Medicare Integrity Program (MIP)
Program Safeguard Contractor (PSC)
Data Assessment & Verification (DAVE)

Prepared for:

Centers for Medicare & Medicaid Services (CMS)

Prepared by:

Computer Sciences Corporation

DAVE Sanitized Medical Record
Version 2.0

July 2004

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7/ 9/2004

ROBERT BROWN

List of Medical Record Documents Requested for MDS DAVE Project

		Initials	Date
Medical Record Face Sheet	Include the Medical Record Face Sheet.	DD	12/12
Minimum Data Set (MDS)	Send a hard copy of ALL MDS's, completed and signed. Supporting documentation from the medical record should include the time frame of the observation period, which is established by the assessment reference date (ARD), in section A3a. Remember that some observation periods look back seven, fourteen, or thirty days.		
Pre-admission Assessments Hospital Documentation Diagnosis	Include a copy of the readmission assessment and any hospital records that support services provided in the hospital and recorded on the MDS. Also include physician documentation that establishes or substantiates the diagnoses reported on the MDS and ICD-9-CM codes on the UB-92. This may include hospital documentation, history and physicals, discharge summaries, transfer forms, physician orders/progress notes, consultation reports, lab work, etc.		
Physician Documentation	Include a copy of all physician orders (including admission orders, telephone orders, and fax orders), as well as documentation of physician visits. Do not limit visits to attending physicians--also include those visits made by consulting physicians and other professionals such as the dentist, ophthalmologist, podiatrist, etc. (*Editor's note:* The Resident Assessment Instrument User's Manual *contains information on physician visits that can be counted on the MDS; see p. 3-160*)		
Nurses Notes and Assessments	All areas on the MDS should be supported. Include assessment documentation, admission/review of systems, pain, bowel and bladder, skin and fall risk assessments. Include specific behavior documentation and flow sheets. The look back period is 30 days for mood indicators. Include documentation that records any mood indicators such as monitoring records, progress notes, or assessments from all disciplines, particularly nursing.		
Medication, treatment records, and clinical flow sheets	A number of MDS questions and RUG categories are based on treatments or monitoring. Include copies of medication, treatment records or flow sheets that contain documentation of oxygen administration, IVs, enteral/parenteral feedings, respiratory therapy treatments, skin treatments, etc. Also include other flow sheets that document fluid input or output, food intake, vital signs, pain, and other monitoring records used to support the MDS and skilled care being provided.		
ADL Documentation	Include all documentation pertaining to activity of daily living (ADL) status across all shifts during the observation period (seven days ending with the ARD on the MDS.) This includes documentation such as nursing notes, ADL flow sheets, observation records, and assessments. The care plan is an additional supporting document for the ADL status.		
Rehab nursing	Include rehab nursing assessments, the care plan, and flow sheets that document the administration of the program, including time of administration and progress notes.		
Therapy Documentation	If residents are receiving therapy, include copies of the evaluation/plan of care (certification/ recertification). Also include a copy of all physician orders for therapy, daily treatment records or flow sheets, including documentation that indicates the actual treatment time. Also include any therapy progress notes written during the observation period. Include copies of the Therapy Log to cover the time period.		
Social Services, Activities, Dietary	Include assessments from all disciplines particularly social services, activities/recreation, dietary/nutrition.		
Other MDS Categories	All areas on the MDS should be supported. Copies of Care Plans, RAP summaries, etc may be included.		
UB-92	Include ALL UB-92 documentation for the observation period.		

CERTIFICATION AND RECERTIFICATION
(Extended Care Facility)

COPY

HAF-509

CERTIFICATION

of patient admission. Required at time of admission.

Brown, Robert
(PATIENT)

7-22-01
(ADMISSION DATE)

(HEALTH INSURANCE CLAIM NUMBER)

I certify that post-hospital ECF services are required to be given on an in-patient basis because of the above named patient's need for skilled nursing care on a continuing basis for the condition(s) for which he was receiving in-patient hospital services prior to his transfer to the ECF.

See admit orders
(PHYSICIAN)

(TIME & DATE)

RECERTIFICATION

of continued ECF in-patient care. On or before the 14th Day.

Date _____

I certify that continued ECF in-patient care is necessary for the following reason(s):

I estimate that the additional period of ECF in-patient care will be _____days (or _____weeks).
Plans for post-ECF care are: ☐ Home Health Agency ☐ Office Care
☐ Other (specify)
Continued ECF care is for same condition for which patient received in-patient hospital services:
☐ Yes ☐ No

D/C 7-29-01

(PHYSICIAN)

(DATE)

2nd RECERTIFICATION

of continued ECF in-patient care. On or before the 44th Day.

Date _____

I certify that continued ECF in-patient care is necessary for the following reason(s):

I estimate that the additional period of ECF in-patient care will be _____days (or _____weeks).
Plans for post-ECF care are: ☐ Home Health Agency ☐ Office Care
☐ Other (specify)
Continued ECF care is for same condition for which patient received in-patient hospital services:
☐ Yes ☐ No

(PHYSICIAN)

(DATE)

3rd RECERTIFICATION

On or before the 74th day of ECF in-patient care.

Date _____

I certify that continued ECF in-patient care is necessary for the following reason(s):

I estimate that the additional period of ECF in-patient care will be _____days (or _____weeks).
Plans for post-ECF care are: ☐ Home Health Agency ☐ Office Care
☐ Other (specify)
Continued ECF care is for same condition for which patient received in-patient hospital services:
☐ Yes ☐ No

(PHYSICIAN)

(DATE)

AMBULANCE SERVICE

I certify that ambulance service was medically needed for the above named patient.

(PHYSICIAN)

(DATE)

Name: BROWN, ROBERT		Admission Date/Time: 7/22/01 3:45PM	# of Admits: 1	Client #: 2112	Health Record #: 21-12
Address: 4509 LEXINGTON LANE Kent Town, WA, 98331		Gender: Male	Date of Birth: 04/15/1920	Age: 81	Marital Status: Married
		Religion: Catholic		Citizenship: USA	Race/Ethnicity: Caucasian
Phone 1: Phone 2:		Occupation: CIVIL SERVICE		Education: Some college	
Pay Type: Medicare	SS#: 093246161	Medicare #: 093246161A	Primary Language:	English Speaking Ability:	
Medicare Part A / B: Y / Y		Medicaid: State:	Eligible: N Approved: N	Number:	N Transferred From: PMC 7/1/01

Home: Office: Relationship:	Next of Kin: BROWN, SHEILA Home: Office: Relationship: Spouse
Next of Kin: Home: Office: Relationship:	Next of Kin: Home: Office: Relationship:

Primary Physician: SMITH, MICHAEL	Office:	Fax:	Pager:
Alternate Physician:	Office:	Fax:	Pager:
Hospital:	Office:	Fax:	Other:
Pharmacy: Principle Medical Center Pharmacy	Office:	Fax:	Other:
Mortuary: Retirement Funeral Chapel	Office:	Fax:	Other:
Allergies: ASA			

Admitting/Subsequent Diagnoses: V54.8 Orthopedic aftercare, 715.95 Osteoarthritis-hip, 401.9 Hypertension, essential unspecified, 715.96 Osteoarthritis, knee, 366.9 Cataract unspecified, 389.9 Hearing loss unspecified

Optional Information: Org Adm Date: (7/22/01); Birthplace: (BROOKLYN, NJ)

Discharge: Discharge to: Home 7/29/01 Reason:

Discharge Diagnoses:

Name: BROWN, ROBERT	Current Location: C01-RMT-	Health Record #: 21-12	Client #: 2112

recadmit.rpt

Numeric Identifier

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME⊙	Robert Brown a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER⊙	1. Male 2. Female 1
3.	BIRTHDATE⊙	04 – 15 – 1920 Month Day Year
4.	RACE/⊙ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin 5
5.	SOCIAL SECURITY⊙ AND MEDICARE NUMBERS⊙ [C in 1st box if non med. no.]	a. Social Security Number 093 – 24 – 6161 b. Medicare number (or comparable railroad insurance number) 093246161A
6.	FACILITY PROVIDER NO.⊙	a. State No. 91500 b. Federal No. 40-9211
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]⊙	N
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 5d 01 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. *Codes for assessments required for Medicare PPS or the State* 1. *Medicare 5 day assessment* 1 2. *Medicare 30 day assessment* 3. *Medicare 60 day assessment* 4. *Medicare 90 day assessment* 5. *Medicare readmission/return assessment* 6. *Other state required assessment* 7. *Medicare 14 day assessment* 8. *Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
a.	Larry Smith	AA	7-22-01
b.	[illegible]	SSD (B, C4, G, E, F, P-2, Q-1)	7/27/01
c.	R. Lantern	PTA Plbt	7-28-01
d.	Johnson V.	ADC P(N)	7/28/01
e.	Robinson, [illegible]	Business Office	A7 7/28/01
f.			
g.			
h.			
i.			
j.			
k.			
l.			

07-26-01

5d -
Raps not required -
Discharge prior to day 14

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊙ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a] = When letter in box, check if condition applies

MDS 2.0 September, 2000

7/ 9/2004

Resident Brown, Robert

Numeric Identifier

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month 07 – Day 22 – Year 2001	
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	5
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility	0
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	98366	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	*(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)* Prior stay at this nursing home Stay in other nursing home Other residential facility—board and care home, assisted living, group home MH/psychiatric setting MR/DD setting *NONE OF ABOVE*	a. b. c. d. e. f. X
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]		
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree	6
8.	LANGUAGE	*(Code for correct response)* a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify	0
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes	0
10.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition	a. X b. c. d. e. f.
11.	DATE BACKGROUND INFORMATION COMPLETED	Month 07 – Day 22 – Year 2001	

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)	*(Check all that apply. If all information UNKNOWN, check last box only)*	
		CYCLE OF DAILY EVENTS	
		Stays up late at night (e.g., after 9 pm)	a. X
		Naps regularly during day (at least 1 hour)	b.
		Goes out 1+ days a week	c. X
		Stays busy with hobbies, reading, or fixed daily routine	d. X
		Spends most of time alone or watching TV	e.
		Moves independently indoors (with appliances, if used)	f. X
		Use of tobacco products at least daily	g.
		NONE OF ABOVE	h.
		EATING PATTERNS	
		Distinct food preferences	i.
		Eats between meals all or most days	j.
		Use of alcoholic beverage(s) at least weekly	k.
		NONE OF ABOVE	l.
		ADL PATTERNS	
		In bed/clothes much of day	m.
		Wakens to toilet all or most nights	n. X
		Has irregular bowel movement pattern	o.
		Showers for bathing	p. X
		Bathing in PM	q.
		NONE OF ABOVE	r.
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	s. X
		Usually attends church, temple, synagogue (etc.)	t. X
		Finds strength in faith	u. X
		Daily animal companion/presence	v.
		Involved in group activities	w.
		NONE OF ABOVE	x.
		UNKNOWN—Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

L. Signature 7/22/01

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.	M. Miller, RN	AA/AC	7/22/01
c.			
d.			
e.			
f.			
g.			

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MDS 2.0 September, 2000

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	a. (First) Robert b. (Middle Initial) c. (Last) Brown d. (Jr/Sr)
2.	ROOM NUMBER	200-1
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* 07-26-2001 (Month Day Year) b. Original (0) or corrected copy of form (enter number of correction) 0
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) (Month Day Year)
5.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced — 2
6.	MEDICAL RECORD NO.	21-12
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	(*Billing Office to indicate; check all that apply in last 30 days*) a. Medicaid per diem; b. X Medicare per diem; c. Medicare ancillary part A; d. Medicare ancillary part B; e. CHAMPUS per diem; f. VA per diem; g. Self or family pays for full per diem; h. Medicaid resident liability or Medicare co-payment; i. Private insurance per diem (including co-payment); j. Other per diem
8.	REASONS FOR ASSESSMENT [*Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed*]	a. Primary reason for assessment: 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* — 01 (5d) b. *Codes for assessments required for Medicare PPS or the State* 1. *Medicare 5 day assessment* 2. *Medicare 30 day assessment* 3. *Medicare 60 day assessment* 4. *Medicare 90 day assessment* 5. *Medicare readmission/return assessment* 6. *Other state required assessment* 7. *Medicare 14 day assessment* 8. *Other Medicare required assessment* — 1
9.	RESPONSIBILITY/ LEGAL GUARDIAN	(*Check all that apply*) a. Legal guardian; b. Other legal oversight; c. ✓ Durable power of attorney/health care; d. ✓ Durable power attorney/financial; e. Family member responsible; f. Patient responsible for self; g. *NONE OF ABOVE*
10.	ADVANCED DIRECTIVES	(*For those items with supporting documentation in the medical record, check all that apply*) a. ✓ Living will; b. Do not resuscitate; c. Do not hospitalize; d. ✓ Organ donation; e. Autopsy request; f. ✓ Feeding restrictions; g. Medication restrictions; h. ✓ Other treatment restrictions; i. *NONE OF ABOVE*

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(*Persistent vegetative state/no discernible consciousness*) 0. No 1. Yes (**If yes, skip to Section G**) — 0
2.	MEMORY	(*Recall of what was learned or known*) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem — 0; b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem — 0
3.	MEMORY/ RECALL ABILITY	(*Check all that resident was normally able to recall during last 7 days*) Current season; Location of own room; Staff names/faces — a. ✓ b. ✓ c. ✓ That he/she is in a nursing home; *NONE OF ABOVE* are recalled — d. ✓
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(*Made decisions regarding tasks of daily life*) 0. *INDEPENDENT*—decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only 2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED*—never/rarely made decisions — 0
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	(*Code for behavior in the last 7 days.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) — 0; a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) — 0; b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) — 0; c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) — 0; d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) — 0; e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) — 0; f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not) — 0
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated — 0

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(*With hearing appliance, if used*) 0. *HEARS ADEQUATELY*—normal talk, TV, phone 1. *MINIMAL DIFFICULTY* when not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*/absence of useful hearing — 1
2.	COMMUNICATION DEVICES/ TECHNIQUES	(*Check all that apply during last 7 days*) a. Hearing aid, present and used; b. Hearing aid, present and not used regularly; c. Other receptive comm. techniques used (e.g., lip reading); d. ✓ *NONE OF ABOVE*
3.	MODES OF EXPRESSION	(*Check all used by resident to make needs known*) a. ✓ Speech; b. Writing messages to express or clarify needs; c. American sign language or Braille; d. Signs/gestures/sounds; e. Communication board; f. Other; g. *NONE OF ABOVE*
4.	MAKING SELF UNDERSTOOD	(*Expressing information content—however able*) 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD* — 0
5.	SPEECH CLARITY	(*Code for speech in the last 7 days*) 0. *CLEAR SPEECH*—distinct, intelligible words 1. *UNCLEAR SPEECH*—slurred, mumbled words 2. *NO SPEECH*—absence of spoken words — 0
6.	ABILITY TO UNDERSTAND OTHERS	(*Understanding verbal information content—however able*) 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*—may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS* — 0
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated — 0

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MDS 2.0 September, 2000

Resident Brown, Robert

Numeric Identifier

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	0
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c. ✓
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	✓

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(*Code for indicators observed in last 30 days, irrespective of the assumed cause*)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS	
a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"	0
b. Repetitive questions—e.g., "*Where do I go; What do I do?*"	0
c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")	0
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	0
e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"	0
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	0
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	0
h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	0
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	0
SLEEP-CYCLE ISSUES	
j. Unpleasant mood in morning	0
k. Insomnia/change in usual sleep pattern	0
SAD, APATHETIC, ANXIOUS APPEARANCE	
l. Sad, pained, worried facial expressions—e.g., furrowed brows	0
m. Crying, tearfulness	0
n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	0
LOSS OF INTEREST	
o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	0
p. Reduced social interaction	0

2.	MOOD PERSISTENCE	**One or more indicators** of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	0
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0
4.	BEHAVIORAL SYMPTOMS	(A) *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	0	0
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	0	0
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	0	0

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a. ✓
		At ease doing planned or structured activities	b. ✓
		At ease doing self-initiated activities	c. ✓
		Establishes own goals	d. ✓
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e. ✓
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h. ✓
3.	PAST ROLES	Strong identification with past roles and life status	a. ✓
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
—Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	2	2
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	2	2
c.	WALK IN ROOM	How resident walks between locations in his/her room	1	1
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	1	1
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	0	0
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	2	2
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	2	2
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	1	1
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	1	1
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	0	1

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2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)*	3	2
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing	2	
		b. Balance while sitting—position, trunk control	0	
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss	(A)	(B)
		a. Neck	0	0
		b. Arm—including shoulder or elbow	0	0
		c. Hand—including wrist or fingers	0	0
		d. Leg—including hip or knee	0	1
		e. Foot—including ankle or toes	0	0
		f. Other limitation or loss	0	0
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* Cane/walker/crutch [a. ✓] Wheeled self [b. ✓] Other person wheeled [c. ✓] Wheelchair primary mode of locomotion [d.] *NONE OF ABOVE* [e.]		
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* Bedfast all or most of time [a.] Bed rails used for bed mobility or transfer [b. ✓] Lifted manually [c.] Lifted mechanically [d.] Transfer aid (e.g., slide board, trapeze, cane, walker, brace) [e. ✓] *NONE OF ABOVE* [f.]		
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes	1	
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs	a. ✓	
		Direct care staff believe resident is capable of increased independence in at least some ADLs	b. ✓	
		Resident able to perform tasks/activity but is very slow	c.	
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.	
		NONE OF ABOVE	e.	
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	2	

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)* 0. *CONTINENT*—Complete control *(includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	0	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	0	
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days [a. ✓] Constipation [b. ✓] Diarrhea [c.] Fecal impaction [d.] *NONE OF ABOVE* [e.]		

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan [a.] Bladder retraining program [b.] External (condom) catheter [c.] Indwelling catheter [d.] Intermittent catheter [e.] Did not use toilet room/commode/urinal [f.] Pads/briefs used [g.] Enemas/irrigation [h.] Ostomy present [i.] *NONE OF ABOVE* [j. ✓]		
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	0	

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		ENDOCRINE/METABOLIC/NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Diabetes mellitus	a. ✓	Multiple sclerosis	w.
		Hyperthyroidism	b.	Paraplegia	x.
		Hypothyroidism	c.	Parkinson's disease	y.
		HEART/CIRCULATION		Quadriplegia	z.
		Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
		Cardiac dysrhythmias	e.	Transient ischemic attack (TIA)	bb.
		Congestive heart failure	f.	Traumatic brain injury	cc.
		Deep vein thrombosis	g.	PSYCHIATRIC/MOOD	
		Hypertension	h. ✓	Anxiety disorder	dd.
		Hypotension	i.	Depression	ee.
		Peripheral vascular disease	j.	Manic depression (bipolar disease)	ff.
		Other cardiovascular disease	k.	Schizophrenia	gg.
		MUSCULOSKELETAL		PULMONARY	
		Arthritis	l. ✓	Asthma	hh.
		Hip fracture	m.	Emphysema/COPD	ii.
		Missing limb (e.g., amputation)	n.	SENSORY	
		Osteoporosis	o.	Cataracts	jj. ✓
		Pathological bone fracture	p.	Diabetic retinopathy	kk.
		NEUROLOGICAL		Glaucoma	ll.
		Alzheimer's disease	q.	Macular degeneration	mm.
		Aphasia	r.	OTHER	
		Cerebral palsy	s.	Allergies	nn.
		Cerebrovascular accident (stroke)	t.	Anemia	oo.
		Dementia other than Alzheimer's disease	u.	Cancer	pp.
				Renal failure	qq.
				NONE OF ABOVE	rr.
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*			
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Clostridium difficile (c. diff.)	b.	Sexually transmitted diseases	h.
		Conjunctivitis	c.	Tuberculosis	i.
		HIV infection	d.	Urinary tract infection in last 30 days	j.
		Pneumonia	e.	Viral hepatitis	k.
		Respiratory infection	f.	Wound infection	l.
				NONE OF ABOVE	m. ✓
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. S/P (R) THA		Y|5|4|.|8|	
		b.			
		c.			
		d.			
		e.			

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*			
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo	f.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Edema	g.
		Inability to lie flat due to shortness of breath	b.	Fever	h.
		Dehydrated; output exceeds input	c.	Hallucinations	i.
		Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.	Internal bleeding	j.
		OTHER		Recurrent lung aspirations in last 90 days	k.
		Delusions	e.	Shortness of breath	l.
				Syncope (fainting)	m.
				Unsteady gait	n.
				Vomiting	o.
				NONE OF ABOVE	p. ✓

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2.	PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	2
3.	PAIN SITE	(If pain present, check all sites that apply in last 7 days) Back pain [ ] a. Bone pain [ ] b. Chest pain while doing usual activities [ ] c. Headache [ ] d. Hip pain [✓] e. Incisional pain [ ] f. Joint pain (other than hip) [ ] g. Soft tissue pain (e.g., lesion, muscle) [ ] h. Stomach pain [ ] i. Other [ ] j.	
4.	ACCIDENTS	(Check all that apply) Fell in past 30 days [ ] a. Fell in past 31-180 days [ ] b. Hip fracture in last 180 days [ ] c. Other fracture in last 180 days [ ] d. NONE OF ABOVE [✓] e.	
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) [ ] a. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem [ ] b. End-stage disease, 6 or fewer months to live [ ] c. NONE OF ABOVE [✓] d.	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem [ ] a. Swallowing problem [ ] b. Mouth pain [ ] c. NONE OF ABOVE [✓] d.	
2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes a. HT (in.) 66 b. WT (lb.) 194	
3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	1 0
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods [ ] a. Regular or repetitive complaints of hunger [ ] b. Leaves 25% or more of food uneaten at most meals [ ] c. NONE OF ABOVE [✓] d.	
5.	NUTRITIONAL APPROACHES	(Check all that apply in last 7 days) Parenteral/IV [ ] a. Feeding tube [ ] b. Mechanically altered diet [ ] c. Syringe (oral feeding) [ ] d. Therapeutic diet [✓] e. Dietary supplement between meals [ ] f. Plate guard, stabilized built-up utensil, etc. [ ] g. On a planned weight change program [✓] h. NONE OF ABOVE [ ] i.	
6.	PARENTERAL OR ENTERAL INTAKE	(Skip to Section L if neither 5a nor 5b is checked) a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night [ ] a. Has dentures or removable bridge [✓] b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) [ ] c. Broken, loose, or carious teeth [ ] d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes [ ] e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff [✓] f. NONE OF ABOVE [ ] g.	

