Wauklehegan Manor Inc.

Admission Responsibilities

Resident Label

Date:_____

RN:_____

- Be sure LPN and PSW are available for arrival of new admission
- Check to make sure everything is in order in the room prior to admission
- Introduce self to new admission, assist LPN if needed
- Forms to dietary and pharmacy
- Set up initial Care Plan (within 24 hours of admission)
- Put history and physical form in doc book
- Admission blood work order

LPN:_____

- Greet at door
- Accompany to room
- Vitals & assessment (fill out admission form)
- Chart admission

PSW:_____

- Put personal items away in room
- Clothing to laundry to be tagged and washed
- **leave enough for 24 hours (pjs, sweater, socks, undergarments, personal items ie, purse)

*Please be sure to check on new resident frequently, especially if on isolation. It has to be scary and lonely coming into a new environment, and additionally being put on isolation. Take the time to be kind.

Waukiehegan Manor Inc.

Admission Assessment Data

Resident Label

Refer to Social Development LTC Geriatric Assessment if unable to assess an area.

Blood Pressure	Respirations	Pulse	Temp	Height	Weight

Admitted From:	Language:
Time of Arrival:	Religion:
Room:	Food Allergies:
Code Status:	Drug Allergies:

Medications: _____

_____

Medical Hx: _____

_____

Assessment Finding: _____

_____

Tobacco Use: Y / N **Cannabis Use:** Y / N **Years:**_____ **Amt/day:** _____ **Alcohol:**_____

Orientated: Person/Place/Time/Situation **Speech:** _____ **Mood:** _____

Sight: Glasses / Blind **Hearing:** Aid/ Lt / Rt **Teeth-Permanent:** Y / N **Dentures:** upper/ lower / partial

Hx Choking/Aspiration: Y / N **Diet:** _____ **Dislikes:** _____

Bladder: continent/ incontinent **Bowel:** continent/ incontinent **Bowel:** Laxatives/ Stool Softener

Tena Size & Colour: _____ **Bathroom Routine:** _____ **UTI Hx:** Y / N

Mobility: Cane/ Walker/ Wheelchair / Own / On Loan **Dressing /Washing Assistance:** Full / Assist / Ind

Sleep/Rest Routine: _____ **Fall Risk:** Y / N **Bed Alarm:** Y / N **Restraint:** Y / N **Type:** _____

Dressings: Y / N **Skin:** Dry / Open Areas / Sores **Description:** _____

Immunizations: Flu: _____ Pneumovax:_____ Covid: 1st: _____ 2nd: _____

Last Examinations: **Braden Score:** _____

Eye Exam	Hearing Test	Dental Exam	Colonoscopy	Mammogram
Date:	Date:	Date:	Date:	Date:
Dr:	Dr:	Dr:	Dr:	Dr:

Waukleheqan Manor Inc.

Admission Assessment Data

Pain:

Location: _____ **Intensity */10:** _____ **Describe Pain:** _____

Chronic or New Onset: _____ **What Relieves Pain in past?** _____

What Causes or Increases Pain: _____

Effect of Pain (circle all that apply): Sleep GI / Appetite Physical Activity Concentration Emotions

Relationship with others (Irritability) Other:_____

Hairdresser Services: Yes / No **Foot Care Services**: Yes / No

Funeral Arrangements: Yes / No Funeral Home: _____

Geriatric Depression Scale: Short Form Choose best answer for how you have felt over the last week.

☐ Unable to complete.

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

Answers in bold indicate depression. Score 1 Point for each bolded answer.

A score of >5 points is suggestive of depression, ≥ 10 points is almost always indicative of depression. A score of > 5 points should warrant a follow-up comprehensive assessment with physician.

Date: _____ Nurse Completing: _____

Waukleheganan Manor Inc.

Pharmacy Transmittal

Please note Waukleheganan Manor has received a New Admission.
The Resident's Information is as follows:

☐ Permanent ☐ Relief

Name: _____

Date of Admission: _____

Date of Birth: _____

Medicare #: _____

Room #: _____

Physician (if relief): _____

Next of Kin:
Name: _____
Address: _____
Phone: _____

Diagnosis:

Allergies:

Additional Comment:

Name of Informer: _____ Date: _____

Wauklehegan Manor Inc.

