

**LTS PLANNING COMMITTEE
COP VARIANCE REQUEST**

Case Manager: Sammy Azuma **Date:** 7/31/17

FUND COP SERVICES FOR PARTICIPANT RECEIVING RECUPERATIVE SERVICES IN AN INSTITUTION (UP TO 90 DAYS).

The purpose of this variance is to maintain a participant's support network during relatively brief institutional stays. No variance is needed for recuperative stays of 30 days or less. When a recuperative stay exceeds 30 days a variance is necessary to allow the use of COP funds to continue to pay for noninstitutional community service expenses for up to 90 days for current COP recipients.

1. INSTITUTION NAME: Hebron Oaks SNF

2. EXPECTED DURATION: 1-2 months

3. PARTICIPANT INFORMATION

- Male ☐ Female ☒ Age 96 Time on COP/Waiver programs 1 year, 3 months Protective Placement ☐ No ☐
- Current living arrangement: ☐ home
☐ AFH
☒ CBRF (name, size) Oakwood Village West [Tabor Oaks, 60 beds]
☐ NH (name)
- Health & medical problems (please use non-medical terms): Client was admitted to the hospital with suspected stroke-like symptoms on 7/8/17. While in the hospital, she had symptoms of difficulty swallowing, slurred speech, and facial drooping. Client discharged from the hospital to Hebron Oaks skilled nursing facility [SNF] on 7/12/17. Since arrival at SNF, she has experienced symptoms of an overactive bladder. She experienced continued weakness, especially with transfers, which she had previously completed independently. Client also experiences fatigue while ambulating, which impedes her ability to ambulate independently. She also has the following diagnoses: hypertension [high blood pressure], dizziness, head pain, degenerative joint disease/DJD [arthritis of the joints], hyponatremia [low sodium level in the blood], sciatica [pain radiating from nerves along lower back through buttocks & hip to the leg], transient ischemic attack/TIA [small strokes], hard of hearing, and anemia.
- Situation requiring rehabilitation and desired outcomes: Client is currently receiving rehabilitation services [physical and occupational therapy] at Hebron Oaks SNF to increase her strength. Client needs to be able to transfer independently to return to assisted living placement. SNF staff report that client has expressed that she is having more difficulty transferring compared to before she was hospitalized. Facility staff also reports that client is relying more on facility staff to assist with dressing, especially with pants and other lower body clothes. Facility staff reports that they will continue to work with client on occupational therapy to help her regain strength and retain as much independence as possible. Facility staff reports that client has lost weight since her hospitalization; client is receiving nutritional supplements like Ensure to help restore weight. Client's goal is to return back to her assisted living facility after completing rehabilitation. When client returns to Tabor Oaks, therapy services will continue for a couple of weeks to help client continue to gain strength. Facility staff also suggests that client continue to exercise on facility bike and walk with facility staff.

- Services to be funded during rehabilitation:

Case Management X \$552.20 [5 hours @ \$110.44/hour]_____

Lifeline _____

Other (identify other) CBRF care & supervision at 50% of the cost [$\$697 \times \text{two months} = \$1,394$
total]_____

LTS Committee action: Chair approval date _____; Full committee approval date _____;

Non approval date _____; Reason _____

Consumer Name: _____