SECTION M. SKIN CONDITION

1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage 0 0 0 0
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	0
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	0
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days) Abrasions, bruises [ ] a. Burns (second or third degree) [ ] b. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) [ ] c. Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster [ ] d. Skin desensitized to pain or pressure [ ] e. Skin tears or cuts (other than surgery) [ ] f. Surgical wounds [✓] g. NONE OF ABOVE [ ] h.	
5.	SKIN TREATMENTS	(Check all that apply during last 7 days) Pressure relieving device(s) for chair [✓] a. Pressure relieving device(s) for bed [✓] b. Turning/repositioning program [ ] c. Nutrition or hydration intervention to manage skin problems [ ] d. Ulcer care [ ] e. Surgical wound care [✓] f. Application of dressings (with or without topical medications) other than to feet [✓] g. Application of ointments/medications (other than to feet) [ ] h. Other preventative or protective skin care (other than to feet) [✓] i. NONE OF ABOVE [ ] j.	
6.	FOOT PROBLEMS AND CARE	(Check all that apply during last 7 days) Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems [ ] a. Infection of the foot—e.g., cellulitis, purulent drainage [ ] b. Open lesions on the foot [ ] c. Nails/callusses trimmed during last 90 days [ ] d. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) [ ] e. Application of dressings (with or without topical medications) [ ] f. NONE OF ABOVE [✓] g.	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning [✓] a. Afternoon [✓] b. Evening [✓] c. NONE OF ABOVE [ ] d.	
	(If resident is comatose, skip to Section O)		
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	1
3.	PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred) Own room [✓] a. Day/activity room [✓] b. Inside NH/off unit [✓] c. Outside facility [ ] d. NONE OF ABOVE [ ] e.	
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(Check all PREFERENCES whether or not activity is currently available to resident) Cards/other games [✓] a. Crafts/arts [✓] b. Exercise/sports [✓] c. Music [✓] d. Reading/writing [✓] e. Spiritual/religious activities [✓] f. Trips/shopping [✓] g. Walking/wheeling outdoors [✓] h. Watching TV [✓] i. Gardening or plants [✓] j. Talking or conversing [✓] k. Helping others [ ] l. NONE OF ABOVE [ ] m.	

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5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	0
		b. Extent of resident involvement in activities	0

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	09
2.	NEW MEDICATIONS	*(Resident currently receiving medications that were initiated during the last 90 days)* 0. No 1. Yes	1
3.	INJECTIONS	*(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)*	1
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)*	
		a. Antipsychotic: 0	
		b. Antianxiety: 0	
		c. Antidepressant: 0	
		d. Hypnotic	0
		e. Diuretic	4

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*	
		TREATMENTS: Chemotherapy a.; Dialysis b.; IV medication c.; Intake/output d. ✓; Monitoring acute medical condition e.; Ostomy care f.; Oxygen therapy g. ✓; Radiation h.; Suctioning i.; Tracheostomy care j.; Transfusions k.	
		Ventilator or respirator	l.
		PROGRAMS: Alcohol/drug treatment program	m.
		Alzheimer's/dementia special care unit	n.
		Hospice care	o.
		Pediatric unit	p.
		Respite care	q.
		Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r. ✓
		NONE OF ABOVE	s.
		b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)* [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days	DAYS (A) / MIN (B)
		a. Speech - language pathology and audiology services	0
		b. Occupational therapy	4 / 0138
		c. Physical therapy	4 / 0148
		d. Respiratory therapy	0
		e. Psychological therapy (by any licensed mental health professional)	0
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	*(Check all interventions or strategies used in last 7 days—no matter where received)*	
		Special behavior symptom evaluation program	a.
		Evaluation by a licensed mental health specialist in last 90 days	b.
		Group therapy	c.
		Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
		Reorientation—e.g., cueing	e.
		NONE OF ABOVE	f. ✓
3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)*	
		a. Range of motion (passive): 0	
		b. Range of motion (active): 0	
		c. Splint or brace assistance: 0	
		TRAINING AND SKILL PRACTICE IN:	
		d. Bed mobility: 0	
		e. Transfer: 0	
		f. Walking	0
		g. Dressing or grooming	0
		h. Eating or swallowing	0
		i. Amputation/prosthesis care	0
		j. Communication	0
		k. Other	0

4.	DEVICES AND RESTRAINTS	*(Use the following codes for last 7 days:)* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails: a. — Full bed rails on all open sides of bed	0
		b. — Other types of side rails used (e.g., half rail, one side)	2
		c. Trunk restraint	0
		d. Limb restraint	0
		e. Chair prevents rising	0
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*	01
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*	00
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*	00
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*	01
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	1

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	1
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	1
		c. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) 0. No 1. Within 30 days 2. Within 31-90 days 3. Discharge status uncertain	1
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	2

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes	1
		b. Family: 0. No 1. Yes 2. No family	1
		c. Significant other: 0. No 1. Yes 2. None	2
2.	SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:		
		a. Signature of RN Assessment Coordinator (sign on above line)	
		b. Date RN Assessment Coordinator signed as complete: Month 07 — Day 29 — Year 2001	

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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)*

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS (A)	MIN (B)
0	

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes — 1

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered. — 13

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered? — 0780

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. **Furthest distance walked** without sitting down during this episode. — 0

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode. — 1

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance in walking** during this episode. — 1

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification). — 1

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode. — 0

0. No 1. Yes

3. CASE MIX GROUP

Medicare RHB

State RMB

MDS 2.0 September, 2000

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SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name: Brown, Robert

Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     - — Complications and risk factors that affect your decision to proceed to care planning.
     - — Factors that must be considered in developing individualized care plan interventions.
     - — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM			
2. COGNITIVE LOSS			
3. VISUAL FUNCTION	✓		—
4. COMMUNICATION	✓	SS notes	✓
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	✓	PT/OT notes	✓
6. URINARY INCONTINENCE AND INDWELLING CATHETER			
7. PSYCHOSOCIAL WELL-BEING	✓	SS notes	✓
8. MOOD STATE			
9. BEHAVIORAL SYMPTOMS			
10. ACTIVITIES			
11. FALLS			
12. NUTRITIONAL STATUS	✓	RD notes	✓
13. FEEDING TUBES			
14. DEHYDRATION/FLUID MAINTENANCE			
15. DENTAL CARE			
16. PRESSURE ULCERS	✓	See Skin assessment	✓
17. PSYCHOTROPIC DRUG USE			
18. PHYSICAL RESTRAINTS			

B. Lauren Jones RN

1. Signature of RN Coordinator for RAP Assessment Process

5 day - discharge prior to 14 d
Rap summary not required

2. 07 – 29 – 2001 (Month / Day / Year)

Lauren Jones RN

3. Signature of Person Completing Care Planning Decision

4. 07 – 29 – 2001 (Month / Day / Year)

MDS 2.0 September, 2000

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ROBERT BROWN

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

● = One item required to trigger

② = Two items required to trigger

★ = One of these three items, plus at least one other item required to trigger

@ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL - Rehabilitation Trigger A@	ADL - Maintenance Trigger B@	Urinary Incontinence/Indwelling Catheter	Psychosocial Well Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psycho tropic Drug Use	Physical Restraints
B2a	Short term memory	1		●																		
B2B	Long term memory	1		●																		
B4	Decision making	1,2,3		●																		
B4	Decision making	3						●														
B5a-B5f	Indicators of delirium	2	●																			
B6	Change in cognitive status	2	●																		●	
C1	Hearing	1,2,3				●															●	
C4	Understood by others	1,2,3				●																
C6	Understand others	1,2,3		●		●																
C7	Change in communication	2																			●	
D1	Vision	1,2,3			●																	
D2a	Side vision problem	X			●																	
E1a-E1p	Indicators of depression, anxiety, sad mood	1,2									●											
E1n	Repetitive movement	1,2																			●	
E1o	Withdrawal from activities	1,2								●												
E2	Mood persistence	1,2									●											
E3	Change in mood	2	●																		●	
E4aA	Wandering	1,2,3												●								
E4aA-E4eA	Behavioral symptoms	1,2,3										●										
E5	Change in behavioral symptoms	1										●										
E5	Change in behavioral symptoms	2	●																		●	
F1d	Establishes own goals	X								●												
F2a-F2d	Unsettled relationship	X								●												
F3a	Strong id past roles	X								●												
F3b	Lost roles	X								●												
F3c	Daily routine different	X								●												
G1aA-G1jA	ADL self-performance	1,2,3,4				●																
G1aA	Bed mobility	2,3,4				●																
G2A	Bathing	1,2,3				●																
G3b	Balance while sitting	1,2,3																			●	
G6a	Bedfast	X																				
G8a,b	Resident staff believe capable	X				●																
H1a	Bowel incontinence	1,2,3,4						●														
H1b	Bladder incontinence	2,3,4																				
H2b	Constipation	X																			●	
H2d	Fecal impaction	X																			●	
H3c,d,e	Catheter use	X						●														
H3g	Use of pads/briefs	X						●														
I1i	Hypotension	X																			●	
I1j	Peripheral vascular disease	X																				
I1ee	Depression	X																			●	
I1ff	Cataracts	X																				
I1ll	Glaucoma	X			●																	
I2j	UTI	X																				
I3	Dehydration diagnosis	276.5															●					
J1a	Weight fluctuation	X															●					
J1c	Dehydrated	X															●					
J1d	Insufficient fluid	X															●					
J1f	Dizziness	X												●							●	
J1h	Fever	X															●					
J1i	Hallucinations	X																			●	
J1j	Internal bleeding	X															●					
J1k	Lung aspirations	X																			●	
J1m	Syncope	X																			●	

ROBERT BROWN

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

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MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL - Rehabilitation Trigger A @	ADL - Maintenance Trigger B @	Urinary Incontinence/Indwelling Catheter	Psychosocial Well Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Hydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
J1n	Unsteady gait	X																					J1n
J4a,b	Fell	X													●						●		J4a,b
J4c	Hip fracture	X																			●		J4c
K1b	Swallowing problem	3																			●		K1b
K1c	Mouth pain	X																	●				K1c
K3a	Weight loss	1														●							K3a
K4a	Taste alteration	X														●							K4a
K4c	Leave 25% food	X														●							K4c
K5a	Parenteral/IV feeding	X														●		●					K5a
K5b	Feeding tube	X															●	●					K5b
K5c	Mechanically altered	X														●							K5c
K5d	Syringe feeding	X														●							K5d
K5e	Therapeutic diet	2														●							K5e
L1a,c,d,e	Dental	X														●			●				L1a,c,d,e
L1f	Daily cleaning teeth	Not X																	●				L1f
M2a	Pressure ulcer	2,3,4														●							M2a
M2a	Pressure ulcer	1,2,3,4																		●			M2a
M3	Previous pressure ulcer	1																		●			M3
M4e	Impaired tactile sense	X																		●			M4e
N1a	Awake morning	X												②									N1a
	Involved in activities	0												②									N2
	Involved in activities	2,3																					N2
N5a,b	Prefer change in daily routine	1,2										●											N5a,b
O4a	Anti psychotics	1 - 7										●									*		O4a
O4b	Anti anxiety	1 - 7													●						*		O4b
O4c	Antidepressants	1 - 7													●						*		O4c
O4e	Diuretic	1 - 7																●					O4e
P4c	Trunk restraint	1,2													●							●	P4c
P4c	Trunk restraint	2																		●			P4c
P4d	Limb restraint	1,2																				●	P4d
P4e	Chair prevents rising	1,2																				●	P4e

DSHS 14-330(X) (REV. 11/2000)

7/ 9/2004

Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊙	Robert (a. First) Brown (c. Last) — b. (Middle Initial) d. (Jr/Sr)
2.	GENDER ⊙	1. Male 2. Female: 1
3.	BIRTHDATE ⊙	04 – 15 – 1920 (Month Day Year)
4.	RACE/ ETHNICITY ⊙	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin: 5
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊙ [C in 1st box if non med. no.]	a. Social Security Number: 093 – 24 – 6161 b. Medicare number (or comparable railroad insurance number): 093246161A
6.	FACILITY PROVIDER NO. ⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊙	N
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment: 06 — 6. Discharged—return not anticipated; 7. Discharged—return anticipated; 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a. Lenora Jones, RN		7/29/01
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] (AA8a=8)

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* 07 – 22 – 2001 (Month Day Year)
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other: 5

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	21-12

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	a. *Code for resident disposition upon discharge*: 2 — 1. Private home/apartment with no home health services; 2. Private home/apartment with home health services; 3. Board and care/assisted living; 4. Another nursing facility; 5. Acute care hospital; 6. Psychiatric hopital, MR/DD facility; 7. Rehabilitation hospital; 8. Deceased; 9. Other. b. *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* 07 – 29 – 2001 (Month Day Year)

⊙ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MDS 2.0 September, 2000

7/ 9/2004

PRINCIPLE MEDICAL CENTER

SYSTEM COPY - NOT FROM CHARTED ORIGINAL
THIS IS NOT AN OFFICIAL AND LEGAL DOCUMENT

Patient Name: BROWN, ROBERT
Unit Number: 000
Account Number: 011

CHIEF COMPLAINT: Right hip pain and stiffness.

HISTORY OF PRESENT ILLNESS: This is an 81-year-old retired hospital corpsman with a history of right hip progressive osteoarthritis. He was first evaluated in my office in June of this year and x-rays demonstrated severe arthritis of the right hip with complete loss of joint space and massive hypertrophic changes. He has a flexion deformity and antalgic gait and marked pain unrelieved with anti-inflammatory medications. He uses a cane. The patient's preoperative assessment included evaluation by Dr. **Andrea Blair** who has recently performed a circumcision for him because of paraphimosis. The patient is admitted at this time for a right total hip replacement. He understands the indications for this reconstructive procedure and the potential risks and complications.

PAST MEDICAL HISTORY: Remote hernia repair on four occasions, cholecystectomy, appendectomy, and removal of a left branchial cleft cyst. The patient also has difficulties with osteoarthritis of his left knee which is less symptomatic than the hip.

CURRENT MEDICATIONS:
1. Hydrochlorothiazide 25 mg once daily.
2. Tylenol for pain. He has used Vicodin in the past but not currently.

ALLERGIES: Sensitive to aspirin which once caused a gastroesophageal irritation which may have been local aspirin burn rather than an allergy.

PRIMARY CARE PHYSICIAN: DR. SMITH

REVIEW OF SYSTEMS: Positive for use of glasses, early cataract formation, presence of hypertension, loss of hearing in the right ear, and positive glucose tolerance test recently controlled with 1,800 calorie ADA diet.

PHYSICAL EXAMINATION: 5 feet 5 inches, 200 pounds. Blood pressure 132/74. Pleasant adult male appearing his stated age or younger. His gait is obviously antalgic with a flexed hip and knee on the right side. He uses a cane. He has difficulty lying supine because of the loss of hip motion. Head and neck exam shows a normal conjunctivae, nose, and mouth. He has upper dentures. Oropharynx is otherwise benign. Neck supple. No thyromegaly. Chest clear to auscultation.

PRINCIPLE MEDICAL CENTER

SYSTEM COPY - NOT FROM CHARTED ORIGINAL
THIS IS NOT AN OFFICIAL AND LEGAL DOCUMENT

Patient Name: BROWN, ROBERT
Unit Number: 0004
Account Number: 0118

Heart tones regular and without murmur. Abdomen soft, moderately protuberant. No hepatosplenomegaly. Musculoskeletal findings; the patient's right hip has 40 degree flexion contracture and maximum flexion of 90 degrees. Internal and external rotation are nil. Slight adduction contracture is noted which corrects to neutral and not beyond. His left hip has essentially full motion and no pain. His left knee has a varus deformity of about 5 degrees with tenderness along the medial joint space and moderate synovitis. The knee is stable. His right knee has normal alignment or very slight varus.

IMPRESSION: Severe right hip osteoarthritis with contracture and moderately severe left knee osteoarthritis.

PLAN: The patient is admitted at this time for right total knee arthroplasty.

Dictated and Authenticated by:
Martin Temps, M.D.

MT/ghs

PRINCIPLE MEDICAL CENTER

Ord#	Drug/Dose Route, Comments	Freq	Sched	Start	Stop	0700 - 1459	1500 - 2259	2300 - 0659
*****	SCHEDULED MEDICATION ORDERS *****							
0017 (1) ME	HYDROCHLOROTHIAZIDE 25 MG HYDRODIURIL [GENERIC] Dose: 25 MG/1 TABLET [ORAL]	QAM		07/18 1000		1000 0830 ✓		
0026 (2) MM	POTASSIUM CHLORIDE 20 MEQ K-DUR Dose: 20 MEQ/1 TABLET CR [ORAL] [DO NOT CRUSH]	BIDWF		07/18 0800		0800 0830 ✓	1730	
	WARFARIN 3W 309-02 COUMADIN 5 MG/1 TABLET [ORAL] QDW QD Ord#: 35 Start 07/20/01 0854						1600	
	SENNA CONCENTRATE 3W 309-02 SENOKOT [GENERIC] 374 MG/2 TABLET [(BID QD Ord#: 34 Start 07/20/01 0853 NOTE DOSE (2 TABS) (SENNA CONC 187 MG = SENNOSIDES 8.6 M(					1000 0945 ✓	2200	
*****	PRN MEDICATION ORDERS *****							
0004 (1) JW	NALOXONE 0.4 MG / 1 ML NARCAN [GENERIC] Dose: 0.04 MG/1 ML [IV] **NOTE DILUTE PER ORDER*** DILUTE 0.4mg to 10ml with NS (CONC=0.04mg/ml), give 1ml of soln q2min until adequate respirations, MR q20min PRN	PRN	PRN	07/17 1200	DC			
0005 (1) JW	DIPHENHYDRAMINE 50 MG / 1 ML BENADRYL [GENERIC] Dose: 25 MG/0.5 ML [IV] FOR ITCHING	Q3-4P	PRN	07/17 1200	DC			
0006 (1) JW	NALBUPHINE 10 MG / 1 ML NUBAIN [GENERIC] Dose: 5 MG/0.5 ML [SC] FOR ITCHING PER EPIDURAL ORDER	Q4HP	PRN	07/17 1200	DC			

OrdRN	STAT MEDICATION	AdmRN	TIME	OrdRN	STAT MEDICATION	AdmRN	TIME

Site Code: R-Right L-Left D-Deltoid G-Gluteal T-Thigh AB-Abdomen ↓-Lower ↑-Upper M-Mid

KEY TO UNADMINISTERED DOSES:
R-REFUSED C-CONDITION OF PATIENT A-ABSENT DO-DOCTOR'S ORDER

INT	SIGNATURE	INT	SIGNATURE

MAR Verified by: Theresa Simmons, RN 7/20/01 0615

Age: 81Y Height: 167.5cm Weight: 85.7(63.80)kg BSA: 1.95sq m
Dx: SEVERE OSTEOARTHRITIS, HIP, RT
Adm: 07/17/01 DOB: 04/15/20 Dr: Martin Temps
Sex: M

BROWN, ROBERT

Page: 1 (more meds follow...)
Covers Doses from 07/20/01 0700 to 07/21/01 0659

MEDICATION ADMINISTRATION RECORD

PRINCIPLE MEDICAL CENTER

Ord#	Drug/Dose Route, Comments	Freq	Sched	Start	Stop	0700 - 1459	1500 - 2259	2300 - 0659
*****	PRN MEDICATION ORDERS (cont.) *****							
0007 (2) JW	DROPERIDOL 2.5 MG / 1 ML INAPSINE Dose: 0.625 MG/0.25 ML [IV]	Q6HP	PRN	07/17 1200		Dcd		
0008 (2) JW	METOCLOPRAMIDE 10 MG / 2 ML REGLAN [GENERIC] Dose: 10 MG/2 ML [IV] FOR NAUSEA	Q4-6P	PRN	07/17 1200		Dcd		
0009 (1) JW	DOLASETRON 12.5 MG / 0.625 ML ANZEMET Dose: 12.5 MG/0.625 ML [IV]	Q4-6P	PRN	07/17 1200		Dcd		
0010 (1) JW	NALOXONE 0.4 MG / 1 ML NARCAN [GENERIC] Dose: 0.04-0.08 MG/0.1-0.2 [IV]	Q1HP	PRN	07/17 1200		Dcd		
0011 (6) JW	MORPHINE SULFATE 4 MG / 1 ML MORPHINE SULFATE Dose: 1-2 MG/0.25-0.5 ML [IV] TITRATE TO PAIN CONTROL	Q1HP	PRN	07/17 1200	07/22 2153	Dcd		
0021 (4) ME	HYDROCODONE/APAP 5-500 VICODIN/LORTAB [GENERIC] Dose: 1-2 TABLET [ORAL] FOR PAIN [NOTE ACETAMINOPHEN CONTENT]	Q4HP	PRN	07/17 1600	07/23 2359	0830(2) JS 1250(2) JS		
	Ducolax Supp PRN					1115 JS		
	MOM 30cc PRN					0815 JS		

OrdRN	STAT MEDICATION	AdmRN	TIME	OrdRN	STAT MEDICATION	AdmRN	TIME

Site Code: R-Right L-Left D-Deltoid G-Gluteal T-Thigh AB-Abdomen
↓-Lower ↑-Upper M-Mid