11 Saunders Road McAdam, NB E6J 1K9
Tel (506) 784-6303 Fax (506) 300-2042
Email: don@wauklehegan.com

Admission Application

General Information

1. Name: _____

2. Permanent Address: _____

3. Present Location, If different than Permanent: _____

4. Phone: _____ 5. Date of Birth (D/M/Y) _____

6. Place of birth: _____ 7. How Long Resident of NB? _____

8. Previous Occupation: _____ 9.Religion: _____

10. Medicare # _____ Pharmacare # _____
    Medicare expiry date: _____
    Social Insurance # _____ DVA# _____
    Band # _____ Health Card # _____

11. Marital Status: _____
    Spouse's First Name: _____
    Parent's Names: Father: _____ Mother: _____

12. Doctor's Name: _____ Phone: _____

Wauklehegan Manor Inc.

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Email: don@wauklehegan.com

Admission Application

13. Does someone have a Power of Attorney: Yes____ No____

If yes, please indicate who possess it: _____

14. The name of the person who will assume responsibility in all matters concerning the resident:

Name: _____
Address: _____
Postal Code: _____
Phone: (h) _____
(w) _____
Email: _____
Relation to applicant: _____

15. Next of kin to be contacted in case of an emergency:

Name: _____
Address: _____
Postal Code: _____
Phone: (h) _____
(w)_____
Email: _____
Relation to applicant: _____

16. Finances: Will the applicant be self - supporting? Yes ___ No ___
If not self - supporting does the Resident receive:
Old Age Pension: Yes___ No ___
Guaranteed Supplement: Yes___ No ___
Canada Pension: Yes___ No ___
Other Income: (please specify) _____

Will the applicant receive government assistance? Yes ___ No ___

Wauklehegan Manor Inc.

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Email: don@wauklehegan.com

Admission Application

17. In event of death, person to be notified and belongings to be released to:

Name: _____
Address: _____
Phone: _____
Relation to applicant: _____

Preferred Funeral Home: _____
Is there Pre-Arrangements Made? Yes___ No ___

18. Brief personal history and reason for application, including any further information which might be needed to assist the staff in caring for the applicant:

_____
_____
_____

I Hereby Certify That the Foregoing Particulars Are Correct, That I Have Read The Information Contained In The Letter Of Introduction, And I Request That _____ (Name Of Applicant) Be Admitted To The Wauklehegan Manor.

_____ _____
SIGNATURE OF APPLICANT SIGNATURE OF RESPONSIBLE PARTY

DATE: _____ DATE: _____

Waukleheqan Manor Inc.

Initial Physician Physical

Resident Label

Vitals:

BP	SP02	RR	PR	Temperature	Weight

Examination:

	No Review	Normal	Abnormal
Gen Appearance			
Head & Neck			
Eye			
Ear/Nose/Throat			
Breast/Chest			
Heart			
Lungs			
Abdomen			
Genitals			
Back			
Extremities			
Skin			
Lymph Nodes			
Nervous System			
Rectal			
Urinalysis			
Pelvic			
Prostate			
HGB			
MMSE			

Abnormalities:

Diagnostic Impression:

Date:_____ Physician Signature:_____

Wauklehegan Manor Inc.

Admission Agreement

Between Wauklehegan Manor Inc. and the Applicant

Inherent in the philosophy of the Wauklehegan Manor is the concern that the nursing home, resident, and family work together to provide as pleasant an environment as possible for our residents. To achieve this end, there must be an ongoing involvement by family and friends from the community, as this will assist us in ensuring a quality lifestyle for the Resident.

In providing a caring atmosphere, the Wauklehegan Manor agrees:

1. To provide accommodation based on the needs of the Resident and the availability of required accommodation. The Manor reserves the right to transfer a Resident at any time from one accommodation to another within the facility based on the needs of the entire resident population. Requests by a Resident for a transfer will be arranged as soon as possible, if deemed advisable by the Nursing Home. Requests for transfer will not by unduly denied.
2. To provide personal care for the Resident in those areas in which a person would normally be independent, but where the Resident is, for some reason, unable to function e.g., assistance with bathing, dressing, eating, etc.
3. To provide a warm and comfortable atmosphere in the Resident's room. This includes the provision of a bed, clothes dresser, bedside table, occasional chair, and closet storage space together with all appropriate linens, bedding, towels, and face cloths as may be required by the Resident from time to time.
4. To provide nursing services as required by the Resident.
5. To provide for the positive identification of the Resident, including, but not being limited to the taking of a photograph on admission, and updating of same as necessary.
6. To facilitate the provision of services of a licensed physician (of the Resident's choice whenever possible), when necessary due to the health condition of the Resident.
7. Where the care of the Resident is beyond that able to be provided by the Manor, to arrange for the transfer of the resident to the hospital, when required, and to immediately notify the responsible party of such transfer.
8. Provide supportive care, as opposed to acute and/or critical care for the Resident.
9. Respect the wishes of the Resident in terms of the provision of such extraordinary/heroic measures as tube feedings, intravenous antibiotics, and resuscitation etc. The wishes of the Resident will be assessed on admission and reassessed at regular intervals.

