in the performance of age appropriate patient treatment and individualizes care based on age specific needs.
- Administers medication in a safe/correct manner, adhering to medication administration guidelines.
- Reports unsafe conditions and equipment in proper/timely manner.
- Responds to emergency situations.

CSRA Sleep Disorder Center, LLC
211 Pleasant Home Road, Augusta, GA 30907
May 5, 2007 – Dec 15, 2009
Job Title: Sleep Lab Technician & Supervisor

- Direct, Manages, and Coordinate the daily administrative and technical operations of the laboratory operated by the CSRA Sleep Disorder Center
- Provide Supervision, Training, Orientation, Competencies, and performance evaluations and performance improvement plan to all technical staff
- Provide oversight of clinical and operational services, and oversight and adherence to sleep Lab protocols
- Implement written or verbal order from a licensed physician that requires the practice of polysomnography.
- Positive airway pressure titration on spontaneously breathing patients
- Supplemental low flow oxygen therapy during polysomnogram (up to six (6) liters per minute) Continuous Pulse oximetry.
- Sleep staging, including surface electroencephalography, surface electrooculography, and surface submental electromyography
- Respiratory effort monitoring including thoracic and abdominal signals
- Nasal and oral airflow monitoring
- Body temperature monitoring
- Audio/video monitoring of movement and behavior during sleep

- Monitoring positive airway pressure modalities used to treat sleep related breathing disorders.
- Providing Durable Medical Equipment (DME) to patients
- Coordinating patient care and education
- Therapy compliance
- Educating patients and their caregivers
- Promoting health and wellness

Medical College of Georgia
1120 15th Street, Augusta, GA 30912
Jan 28, 2004 – Dec 11, 2008
Job Title: Unit Secretary

- Answer telephones and direct calls to appropriate staff.
- Schedule and confirm patient diagnostic appointments, surgeries, or medical consultations.
- Greet visitors, ascertain purpose of visit, and direct them to appropriate staff.
- Operate office equipment, such as voice mail messaging systems, and use word processing, spreadsheet, or other software applications to prepare reports, invoices, financial statements, letters, case histories, or medical records.
- Complete insurance or other claim forms.
- Interview patients to complete documents, case histories, or forms, such as intake or insurance forms.
- Receive and route messages or documents, such as laboratory results, to appropriate staff.
- Compile and record medical charts, reports, or correspondence, using typewriter or personal computer.
- Transmit correspondence or medical records by mail, e-mail, or fax.
- Maintain medical records, technical library, or correspondence files.

REFERENCES AVAILABLE UPON REQUEST

Resume for Carol Tracy Schneer, RN

Applicant Name: Carol Tracy Schneer, RN
Address: P.O. Box 521252
Telephone (907) 414-8097
Email Address: cross@wellspringhomehealth.com

Wellspring Home Health Center, LLC
201 E Swanson Ave., Suite 7, Wasilla, AK 99654
Program Administrator for Wellspring Home Health Center

Employment

Current Employer

Wellspring Home Health Center, LLC
Mailing Address: 201 E Swanson Ave., Suite 7, Wasilla, AK 99654
Physical Address: 201 E Swanson Ave., Suite 7, Wasilla, AK 99654
Telephone: (907) 357-3655
Name of contact who can verify employment: Joyce Ibanga
Position: Director of Nursing
Full-time or part-time, hours worked per week 40 hours
Dates of employment (Month and year to Present)
January 9, 2017 to current
Duties:

- Immediate supervisor for RN, PT, PTA, LPN, ST, CNA
- Complete all QA processes/measures for Agency
- Complete/coordinate Case Management/Utilization reviews process

Past Employer

Mat Su Regional Home Health and Hospice
Mailing Address: 950 East Bogard Road, Ste 132, Wasilla, AK 99654
Physical Address: 950 East Bogard Road, Ste 132, Wasilla, AK 99654
Telephone: (907) 352-4800
Name of contact who can verify employment: MatSu Regional Medical Center HR Dept
Position: Clinical Director
Full-time or part-time, hours worked per week 40
Dates of employment (Month and year to Present)
September, 2014 – December, 2016
Duties:

- Review all Oasis and 485 POC, approve and process all physician orders and coordination notes
- Attend corporate meetings and educational seminars
- Case Management/Utilization review/QA processes
- Direct supervisor for all clinical staff including: RN, LPN, PT, ST, CNA
- Participate/coordinate/assist Administrator in any site surveys or review processes

Past Employer

Copper River Native Association (CRNA)
Mailing Address: Mile 111.5 Richardson Hwy, Copper Center, AK
Physical Address: Mile 111.5 Richardson Hwy, Copper Center, AK
Telephone: (907) 822-5241
Name of contact who can verify employment: Robert Ottone, CEO
Position: Clinic Manager

Full-time or part-time, hours worked per week: 40
Dates of employment (Month and year to Present)
March, 2014-September, 2014

Duties:

- Responsible for all day-to-day operations of the urgent care/outpatient clinic
- Immediate supervisor for Provider staff including: MD, CNP, MA, RN/LPN, CHA II-!V and administrative staff
- Provide direct skilled nursing care to patients
- Case Management Utilization reviews
- Participate in Wellness/Diabetes programs/grants

Past Employer

Divine Home Care of Ohio, LLC
Mailing Address: 904 N. Cable Road, Lima, OH 45805
Physical Address: 904 N. Cable Road, Lima, OH 45805
Telephone: (419) 222-9410
Name of contact who can verify employment: Dawn Good
Position: Director of Nursing
Full-time or part-time, hours worked per week: 40
Dates of employment (Month and year to Present)
August, 2012 through February, 2014
Duties:

- Responsible for all clinical aspects of home health organization
- Immediate supervisor for nurses and home health aides
- Manage scheduling/visits for all patients
- Case Management duties
- Correspond with caseworkers and State agencies for compliance/regulations
- Direct skilled nursing care to home health patients

Past Employer
Aspire Home Health Care Services, LLC
Mailing Address: 12 E. Auglaize Street, Wapakoneta, OH 45895
Physical Address: 12 E. Auglaize Street, Wapakoneta, OH 45895
Telephone: (419) 738-1176
Name of contact who can verify employment: Carol Schneer (self)
Position: Director of Nursing/Co-Owner
Full-time or part-time, hours worked per week: 40 hours
Dates of employment (Month and year to Present)
April, 2011 through August, 2012
Duties:

- Successfully owned and managed Home Health Agency and became accredited Medicare/Medicaid deemed agency through CHAP and CMS
- Responsible for all clinical aspects of home health aids
- Manage scheduling/visits for all patients
- Correspond with caseworkers and State agencies for compliance/regulations
- Direct skilled nursing care to home health patients

Past Employer
Community Home Health and Hospice Services of Lima
Mailing Address: 2440 Baton Rouge Avenue, Lima, OH 45805
Physical Address: 2440 Baton Rouge Avenue, Lima, OH 45805
Telephone: (419) 331-2273
Name of contact who can verify employment: HR Dept
Position: Director of Nursing/Clinical Manager
Full-time or part-time, hours worked per week:40
Dates of employment (Month and year to Present)
January, 2010-April, 2011

Duties:

- Responsible for all clinical aspects of home health and hospice organization
- Immediate supervisor for nurses and home health aides
- Manage scheduling/visits for all patients
- Direct skilled nursing care to home health patients

Past Employer
Heartland of Indian Lake, Lakeview, Ohio
Mailing Address: 14442 US 33, Lakeview, OH 43331
Physical Address: 14442 US 33, Lakeview, OH 43331
Telephone: (937) 843-4929
Name of contact who can verify employment: Cindy HR Dept
Position: Registered Nurse Supervisor
Full-time or part-time, hours worked per week: 36
Dates of employment (Month and year to Present)
August, 2008 through January, 2010
Duties:

- Performed skilled nursing duties to residents for all needs
- Direct supervisor to State Tested Nursing Assistants
- IV, TPN infusion therapy insertions and infusions

Education

Enrolled and attending to obtain MSN Degree, Currently, Chamberlain University
BSN, June, 2010 Ohio State University
Registered Nursing, June, 2008, James A Rhodes State College
Applied Business Administration, June 2001, Lima Technical College

Exhibit 15A.