KEY TO UNADMINISTERED DOSES:
R-REFUSED C-CONDITION OF PATIENT A-ABSENT DO-DOCTOR'S ORDER

Age: 81Y Height: 167.6cm Weight: 85.7(63.80)kg BSA: 1.95sq m
Dx: SEVERE OSTEOARTHRITIS, HIP, RT
Adm: 07/17/01 DOB: 04/15/20 Dr: Martin Temps
Sex: M

BROWN, ROBERT

INT	SIGNATURE	INT	SIGNATURE

MAR verified by: Theresa Simpson, RN
7/20/01 01:15

Page 2 (end of MAR)
Covers doses from 07/20/01 0700 to 07/21/01 0659

MEDICATION ADMINISTRATION RECORD

PRINCIPLE MEDICAL CENTER

PHYSICAL THERAPY INITIAL ASSESSMENT

Patient: Robert Brown Physician: Dr Martin Temps

Assessment Date: 7-20-01 Admit Date: 7-19-01 Time: 0930-1030 Tx: ASI FA 2 Tx 1

Order: ☒ PT Eval & treat: THA

Pertinent Hx: _____

Previous Hx ☐ Nursing H & P Noted _____

Precautions/ Comments: 50% WB; ΦV > 90°; ΦAD, ΦIR

PATIENT'S GOAL AS STATED BY PATIENT:

HOME SITUATION/OCCUPATION/ STATUS PRIOR TO ADMIT/ ESTIMATED PRE-ADMISSION HILS SCORE: _____

___ falls in 6 months Lives w/ spouse; plans R.T.N.H. P d/c

THERAPEUTIC ADAPTATIONS:

Equipment in Place ☐ RTS ☐ BSC ☐ shower/ bath chair ☐ tub transfer bench ☐ grab bars ☐ hand held shower ☐ ramp ☐ hospital bed ☐ cane ☐ FWW ☐ pick up walker ☐ w/c ☐ mechanical lift ☐ lift chair ☐ none

Other:

ENVIRONMENTAL BARRIERS: ___ # of Stairs Outside ☒ Railing 2 ___ # of Stairs Inside ☐ Railing

Prefers using 2 rails for stairs

PSYCHOSOCIAL STATUS:

Mood: ☒ appropriate ☐ depressed ☐ labile ☐ anxious ☐ irritable ☐ angry ☐ other

Affect: ☐ appropriate ☐ flat ☐ blunted ☐ lethargic ☐ other

COMMENTS:

AROUSAL/ORIENTATION:

Level of Arousal: ☒ Alert ☐ Lethargic ☐ Able to arouse with stimuli ☐ Difficult to arouse ☐ Unable to arouse ☐ Sedated

Orientation: ☐ Person ☐ Place ☐ Time ☐ Situation ☒ Not Formally Tested – WNL ☐ Dementia

COMMENTS:

SUBJECTIVE:

PAIN: mod. sciatic pain > hip pain

SENSORIMOTOR SKILLS:

SENSATION: ☒ Intact ☐ Impaired ☐ Absent ☐ Not Tested

COMMENTS:

ROM:

RUE: ☒ WFL ☐ Except _____ ☐ Not Tested

LUE: ☒ WFL ☐ Except _____ ☐ Not Tested

RLE: ☐ WFL ☒ Except ltd. by pain ☐ Not Tested

LLE: ☒ WFL ☐ Except _____ ☐ Not Tested

TONE: ☐ Normal ☐ Hypotonicity ☐ Hypertonicity ☒ Not Tested

COMMENTS:

RUE: ☒ WFL ☐ Except _____ ☐ Not Tested

LUE: ☒ WFL ☐ Except _____ ☐ Not Tested

RLE: ☐ WFL ☐ Except ltd by pain ☐ Not Tested

LLE: ☒ WFL ☐ Except _____ ☐ Not Tested

COORDINATION: ☐ WFL ☐ Impaired ☒ Not Tested COMMENTS:

BALANCE: ☒ FWW ☐ Pick-up walker ☐ Hemi-walker ☐ LBQC ☐ SBQC ☐ SPC ☐ Crutches ☐ Hand Held Assist ☐ No Device

Sitting (static)	☐ T	☐ T+	☐ P-	☐ P	☐ P+	☐ F-	☐ F	☐ F+	☐ G-	☒ G	☐ G+	☐ Normal	☐ Not Tested
Sitting (dynamic)	☐ T	☐ T+	☐ P-	☐ P	☐ P+	☐ F-	☐ F	☐ F+	☐ G-	☒ G	☐ G+	☐ Normal	☐ Not Tested
Standing (static)	☐ T	☐ T+	☐ P-	☐ P	☐ P+	☐ F-	☐ F	☐ F+	☐ G-	☒ G	☐ G+	☐ Normal	☐ Not Tested
Standing (dynamic)	☐ T	☐ T+	☐ P-	☐ P	☐ P+	☐ F-	☐ F	☐ F+	☐ G-	☒ G	☐ G+	☐ Normal	☐ Not Tested

Comments _____

ENDURANCE: ☐ T ☐ T+ ☐ P- ☒ P ☐ P+ ☐ F- ☐ F ☐ F+ ☐ G- ☐ G ☐ G+ ☐ Normal ☐ Not Tested

Comments:

Evaluation continues on reverse

MR#: AGE:81Y
SEX:M DOB:04/15/1920
BROWN, ROBERT

PRINCIPLE MEDICAL CENTER

VITAL SIGNS	PRE	POST I	POST II
Sp02			
Pulse			
Blood Pressure			

MOBILITY:

	N/T	Dep	Max	Mod	Min	CGA	SBA	Ind	Comments
Rolling (Right)	✓								
Rolling (Left)	✓								
Supine → Sit					✓				Cues
Sit → Supine									
Sit → Stand						✓			Cues
Stand → Sit						✓			
Bed Transfers						✓			c FWW
CHAIR / BSC Transfer									

GAIT: ☐ FWW ☐ Pick-up walker ☐ Hemi-walker ☐ LBQC ☐ SBQC ☐ SPC ☐ Crutches ☐ Hand Held Assist ☐ No Device

Distance	N/T	Dep	Max	Mod	Min	CGA	SBA	Ind	Comments/ Deviations
1. to w/c									
2.									

FAMILY EDUCATION NEEDS: ☐ Total Hip Protocol Patient / Family Education Packet Provided

EQUIPMENT RECOMMENDATIONS:
☐ w/c ☐ FWW ☐ Pick-up walker ☐ hemi-walker ☐ LBQC ☐ SBQC ☐ SPC ☐ Crutches ☐ RTS ☐ BSC ☐ Shower / Bath Chair
☐ w/c transfer bench ☐ grab bars ☐ hand-held shower ☐ ramp ☐ hospital bed ☐ lift ☐ None
Other:

ASSESSMENT: HILL SCORE: I / IV - 2

Patient's improvement complicated by lower back pain with sciatica; will need to be completely independent as wife will be unable to help. Should do reasonably well, but will benefit from short term nursing home placement for skilled rehab.

IMMEDIATE TREATMENT GOALS

1. Amb 5' by 7/28
2.
3.

☑ The patient demonstrates an understanding and agrees with the above established treatment goals.

☐ The patient is unable to participte ind/or does not understand the established goals due to decreased cognition.

TREATMENT PLAN

☑ Gait Training
☑ Muscle Strengthening
☑ Endurance Training
☐ Adaptive Equipment
☐ Balance
☐ Modalities
☐ Other
☑ Transfer Training
☑ Range of Motion
☐ Stroke Rehabilitation
☐ Pain Control
☐ Cardiac Rehabilitation
☐ Coordination
☐ Caregiver Training

LONG TERM (DISCHARGE) GOALS: ☐ Adequate mobilization for least restrictive discharge environment.
☐ Other

FREQUENCY/DURATION OF TREATMENT: ☑ BID ☐ QD ☐ QOD ☐ Other

REHABILITATION OPTIONS:
☐ HOME INDEPENDENT
☐ HOME WITH SUPPORT
☐ HOME WITH HOME HEALTH
☐ OTHER _____
☑ SKILLED NURSING
☐ NURSING HOME
☐ INPATIENT REHAB

CONTINUED P.T. NEEDS
☑ SKILLED NURSING P.T.
☐ OUTPATIENT P.T.
☐ INPATIENT REHAB P.T.
☐ HH P.T.
☐ NO P.T. NEEDED

THERAPIST SIGNATURE: M. Summit, PT

7/ 9/2004

PRINCIPLE MEDICAL CENTER

POST-ACUTE CARE ORDERS

PHYSICIAN: PLEASE FILL OUT ALL ORDERS

DATE TO BE ADMITTED: _____ (MONTH/DAY/YEAR)

Upon discharge from facility, transfer to:

- [x] Nursing Facility NOSTALGIC VIEW
- [ ] Hospice _____
- [ ] Home Health Agency _____
- [ ] Other _____

Admit to service of Dr. TEMPS — Next visit: _____

Consulting Dr. SMITH — Next visit: 3 WEEKS

PRINCIPAL DIAGNOSIS Severe Osteoarthritis (R) Hip — List one condition only

(The condition established after study and tests to be chiefly responsible for causing the admission to the SNF, Home Health Agency, or Hospice)

SECONDARY DIAGNOSIS [ ] Hypertension

MAJOR PROCEDURES PERFORMED/DATE(S) [ ] 7/19/01 (R) THA

PRIOR CONDITIONS *Mark any of the following condition experienced within the last 14 days:*

- [ ] Urinary incontinence
- [ ] Indwelling/suprapubic catheter
- [ ] Intractable pain
- [ ] Impaired decision-making
- [ ] Memory loss to the extent that supervision required
- [ ] Disruptive or socially inappropriate behavior

CODE STATUS [x] Full Code [ ] No Code *(indicate with whom discussed)* _____

Date of progress note documenting discussions of above: _____ (MONTH/DAY/YEAR)

Comments:

DIET

- [x] General
- [ ] Na Restriction _____
- [ ] ADA/LoCal _____ calories
- [ ] Soft
- [ ] Mechanical soft
- [ ] Pureed
- [ ] Unrestricted diet on special occasion:
- [ ] NPO
- [ ] Dysphagia Liquids: [ ] spoonable [ ] honey thick [ ] nectar thick [ ] regular
- [ ] Oral supplements:
- [ ] NG Tube _____
- [ ] Gastrostomy tube _____

Tube feeding: [ ] Temporary [ ] Permanent Tube size _____ Change prn/MD or

Formula _____ Amount & frequency _____ [ ] Facility residual protocol

Flush with _____ Amount & frequency _____

Comments:

MOBILITY

- [ ] Up ad lib
- [x] Partial Weight Bearing: 50-75 %
- [ ] Ambulation with A
- [ ] Other _____
- [ ] Non Weight Bearing Right/Left
- [ ] Bed Rest
- [x] Equipment, List: WALKER Hip Dislocation Precaution

REHAB POTENTIAL *(Anticipated level of functioning following treatment)*

For ADL:	[x] Independent	[ ] Will Require Assist	[ ] Dependent
For Mobility:	[x] Independent	[ ] Will Require Assist	[ ] Dependent

ANTICIPATED DISCHARGE PLAN

- [ ] Expect long term placement
- [ ] Assisted Living
- [x] Home Independent
- [ ] Home with Assist
- [ ] Home Health
- [ ] Other:

CERTIFICATION FOR SKILLED NURSING (SNF) OR HOME HEALTH CARE:

I certify that post hospital Skilled Nursing Care/Home Health Services is medically necessary on a continuing basis for one or more of the conditions for which he/she received care during this hospitalization.

[x] **Patient requires skilled care.** *Select service desired (home health requires frequency/duration)*

[x] Nursing Facility	[ ] Home Health Services	[ ] Home Hospice Care
[x] Physical Therapy [x] Occupational TX [ ] Speech/Swallow TX [ ] Hospice Care @ NH [ ] Patient has a six month or less life expectancy.	[ ] Skilled Nursing [ ] ___ x a week x ___ weeks, [ ] _____ [ ] daily x ___ days, [ ] BID X ___ days, [ ] then reevaluate frequency [ ] Physical Therapy: Evaluation and treatment [ ] Occupational Therapy: Evaluation and treatment [ ] Speech/Swallow Therapy: Evaluation and treatment [ ] Home Health Aide _____ times a week x _____ weeks [ ] MSW Consult [ ] Dietitian Consult	for end-stage illness [ ] Patient has a six month or less life expectancy.

[ ] **No skilled care required** [ ] **Custodial inpatient care** [ ] **Hourly Care/Agency:**

ATTENDING PHYSICIAN SIGNATURE: Michael Temps, M.D. DATE: 7/21/01

RESIDENT	PHYSICIAN	ROOM/BED
ROBERT BROWN	TEMPS	

MR#: 462 AGE:81Y
SEX:M DOB:04/15/1920

7/ 9/2004

PRINCIPLE MEDICAL CENTER

POST-ACUTE CARE ORDERS

SKIN/WOUND CARE ORDERS # Skin lesions present at time of discharge:

Location:

Wound Care Procedure: (R) Hip wound. — MAY SHOWER
New Dressing PRN
Remove Staples on 7/28/01

Frequency: ☐qd ☐BID ☐q_____hrs ☐Other:

☐Preventative skin care protocol: or ☐Agency/Facility Protocol

CATHETERS Catheter type: ☐Foley ☐Suprapubic ☐N/A-no catheter

Treatment Plan: Catheter size_____Frequency of catheter change _____☐per protocol

☐ Indwelling catheter/ Specific indication:

- ☐Neurogenic bladder
- ☐Urinary retention
- ☐Contamination of wound
- ☐Other

Comment:

LABORATORY Protime qwk on Monday X2

OXYGEN THERAPY _____ L/min. per ☐ N/C ☐ Mask

☐Titrate to keep sats above:

MEDICATIONS AND OTHER ORDERS *Generic and therapeutic equivalents will be used unless otherwise indicated.*

☒Nursing Home/Agency/ bowel Protocol, including protocol medications

☒May go out on pass with medications(SNF)

☒Tylenol 650 mg. P.O q 4 hr PRN Temp. or generalized pain.

☐Fluogen vaccine 0.5 cc IM q year (Fall) ☐May have Pneumovac XI ☐TD Booster 0.5 cc IM q 10 years

For SNF Resident: ☒2 Step PPD (required by State Law) unless patient has history of T.B. or positive testing. If positive or history & first admit to SNF -order chest X-Ray to rule out active T.B.. Repeat PPD per facility protocol.

All meds must have diagnosis/indication for use. I.E., pain, elevated temperature, nausea/vomiting. Any p.r.n. meds not used for 60 days may be discontinued after being assessed and documented by a licensed nurse.

	Allergies/Sensitivity
Vicodin ī - ii po q4-6hrs prn pain	
HCTZ 25 mg po qd.	UKA
KDUR 20 meq po qd	
Coumadin 4.0 mg po q.d.	
MVI ī po qd	
Fe SO4 325 mg po bid.	
Genokot ī - ii po q12hrs prn constipation	

noted 7-22-01
Theresa Simpson, RN

MR#: 462 AGE:81Y
SEX:M DOB:04/15/1920
BROWN, ROBERT

COPIES SENT TO NURSING FACILITY/HOMECARE AGENCY

☐History and Physical ☐Care Summary RN, MSW, RDT ☐Med Sheets for last 7 days

☐Lab Reports for last 7 days ☐X-Ray Reports for last 7 days ☐Therapy Reports: ☐PT ☐OT ☐ST

☐Other:

RESIDENT	PHYSICIAN	ROOM/BED
ROBERT BROWN	TEMPS	

Principal Medical Laboratories, Inc. P.S.

M7657 COLL: 07/26/01 35 REC: 07/26/01 10:30 PHYS: SMITH, MICHAEL

PROTIME & INR

PT	H 41.3		
INR	3.7	[10.5-13.3]	seconds

Called to Dr. Temps re orders rec. 7/27/01 L Signature

BROWN, ROBERT DOB 04/15/1920 M
33701856
SMITH, MICHAEL
COPY TO: Nostalgic View
PRINTED: 07/26/01 11:32
INTERIM REPORT

COAGULATION - PML LAB

DATE: 07/23/01
TIME: 0535

		REF RANGE	UNITS
PROTIME	41.3 H		
INR	3.7	10.5-13.3	seconds

ROBERT BROWN
DR. MICHAEL SMITH
COPY TO: NOSTAGIC VIEW

DOB: 04/15/1920 M

OUTPATIENT FINAL REPORT

PHYSICIAN ORDERS

FACILITY	CYCLE START	CYCLE END	CHART CO

D.C	ORDER DATE	ORDER CODE	TIME	ORDER TEXT	DESC. T

ORIGINAL COPY - PHYSICIAN PLEASE SIGN & RETURN

RESIDENT'S NAME	PRESCRIBING PHYSICIAN	FACILITY	ADMISSION NUMBER	ROOM NO.
Brown Robert	Dr. Temps	PMT	21-12	200-1

DELETE	ORDER NO.	ORDER DATE	CODE	TIME	PHYSICIAN ORDERS / DIAGNOSIS / PROBLEM
				1550	(R) Hip - THA
		7-25-01			Hold Coumadin 7/25, 7/26
					Then start Coumadin 2mg po qd
					next PT/INR 8/01
					TO: Dr. Temps / Michelle Trends, RN

GENERIC DRUG MAY BE SUBSTITUTED UNLESS SPECIFICALLY INDICATED OTHERWISE

SIGNATURE OF NURSE

SIGNATURE OF PHYSICIAN Martin Temps MD DATE 8/6/01

RESIDENT NOTIFIED _____ FAMILY NOTIFIED _____ CARE PLANNED YES ☐ NO ☐ N/A ☐

PHYSICIAN	PHONE NO.	ALTERNATE PHYSICIAN	PHONE NO.

DIAGNOSES	ALLERGIES
	ASA - Gastric Irritation

NAME	RECORD NO.	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PA
Brown, Robert	21-12	200-1				

PHYSICIAN ORDERS

CHART CO

FACILITY	CYCLE START	CYCLE END

D/C	ORDER DATE	ORDER CODE	TIME	ORDER TEXT	DESC. T
	7-29-01			Resident may DC to home c̄ current medications and Harrison Home Health therapies of RN for wound mngmt, PT, OT and bath aide	
				HCTZ 25mg PO QD	
				K-dur 20mEq PO QD	
				multivit. i̇ tab PO QD	
				$FeSO_4$ 325mg PO BID	
				Coumadin 2mg PO QD	
				Docusate 250mg PO QD	
				Vicodin i̇ or ii̇ tabs PO prn 6°	
				TO: Dr. Tamps / L. Signature, RN 7/29/01	

PHYSICIAN	PHONE NO.	ALTERNATE PHYSICIAN	PHONE NO.
		Dr. Smith	

DIAGNOSES	ALLERGIES

NAME	RECORD NO.	LOCATION	BIRTHDATE	AGE	ADMIT DATE	D/
Brown, Robert	21-12	200-1				

Page 1 of 1

NOSTALGIC VIEW
4509 LEXINGTON LANE
KENT TOWN, WA 98331

Facsimile Physician Notification; Order Request

Date: 7-26-01 Time: 1210 ~~X~~a.m. ~~X~~p.m.

Patient: Brown, Robert Room # 200-2
To Doctor: Temps
From: L Signature (RN) LPN

[ ] URGENT Urgent requires immediate physician contact and response
[ ] Routine (Physician please respond today)
Diagnosis: @ his THA, constipation
Vitals: B/P ____ P ____ T ____ Resp ____ O2 Sat ____
Allergies: ____

Nurse's Assessment and Request of Physician:

Dr. Temps, Mr. Brown is c/o constipation. He is on Vicodin for pain, which he is taking ~ 3 x day. We were wondering if DOSS 250 mg po BID would be appropriate for him.

Thank you
L Signature

PHYSICIAN ORDERS	DIAGNOSIS/PROBLEM
DOSS 250 mg po bid	
Senolest I-II po bid prn	

Noted Lunar 7-27-01

GENERIC DRUG MAY BE SUBSTITUTED UNLESS SPECIFICALLY INDICATED OTHERWISE

SIGNATURE OF NURSE	SIGNATURE OF PHYSICIAN	DATE
	[signature] Temps MD	7/27/01

(NOTE: This form does not replace required physician intervention including necessary physician visit and examination of the patient. RMT reserves the right to refer urgent matter to its Medical Director. Such referral does not alleviate the attending physician's responsibility to his/her patient.)
4/9/98

Page 1 of ____

NOSTALGIC VIEW

Facsimile Physician Notification, Order Request

Date: 7/28/01 Time: 11:40 [✓] a.m. [ ] p.m.

Patient: Brown, Robert

To Doctor: Smith Room # 200-1

From: Lissa Horn RN / LPN

[ ] URGENT Urgent requires immediate physician contact and response

[ ] Routine (Physician please respond today)

Diagnosis:

Vitals: B/P ____ P ____ T ____ Resp ____ O2 Set ____

Allergies:

Nurse's Assessment and Request of Physician:

Request for DC orders:

May we please have orders for Mr Brown to DC to home tomorrow (7/29) c̄ current medications, Lasting Way Home health PT, OT + bath aide? He has done very well + is ready to be DCd

L. Horn RN

PHYSICIAN ORDERS DIAGNOSIS/PROBLEM

Dr. Temps to give order

Rec'd Temps from Dr. [illegible] 0940 [illegible]

GENERIC DRUG MAY BE SUBSTITUTED UNLESS SPECIFICALLY INDICATED OTHERWISE

SIGNATURE OF NURSE	SIGNATURE OF PHYSICIAN	DATE
	[signature]	7/28/01

(NOTE: This form does not replace required physician intervention including necessary physician visit and examination of the patient. RMT reserves the right to refer urgent matter to its Medical Director. Such referral does not alleviate the attending physician's responsibility to his/her patient.)