10. As Nursing Homes do not have extensive life advanced life support equipment, nor in-house medical staff available 24 hours a day, and as residents in Nursing Homes have a high incidence of pre-existing illness and a slow decline in body function is expected: it is therefore the policy of the Wauklehegan Manor not to resuscitate residents through Cardiopulmonary Resuscitation during a medical crisis, unless specifically requested by the resident or family member.
11. To make available an advisory council of Residents (Resident Council) as a means through which the Resident or their family may have input into the functioning of the home.
12. That the manor provides a safe smoke-free environment and to thus admissions to the manor must accept that they will not be permitted to smoke.

As Their Responsibility in The Provision of Care, The Applicant and/or Responsible Party For The Applicant Agree (S) To:

1. Respect the rights of all individuals living, visiting, or working at the facility.
2. Have one designated advocate (Responsible Party) available to speak on behalf of the Resident if he or she is unable to do so.
3. Provide such personal clothing and effects as needed and desired by the Resident in order for them to be comfortable in their new surroundings.
4. Provide such monies as might be needed or desired by the Resident in order to maintain a degree of independence and to enable the Resident to purchase or rent items consistent with their interests and needs.
5. Be responsible for pharmacy bills, and other treatments or aids, which are not covered through the Prescription Drug Program or other benefit program.
6. Be responsible for any hospital or ambulance charges, which are not already covered, should hospitalization or transportation to another facility become necessary.
7. Pay the monthly nursing home rate by the 5th day of the following month, including making arrangements for such subsidies as may be necessary.
8. Arrange for such professional services, and payment thereof, as may be required, but not available at the home, e.g., Dental, Optometry, etc. and to provide for transportation to these appointments.
9. To abide by all rules and regulations as may be issued from time to time by the nursing home.

Wauklehegan Manor Inc.

Admission Agreement

Standard Admission Waiver:

Recognizing That This Is a Residential Facility:

1. The nursing home agrees to exercise such reasonable care toward the Resident as his or her known condition may require; however, the home is in no sense an insurer of the Resident's safety or welfare and assumes no liability as such.
2. The home will not assume responsibility for valuables or money left in the possession of the Resident while he or she is a Resident of the nursing home.
3. When the Resident is absent from the facility, responsibility must be assumed by the Resident themselves, and/or the person accompanying the Resident.

Duration Of Agreement:

Either party may terminate this agreement within 15 days of written notice. Otherwise, it will remain in effect until a different agreement is executed. However, the Resident will not be forced to remain in the home against his or her will for any length of time and is free to apply to any other home at any time. The home retains the right to waive the 15-day notice.

The Resident and/or Responsible party hereby acknowledges receipt of the Resident information brochure.

THIS AGREEMENT shall be binding upon the parties hereto, their successors, administrators, heirs, and assigns.

DATED this _____ day of _____ 20__.

_____	_____
WITNESS	WAUKLEHEGAN MANOR
_____	_____
WITNESS	RESIDENT
_____	_____
WITNESS	RESPONSIBLE PARTY.

Wauklehegan Manor Inc.

Medical Directive

The Purpose of The Medical Directive Is to Make Clear My Wishes In Terms Of The Extent Of Medical Treatment Desired In Case I Am Unable To Convey My Wishes At The Time.

Personal Medical Directive

This Medical Directive Expresses and Shall Stand For My Wishes Regarding Medical Treatment In The Event That Illness Should Make Me Unable To Communicate Them Directly. I Make This Directive Being 19 Years or More Of Age, Of Sound Mind And Appreciating The Consequences Of My Decisions.

Proxy Medical Directive

This Medical Directive Sets Forth The Wishes Of _____(The Resident) Regarding Medical Treatment As Known To _____ His/Her Attorney, Trustee, Or Proxy And /Who Is Authorized To Communicate These Wishes Pursuant To _____, The Resident Being Unable Due To Illness To Communicate His/Her Wishes Directly, The Said Wishes Of The Resident Being Known To Me By Virtue Of The Resident Having Informed Me Directly Or By My Intimate Knowledge Of The Resident, And I Being 19 Years Or More Of Age, Of Sound Mind, And Appreciating The Nature And Consequences Of My Communication Of The Resident's Wishes

I Understand That Some of The Interventions Listed Will Require Transfer to An Active Treatment Hospital or Health Centre.