Wellspring Home Health Center CMS Survey Activity Report

Survey Activity Report: Survey History

Provider or Supplier Name:	WELLSPRING HOME HEALTH CENTER
CMS Certification Number:	027036
Provider or Supplier Type:	Home Health Agency
Address:	201 E SWANSON AVE STE 7 WASILLA, AK 99654
Phone Number:	907 357-3655
Participation Date:	05/17/2017
Region:	(X) Seattle
Accreditation Organization:	COMMUNITY HEALTH ACCREDITATION PROGRAM
Accreditation Type:	Deemed Status
Ownership Type:	For Profit

Surveys for FY 2021 No Surveys Found

Surveys for FY 2020 No Surveys Found

Surveys for FY 2019 No Surveys Found

Surveys for FY 2018 No Surveys Found

Surveys for FY 2017

05/17/2017 STANDARD SURVEY HEALTH SURVEY

No Deficiencies Found.

No Followup Visits.

Exhibit 15B.

Community Health Accreditation Partner (CHAP)

Letter and Certificate

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

April 21, 2020

Mrs. Joyce Ibanga
Administrator
Wellspring Home Health Center, LLC
201 E. Swanson Ave., Suite #7
Wasilla, AK 99654

RE:	Customer ID:	3003211
	Service:	Home Health [Deemed]
	CCN/PTAN:	02-7036

Location and/or Site Accredited:
Wellspring Home Health Center, LLC
201 E. Swanson Ave., Suite #7
Wasilla, AK 99654

Wellspring Home Health
5700 Old Seward Hwy., Suite 102
Anchorage, AK 99518

Site Visit Dates:	February 4, 2020 - February 6, 2020
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	April 2, 2020
CHAP Accreditation Dates:	May 17, 2020 - May 17, 2023
Method of Follow-up:	Acceptable POC

Dear Mrs. Ibanga,

I am pleased to inform you that based on the findings of the site visit conducted February 4, 2020 - February 6, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Quanicia McDonald at quanicia.mcdonald@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: FEB0420_DNQ
Ref: GMCB314878

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
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April 21, 2020

Mrs. Joyce Ibanga
Administrator
Wellspring Home Health Center, LLC
201 E. Swanson Ave., Suite #7
Wasilla, AK 99654

RE:	Customer ID:	3003211
	Service:	Home Health [Deemed]
	CCN/PTAN:	02-7036

Location and/or Site Accredited:
Wellspring Home Health Center, LLC
201 E. Swanson Ave., Suite #7
Wasilla, AK 99654

Wellspring Home Health
5700 Old Seward Hwy., Suite 102
Anchorage, AK 99518

Site Visit Dates:	February 4, 2020 - February 6, 2020
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Medicare Certification:	Recertification
Deemed Status Recommendation:	Continued Deemed Status
Plan of Correction Accepted Date:	April 2, 2020
Effective Date of Accreditation:	May 17, 2020
Expiration Date of Accreditation:	May 17, 2023
Method of Follow-up:	Acceptable POC

Dear Mrs. Ibanga,

I am pleased to inform you that based on the findings of the site visit conducted February 4, 2020 - February 6, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended continued Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Quanicia McDonald at quanicia.mcdonald@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

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CC: CMS Regional Office (CMS RO X - Seattle)
CMS Central Office
State Agency

CHAP Community Health Accreditation Partner

Certificate of Accreditation

This is to certify that the following organization has met the requirements of the Community Health Accreditation Partner (CHAP) Standards of Excellence and demonstrated a commitment to providing quality patient care and services.

Wellspring Home Health Center, LLC

Wasilla, AK

is therefore granted accreditation for the following:

Home Health

Effective: May 17, 2020

Expiration: May 17, 2023

Nathan J. DeGodt
President and CEO, CHAP

Maureen A. Spivack
Chair, CHAP Board of Directors

CHAP is an independent, nonprofit accrediting body for organizations providing home and community-based health care services in accordance with nationally recognized CHAP Standards of Excellence. Additional information regarding CHAP Accreditation and a listing of individual accredited organizations can be obtained by visiting www.CHAPinc.org.

Customer ID: 3003211