4/9/98

Copyright Pending HRF

NOSTALGIC VIEW

HRF-324

INCLUDED IN THIS COLUMN:
Therapy - Programs
Fitting of Prosthetic Device

DATE	Diagnoses	DR. &/or Nurse's Initials	Date Resolved	ICD No.	Circumstances surrounding incident	ICD No
7/22/01	Severe O arthritis			715.95		
	@ THA			V54.8		
	HTN			401.9		
	Ostoarthritis @ Knee			715.96		
	Remote hernia repair on four occasions			—		
	Hx of cholecystectomy Appendectomy, removal of branchial cleft cyst			—		
	early cataracts	/		366.9		
	loss of hearing @ Ears			389.9		
✓	⊕ glucose tol. test diet controlled					

DIAGNOSES UPDATE RECORD

PATIENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
BROWN, ROBERT	SMITH, MICHAEL	21-12	200-1

NOSTALGIC VIEW

ADMISSION INFORMATION	MODE OF TRANSPORT
Date 7-22-01 Time 1545 Admitted from PMC Accompanied by wife Occupation navy corpsman/	[ ] Ambulance [ ] Private Car [X] RMT Van [ ] Stretcher [X] Wheelchair [ ] Ambulatory Other Comments

NEUROLOGICAL	PULMONARY
Speech [X] Clear [ ] Garbled Oriented to [X] Person [X] Place [X] Time Follows Command [X] Yes [ ] No Grips [X] Equal [ ] Unequal (____ > ____) Movement [X] R Arm [X] R Leg [X] L Arm [X] L Leg Mobility Status [ ] Independent [X] One Person Assist [ ] Two Person Assist Assistive Devices FWW Prosthetic Devices Other Comments	[ ] Shortness of Breath Respirations [X] Regular [ ] Irregular [X] Deep [ ] Shallow Breath Sounds [X] Clear [ ] Diminished [ ] Wheezes Rales Rhonchi O2 sat ____ Amt. O2 on ____ Other Comments

HAND DOMINANCE
[X] R [ ] L

CARDIOVASCULAR	GASTROINTESTINAL
Heart Sounds (S1) (S2) S3 S4 Apical Pulse 92 B/P [ ] Rub [ ] Click [ ] Murmur [ ] JVD Pulses [X] Dorsalis [ ] Post Tibial C/P [ ] Yes [X] No Other Comments	Bowel sounds [ ] Absent [ ] Present Date last BM 7/20 Abdomen [ ] Soft [ ] Firm [ ] Ridged [ ] Distended Tube Feeding [ ] Ostomy N/V/D [ ] Yes [X] No Other Comments

ASSISTIVE DEVICES	RENAL
Hearing Aid [ ] Left [ ] Right [X] Glasses Does resident use device [ ] Yes [ ] No Is device effective [ ] Yes [ ] No Dentures [X] Upper [X] Lower [ ] Partial Own Teeth [ ] Yes [X] No	[X] Voids [ ] Catheter [ ] Ostomy Urine Color/Sed Continent [X] Yes [ ] No Other Comments foley DC'd 7/21

Signature:_____ Date:_____

ADMISSION NURSING ASSESSMENT

RESIDENT	PHYSICIAN	ADMIT #	BED #
ROBERT BROWN	SMITH	21-12	200-1
Admit Info Form			

NOSTALGIC VIEW

BASELINE MEASUREMENTS (In Centimeters)

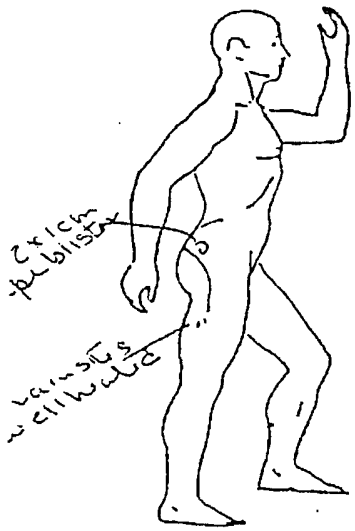
Arch: (R) 23cm (L) 24cm Measure 4" from tip of great toe around arch of foot
Ankle: (R) 20.5cm (L) 21.5cm Measure directly above ankle bone
Calf: (R) 33.5cm (L) 34cm Measure 8" above ankle bone at mid-calf

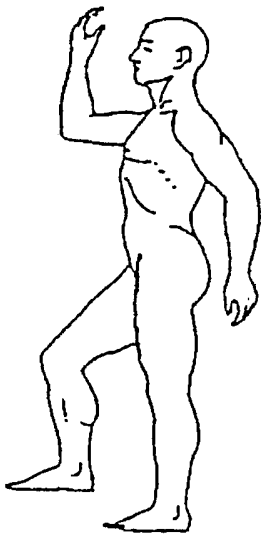
---

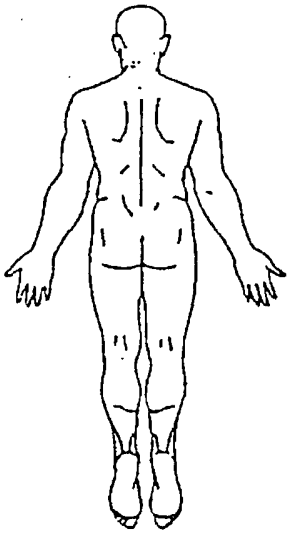
SKIN ASSESSMENT

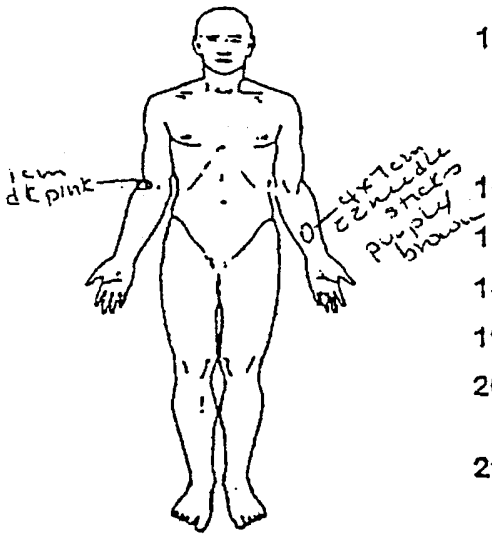
Indicate type of condition on diagrams

HEIGHT 6'6"









1. Dry Skin ___
2. Scaly Skin ___
3. Oily Skin ___
4. Jaundice ___
5. Cyanosis ___
6. Decubitus ___
7. Pressure Area ___
8. Blister ___
9. Bruise ___
10. Scratch ___
11. Abrasion ___
12. Scab ___
13. Burn ___
14. Swelling ___
15. Surgical Incision
    a. Old ___
    b. New ___
16. Mass/Tumor ___
17. Corns ___
18. Calluses ___
19. Discoloration ___
20. Other (Specify) ___
21. None apparent ___

Skin Temperature: warm, dry

Posture: erect

Signature: L Signature, RN Date: 7-22-01

Robert Brown

7/ 9/2004

NOSTALGIC VIEW

Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines
7-22-01	1545	Nsg		81 yr old male appearing younger than stated age. Admitted from PMC via STE van. In w/c. Alert, oriented X 3. Skin WID, lungs clear - good air exchange all lobes. Abd soft, BS (+), pedal pulses palpable bilaterally. Ø edema in LE's. Oriented to room, call light. Wife @ bedside. Surg incision (R) hip c̄ edges well approximated. Staples intact. Drain-site closed and healing. 2x1 cm intact blister @ surg site (R) hip. —— Lenda Adams, RN
7/22/01	2230	Nsg		A&O x 3. Lungs clear c̄ good air exchange. No pedal edema. Pedal pulses (+). Up amb c̄ FWW c̄ steady gait. OT/PT here for eval. Ate c̄ good appetite in room. Intake 480, voids x 3. Requested + given vicodin ii p.o. for c/o mod (R) hip pain c̄ good relief obtained. (R) hip c̄ staples intact, no s/s of infection. Vss. No abnormal bleeding. Will monitor —— Lenda Adams, RN
7/23/01	0745	SW		Admit Note: 81 year old male admitted from PMC. He presented for (R) total Knee arthroplasty due to ↓ gait, pain, progressive osteoarthritis. Hx include hernia repair x 4, cholecystectomy, removal of (L) branchial cleft cyst. He does not drink or smoke. Patient resides with wife who had surgery 1 year ago and is very frail. She is not able to help husband with care at this time. Both still drive. Patient uses glasses, has loss of hearing in (R) ear. Cognition x 4. Very pleasant, talkative. Adm. coordinator completed all paperwork c̄ resident expressing understanding of bed hold, rules + regulations, HCP of facility offerings. Resident has a Health Care Package (HCP) which is under legal section. Resident plans on returning
Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines

MULTIDICIPLINARY PROGRESS NOTES

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
ROBERT BROWN	SMITH	21 - 12	200 - 1

NOSTALGIC VIEW

Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines
7/23/01	0745	SW-Cont		home with wife and will probably need some in-home assistance for wife / resident upon discharge. With Team, SW follows with any psychosocial issues that may arise at d/c planning. ——— M. Binder, SSD
7/23/01	1500	NSg		VS 138/76 98.4 88. (R) hip surgical incision c staples intact. Ø s/s of infection noted. Ø LE edema noted. Lungs CTA - Ø SOB c exertion. Continue to work c therapy services. Medicated c vicodin for PRN hip pain c good relief provided. Resident A+OX3, mood pleasant, enjoys visiting + joking c staff. Intake 1350 cc, voided x3. ——— Linda Adams, RN
7/23/01	2330	NSg		A+O. Cooperative c care. Able to make needs known. Staples intact, pain point dry, sero sang drainage to old dsg from hospital. Ø s/s of infection. Ø abnormal bleeding noted. Ø s/s of hypo/hyper glycemia. c/o (R) hip pain x's ÷. Medicated c vicodin c good results. — Michelle Brenda, RN
7/24/01	0815	NSg		VSS A+OX3. Quiet night c no c/o discomfort. Able to make needs known. (R) hip c dsg clean dry + intact. Hip precautions observed. Will monitor. Ipason, RN
7/24/01	1300	NSg		VS 142/68 98.0 88 20. A+OX3. Makes needs known. Enjoys visits from family + visiting c staff. Staples intact to (R) hip surgical incision c Ø s/s of infection noted. Vicodin providing relief to PRN surgical pain. Lungs CTA Ø LE Edema. Appetite good. Intake 920 cc, voided x3. No s/s of hypo/hyper glycemia. No new signs problems noted - Ipason, RN
7/24/01	2330	NSg		A+O. Cooperative c care. Able to make needs known. Staples intact to (R) hip. Scant amount of sero drainage to old dsg. Ø s/s of infection. Ø abnormal bleeding noted. C/O severe (R) hip pain
Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines

MULTIDICIPLINARY PROGRESS NOTES

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
ROBERT BROWN	SMITH	21 - 12	200 - 1

NOSTALGIC VIEW

Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines
7/24/01	2300	Nsg (Cont)		X's ii. Medicated c̄ vicodin c̄ good results. (R) LE c̄ non pitting edema ——— Michelle Brands, RN
7/25/01	0800	Nsg		VSS. A+O x3. Aware of health status. Hip precautions observed. Resp even, non-labored. Denies discomfort — Brenda Sills, RN
7/25/01	1400	Nsg		Appt made with Dr. Temps on Aug 16th @ 1:30p — Resident notified. ——— Brenda Sills, RN
7/25/01	1430	Nsg		VSS. Afebrile. A+O x3. Pleasant, cooperative, able to direct own care. Follows hip precautions. No S/S of infected (R) hip incision — edges well approximated. ——— S. Anderson, RN
7/25/01	2330	Nsg		A+O. Cooperative c̄ care. Able to make needs known. Staples intact to (R) hip. Pin point spots of sero drainage to old dsg. Dsg Δ'd per order. Ø S/S of infection. Superficial blister resolving s̄ complications. Ø abnormal bleeding. Ø S/S of hypo/hyperglycemia. C/O hip pain X's ii. Medicated c̄ vicodin c̄ good results. Coumadin on hold X's ii days, then 2 mg Qd — med in from pharmacy. ——— Michelle Brands, RN
7/26/01	0420	Nsg		Resting quietly, Ø c/o pain or discomfort thus far tonight. VSS. Afebrile. ——— Michelle Brands, RN
7/26/01		RD		Nutrition Eval - Filed Diet ——— Mary Bancroft, RD
7/26/01	1500	Nsg		VSS. Afebrile. A+O x3, Pleasant and cooperative. C/O severe constipation this am. Did not respond to MOM. Very large BM c̄ Dulcolax Suppository. States, "Oh yeah, I feel a lot better." Request sent to Dr. Smith for stool softner. He replied, "Order needs to come from admitting physician." Request sent to Dr. Temps. Awaiting reply. Ø S/S of inf. (R) hip incision - edges well approximated. PT results 7/25 faxed to MD. ——— Jenida Adams, RN
Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines

MULTIDICIPLINARY PROGRESS NOTES

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
ROBERT BROWN	SMITH	21 - 12	200 - 1

NOSTALGIC VIEW

Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines
7/26/01	2230	Nsg		A+O x3. Dsg Δ to Rt hip, staples intact. No s/s of infection, tape burn healing well. No pedal edema, pedal pulses (+). Up amb c̄ FWW. Continues working c̄ therapies. Requested + given Tylenol 650mg P.O. x2 this pm for mild hip pain c̄ good relief — Linda Adams, RN
7/27/01	0500	Nsg		Ø c/o pain or discomfort. VSS. Afebrile. Resting quietly the entire night. ——— Michelle Grends, RN
7/27/01	1500	Nsg		VS 108/60 99.5 88 20. Received faxed orders for routine DOSS + prn Senokot. Resident made aware, pleased c̄ new order. Resident had shower c̄ skilled therapies, staples intact to (R) hip c̄ Ø s/s of infection. Staples to be removed tomorrow. Ø LE edema noted. Resident medicated c̄ tylenol for c/o mod surgical (R) hip pain. "Tylenol is working" he states. BS clear. A+O x3. Supportive wife eating lunch c̄ resident today. — S Anderson, RN
7/27/01	2230	Nsg		A+O x3. Up amb (I) c̄ FWW, continues to work c̄ therapies. Dsg Δ to (R) hip, staples intact, no s/s of infection. Tape burn healing well. Requested and given Tylenol 650mg po for c/o mod hip pain c̄ good relief obtained. No abnormal bleeding. VSS ——— Michelle Grends, RN
7/28/01	0400	Nsg		VSS. Afebrile. Quiet night. No c/o discomfort. Resp even, non labored. Resting c̄ eyes closed. Hip precautions observed. A+O x3. Able to make needs known. ——— Michelle Grends, RN
7/28/01	0800	SW		Resident doing well in therapies (see rehab notes). He says he'd like to go home tomorrow. He'd appreciate Home Health support. (Suggest PT, OT, aide) His wife can drive him home 10 am. Defer to nsg to contact MD for orders — K. Binder, SSD
7/28/01	1220	Nsg		VS 110/68 99.3 90 20. Staples removed from (R) hip surgical incision. Resident tolerated procedure well. Ø ax sent to Dr Smith regarding (CONT)

Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines

MULTIDICIPLINARY PROGRESS NOTES

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
ROBERT BROWN	SMITH	21 - 12	200 - 1

NOSTALGIC VIEW

Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines
7/28/01	1220	Nsg		D/C orders for tomorrow 7/29/01. Ø LE edema. Lungs CTA. Resident denies any surgical pain at this time. No new skin problems - skin warm + dry. Resident appears well hydrated. Wife visiting resident throughout the morning. Brenda Sills, RN
7/28/01	1310	Act/Lei		Activity/Leisure: Care plan assessment and approaches have been completed. Nancy Riley, ADCP
7/28/01	2330	Nsg		A+O. Cooperative c̄ care. Able to make needs known. Steri strips to (R) hip. Ø s/s of infection. c/o mild/mod hip pain K's ii̇, medicated c̄ tylenol c̄ good results. Ø abnormal bleeding noted. Ø s/s of hyp/hyperglycemia. Ø c/o constipation this shift. Ø A's/side effects noted to DOSS. Resident looking forward to going home tomorrow - M. Trends, RN
7/29/01	0430	Nsg		VSS. A+O X3. Able to make needs known. (R) hip c̄ steri strips intact. Incision healing c̄ difficulty. No c/o's pain at this time. Hip precautions observed. Will monitor Michelle Trends, RN
7/29/01	1245	Nsg		Discharge now: order received this AM from Dr Smith. The resident may D/C to home c̄ current meds + Lasting Ways Home Health therapies for RN, PT, OT + bath aide. Discharge instructions carefully explained to resident, his wife + four daughters. Resident indicates understanding of D/C orders + all meds. Indicates meds to be ordered from "All About You" pharmacy. This RN is ordering all meds. Resident in usual jovial mood, all packed up by early am. Propelling self in w/c + transferring self to position to drive home. — Lyonson, RN
7/29/01		SW		Referral faxed to Lasting Ways Home Health per MD orders. K. Binder, SSD
Date	Time	Discipline	Prob #	Notes Must Be Signed by Physician & Other Disciplines

MULTIDICIPLINARY PROGRESS NOTES

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
ROBERT BROWN	SMITH	21 - 12	200 - 1

NOSTALGIC VIEW
FALL RISK ASSESSMENT

CHECK ALL THAT APPLY

DATE 7/22/01				
				PT DATA
				Dx of CVA
				Dx of Dmta-Alz
				Card-sync-arrhy
				Dizziness
				Orthostatic HTN
2				SUBTOTAL*
				MENTAL STAT
				Denies assist
				Implsv pr jdgmnt
				Can't use call bt
				Agitated/Anxious
X				Unfamiliar w/rm
				Prob w/direction
				SUBTOTAL*
				SENSORY STAT
				Legally blind
				Visual field cut
X				Hearing loss
				Poor LE feeling
1				SUBTOTAL*
				PSYCHOSOCIAL
				Can't communicate
				Fear of falling
				Depressed/withdrawn
2				SUBTOTAL*
				RECENT CHANGES
X				New admit < 30 days
				Acute illness
X				Surg < 30 days
				Fall w/in 6 mo
				Mult. Falls < 6 mo
2				SUBTOTAL*

* SUBTOTAL = Total of identified risks per category
SCORING = 0-10 Standard precautions
11-20 Mod risk-modify precaution
~~Care Plan~~
21-30 High risk strict precaution

SIGNATURE DATE

SIGNATURE DATE

CHECK ALL THAT APPLY

DATE 7/22/01				
				GAIT & M
				Ftwear = poor fit
X				Assist to amb
X				Asst device-w/c
X				Gait unsteady
X				Impaired balance
4				SUBTOTAL*
				PHYS COND
X				Weak LE's
				Kyphosis/pr pstr
				Rigidity/spastic
				Contractures
1				SUBTOTAL*
				MEDS
				Antidepressant
X				Diuretic
				Antihypertensive
				Vasodilator
				Anti-seizure
X				Analgesics/NSAID
				Antipsychotic
2				SUBTOTAL*
				TX / DEVICES
				NG/IV
				Cast/immobilizer
				Prosthesis/brace
				Soft posy rstmt
X				Side rls elevated
1				SUBTOTAL*
				ELIMINATION
				B/B incont.
				Urinary urgency
				Urinary frequency
X				Nocturia
1				SUBTOTAL*
13				GRAND TOTAL (add all categories)

Linda Adams, RN 7/22/01
SIGNATURE DATE

SIGNATURE DATE

NAME ROBERT BROWN PHYSICIAN DR SMITH ROOM 200-1 ADMIT# 21-12

NOSTALGIC VIEW

SELF-ADMINISTRATION OF MEDICATION

Preliminary Evaluation

no 1. Does the resident want to self-administer his/her own medicine? (If no, do not proceed.)

_____ 2. Is resident mentally alert and oriented all day? (If no, do not proceed.)

_____ 3. Does the resident have the manual dexterity to take his/her own medications safely? (If no, do not proceed.)

_____ 4. Has the resident had a problem with mis-medication in the past? Has the resident omitted ordered medications or over-medicated in the past? (If yes, do not proceed.)

If the resident has passed this preliminary screening, staff & resident may begin step 1 of the self-medication program.

Nurses signature Linda Adams, RN Date 7/22/01

Self-Administration of Medication

Resident	Physician	Admit #	Room
ROBERT BROWN	DR. SMITH	21-12	200-1

NOSTALGIC VIEW

SKIN AT RISK ASSESSMENT

					Indicate appropriate numbers
SENSORY PERCEPTION ability to respond meaningfully to pressure related discomfort	1. Completely Limited: Unresponsive, (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.	2. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment: Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist: Skin is often, but not always, moist. Linen must be changed least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals.	3
ACTIVITY degree of physical activity	1. Bedfast: Confined to bed	2. Chairfast: Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally: Walks occasionally during day, but for very short distances, without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	3
MOBILITY ability to change and control body position	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance	2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited: Makes frequent though slight changes in body OR extremity position independently.	4. No Limitations: Makes major and frequent changes in position without assistance.	3
NUTRITION *	1. Consumes < 50% of recommended diet	2. Consumes 50% to 75% of recommended diet	3. Consumes > 75% of recommended diet	4. Consumes more than adequate amount for height and weight	3
FRICTION AND SHEAR	1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, agitation lead to almost constant friction.	2. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No apparent problem: Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		2
COEXISTING CONDITION *	1. Advanced	2. Moderate	3. Controlled	4. Absent	3
COMMENTS: Assess medication that could contribute to breakdown					
				TOTAL	21

24 and above = LOW RISK 15 - 23 = MOD RISK 14 or less = HIGH RISK

* NUTRITION: If a resident's diet is being supplemented by TPN or NG feedings, determine whether the resident's dietary needs are being met by this means

* PRESENCE OF COEXISTING CONDITION: This refers to any medical condition that may influence tissue integrity. Diseases that can affect the risk of breakdown include cancer, diabetes, vascular disease, COPD, sepsis, renal disease, liver disease, immuno-suppression (drug or disease related), etc. Assess the resident's condition and record whether the disease is controlled, moderate, or advanced. For example, residents with controlled diabetes, early stages of vascular disease, or slight anemia would score 3. Residents with unstable diabetes, progressing vascular disease, anemia, or who are receiving steroid therapy would score 2. Residents with brittle diabetes, advanced vascular disease, severe anemia, neurologic paralysis, or who are steroid dependent would score 0.