It is the family's responsibility to transport residents to and from any medical appointments; however, if they are unable to transport a resident in their vehicle due to wheelchair accessibility, arrangements can be made to use the village's mini-bus or by ambulance.

My Personal Statement (including any feelings about transfer to hospital)

_____

_____

_____

_____

Wauklehegan Manor Inc.

Medical Directive

Review Below Directives Below, Indicating if you would like (Yes), would not like (No) or that you would like to decide at the time (Decide). A decision at the time will warrant a call prior to services being completed.

	Yes	No	Decide
CARDIOPULMONARY RESUSCITATION: Using drugs and Electric shock, Compression to keep the heart beating: artificial breathing			
ARTIFICIAL NUTRITION AND HYDRATION: Giving nutrition and fluid through a tube in the veins, nose, or stomach			
MINOR EXCISION: Such as removing some tissue from an infected toe, cyst.			
SIMPLE DIAGNOSTIC TESTS:			
Blood Tests, Specimen (Urine), Swabs (Infection: COVID, MRSA, Flu) etc.			
Radio imaging- Xray, CT, MRI (at hospital)			
IMMUNIZATION:			
Annual Flu			
Covid-19 Initial or Booster			
Pneumovax			

RESIDENT SIGNATURE: _____ DATE: _____

PROXY SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

PHYSICIANS SIGNATURE: _____ DATE: _____

Wauklehegan Manor Inc.

Consent for Release of Medical Information

At Wauklehegan Manor from time to time we will be in contact with various Health Care Providers to provide you with the best care possible. We would like your permission to share relevant health care information with the following agencies.

- Attending Physician- for prescribing, ordering and medical management
- Pharmacy- for prescriptions and consultations
- Acute Care Facilities- Hospital, Outpatients, Consulting Physicians/Providers for medical diagnostics, admissions, appointments.
- Extra Mural Program- Respiratory, Speech-Language, Occupational Therapy, Physiotherapy, and their associated programs: Equipment Loan (Easter Seals, Red Cross) etc.
- Electoral for municipal, provincial, and federal government.
- Nursing Home Services- quality assurance.
- Social Development- for licensing, inspection.
- Department of Veterans Affairs- if entitled to Veteran's Services.
- Other Nursing Homes- in the event of transfer at your request.

If you require care from another agency than what is listed, a separate consent form will be required.

I hereby consent to the (Applicant) _____ being admitted, consulted, and personal medical information released to the above-named parties and to receive such medical or health related examination, treatment or services deemed advisable. I acknowledge that the management regimen and its possible modifications have been explained to me.

I further acknowledge that I have received full and sufficient responses to all questions raised by myself and/or Power of Attorney. I also understand that this also permits entry to the above-named address, or such other places designated to me, to carry out services required.

Social Development Equipment Loan Agreement: I understand that the equipment provided may be new or recycled. I agree to care for this equipment as I have been instructed. I will have all repairs and maintenance completed by a certified technician. I agree to operate this equipment safely. I agree to not abuse or misuse this equipment in any way. I agree to return this equipment to the appropriate agency once it is no longer required or it is replaced.

Services the applicant does not wish to consent to sharing health information with:

_____

_____

Signature: _____ Date: _____

Relationship to the Applicant: _____

Signature of Witness: _____ Date: _____

Waukleheegan Manor Inc.

Consent Form For Optional Charges

By signing one or all of these you are providing us with consent to draw money from the resident's comfort and clothing account. You may withdraw from these services at any time by contacting the business office.

Cable TV $12.00 monthly

Signature:_____ Date:_____, 20____

Telephone $25.00 monthly

Signature:_____ Date:_____, 20____

Specialized Nail Care $30.00 per session (every 4-6 wks.)

Signature: _____ Date:_____, 20____

Hair Care Style $15, Style & Cut $22, Men's $12-14, Perm $45 (Friday's)

Signature: _____ Date: _____, 20____

Additional Consent

Photo consent Internal Y N

External Y N

_____
Resident Name

_____ _____
Resident or Responsible Party: Date

_____ _____
Witness Date

Wauklehegan Manor Inc.
11 Saunders Rd. E6J 1K9
McAdam, NB.