RESIDENT NAME ROBERT BROWN MD DR. SMITH SIGNATURE Linda Adams RN DATE 7/22/01

Rev: 6/98 ADMIT # 21-12 ROOM # 200-1

NOSTALGIC VIEW
MEDICATION RECORD

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3
7/22/01 HCTZ 25mg PO qd *HTN*	0900 B/P																						X	BS 138/76	Tg 142/68	BS 142/70	Tg 120/64	BS 108/60				
7/22/01 K-Dur 20mEq PO qd *Diuretic Tx*	0900																						X	BS	Tg	BS	Tg	BS	BS			
7/22/01 MVI I PO qd *Wound Healing / DVT / Supplement*	0900																						X	BS	Tg	BS	Tg	BS	BS			
7/22/01 $FeSO_4$ 325mg PO BID *Post-op Anemia*	0900 1700																						X SA	BS SA	Tg SA	BS SA	Tg SA	BS SA	BS BS			
7/22/01 Coumadin 4.0mg PO qd *DVT Prophylactic*	1700																						SA	SA	SA	Hold - See new orders						
7/22/01 PT/INR qwk on Monday X2wks	Info																															
7/25/01 Coumadin 2mg PO qd *Start 27th*	1700																											SA	BS			

Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE
		LA	Linda Adams, RN	Tg	Tamie Grason, RN		
		SA	Sheri Anderson, RN				
				BS	Brenda Sills, RN		

RESIDENT'S NAME	PHYSICIAN	ALLERGIES	RECORD NUMBER	ROOM NUMBER	BED	Month/Year
ROBERT BROWN	MICHAEL SMITH	ASA-GI IRRITATION	21-12	200	1	July/2001

NOSTALGIC VIEW

USE OF SIDERAILS

6-5-97

PURPOSE: Siderails are used for several purposes. These include:

- Restraint - which keeps the resident in bed when the resident wants out of bed.
- Enabler - which increases the resident's independence for turning and repositioning in bed.
- Safety device - to prevent injury to the resident with a known seizure disorder; when used for this purpose the rails are padded.
- Safety device - to prevent rolling out of bed for the resident with decreased cognition who moves in bed but is not trying to get out of bed.
- Enhance a feeling of well-being and personal safety, resident's frequently request rails up because they are used to sleeping in a larger bed and are afraid they will roll out of the narrower bed. Rails help define the sides of the bed for them. This is also true for the resident with impaired vision who cannot see the edge of the bed.

These are the potential risks inherent in the use of siderails:

1. Increased injury: from trying to climb over rails, out of bed, getting limbs caught in the rails.
2. Incontinence or increased incontinence.
3. Skin breakdown, including pressure sores, skin tears, bruises.
4. Agitation and increased agitation.
5. Decline of functional mobility (walking).
6. Confusion.
7. Becoming withdrawn.
8. Strangulation, suffocation and death.

There are also benefits in using siderails:

1. Enable bed mobility for independent turning, positioning and sitting.
2. Define edges of the bed for the resident who cannot see well or is used to a wider bed.
3. Enhance feeling of personal safety for the resident who is afraid of falling or has a known seizure disorder.

The risks/benefits of siderails have been discussed with ROBERT BROWN (resident), and/or _____ (surrogate decision maker). I wish to have siderails BOTH 1/2 RAILS ↑ (position) for the following reason:

TO ↑ BED MOBILITY

Duration of use: WHILE HOME

Date: 7/22/01 Resident ROBERT BROWN

Date: _____ Surrogate decision maker: _____

Date: 7-22-01 Licensed Nurse Linda Adams, RN

21-12 200-1

NOSTALGIC VIEW
MEDICATION RECORD

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Natural Lax 15cc – 30cc PO daily unless stools occur *Bowel regularity*	5pm																						LA 15	LA 15	LA 15	SA 15	LA 15	SA 15	BS 15			
MOM 30cc PO PRN if no bowel movement X3 days *Constipation*	PRN																															
Dulcolax (bisocodyl) suppository 1 qd ® PRN if MOM ineffective *Constipation*	PRN																										Lg					
Tylenol 650mg PO q4h PRN *Temp 101 or Mild Pain*	PRN																										Lg LA	SA	LA LA	BS		
7/22/01 Vicodin İİ Tabs PO q4-6h PRN *Mod Pain*	PRN																									SA	LA					
7/22/01 Vicodin İİ Tabs PO q4-6h PRN *Severe Pain*	PRN																						LA	BS LA	Lg	BS SA						
7/22/01 Senokot İ - İİ q12h PRN *Constipation*	PRN																									BS	Lg					

Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE
SA	Sheri Anderson, RN			BS	Brenda Sills, RN		
Lg	Lourie Grason, RN	LA	Linda Adams, RN	MS	Michelle Grends, RN		

RESIDENT'S NAME	PHYSICIAN	ALLERGIES	RECORD NUMBER	ROOM NUMBER	BED	Month/Year
ROBERT BROWN	MICHAEL SMITH	ASA-GI IRRITATION	21-12	200	1	July/2001

NOSTALGIC VIEW
MEDICATION RECORD

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
HYPOTENSION – Postural B/P's Q Shift X72h then PRN	Noc Lying Pulse																								132/60							
																									98							
	Sit Pulse																								132/64							
																									102							
	Stand Pulse																								Refused							
	Days Lying Pulse																															
	Sit Pulse																															
	Stand Pulse																															
	PM Lying Pulse																							110/62	112/60	116/62						
																								84	82	84						
	Sit Pulse																							120/60	112/72	118/60						
																								84	76	92						
	Stand pulse																							120/62	112/80	Refused						
																								82	82							

Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE
LJ	Laurie Jackson, RN	LA	Linda Adams, RN			MS	Michelle Stends, RN
		BS	Brenda Sills, RN	SA	Sheri Anderson, RN		

RESIDENT'S NAME	PHYSICIAN	ALLERGIES	RECORD NUMBER	ROOM NUMBER	BED	Month/Year
ROBERT BROWN	MICHAEL SMITH	ASA-GI IRRITATION	21-12	200	1	July/2001

7/ 9/2004

NOSTALGIC VIEW
MEDICATION RECORD

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7/27/01 Doss 250mg PO BID *Constipation*	0900 1700																											X SA	BB BB	BB		
7/27/01 Senokot I - II Tabs PO BID PRN *Constipation*	PRN																															

Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE
LA	Linda Adams, RN			LG	Laurie Gibson, RN		
		BB	Brenda Sibbs, RN				
SA	Sheri Anderson, RN						

RESIDENT'S NAME	PHYSICIAN	ALLERGIES	RECORD NUMBER	ROOM NUMBER	BED	Month/Year
ROBERT BROWN	MICHAEL SMITH	ASA-GI IRRITATION	21-12	200	1	July/2001

7/ 9/2004

NOSTALGIC VIEW
PRN MEDICATION RECORD

Date	Hour	Initial	Drug/Dose/Route	Reason Given	Result	Hour	Initial
7/22/01	2100	LA	Vicodin ii P.O.	c/o Severe (R) hip pain	helpful	2135	LA
7/23/01	1040	BS	Vicodin ii PO	c/o Severe (R) hip pain	helpful	1135	BS
7/23/01	2030	LA	vicodin ii P.O.	c/o Severe (R) hip pain	helpful	2130	LA
7/24/01	0845	fg	vicodin ii PO	c/o (R) hip pain	helpful	0940	fg
7/25/01	0830	BS	vicodin ii PO	c/o Severe (R) hip pain	helpful	0945	BS
7/25/01	0915	BS	2 Senocot	c/o Constipation			BS
7/25/01	1725	SA	Vicodin ii P.O.	c/o (R) hip pain	helpful	1825	SA
7/25/01	2140	SA	Vicodin ii P.O.	c/o severe (R) hip pain	Some relief	2240	SA
7/26/01	0830	fg	Senokot ii	c/o Constipation			
7/26/01	0830	fg	Tylenol 650 mg	c/o (R) hip pain	relief	0945	fg
7/26/01	1030	fg	Dulcolax (R)	c/o Constipation	relief	1510	LA
7/26/01	1710	LA	Tylenol 650 mg P.O.	c/o mild (R) hip pain	helpful	1810	LA
7/26/01	2105	SA	Tylenol 650 mg P.O.	c/o mild (R) hip pain	helpful	2210	LA
7/27/01	2040	SA	Tylenol 650 mg P.O.	c/o mild (R) hip pain	helpful	2140	SA
7/28/01	1730	LA	Tylenol 650 mg P.O.	c/o mild (R) hip pain	helpful	1830	LA
7/28/01	2130	LA	Tylenol 650 mg P.O.	c/o mod (R) hip pain	helpful	2230	LA
7/29/01	0820	BS	Tylenol 650 mg PO	c/o mild (R) hip pain			

RESIDENT'S NAME	PHYSICIAN	ALLERGIES	RECORD NUMBER	ROOM NUMBER	BED	Month/Year
ROBERT BROWN	MICHAEL SMITH	ASA-GI IRRITATION	21-12	200	1	July/2001

7/ 9/2004

NOSTALGIC VIEW
TREATMENT RECORD

MEDICATION	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7/22/01 50 – 75% wt bearing on ® leg	Info																															
7/22/01 May shower over ® hip incision	FYI																															
7/22/01 Assess ® hip incision q shift for S/S of infection	NOC																							MS	MS	MS		MS	MS	MS		
	Day																							BS	BS	BS	BS	BS	BS			
	PM																						LA	LA	LA	SA	LA	SA	BS			
7/22/01 Dsg Δ to ® hip qd and PRN until healed	PM																												BS			
																							LA	LA	BS	SA	LA	SA	D/C 7/28			
7/22/01 Remove staples 7/28	PM																												BS			

Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE	Initials	NURSES SIGNATURE
LA	Linda Adams, RN	SA	Sheri Anderson, RN	BS	Laurie Grason, RN		
				BS	Brenda Sills, RN	MS	Michelle Hends, RN

RESIDENT'S NAME	PHYSICIAN	ALLERGIES	RECORD NUMBER	ROOM NUMBER	BED	Month/Year
ROBERT BROWN	MICHAEL SMITH	ASA-GI IRRITATION	21-12	200	1	July/2001

7/ 9/2004

NOSTALGIC VIEW
Nursing Care Directives

Prefers to be called:

NAIL CARE

☒ Fingernails LN

☒ Toenail care by:

☐ Podiatrist

☒ Nurse LN to cut

☒ NA-C to clean and check

* Anticoagulant tx new dx-diabetes

SLEEP

☒ Naps [illegible] chose times

EATING

Assist Set up → Supervise

Location: room General - RCS

Diet info: Reg. Text Thin liq

Supplement: pr LN

☒ Measure Intake

☒ Diet Monitor PLN

☐ Thickened Liquids Only

☐ No Water Pitcher at Bedside

☐ Fluid Restrictions:

☐ Tube Feeding

☐ NPO

EQUIPMENT

☒ Special Mattress high density foam

☐ Protectors: ___Heel ___Elbow

☐ Footboard ☐ Cradle

☒ Wedge ☐ Trapeze between Knees

☐ Hand Cones/Roll

☐ Cushion in chair

☐ Arm Glove

☐ Other

BEHAVIOR/MENTAL

LEVEL OF CONSCIOUSNESS:

☒ Alert ☐ Comatose

☐ Non-verbal

☐ Unaware of environment

BEHAVIOR: ☒ OK

☐ Wander ☐ Inside ☐ Outside

☐ Abusive ☐ Physical ☐ Verbal

☐ Disruptive

MEMORY: ☒ OK

☐ Short term ☐ Long term

☐ DISORIENTED ☒ ORIENTED

☒ Time ☒ Place ☒ Person

Nursing Care Directives

BEHAVIOR/MENTAL		ACTIVITIES	
ok - very pleasant good sense of humor	Dx of osteoarthritis @hip c̄ @THA HTN new dx diabetes diet controlled	TV music Visiting 1:1	Assessed by: Date: 7/22/01 Reviewed by: Linda Adams, RN Date: Reviewed by: Date: Reviewed by: Date:

NAME	PHYSICIAN	NUMBER	ROOM
ROBERT BROWN	DR. SMITH	21-12	200-1

7/ 9/2004

NOSTALGIC VIEW

NURSING CARE DIRECTIVES CON'T

HYGIENE/GROOMING

per Assist set-up

wer Assist limited → ext

Bed Bath ☐ Tub Bath

Shower protect @ hip incision til healed

2x week & prn

sist set-up

Make-Up ☒ Shave

sist Oral Care: set-up

Own teeth ☐ None

Denture/bridge

☒ Upper ☒ Lower

X Used ___ Not used

Special Mouth Care ___

DRESSING

Upper body set-up

Lower body limited → ext

Shoes/socks assist ext → depend.

Undressing assist depend

Assistive device ___

BED MOBILITY

POSITIONING

Assist limited

☐ Remind to turn

☒ Turn & position q 2 hrs

☒ 2 side rail up for positioning and to define edges of bed

TRANSFER

Assist limited

☒ 1 person assist

☐ 2 person assist

☐ Mechanical lift ☐ Pivot

Weight bearing ☒ Partial

50-75% WB on @ leg ☐ None

LOCOMOTION

Assist limited

☒ W/C ☐ Special ___

☐ Cane ☒ Walker

ELIMINATION/TOILETING

Assist limited

Continent ☒ Bladder ☒ Bowel

Incontinent ☐ Bladder ☐ Bowel

☒ Peri-care ☐ Catheter

☒ Measure Output ☒ Urinal per LN

☐ Commode ☐ Bed Pan

☒ Toilet

☐ Briefs ___

☐ Pads ___

☐ Ostomy: ___

☐ Toileting schedule ___

MUSCULOSKELETAL

☐ Contractures: ___

☐ Amputation ___

☒ Generalized Weakness

PARALYSIS ___ LT ___ RT

VISION

☒ No Problem

☐ Blind ☐ Right ☐ Left

☒ Glasses ☒ Used ☐ Not Used

☐ Glass Eye ☐ Right ☐ Left

☐ Field Loss ☐ Right ☐ Left

early cataracts

HEARING

☒ No Problem

☐ Deaf ☐ Right ☐ Left

☐ Hearing Aid ☐ Right ☐ Left

☐ Assist ☐ Used ☐ Not Used

loss of hearing @ ear.

SPEECH/COMMUNICATIONS

☒ No Problem

☐ Other Language: ___

☐ Difficulty Speaking

☐ Difficulty Making Needs Known

☐ Difficulty Understanding Others

☐ Alternate form of communication: ___

ROBERT SMITH DR. SMITH 21-12 200-1

DISCIPLINE: Nursing Assistant

FACILITY

MONTH/YEAR: July 2001

DOCUMENTATION RECORD

PLEASE SIGN FULL SIGNATURE ON BOTTOM OF THIS FORM

PROBLEM # / INTERVENTION #	INTERVENTION	TIME	SU	MO	TU	WE	TH	FR	SA	SU	MO	TU	WE	TH	FR	SA	SU	MO	TU 19	WE 20	TH 21	FR 22	SA 23	SU 24	MO 25	TU 26	WE 27	TH 28	FR 29	SA 30	SU 31	MO	TU
0001	SIDERAILS: per pat. choice	INFO ONLY	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**
0002	DIET MONITOR new admit new diabetic - diet controlled	INFO ONLY	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**
0003	SEE RESIDENT CARE DIRECTIVES FOR MORE INFORMATION	DOC NOT NEEDED	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**
0004	SHOWER 2X/WEEK SHAMPOO WEEKLY	AM																															
0005	FINGERNAIL CARE: Q WED AM. KEEP CLEAN	AM DAYS	**	**	**	—	**	**	**	**	**	**	—	**	**	**	**	**	**	—	**	**	**	**	**	**	—	**	**	**	**	**	**
0006	TOENAIL CARE Q WED PM. KEEP CLEAN	PM'S	**	**	**	—	**	**	**	**	**	**	—	**	**	**	**	**	**	—	**	**	**	**	**	**	—	**	**	**	**	**	**
0007	NAIL CUTTING BY LN ONLY INFORM LN OF NEED		PLEASE DOCUMENT ONLY WHEN REPORTED TO CHARGE NURSE																														
0008	CUE AND ASSIST RES W/ MEALS & SNACKS: newly Dx'd diet controlled diabetic - set up tray - supervise	NITES +/0 AM +/0 PM +/0																															
0009	CUE & ASSIST RES WITH AMBULATION USING: FWW throughout distances to be set in hallway + = ABLE / 0	NIGHTS DAYS PM'S																															
	= UNABLE																																
0010	ROM TO ALL EXTREMITIES DURING CARE. GOAL = 15 (OR AS TOLERATED) TO EACH EXTREMITY. DOC # DONE.	NOC # DAYS # PM'S #																															

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
ROBERT BROWN	21-12	200-1			7/22/01	DR. SMITH	1

NOSTALGIC VIEW

DISCIPLINE: Nursing Assistant

FACILITY: RIDGEMONT TERRACE

MONTH/YEAR: July 2001

DOCUMENTATION RECORD

PLEASE SIGN FULL SIGNATURE ON BOTTOM OF THIS FORM

PROBLEM # INTERVENTION #	INTERVENTION	TIME	SU	MO	TU	WE	TH	FR	SA	SU	MO	TU	WE	TH	FR	SA	SU	MO	TU	WE	TH	FR	SA	SU	MO	TU	WE	TH	FR	SA	SU	MO	TU
																				20	21	22	23	24	25	26	27	28	29	30	31		
0011	RECORD # OF TIMES RESIDENT INCONTINENT OF URINE.	N D H																															
0012	MONITOR BMS Q SHIFT. RECORD IN NURSING ORDERS.	NIGHTS DAYS PM'S																															
0013	IF NO BM X 3 DAYS REPORT TO NURSE.		PLEASE DOCUMENT ONLY WHEN REPORTED TO CHARGE NURSE																														
0014	RECORD # OF TIMES INCONTINENT OF BOWEL.	NIGHTS DAYS PM'S																															
0015	CUE & ASSIST RESIDENT TO COMMUNICATE: N A Linda Adams RN	NIGHTS DAYS PM'S																															
0016	CUE & ASSIST RES TO ASSIST WITH DRESSING/ undressing! to dress indep. sit up, LB & limited assist	AM +/O PM +/O																															
0017	CUE & ASSIST RES WITH TRANSFERS: to place feet firmly on floor, push-up & assist maintaining sitting posture, Pivot turning & grasp rail	NITES +/O AM +/O PM +/O																															
0018	NOTIFY L.N. OF ANY DECREASE IN ABILITY TO ASSIST W/SELF CARE AND INITIAL IF OCCURS.		PLEASE DOCUMENT ONLY WHEN REPORTED TO CHARGE NURSE																														
0019	I HAVE PROVIDED CARE ACCORDING TO NURSING CARE DIRECTIVES AND FACILITY POLICIES.	NIGHTS DAYS PM'S																															

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
ROBERT BROWN	21-12	200-1			7/22/01	DR. SMITH	2

7/ 9/2004

NOSTALGIC VIEW
DOCUMENTATION RECORD
PLEASE SIGN FULL SIGNATURE ON REVERSE SIDE OF THIS FORM

DISCIPLINE	— Hip Fx N4 orders —
FACILITY	
PROBLEM / INTERVENTION	

INTERVENTIONS	TIME	22	23	24	25	26	27	28	29	30	31
No hip flexion greater than 90° degrees	N A D	LH	CE DP	CE DP SS	DP N	DP MP	CE WE MP	CE WE HH			
weight bearing precautions:	N A D	LH	CE DP	CE DP SS	DP N	MP	CE WE MP	CE WE HH			
to lie on operated side or back to keep proper alignment of repair	N A D	LH	CE DP	CE DP SS	DP N	MP	CE WE MP	CE WE HH			
Keep pillows or wedge between knees when lying on back to keep proper alignment	N A D	LH	CE DP	CE DP SS	DP N	MP	CE WE MP	CE WE HH			
Keep small pillow between knees when up in chair	N A D	LH	CE DP	CE DP SS	DP N	MP	CE WE MP	CE WE HH			
Float heels/ankles to prevent pressure on heels. Should not touch bed/pillow at any time	N A D	LH	CE DP	CE DP SS	DP N	MP	CE WE MP	CE WE HH			
For knee repair: keep knee as fully extended as possible. Use immobilizer if provided	n/a										
Tell LN immediately if dressing soiled, loose or missing											

NAME	LOCATION	NUMBER	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
ROBERT BROWN	200-1	21-12			7/22/01	DR. SMITH	3

NOSTALGIC VIEW

HRF-339

VITAL SIGNS

DATE	TIME	B/P	CODE	T	CODE	P	CODE	R	SIGNATURE/TITLE
7-22	1900	104/36		99.2		90		14	Linda Adams, RN
7-23	0100	142/93		98.9		92		22	Michelle Grenda, RN
7-23	1000	140/64		98.2		88		18	Brenda Sills, RN
7/23/01	1100	138/76		98.4		88		18	Linda Adams, RN
7-23		120/101		99.1		84		22	Linda Adams, RN
7/24/01	9	124/60		99.3		84		20	Linda Adams, RN
7-24	0100	132/60		98.9		98		20	Michelle Grenda, RN
7-25	9	132/64		—		102		—	Michelle Grenda, RN
7-25	0940	142/68		98.0		88		20	Brenda Sills, RN
7-25	1600	112/50		99.7		82		20	S. Anderson, RN
7-25	9	116/62		X		76		X	
7-25	9	115/50		X		82		X	
7/26	0900	140/70		98.4		68		20	Sigrason, RN
	9	140/64				68			Sigrason, RN
	9	138/68				76			Sigrason, RN
7/26	1600	116/60		99.5		84		16	Linda Adams, RN
	9	118/60		—		92		—	Linda Adams, RN
	9	[illegible]						—	Linda Adams, RN
7/27/01	0100	110/52		98.5		82		20	Michelle Grenda, RN
	9	100/50		—		[illegible]		—	Michelle Grenda, RN
7/27/01	0900	120/64		99.2		88		18	Brenda Sills, RN
7/27/01	1200	////		98.8		////		////	S. Anderson, RN
7/27/01	1600	108/60		99.5		88		18	S. Anderson, RN
7/28/01	0100	128/64		98.9		86		20	Michelle Grenda, RN
7/28/01	1145	110/68		97.3		88		20	Brenda Sills, RN
7/28/01	1600	130/60		98.3		80		18	Brenda Sills, RN
7/28/01	0100	122/60		98.9		92		20	Michelle Grenda, RN
7/29	9:30	110/68		99.3		90		20	Brenda Sills, RN

WEIGHTS

DATE	WT.	SIGNATURE/TITLE
7-23	193.2	Brenda Sills, RN
7-24	192.2	Linda Adams, RN
7-25	194#	Brenda Sills, RN

B/P CODES: ST-Standing, S-Sitting, L-Laying
TEMP CODES: O-Oral, R-Rectal, A-Axilla, E-Ear (Tympanic)
PULSE CODES: R-Radial, A-Apical

HEIGHT: _____
DESIRED WT.: _____

VITAL SIGNS & WEIGHT FLOW SHEET

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO
ROBERT BROWN 7/ 9/2004	SMITH	21-12	200-1

NOSTALGIC VIEW

COPYRIGHT HEALTH RECORD FORMS
REVISED 10/90

HRF - 328

DATE	SHIFT	INTAKE	OUTPUT	DATE	SHIFT	INTAKE	OUTPUT	DATE	SHIFT	INTAKE	OUTPUT
7/	11 - 7		X		11 - 7				11 - 7		
	7 - 3		X		7 - 3				7 - 3		
22	3 - 11	480	X3		3 - 11				3 - 11		
	TOTAL	480	X3		TOTAL				TOTAL		
	11 - 7	0	X1		11 - 7				11 - 7		
7/	7 - 3	1350	X3		7 - 3				7 - 3		
23	3 - 11	0575	X3		3 - 11				3 - 11		
	TOTAL	2000	X7		TOTAL				TOTAL		
7/24	11 - 7	120	X0		11 - 7				11 - 7		
	7 - 3	920	X3		7 - 3				7 - 3		
	3 - 11	680	X3		3 - 11				3 - 11		
	TOTAL	1720	X6		TOTAL				TOTAL		
7/25	11 - 7	80	X1		11 - 7				11 - 7		
	7 - 3	1500	X3		7 - 3				7 - 3		
	3 - 11	880	X3		3 - 11				3 - 11		
	TOTAL	2480	X7		TOTAL				TOTAL		
7/26	11 - 7	0	X1		11 - 7				11 - 7		
	7 - 3	480	X3		7 - 3				7 - 3		
	3 - 11	780	X3		3 - 11				3 - 11		
	TOTAL	1260	X7		TOTAL				TOTAL		
	11 - 7	120	X1		11 - 7				11 - 7		
7/	7 - 3	1260	X3		7 - 3				7 - 3		
27	3 - 11	720	X3		3 - 11				3 - 11		
	TOTAL	2100	X7		TOTAL				TOTAL		
7/28	11 - 7	120	X2		11 - 7				11 - 7		
	7 - 3	1200	X3		7 - 3				7 - 3		
	3 - 11	880	X3		3 - 11				3 - 11		
	TOTAL	2200	X8		TOTAL				TOTAL		
	11 - 7	240	X2		11 - 7				11 - 7		
7/	7 - 3				7 - 3				7 - 3		
29	3 - 11				3 - 11				3 - 11		
	TOTAL				TOTAL				TOTAL		
	11 - 7				11 - 7				11 - 7		
	7 - 3				7 - 3				7 - 3		
	3 - 11				3 - 11				3 - 11		
	TOTAL				TOTAL				TOTAL		

24 HOUR INTAKE AND OUTPUT RECORD

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO
ROBERT BROWN	SMITH	21-12	200-1

NOSTALGIC VIEW

PHYSICAL THERAPY LOG

Patient Name: Robert Brown

Treatment Dx and ICD-9 Code: √ FM 780.9

MONTH/YEAR: 7/01

Physician: Smith

Onset Date of Symptoms/Illness: 7/19/01
(This date indicates the date the patient first became aware of the symptoms or illness being treated)

Date Plan Established or Last Reviewed: 7/22/01
Date Treatment Started

[√] Medicare Part A
[ ] Part B with Insurance [ ] Part B without Insurance
[ ] Medicaid with Insurance [ ] Medicaid without Insurance
[ ] Private with Insurance [ ] Private without Insurance.
[ ] Managed Care

HCPCS	Therapist Initials > / Description	occ	r.e	22	23	24	25	26	27	28	29	30	31	Total Units	Charge	Total Charge
97001GP	Evaluation	X		1										1		
97110GP	Therapeutic Exercises		X	1	1		1	1	1	1				6		
97116GP	Gait Training		X	1	1		1		1	1				6		
97542GP	w/c Manage & Train		X													
97112GP	Neuromuscular re-ed		X	1	1		1							3		
97504GP	Orthotics Fit & Train		X													
97010GP	Hot or Cold Packs		X													
97035GP	Ultrasound		X													
97124GP	Massage		X													
97250GP	Soft Tissue Mobilization		X													
11040GP	Debridment - Partial		X													
11041GP	Debridment - Full		X													
				75	40		48	5								
				1	2		3	4								
	Total Units			4	3		3	1	1	2				16		
	Total Minutes			70	40		48	15	46	30				264		
	Total Visits			1	1		1	1	1	1				6		

Therapist Name Printed	Initials	Signature, Credentials and Date	Therapist Name Printed	Initials	Signature, Credentials and Date

PHYSICAL THERAPY PROGRESS FLOW SHEET
GENERAL MEDICINE

* Please see Physical Therapy Abbreviations, definitions and Functional Scales on the backside of this form for numbers definitions.

Date	7/22	7/23	7/25	7/26	7/27	7/28
Ankle Pumps		20	✓	15	15	
Quad Sets		10		10		
Glute Sets				16		
Hip Abduction		10	2 standing x15	10	10	15
Straight Leg Raise						
Short Arc Quad		10	2x10	10	15-	15
Hip/Knee Flexion		10	2x10	10	10	15
Hs curls (yellow T-band)			2x10			15
hip ext.			1x15			15
heel/toe raises			✓			15
W/C Mobility						
Self Performance (See Reverse)						
Bed Mobility: Sit, Scoot		2	8		0	0
Scoot Up/Down		2			0	
Roll Right/Left		2			8	
Supine to Sit		2			0	
Sit to Supine		2-3A	✓		8	
Transfer: Sit to Stand		2-3A	2		0	
Bed to Chair		2	2 FWW		0 FWW	✓
Sitting Balance		0	0		0	0
Standing Balance		2	2-1		0-1 FWW	0-1 FWW
Gait: Assist Needed		2	1-2		0-1	0-1
Device Needed		FWW	FWW		FWW	FWW
Distance		100x4	20'x2		2x200'	200'x2
Distance/Time			200'/6'		200'/5-6 mins	N.T
Straigait/curb			7/13x2		7/13 3 stairs FWW - railing	
Safety Awareness		2	VCs		SBA	2
Patient/Caregiver inst.						1-2
Initials	DA	DA	DT	DT	DA	DT
Co Initials						

7/22/01 Eval completed and Rx initiated. See P.O.T. Smith PT

7/25/01 Rolled walker. Weight 20% PT leaning hand at trunk - Smith PT

7/26/01 Pt to shorten session today 20 bowel problems. Pt rotated - Pt would do it until tomorrow to do more PT" D Lucini PTA

7/27/01 - Needs vc on stairs for lead LE ↑↓. Maintains WB precautions + hip precaution 3 cues. Pt progressing well towards safe return home.

Patient Name: Brown, Robert Jr. # 200-1
Sex: M Age: 81 Dx: (R) hemi-arth
Doctor Name:
Admit Date: Admit #:
Precautions: 50-75% WB
Post hip precautions

Signatures with Initials:
David Adams DA
Diana Tate DT

NOSTALGIC VIEW PHYSICAL THERAPY PLAN OF TREATMENT

PATIENT NAME: Brown, Robert — ☒ PART A ☐ PART B ☐ OTHER

PRIMARY DIAGNOSIS (ICD-9): (R) hip hemiarthroplasty 2° DJD — TREATMENT DIAGNOSIS (ICD-9): ↓ROM 780.9

ONSET DATE: 7/19/01 — SOC DATE: 7/22/01 — HCN: 093241616A — PRIOR HOSPITALIZATION: 7/19/01 to 7/22/01 — PROVIDER #: 50 5217

FUNCTIONAL GOALS

Short Term 2 wks
1. Indep bed mob
2. Amb 250' c CGA
3. Trans c supervision for prec

Long Term 4 wks
1. Indep trans
2. Indep Amb 500' over level/steps
3. Home to prior living situation

PLAN:
- ☒ EVALUATION
- ☒ THERAPEUTIC EXERCISE
- ☒ GAIT TRAINING
- ☐ THERAPEUTIC ACTIVITIES
- ☒ TRANSFER TRAINING
- ☒ BED MOBILITY TRAINING
- ☒ BALANCE TRAINING
- ☐ WHEELCHAIR MANAGEMENT & TRAINING
- ☒ NEUROMUSCULAR RE-EDUCATION
- ☐ MODALITIES
- ☒ HOT OR COLD PACKS prn
- ☐ CAREGIVER / STAFF TRAINING
- ☒ DISCHARGE PLANNING
- ☒ HOME EVALUATION prn
- ☐ OTHER:

THERAPIST SIGNATURE: Diana Tate — DATE: 7/22/01 — FREQUENCY / DURATION: ex wk x 4 wks

PHYSICIAN'S SIGNATURE: Dr. Smith — DATE: 7/22/2001 — CERTIFICATION: FROM: 7/22/01 THROUGH: 8/19/01

ASSESSMENT ☒ MALE ☐ FEMALE AGE: 81

MEDICAL HISTORY: Hx DJD (R) hip. PMHx: HTN

PRIOR LEVEL OF FUNCTION: Indep Community level. Used cane past 2-3 w 2° pain (R) hip

D/C PLAN: Home to previous living situation

REASON FOR REFERRAL: ↓'d mobility p hip surg. To maximize return to funct independence

PREVIOUS LIVING SITUATION: ☐ ALONE ☒ SPOUSE ☐ OTHER ☐ APT ☐ MOBILE HOME ☒ HOUSE ☐ N.H. ☐ ADULT FAMILY HOME
Split level

STAIRS: ☒ Entrance ☐ Inside ☐ Railings — OWNED EQUIPMENT: ☐ Wheelchair ☐ Wheeled Walker ☐ Cane

☒ INITIAL ☐ INTERIM	OUTCOMES ☐ INTERIM ☒ D/C
STRENGTH/DEFICITS	STRENGTH
RUE: > normal	
LUE:	
RLE: Antigravity quad	
LLE: normal	
A/PROM:	A/PROM:
RUE: > normal	
LUE:	
RLE: hip/knee to 90°. Some pain/guarding	
LLE: normal	
BED MOBILITY: Sitting to Sit: Min (A) - cues for precautions; Rolling: Mod (A) - cues for precautions	mobility - indep
Scooting Up/Down	
TRANSFERS: Sit to Stand: Min (A) cues for precautions	
Bed to Wheelchair: Min (A)	GAIT: indep c FWW, level
BALANCE: Sitting: Good	SBA for squatting & stairs
Standing: fair - forward flexed posture	
GAIT/DISTANCE: 4 few steps c FWW, CGA	
	SUMMARY/RECOMMENDATIONS:
OTHER: 50-75% WB'ing, No flex >90° (R)	Pt has progressed well c PT & OT. No cardiac or lung precautions during
IMPRESSION/FINDINGS: Alert, coop & n.a. c ↓ mobility p recent hip replacement. Main barrier to d/c is split level home access. PT will need teaching prog for mobility, amb, steps in order to safely return home. Excellent rehab candidate	Recommend Home Health PT to step through gait training & progression to cane.

THERAPIST SIGNATURE: Diana Tate — DATE: 7/28/01 — SERVICE DATES: 7/22/01 - 7/28/01 — TOTAL VISITS: 6

PATIENT NAME: Brown, Robert — PHYSICIAN: Smith — MEDICAL RECORD #: — ROOM NO.:

PHYSICAL THERAPY ABBREVIATIONS, DEFINITIONS AND FUNCTIONAL SCALE

Functional Scale		MDS Scale
Independent: Patient completes entire task with no physical, supervisory, or verbal assistance.	0—0	Independent: No Help or oversight
Stand by Assist: SBA. Patient requires someone close at hand during the activity. The Patient may require verbal cues to insure proper sequencing in completing the activity.	1—1	Supervision: Oversight, encouragement or cueing provided.
Contact Guard Assist: Non-weight bearing assist touch assist.	2—2	Limited Assistance: Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance.
Minimal Assist: Patient able to perform 75% of the work.	3a	Extensive Assistance: While resident performed part of activity, help of following type(s) provided 3 or more times:
Moderate Assist: Patient able to perform 50% of the work.	3b—3	
Maximal Assist: Patient is able to perform 25% of the work.	3c	Weight bearing support
Dependent: Patient is unable to either actively or verbally assist in the performance of a task.	4—4	Full staff performance Total Dependence
Activity did not occur	8—8	Activity did not occur

ADL SUPPORT PROVIDED

- 8 Activity did not occur
- 3 Two + person phy assist
- 2 One person phy assist
- 1 Set – up only
- 0 No set – up or physical help from staff

Distance/Time

Long distance patient walks without sitting down and the time it takes them to do it.

Weight Bearing

FWB	Full weight bearing
WBAT	Weight bearing as tolerated
TTWB	Toe touch weight bearing
PWB	Partial weight bearing
NWB	Non weight Bearing

Strength

5/5	Normal	1/5	Trace
4/5	Good	0/5	Zero
3/5	Fair		
2/5	Poor		

Abbreviations

N.T.	Not Tested
N.A.	Not Applicable
ref.	Refused treatment
RUE	Right Upper Extremity
LUE	Left Upper Extremity
RLE	Right Lower Extremity
BUE	Bilateral Upper Extremity
BLE	Bilateral Lower Extremity
A+Ox4	Alert and Oriented to person, Place, time, purpose
xfer	Transfer

Assistive Device

FWW	Front wheeled walker
PUW	Pick up walker
SPC	Single point cane
NBQC	Narrow based quad cane
WBQC	Wide based quad cane
CRX	Crutches
PLAT/ CRX	Platform crutches
PLAT/ W	Platform walker

Weekly Summary:

7/28/01 See D/C summary in lieu of W.P.N.

D. Tate PTA

NOSTALGIC VIEW

OCCUPATIONAL THERAPY LOG

Patient Name: Robert Brown
Treatment Dx and ICD-9 Code: FM 780.9
Physician: Smith
MONTH/YEAR: 7/01

Onset Date of Symptoms/Illness: 7/19/01
(This date indicates the date the patient first became aware of the symptoms or illness being treated)

Date Plan Established or Last Reviewed: 7/22/01
Date Treatment Started:

[X] Medicare Part A
[ ] Part B with Insurance
[ ] Medicaid with Insurance
[ ] Private with Insurance
[ ] Managed Care
[ ] Part B without Insurance
[ ] Medicaid without Insurance
[ ] Private without Insurance

HCPCS	Therapist Initials >	ecc	r.a.	22	23	24	25	26	27	28	29	30	31	Total Units	Charge	Total Charge
	Description															
97003GO	Evaluation	X		1										1		
97530GO	Therapeutic Activities		X	1					1	2				5		
97535GO	Self Care/Home Manage		X	1	3		2	1	1					8		
														14		
97504GO	Orthotics- Fit & Train		X													
	Total Units			1	3		3	4						14		
	Total Minutes			1	3		2	1	2	2				218		
	Total Visits			1	1		1	1	1	1				6		

Therapist Name Printed	Initials	Signature, Credentials and Date	Therapist Name Printed	Initials	Signature, Credentials and Date

Part A ✓ Part

PLAN OF PROGRESS FORM FOR INPATIENT REHABILITATION

1. PATIENT'S LAST NAME: Brown
FIRST NAME: Robert
MI:
2. PROVIDER NO.: 505217
3. HICN:
4. PROVIDER NAME: Nostalgic View
5. MEDICAL RECORD NO.:
6. ONSET DATE: 07-14-01
7. SOC DATE: 07-22-01
8. TYPE: ☐ PT ☒ OT ☐ SLP
9. PRIMARY DX: Osteoarthritis (R) hip
10. TREATMENT DIAGNOSIS: 780.9 ↓'ed Funct. mob
11. VISITS FROM SOC: 6

12. PLAN OF TREATMENT FUNCTIONAL GOALS

GOALS (Short term) – 1wk
1. Pt. to stand + complete grooming c̄ SBA
2. Pt. to complete LB dressing w/ adapt. equip. c̄ CTG (A)
3. Pt. to complete funct. mob c̄ CTG (A)
4. Pt. to shower c̄ min (A)
5. Pt. complete Fair/Faint standing balance for safety for ADLs
6. Pt. to follow hip prec. c̄ 2 vcs c̄ ADL activity.

OUTCOME (Long Term) 4wk
(I) c̄ ADLs, funct mob c̄ safety + effective d/c

PLAN
✓ Evaluation
✓ ADL Training
✓ Func. Mobility
__ Func. Maint. Pgm
__ Sensory Stimulation
__ Seating/Positioning
✓ Equipment recommendation
✓ Cont. Balance
__ Cog/Perceptual
__ Energy Mgt.
✓ High level ADL's
__ Staff/Family Trng.
__ Edema Control
✓ Home Assment
__ UE Management (ROM/Strengthening Mgt)
__ UE Ex. Program
__ Splinting
__ Body Mechanics
✓ Reinforce Precautions
__ D/C Planning

13. SIGNATURE (professional attaching POC signature and designation): Jennet Simpson OTR/L
14. FREQ/DURATION (e.g. 3x/wk x 4 wks): 6x1wk x 2wks
15. I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE.
PHYSICIAN SIGNATURE: Martin Tempa
16. DATE: 7/29/2001 ☐ N/A
17. CERTIFICATION: FROM 07-22-01 THROUGH 08-05-01 ☐ N/A
18. ON FILE (Prototype physician's name): ☐ N/A Dr. Smith

20. INITIAL ASSESSMENT (History, medical complications, level of at start of care. Reason for referral)

Age: 81 F/C Rehab. Potential: Good for stated goals.
Reason for Referral: Teach/train THR prec. for ADLs/funct. mob to return to prior level of functbal
Prior level of function: Pt. married lives in single level home (R) all (I) c̄ ADLs, funct mob, had care 24hrs
Medical History: Dx: Osteoarthritis (R) hip S/P THR
Pmhx: remote Hx hernia repair - chemotherapy, Dx: colon cancer, left eye OA or glaucoma
Vision/Hearing: Glasses, hearing - WFL
Mental Status: Pt. alert, oriented, follows directions, recalled 4/3 hip prec. Pleasant cooperative
Prior therapy services:
Patient Goals: Return home
Adaptive equipment (list): walk in shower, sock aid, reacher, ETS, long handled sponge
Summary of Problems: ☒ Balance ☐ Strength ☐ ROM ☒ Activity Tolerance ☐ Cognition ☒ Pain ☐ SOB
☒ Comments: 50-75% WB, hip prec.

19. PRIOR HOSPITALIZATION
FROM 07-19-01 TO 07-22-01 ☐ N/A

ADL Status	N/A	Max	Mod	Min	SBA	Ind
Set Feeding						
Grooming						X
Dressing UE					X sitting	
Dressing LE				-	✓	
Toilet Transfer				min+		
Toilet Hygiene				✓		
ADL R.W. Mob.				min+		
Bathing	NT					
Safety	Recalls 2/3 hip					

(A) RANGE OF MOTION

	R	L
Sh Flex:	0-120	0-120
ABD:	0-120	0-120
Elbow:	1-140	0-140
Wrist:	0-40	0-40
Hand:	WFL	WFL

(B) VOLUNTARY MOVEMENT

R	L
S/S	S/S

BALANCE: Static: Fair Stand
Dynamic: Fair Stand
Sensation:

21. FUNCTIONAL LEVEL (End of billing period) PROGRESS REPORT

ADL Status:	N/A	Max	Mod	Min	SBA	Ind
Grooming						✓
LB Dress						✓ c̄ ted
Funct. mob						✓
Shower						
Stand	Faint					
Hip prec						

☐ CONTINUE SERVICES OR ☒ DC SERVICES

SUMMARY OF PROGRESS
Pt. has made excellent progress toward LTG since time of eval evidenced by objective data. Pt. has reached max level of funct. perf. d/c from skilled OT. Services c̄ returning home c̄ (A) from W/C as needed.