Telephone: 506-784-6303
Fax: 506-300-2042
Email: admin@wauklehegan.com

Pre-Authorized Debit Agreement (PAD)

Customer Information

Name:
Address:

Phone:

Date:

Bank Account Information

Account #

Branch Transit #

Financial Institution #

☐ Chequing ☐ Savings
(check account type)

Financial Institution
Name
Address

Pre-Authorized Debit (PAD) Details-Board

You, the Payor, authorize Wauklehegan Manor, Inc. to debit the bank account identified above for $_____
On the 1st day of the month, or the next business day.

These services are for (check one): ☐ Personal ☐ Business Use

You, the Payor, may revoke your authorization at any time in writing or by phone, subject to providing notice of 14 days. To obtain a sample cancellation form, or for more information on your right to cancel a PAD Agreement, contact your financial institution or visit www.cdnpay.ca

_____ _____
Signature of Account Holder Signature of Joint Holder (if applicable)

_____ _____
Date Date

You have certain recourse rights if any debit does not apply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca

Wauklehegan Manor Inc.
11 Saunders Road
McAdam, NB E6J 1K9
Tel (506) 784-6303 Fax (506) 784-6344

Food Service Department Transmittal Slip

Date: _____ **Name:** _____ **Room # :** _____

☐ **Permanent** ☐ **Relief** ☐ **Change** ☐ **Discharged** ☐ **Death**

☐ **Returned to Facility** ☐ **Isolation Precautions Required**

***Diet Order:** _____

***Ht:** _____ ***Wt:** _____

***Food Texture:** ☐ Regular ☐ Soft ☐ Puree

***Fluid Consistency:** ☐ Regular ☐ Thickened: Nectar/Honey

***Adaptive feeding aid:** ☐ Nosey cup ☐ Non-slip mat ☐ Plate guard
☐ Special utensil: _____ Other: _____

***Food Allergies:** _____

***Food Intolerances:** ☐ Lactose ☐ Gluten ☐ other: _____

***Food Dislikes:** _____

Absent for Meals: ☐ Breakfast ☐ Dinner ☐ Supper

Notes: _____

Signed: _____

*** Nursing Home Standards require that within 24 hours of admission the items with a asterisk must be completed.**

Revised: Jul/09, Nov/16

Wauklehegan Manor Inc.

Physician Order & Pharmacy Requisition

Allergies:

Date/ Time	Resident:	Nurse Processing	Physician Signature

Nurses are Held Responsible Only for Written and Signed Orders. Nurse Processing to sign when sent to Pharmacy. Redline to be dated and signed when in EMAR, and Medication Received.

Wauklehegan Manor Inc.
11 Saunders Road
McAdam, NB E6K 1K9
Tel (506) 784-6303 Fax (506) 784-6344

November 14 2017

Subject: External Food brought in for the Resident in the Manor

To whom it may concern,

Individual residents may have food brought into the nursing home by their family members, friends, trustees, etc.

Due to the potential risk of food borne illness and the high level of risk to our resident's food brought in must be handled as follows:

- Food should be freshly prepared or obtained from reputable sources
- Only food that will be eaten the same day should be brought into the manor as we are unable to store food that is not being consumed immediately due to food safe practices
- Perishable food should be handled properly ie: cold foods should be transported in a cooler
- The nurse manager/designate on duty must be notified when food is brought in for a resident for awareness purposes only
- All staff need to be vigilant and direct the applicable party to the nursing station when food is brought in
- Unless approved by the nurse manager food presenting a high risk for choking or allergies such as nuts, trail mix, jelly beans, jujubes, peppermints, popcorn, etc shall not be allowed into the manor

Thank you in advance for your consideration!

D Bourque

Debi Bourque
Executive Director
Wauklehegan Manor Inc.
(506) 784-6303 Ext 202
harvey_mike@rogers.com

Wauklehegan Manor Inc.

GETTING TO KNOW YOUR FAMILY MEMBER

In order to make the transition from home to Nursing Home, we would like you to take a few minutes and think about the following questions and answer them as accurately as possible, This will help us become better aquatinted more quickly with your family member and ensure we are offering the best possible care. The better we know them, the better we are able to help them. Thank you for your time in this matter.

1. What gives the most pleasure (e.g. conversation topics, activities)

_____

_____

_____

_____

2. What does your family member dislike?

_____

_____

_____

_____

3. When/if your family member becomes upset, what helps resettle them?

_____

_____

_____

_____

Waukhegan Manor Inc.

4. Is there a certain time of day they are unsettled? (i.e. bath time, meal time, hair care, bed time)

5. Is there anything that will trigger anxiety?

6. What helps settle anxious moments?

7. Does your family member prefer early or late morning care?

8. Are there any other areas of concern and/or tips for care?