Equipment Recommendations:
- RTC c̄ Arm Rest
- Shower chair
- W.W. OT

22. SIGNATURE (Name of professional, including prof. designations): Lester Simpson
DATE: 07-28-01
23. SERVICES DATES FROM 07-22-01 THROUGH 07-28-01
ROOM #: 200-1

NAME	TITLE	INITIAL	NAME	TITLE	INITIAL
Nancy Toms	OTR/L	NT			
Robin Ayers	COTA/L	RA			
Nina Riley	COTA	NR			

July 2001

INITIAL WHEN TREATMENT GIVEN

COUNTER INITIAL BY LICENSED/REGISTERED THERAPIST

KEY: R = Refused; W = Treatment Withheld - Reason Documented Below; D = Discharged

TREATMENT		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Eval	qd																						M									
	bid																															
ADLs	qd																						M	KL		R	R	R				
	bid																															
Funct MOB	qd																						M	KL			R	R	R			
	bid																															
Balance	qd																						M	KL			R	R	R			
	bid																															
Hip Prec	qd																							KL		R	R	R	R			
	bid																															
	qd																															
	bid																															
	qd																															
	bid																															
Daily Units																																
Daily Minutes																																

DATE	PROGRESS NOTES
7-22-01	OT orders received, chart reviewed, evaluation completed + tx initiated. Pt. presents c̄ ↓ded ADLs, funct MOB, Balance 2°to New @ TNR. Pt. will need OT for ADL retraining, funct MOB + teach/train TNR prec. See HCFA 700 form for details. Nini Tayet, OTR
7/23/01	Pt seen for ADL retraining c̄ focus on funct MOB + funct Bal c̄ regard to hip precautions & WB status. Pt. instruction in Sit → Stand tech c̄ PWW, also instructed in use of AE. Pt familiar + (I) c̄ reacher + sockaid. Pt c̄ 0 c/o pain, required SBA for mobility task. Pt required strong instruction to call for help c̄ mobility. Pt requires V/c's + supervision to maintain WB status — Robin Ayers COTA

PATIENT NAME	HIC NUMBER	ROOM NO.	
Brown, Robert		2001	☒ OT ☐ PT ☐ SLP

DATE	PROGRESS NOTES
07-25-01	Pt seen this p.m. c̄ tx focus on review of hip pec & discussion of AE use c̄ ADL's (wife present) 2° pt c/o constipation declining out out of bed. Pt able to recall 2/2 hip pec & reports having (I) c̄ dressing using adap. Equip. Pt pleasant & eager to participate in more entire tomorrow a.m. D. Tate
07-26-01	Pt seen this p.m. c̄ tx focus on hip pec & LB dsg using AE. wife present. Tx time b/d 2° pt's c/o constipation & preoccupation c̄ trying to relieve bowels. Pt eager to participate more once current bowel condition relieved. D. Tate
07-27-01	Pt seen this p.m. c̄ tx focus on self care (shower), fine mobility & t/f (shower chair), & stand balance c/t ADL's. Pt t/f on/off shower chair CGA + adapt s/u & completed bathing SBA - (S) + AE. Pt completed dsg c̄ modified (I) & (R)ted hose done good hip pec. Pt could benefit from raised toilet seat (BTS) c̄ arm rests & shower chair. Pt eager to return home & feeling much better today.
07-28-01	Pt seen this p.m. c̄ tx focus on fine mobility, stand balance & conformation of AE needs. Pt d/c'd from skilled in OT. Please refer to HCFA form 700 for details. D. Tate

PATIENT NAME	HIC NUMBER	ROOM NO.	
Brown, Robert	Smith		☐ OT ☐ PT ☐ SLP

MENTAL STATUS ASSESSMENT

LANGUAGE

Naming
Point to a wristwatch and ask resident to name the object. _____
Point to a pen and ask resident to name the object. _____

Repetition
Ask resident to repeat after you:
"No ifs, ands or buts." _____

Following Directions
Ask the resident to follow this 3-step command:
"Take this paper, fold it in half, and put it down in front of you." _____

Reading
Have the resident read this message and do what it says,
"Close your eyes." _____

Writing
Ask the resident to write a sentence.

_____

Ask the resident to copy these figures. ○ △ ▭

_____

SUMMARY OF ASSESSMENT
Formal MSA testing is deferred as resi intact cognition is apparent. He makes consistent, reasonable decisions. Mood is intact and upbeat. A joy to know this gentleman.

SIGNATURE K. Binder, SSD DATE 7/22/01

NAME	PHYSICIAN	ADMISSION NUMBER	ROOM/BED
Brown, Robert	Smith		

Initial Psychosocial Assessment
RAP Reference
July 28, 2001

Cognition, communication: **No triggers. Do not proceed.**

Formal MSA testing is deferred, as res's strongly intact cognition is apparent. He makes solid decisions, based on logic and forethought, gauging secondary consequences. Speech is clear and eloquent. He communicates clearly both expressively and receptively. It is anticipated that he will maintain strengths in these areas.

Mood, behavior, psychosocial well-being: **Proceed per PCP # 4**

Res. presents with intact mood. He appears motivated, upbeat, cheerful, gregarious. He receives staunch, loving support from his wife and her daughter (who lives out of state). Res thoroughly enjoys chatting at length with staff and fellow residents, his Brooklyn accent quite endearing. Res is an avid gardener, and he looks forward to seeing to his home garden and sharing his bounty with others. It is anticipated that he will maintain strengths in these areas.

Discharge planning: **Proceed per PCP # 3**

Res. lives at home with his wife where he is generally independent and active. He and his family share the goal that res. will return home as soon as possible. Res's wife is unable to provide a great deal of hands-on care due to her own physical limitations, so res. will need to be quite independent before returning home. Their home has multiple levels with many stairs, but res made amendments to the house last year when his wife had her orthopedic surgery and home rehab, so he feels quite confident that "I'll do fine." Res says he will welcome home health supports. It is suggested that he have home PT, OT, and aide. With team, SW follows for discharge planning and facilitation.

K. Binder, SSD

K. Binder, SSD

MENTAL STATUS ASSESSMENT

DATE 7-28-01 TIME 0800

ELEMENTS OF ASSESSMENT — RESIDENT'S RESPONSE

ORIENTATION

Person

Name _____

Age _____

What kind of work did you do? _____

Place

City & State _____

Where are you now? _____

Time

Date: Month, Day, Year _____

Day of Week _____

Time of Day _____

MEMORY

Long Term

Name of Physician _____

Who do you trust for help with complex decisions? _____

Where were you living before you came here to this facility? _____

Short Term

Why are you here? _____

Repeat name of interviewer _____

Formal MSP testing is deferred. Per order

ARITHMETIC

Count from 1 to 10 _____

If you went to the store with $1.00 and you bought a loaf of bread for 75c, how much change would you get back? _____

JUDGMENT

If your roommate needed help, what would you do? _____

If there were a fire at home, what would you do? _____

REASONING

What does the old saying mean, "The early bird catches the worm?" _____

EMOTIONAL STATE/ CONTENT OF THOUGHT

How have your moods been? (Observe resident's manner during interview. Ask about hopefulness, future plans.) _____

NAME	PHYSICIAN	ADMISSION NUMBER	ROOM/BED
ROBERT BROWN	DR. SMITH	21-12	200-1

PATIENT/FAMILY CARE CONFERENCE

Date

PARTICIPANTS:	DISCUSSION AND DECISION SUMMARY, ACTION PLAN

MULTI-DISCIPLINARY DISCHARGE SUMMARY

DATE AND TIME	SUMMARY OF PATIENT STAY, COMPLICATIONS, CHANGE IN DIAGNOSIS, CONDITION ON DISCHARGE, AND INSTRUCTIONS TO PATIENT
7/22/01 SW	See SWA. Anticipate SI NHP + home c̄ wife when (I). NH SW to assess for HH. — K. Binder, SSD
23 July 01	81 y.o male c̄ RTH, 50% WB, clean + dry stapled incision c̄ coverlet. + CMST, amb c̄ walker, stable gait. Vicodin effective for pain. + v/o per urinal c̄ cl. yellow v/o. Pt A + Ox c̄ very pleasant. Lungs clear A + P. O_2 sat 94% RA. Supportive wife. — Sing on 7-19-01 — K. Signature
7-23-01	PT (1600) Pt s/p (R) THA; 50% WB; no ✓ > 90°, no AD, no IR. OOB c̄ cueing, mod (A); [illegible] 70 c̄ CNN CGA O_2 @ 2L. Desatted on RA today but 99% on 2C p̄ amb. Doesn't tolerate full (R) knee ✓, though this may be 2° to intolerance of hip ✓. Pain [illegible] TA ex c̄ min (A). Requires cueing to maintain pressure [illegible] Reads TH protocol + gait training as tol. Brown PT
7/24/01	NSG Summary. See above notes. Tolerating Vicodin were for pain. Vitals a. Sim this am. dressing dry so new change. — Brenda Gillis RN

PATIENT DISCHARGED: DATE: 7/29/01 TIME:

Date: 7-23-01

Medicare/Rehabilitation Meeting

Admission Date: 7-22-01 Admission Diagnosis: _____

Discharge Planning – *Anticipated Goals:*

Resident's/Family's Goal: home & wife

☐ Return Home ☒ Home with Assist. ☐ Assisted Living ☐ Long Term Care

Comments: home health

P.T. - *Current Level of Function:* Estimated Duration: _____

☐ Bed Mobility ☒ Transfers ☒ Ambulation ☒ Strength

☐ Therapeutic Exercise ☒ Balance ☐ Wound Care

Comments: work on stairs

O.T. - *Current Level of Function:* Estimated Duration: _____

☐ Dressing ☐ Bathing/Grooming ☐ Self-Feeding ☐ Orthotic

☐ Functional Mobility ☒ Higher/Living Skills ☐ UE PRE's

☐ Balance for ADL's

Equipment Needs: _____

Comments: _____

S.L. - *Current Level of Function:* Estimated Duration: _____

☐ Expressive Communication ☐ Auditory Comprehension ☐ Reading/Visual

☐ Cognition ☐ Oral Motor ☐ Chew/Swallow

Comments: _____

Nursing - *Skilled Services:* Benefit Days Remaining: _____

☐ Injection/IV ☐ Epidural ☐ Tube Feeding ☒ Wound Care ☐ Care Plan ☐ Observation

☐ Trach ☐ Air Bed ☐ Change in Condition ☐ Teaching

Nursing issues/orders to be obtained: staples

Resident Name: Brown, Robert Physician: Smith Room # 2001

10/95

NOSTALGIC VIEW

HRF-371
Page 1 of 2

DISCHARGE DATE 7/29/01 DISCHARGE TO home

Reason for Discharge therapies completed

Financial Arrangements

RECAPITULATION OF RESIDENT'S STAY

(reason for admission, interventions, course of stay, outcome)

Mr. Brown was admitted on 7/22/01 from PMC s/p (R) THR. Resident has diagnosis of severe osteoarthritis. While @ NV resident received skilled therapy services. Staples to (R) hip incision were removed yesterday. Resident was medicated c̄ prn Vicodin for (R) hip surgical pain + deemed Vicodin effective. Resident has been using only tylenol for past 4 days for mild hip pain. He is ready to return home c̄ his wife.

CONDITION ON DISCHARGE

Date 7/29/01 Time 0900 Vital Signs T: 97.8 P: 88 R: 16 BP: 140/82 Date 7/29/01 Wt. 194 lbs

Date of last bowel movement 7/28 (yesterday) Height:

Vision: clear Hearing: clear Speech: clear

Decision Making Ability good

Psychosocial

ACTIVITIES and MOBILITY

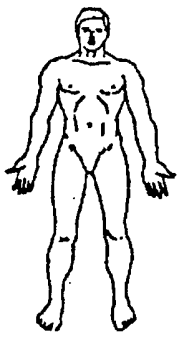
Indicate amount of assist needed

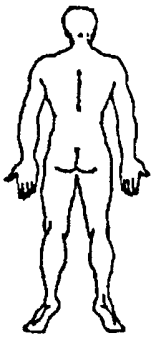
Bathing	needs assist	Transfer	IS
Dressing	Independent	Bed Mobility	
Eating		Walking	Dr.
Personal Hygiene		Toileting	Independent

Assistive Device For Toileting: Independent Assistive Device Used For Walking: Front wheel walker

Other Equipment Needs: Wheel chair for long distances

SKIN CONDITION





Description or Precautions Needed

Sgrason, RN
Signature of Nurse

7/29/01
Date

DISCHARGE SUMMARY/DISCHARGE INSTRUCTIONS

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
BROWN, ROBERT	SMITH	21-12	200-1

White - Resident's Copy • Canary - Facility Copy

DISCHARGE INSTRUCTIONS AND PLAN FOR POST-DISCHARGE CARE

MEDICATIONS

Document Instructions in Layman's Terms — No Abbreviations

RX #	MEDICATION/DOSAGE	AMOUNT SENT	TIME TO BE GIVEN	SPECIAL INSTRUCTIONS
	HCTZ (Hydrchlorothiazide) 25mg		9am	
	K-dur 20 mEq		9am	
	Multivitamin		9am	
	FeSO4 (Iron) 325mg		9am and 5pm	
	Coumadin 2mg		5pm	
	Ducosate 250mg		9am and 5pm	
	Vicodin 1 or 2tablets only if needed up to 6 hours			

Dietary Instructions: _____

Treatments and Special Instructions: _____

Next protime to be drawn 8/1/01

Activity Abilities and Limitations: _____

Forms which accompanied the resident: D/C Instructions

APPOINTMENTS/COMMUNITY AGENCIES/POST-DISCHARGE SERVICES

Appointments: August 15, at 1:30 Dr. Temps

Community Agency Contacts: Address Telephone

Lasting Ways Home Health

Physician (call if you have questions): _____ Telephone: _____

I have received the above information and instructions and have had an opportunity to ask questions.

Robert Brown — Signature of Resident/Responsible Party — Date 7/29/01

Cynthia Jerrs, RN — Signature Title — Date 7-29-01

DISCHARGE SUMMARY/DISCHARGE INSTRUCTIONS

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
ROBERT BROWN	MICHAEL SMITH	21-12	200-1

White - Resident's Copy Canary - Facility Copy

RECREATION DEPARTMENT ASSESSMENT

Reason For Assessment:
✓ Initial ___ Re-admit ___ Annual ___ Significant Change
Primary Diagnosis: Orthopedic Aftercare

PERSONAL INFORMATION

Resident Prefers To Be Called: Bob
Date of Birth: 4-15-20 Age: 81 Place of Birth: Brooklyn, NY
Marital Status: ✓ M ___ D ___ W ___ S Name of Spouse: Carolyn
Former Occupation: Health physicist
Religious Preference: Catholic
Veteran: ✓ Yes ___ No Branch Navy
Registered Voter: ✓ Yes ___ No ✓ Absentee Ballot

LEISURE PURSUIT PREFERENCES

P = Past C = Current F = Future

Physical Activities

C Exercise	C Walking	___ Wheeling	___ Hunting
___ Fishing	C Gardening	C Sports Mariners	___ Bowling
___ Traveling	___ Bicycling	___ Dancing	___ Other

Intellectual Activities: fav

___ Pinnocle	___ Poker	___ Solitaire	___ Cribbage
C Crossword	C Circle-a-word	C Word Games	C Cards
C Magazines	C Books	C Current Events	___ Newspaper
C Writing	C Reading	___ Large Print	___ Bingo

Emotional / Creative Activities:

___ Drawing	___ Painting	___ Cross Stitch	___ Needlepoint
C Sewing	___ Knit	___ Crochet	___ Arrange Flowers
C Crafts (Wood)	___ Cook/Bake	___ Bible Study	___ Pastoral Visit
C Music	C Country / West	___ Jazz	___ Soft Rock
___ Classical	C 40's	C 50's	___ Other

Social Activities:

___ Beauty Shop	C Barber Shop	___ Manicures	___ Movies
C Parties	___ Bands	C Entertainment	___ Lunch Out
C Outings	___ Picnics	___ Resident Counc	___ Other
___ Clubs			

RESIDENT'S NAME	PHYSICIAN	Admit#	Room#
Brown, Robert	Smith	21-12	200-1

Brown, Robert

LEISURE TIME PREFERENCES:

✓ Morning ✓ Afternoon ___ Evening

___ Independent Activities
✓ Small Group
___ Staff Visits

___ Likes To Be Alone
✓ Large Group
___ Unable To Attend Group

COGNITIVE

✓ Alert & Oriented ___ Confused ___ Aphasic
___ Non-Responsive

MOOD / BEHAVIOR: Upbeat, happy.

MOBILITY

___ Ambulates ___ Alone ✓ Walker ✓ Assist To All Areas
___ Wheel Chair ___ Assist ___ Self Propel

SIGHT / HEARING

Vision: ___ Good ✓ Fair ___ Poor Glasses: ✓ Yes ___ No
Hearing: ___ Good ✓ Fair ___ Poor Hearing Aids ___ R ___ L

INFORMATION RECEIVED FROM:

✓ Resident ___ Family Member ___ Friend

INITIAL PLAN / ASSESSMENT

Resident will accept an invitation to group activity 3x per week

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a. ✓	Evening	c. ✓
		Afternoon	b. ✓	NONE OF ABOVE	d.

(If resident is comatose, skip to Section O)

2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most – more than 2/3 of time 1. Some – from 1/3 to 2/3 of time 2. Little – less that 1/3 of time 3. None			1
3.	PREFERRED ACTIVITY SETTING	(Check all settings in which activities are preferred)			
		Own room	a. ✓		
		Day/activity room	b. ✓	Outside facility	d.
		Inside HH/off unit	c. ✓	NONE OF ABOVE	e.

4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(Check all PREFERENCES whether or not activity is currently available to resident)			
		Cards/other games	a. ✓	Trips/shopping	g. ✓
		Crafts/arts	b. ✓	Walking/wheeling outdoors	h. ✓
		Exercise/sports	c. ✓	Watching TV	i. ✓
		Music	d. ✓	Gardening or plants	j. ✓
		Reading/writing	e. ✓	Talking or conversing	k. ✓
		Spiritual/religious activities	f. ✓	Helping others	l. ✓
				NONE OF ABOVE	m.
5.	PREFERS CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines 0. No change 1. Slight change 2. Major change			
		a. Type of activities in which resident is currently involved			0
		b. Extent of resident involvement in activities			0

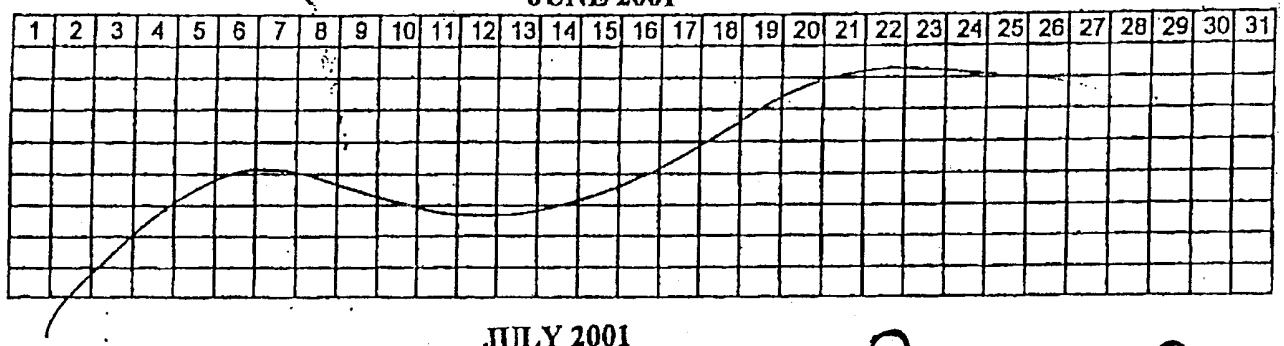
Completed by: Nancy Riley ADCP Date 7-26-01

7/ 9/2004

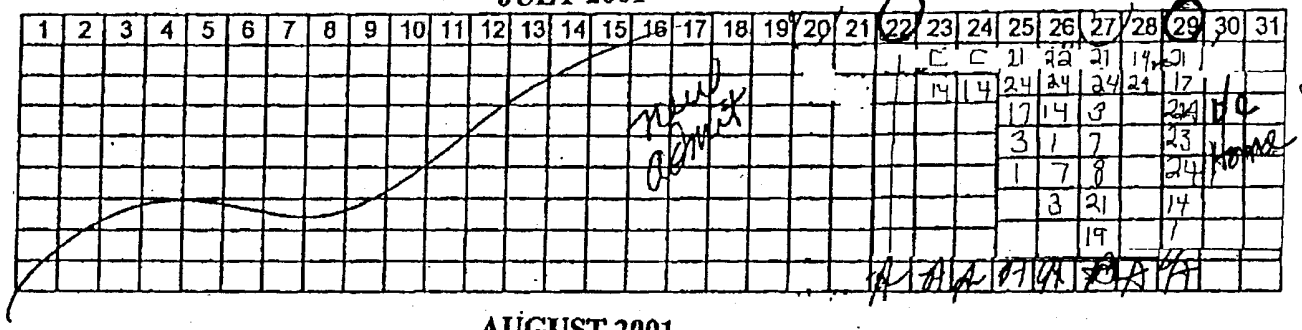
ACTIVITY RECORD

1. 1:1 Visit
2. News
3. Word Games
4. Bingo/Table Games
5. Crochet/Knit
6. Party/ Special Events
7. Music/Rythym
8. Remin/Discuss
9. Church Service
10. Sing-A-Long
11. Pet Visit
12. Gardening/Flower Arr.
13. Resident Council
14. Movie, VCR, TV.
15. Out of Facility
16. Bus Trip/ Outing
17. Reading/Book Club
18. Arts & Crafts
19. Pastoral Visit
20. Cooking/Writing
21. Greeting/Short Visit
22. Exercise/Phy Games
23. E-Mail/Mail
24. Social Area
25 Beauty/Barber
26. Manicures
27. Sensory Group
28. Sensory 1:1
    A. Eye Con/Track
    B. Sounds/Words
    C. Resp. Touch
    D. Resp. Sounds

JUNE 2001

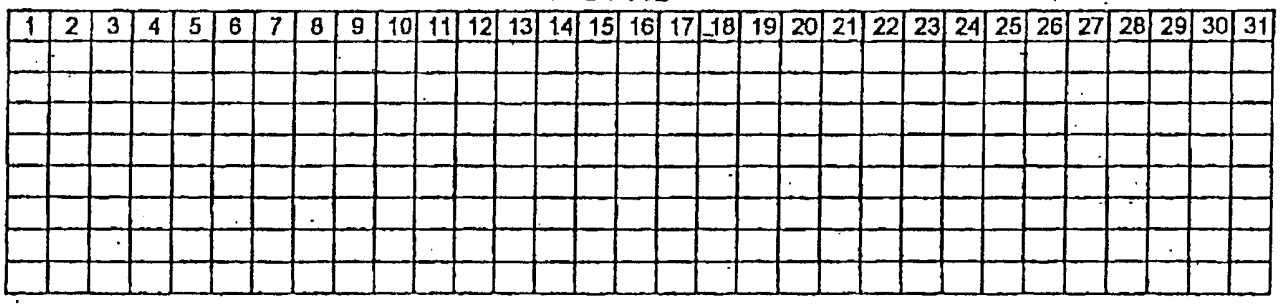


JULY 2001



D/C Home

AUGUST 2001



Key: A- Active P- Passive R- Refused U-Unable I- Independent C- Company S- Sleeping V- Volunteer

Lary Flynn
Recreation Director

Allison Myers
Activity Assistant

Linda Williams
Activity Assistant

Resident Brown, Robert

Room # 200-1

7/ 9/2004

INDIVIDUAL ACTIVITY LOG

DATE	TIME	ACTIVITY	RESPONSE
7-25 01	10 min	1 on 1	Introduction and welcome to facility
			Bob is alert and smiling. H
7-26 01	30 min	1 on 1	Activity assessment completed. H
7-27-01	10 min	1 on 1	Bob alert sat in an exceptionally good mood. H
7-29-01	10 min	1 on 1	Delivered mail Bob was very happy. Communicating with head nods. H

Larry Flynn
Recreation Director

Allison Myers
Activity Assistant

Linda Williams
Activity Assistant

Resident_ Brown, Robert

Room # 270-1

Individual Act. Log

7/ 9/2004

DIET ORDER: RCS, Regular

Has Patient Been On Diet Previously: ____ Yes X No ____

Does Patient Understand Reason for Special Diet: Yes X No ____

Does Family Understand Reason for Special Diet: Yes X No ____

ADM DATE: 7/22/01

Comment

Newly Diagnosed Diabetic

(If yes, specify reactions: cramps, diarrhea, etc.)

FOOD ALLERGIES

Milk Yes ____ No ____

Milk Products Yes ____ No ____

Other NKA

PREVIOUS EATING HABITS — USUAL MEALS FOR 1 DAY

BREAKFAST

LUNCH

DINNER

SNACKS
Candy
Potato Chips
Nuts
Pop
Alcohol
Other:

Time of Meals: ____ Appetite: "Starting to come back"

Cultural/Religious Food Preference: None

DIET PREFERENCE LIST

Likes	Dislikes	Likes	Dislikes
MILK/BEVERAGE: NF milk, Coffee, SF Cocoa		MEAT/FISH/POULTRY/EGGS:	Liver
FRUIT		BREAD/CEREAL: Wheat Bread, Cold Cereal, Raisin Bran	
VEGETABLES:	~~Spinach~~ said can eat.	OTHER: DR for All meals	

Signature Lynn Baxter Title CDM Date 7/24/01

DIETARY INTERVIEW

PATIENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
Brown, Robert	Smith		200-1

ADM. DATE: 7-22-01 AGE: 81 HEIGHT: 66 WRIST CIRCUM: _____ OTHER: BMI 31.0 L

WEIGHT: 7-22 197.2 7-23 193.2 USUAL WEIGHT: _____ IDEAL BODY WEIGHT: 146-164

DIAGNOSES/PROBLEMS RELEVANT TO NUTRITION: R hip THA, sev osteoarthritis + glu tol test - HTN diet control

DIET ORDER: Gen DINING LOCATION: Rm / DR

Dietary: Red Conc Sweets

APPLICABLE CURRENT LABORATORY WORK (note date, test, result): _____

MEDICATIONS and OTHER FACTORS (that may affect appetite and/or nutrition): Vicodin, HCTZ, Kdur 20, MV, FeSO4/325 BID, senokot

PATIENT FUNCTIONAL STATUS

Function (per nursing's assessment)	Impaired Yes	Impaired No	Comments
Ability to feed self		✓	
Chewing		✓	
Swallowing		✓	
Taste		✓	
Vision			
Hearing			
Ability to Talk		✓	No c/o
Bowels (constipation diarrhea, etc.)			

Est Needs Cal 18-1900

Pro 69-87g

Total Fluids 2600 cc

Bev Est: 19-2000cc

OBSERVATIONS OF DIETARY INTAKE IN FACILITY: 50-100%. The last 2 days my appetite's back." I don't need diab. education - my wife gets books & charts & measures. Won't let me have more. Ate last 2 days 1400, 1700, 2000, - I want to get to 167 lb. She has me on 1800 cal

DIETARY NOURISHMENTS: _____

ASSESSMENT/PLAN: 81 yo ♂ s/p THA. Diuretic Rx c̄ K+ repl. Rx MV, Fe. Dx DM per + glu tol test. - diet control. Rec goal for planned wt ↓.

P-1) Gen / Red Conc Sweets - rec MD clarify

2) Mon wt - STG ø ↑ LT ↓ - rec goal

3) BG ✓ per MD

Signature Mary Bancroft RD Title CD Date 7-25-01

NUTRITIONAL ASSESSMENT

PATIENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
Brown, Robert	Smith	21-12	200-1

FACILITY	DATE
Nostalgic View	July 2001

PLAN OF CARE

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVED DATE
~~01/01/2001~~ 7-20-01	001 - SELF CARE DEFICIT: weakness, ↓ mobility R/T @ THA, osteo-arthritis @ knee	RES WILL RECEIVE CUES & ASSISTANCE WITH ADL's and drug to reach goals set by ned, PT/OT	8-22-01	SIDERAILS: per res. choice	NA	
				DIET MONITOR - new admit new diabetic - diet controlled	NA	
				SEE RESIDENT CARE DIRECTIVES FOR MORE INFORMATION	NA	
		RES WILL amb short distances c FWW to BR and in hallways	8-22-01	SHOWER 2X/WEEK SHAMPOO WEEKLY	NA	
				FINGERNAIL CARE: Q WED AM. KEEP CLEAN AND SHORT.	NA	
				TOENAIL CARE Q WED PM. KEEP CLEAN AND SHORT.	NA	
				NAIL CUTTING BY LN ONLY - INFORM LN OF NEED	NA	
				CUE AND ASSIST RES W/ MEALS & SNACKS: newly Dx'd diet controlled diabetic - set up trays - as per wise	NA	
				CUE & ASSIST RES WITH AMBULATION USING: FWW to amb short distances to BR and in hallway + = ABLE / 0 = UNABLE	NA	
				ROM TO ALL EXTREMITIES DURING CARE. GOAL = 15 (OR AS TOLERATED) TO EACH EXTREMITY. DOC # DONE.	NA	

DIAGNOSES

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
NAME, NAME Brown, Robert	2172	200-1			7/22/01	Smith	1

FACILITY	DATE	PLAN OF CARE
Nostalgic View	July 2001	

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVED DATE
7-21-01	(CONTINUED) 001 - SELF CARE DEFICIT:			RECORD # OF TIMES RESIDENT INCONTINENT OF URINE.	NA	
				MONITOR BMS Q SHIFT. RECORD IN NURSING ORDERS.	NA	
				IF NO BM X 3 DAYS REPORT TO NURSE.	NA	
				RECORD # OF TIMES INCONTINENT OF BOWEL.	NA	
				CUE & ASSIST RESIDENT TO COMMUNICATE: DC [illegible]	NA	
				CUE & ASSIST RES TO ASSIST WITH DRESSING/undressing: to dress UB indep & setup - LB & limited assist	NA	
				CUE & ASSIST RES WITH TRANSFERS: to place feet firmly on floor, push up & arms maintaining hip precautions [illegible]	NA	
				NOTIFY L.N. OF ANY DECREASE IN ABILITY TO ASSIST W/SELF CARE AND INITIAL IF OCCURS.	NA	
				I HAVE PROVIDED CARE ACCORDING TO NURSING CARE DIRECTIVES AND FACILITY POLICIES.	NA	

DIAGNOSES

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
NAME. NAME Brown, Robert	2142	2001			07-22-01	Smith	2

FACILITY	DATE
Nostalgic View	July 2001

PLAN OF CARE

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVED DATE
7-22-01	(CONTINUED) 001 - SELF CARE DEFICIT:			PT & OT, FOLLOW PLAN OF CARE	PT	
				FALL RISK: moderate R/T unsteady gait 2° to @ THA	LN	
7-22-01	002 - POTENTIAL SKIN BREAKDOWN DUE TO: weakness, ↓ mobility 2° to @ THA, osteoarthritis @ knees, peripheral diabetes	SKIN WILL BE FREE OF BREAKDOWN R/T FRICTION, SHEAR PRESSURE W/NURSING MEASURES.	8-22-01	CHECK SKIN Q SHOWER DAY. TELL LN IF SKIN IS RED, BRUISED OR TORN. INITIAL IF REPORTED.	NA	
		RESIDENT WILL RECEIVE CUES & ASSIST W/ BED MOBILITY TO LEARN TO DECREASE TIME SPENT IN 1 POSITION.	8-22-01	CHECK SKIN DURING DAILY CARE. TELL LN IF RESIDENT HAS REDDENED, BRUISED OR TORN AREAS.	NA	
				LOTION TO ALL EXTREMITIES AT HS	NA	
				CUE & ASSIST RES WITH BED MOBILITY: to reach for and use SRD to turn and reposition in bed	NA	
				SKIN AT RISK ASSESSMENT: quickly and gen 2° to underlying diabetes	LN	
7-22-01	003 - POTENTIAL FOR DISCHARGE: good for return to home w/ spouse	RESIDENT WILL RESIDE IN MOST APPROPRIATE, LEAST RESTRICTIVE LEVEL OF CARE.	8-22-01	ASSIST RESIDENT & FAMILY TO IDENTIFY THEIR DISCHARGE GOAL AND STEPS TO MEET GOAL.	SS	
				Res. and wife plan that he will return home very soon	SS, LN, rehab	

DIAGNOSES

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
NAME NAME Brown, Robert	21-1K	200-1			07-22-01	Smith	3

PLAN OF CARE

FACILITY	DATE
	July 2001

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVED DATE
7-22-01	004 - POTENTIAL FOR CHALLENGED PSYCHOSOCIAL WELL-BEING DUE TO HEALTH LOSSES, ADMISSION ADJUSTMENT.	RES WILL ADJUST TO FACILITY ST/LT	8-22-01	ORIENT RESIDENT TO ROOM, FURNISHINGS, AMENITIES.	NA	
		RESIDENT WILL EXPRESS NEEDS AS THEY ARISE & WILL ACCEPT PROBLEM-SOLVING APPROACH IF PROBLEMS.	8-22-01	FOLLOW RESIDENT'S USUAL LIFE PATTERNS/CHOICES FOR ADLS TO MAX PRACTICABLE EXTENT.	NA	
				INTRODUCE SELF, EXPLAIN ALL CARE BEFORE EACH INTERACTION.	NA	
				OBTAIN BASELINE MENTAL STATUS TESTINGS AND REPEAT AS CLINICALLY APPROPRIATE.	SS	
				SW SUPPORTIVE INTERVENTION UPON REFERRAL/REQUEST.	SS	
				SUPPORT RESIDENT/FAMILY PER THEIR AGENDAS.	SS	
					SS	
					SS	
					SS	

DIAGNOSES

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
Brown, Robert	21-12	200-1			07-22-01	Smith	4

FACILITY	DATE	PLAN OF CARE
	July 2001	

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVED DATE
7-22-01	005 - POTENTIAL FOR ABNORMAL BLEEDING R/T anticoagulant tx, Coumadin	WILL NOT SHOW Sx OF EXCESSIVE BLEEDING.	8-22-01	TELL LN IF REISDENT HAS Sx OF BLEEDING AS LISTED IN FRONT OF NAC FLOW BOOK.	NA	
				AVOID ACCIDENTIAL BUMPING OR SKIN TEARS. PROTECT W/ LONG SLEEVES OR PADS PRN.	NA	
				NAIL CUTTING BY L.N. ONLY. INFORM L.N. IF NEEDED.	NA	
7-22-01	008 - ALTERATION IN METABOLISM R/T NON-INSULIN/INSULIN-DEPENDENT DIABETES. — newly Dx'd Diet controlled	WILL NOT SHOW Sx OF HYPO / HYPERGLYCEMIC REACTION.	8-22-01	TELL LN IF SHOWS Sx OF GLYCEMIC REACTION AS LISTED IN FRONT OF NAC	NA	
				PROVIDE PROPER FITTING SHOES. NOTIFY SOCIAL WORKER IF NEEDS SHOES OR SOCKS.	NA	
				HS SNACK - DOCUMENT % EATEN & CCS TAKEN	NA	
7-22-01	007 - POTENTIAL ALTERATION COMFORT: PAIN R/T (R) THA, osteoarthritis (R) knee	RESIDENT WILL exhibit / verbalize good relief of pain & side effects of pain Rx & NRB Lab checking RESIDENT WILL	8-22-01	INFORM LN IF RESIDENT C/O PAIN, MOANS, CRIES OR IS GUARDING AN AREA.	NA	
				MEDS / TxS PER MD ORDERS	LN	
				positioning for comfort, use pillows for support	LN	
7-22-01	008 - ACTIVITY/LEISURE: ~~SOCIAL STRENGTHS/DEFICITS:~~ Strength in independence slight ↓ in hearing	RESIDENT WILL accept an invitation to group activity 3x per week	8-22-01	RESIDENT PREFERS TO BE CALLED. Bob	All	
				MONTHLY CALENDAR Newsletter	TAO	

DIAGNOSES

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
NAME, NAME Brown, Robert	21-13	200-1			07-22-01	Smith	5

7/ 9/2004

FACILITY	DATE
	July 2001

PLAN OF CARE

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVED DATE
7-22-01	(CONTINUED) 008 - ACTIVITY/LEISURE: SOCIAL STRENGTHS/DEFICITS			CHAPLAIN VISITS	CHP	
				OFFER MAGAZINES AND BOOKS IN ROOM	TAD	
				OFFER PET VISITS VIA FACILITY ~~DOG SQUIRE~~. animals	TAD	
				TARGET: reading, writing, trivia, reminiscing, religious activities	TAD	
				If res. doesn't answer you may need to raise your voice - slightly & hearing	all	

DIAGNOSES

NAME	NUMBER	LOCATION	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
NAME, NAME Brown, Robert	21-12	200-1			07-22-01	Smith	6

FACILITY | DATE

PLAN OF CARE

ORIGINAL DATE	PROBLEMS/STRENGTHS	GOALS	ESTIMATED DATE	INTERVENTIONS	DISCIPLINES	RESOLVE DATE
009 7-22-01	~~10~~ - ALTERATION IN MOBILITY 2*PRECAUTIONS R/T HIP/(R) ~~KNEE~~ SURGERY	RESIDENT WILL LEARN TO OBSERVE PRECAUTIONS WITH THERAPY/STAFF CUES AND ASSIST	8-22-01	NO HIP FLEXION GREATER THAN 90°	NA	
				WEIGHT BEARING PRECAUTIONS: 50-75% @ Lg	NA	
				TO LIE ON ONLY OPERATED SIDE OR BACK TO KEEP PROPER ALIGNMENT OF REPAIR	NA	
				KEEP PILLOWS OR WEDGE BETWEEN KNEES WHEN LYING ON BACK TO KEEP PROPER ALIGNMENT	NA	
				KEEP SMALL PILLOW BETWEEN KNEES WHEN UP IN CHAIR	NA	
				FLOAT HEELS AND ANKLES TO PREVENT PRESSURE ON HEELS. SHOULD NOT TOUCH BED OR PILLOW AT ANY TIME	NA	
				FOR KNEE REPAIR: KEEP KNEE AS ~~FULLY EXTENDED AS POSSIBLE.~~ ~~USE IMMOBILIZER IF PROVIDED.~~ DC-LC	NA	
				TELL LN IMMEDIATELY IF DRESSING SOILED, LOOSE OR MISSING	NA	

DIAGNOSIS

NAME	LOCATION	NUMBER	BIRTHDATE	AGE	ADMIT DATE	PHYSICIAN	PAGE
Brown, Robert	21-12	200-1			7-27-01	Smith	

DATE	INIT.	PLAN OF CARE COMMENTS
		Initiated 7-22-01 L. Signature

INT.	SIGNATURE	TITLE	INT.	SIGNATURE	TITLE	INT.	SIGNATURE	TITLE

NAME	NUMBER	LOCATION	REVIEWED BY	PAGE
NAME Brown, Robert	21-12	208-1		7

83

7/ 9/2004

I. ASSESSMENT - Consider these areas in making a decision regarding the need for siderails, the risk and benefit.

II. ASSESSMENT DATA:	YES	NO
1. Cognitive:		
a. Memory problem		X
b. Impaired decision making		X
c. Aware of safety needs	X	
d. Awareness of edges of bed	X	
2. Physical Functioning:		
a. Transfer one or more physical assist	X	
b. Needs weight bearing support of 1 or more person assist		X
c. Non-weight bearing		X
3. Body Control Problems		
a. Partial ability to balance	X	
b. Total loss of ability to balance self		X
c. Partial/total loss of voluntary movement		X
d. Unsteady gait	X	
e. Partial or total loss of ability to position	X	
f. Hemiparesis - paresis		X
g. Quadriplegia		X
h. Poor body alignment		X
i. Severe contractures		X
j. Slides from chair		X
4. History of Falls		
a. Fell past 30 days - #		X
b. Fell past 30 - 180 days - #		X
c. Injuries		X
Specify -		

	YES	NO
5. Sensory Deficit Specify - glasses-sight	X	
6. Incontinence		X
7. Bed Mobility		
a. Requires bed rail to move in bed	X	
b. Can get out of bed independently	X	
c. Has used a double bed in the past	X	
d. Has used a wall as a safety precaution (bed against wall)		X
8. Other Conditions		
a. Drop is systolic BP of 20 mm Hg or more between laying and standing/sitting	not tested	
b. Unstable/acute episode		X
c. Wound care/treatment - interference (R) hip incision	X	
d. Siderails requested by resident/family (circle one)	X	
e. Climbs over rails		X
f. Emergency usage due to:		X
9. Medications which may contribute to unsteadiness		
a. Psychoactive drugs: Reason:		X
b. Other medications?	X	
___ Antihypertensive		
___ Hypoglycemic		
___ Sedatives		
___ Antihistamine		
___ Benzodiazepines		
___ Antiseizure		
X Narcotics		
___ Hypnotics		
X Diuretics		
c. Clinical conditions that require use: weakness 2° (R) THA		
10. Resident's Response to Siderails		
a. Accepts as treatment	X	
b. Apparent unaware of device		X
c. Request removal		X
d. Not applicable		X

SIDERAIL ASSESSMENT

Resident	Physician	Record No.	Room
Brown Robert	Smith	21-12	200-1

7/ 9/2004

10. Associated Diagnosis/Health Conditions that contribute to potential for falls, need for safety or as an enabler, such as brain damage - seizure disorder - ADLs, Diagnoses, Health Conditions -

Severe osteoarthritis (R) hip

11. Evaluation by ___ OT ___ PT ___ Other _____ Dated _____

Findings/Recommendations related to gait, balance, positioning or use of siderails

impaired gait/bal

III. ALTERNATIVE METHODS

Alternatives Tried ∅

IV. CURRENT USE OF SIDERAILS:

2 Right/Left up at all times
___ Right/Left down at all times
___ Right up / Left down at all times
___ Left up / Right down at all times
___ Use of half rail ___ Right or ___ Left

Special request for siderail use at night differ from days _____

V. CONCLUSION:
(Based on assessment data, evaluations and use of siderails.)

Res. - choosing both 1/2 SR's up to define bed edges + assist c̄ bed mobility
potential risks made, aware res. A/O x 3

VI. PLAN:

1/2 SR's ↑↑ bilat

VII. REVIEW TEAM:
(The team reviewed the decision and the risks/benefits associated with siderail usage.)

Restorative	Date	Signature Nursing	7-22-01 Date
Social Service	Date	Activities	Date

RESIDENT INTERVIEW (Quote Resident Response, When Possible)

Are You Aware of the Need to Void: Yes X No____ If Yes, How Long Can You Wait to Urinate Once You Feel The Urge?

Can You Feel When the Urine is Flowing: Yes X No____ Comment

Can You Stop the Stream of Urine Once You Have Started: Yes X No____ Comment

Do You Have Discomfort in Urination: Yes____ No X If Yes, Describe

What Help Do You Need to Avoid Accidents:

Do You Wish to Participate in A Bladder Retraining Program: Yes____ No X Additional Comments

SENSORY/COGNITIVE/COMMUNICATION BEHAVIOR

	GOOD	FAIR	POOR	COMMENTS
Sensory				
Vision/Perception	X			c glasses
Hearing	X			
Cognitive				
Orientation(Time,Person,Place)	X			A & O x 3
Alertness	X			
Memory/Carryover	X			
Communication				
Verbal	X			
Written	X			
Ability to Make Needs Known	X			
Behavior				
Cooperation	X			
Motivation	X			

L. Signature RN 7-22-01

NURSING DIAGNOSIS (Alterations in Urinary Elimination)

Incontinence: Functional____ Reflex____ Stress____ Urge____ Total____

Other____ Related To:

Retention: Yes____ No____ Related To:

RESIDENT A CANDIDATE FOR BLADDER RETRAINING PROGRAM: Yes____ No X If Yes, Continue on Other Side

If No, Reason: Res. continued of both B/B

SIGNATURE S. Harvey TITLE Rehab DATE 7/27/01

DATE PROGRAM INITIATED____ DATE PROGRAM DISCONTINUED____

SUMMARIZATION OF RESULT OF PROGRAM

BLADDER RETRAINING ASSESSMENT

RESIDENT'S NAME	PHYSICIAN	ADMISSION NO.	ROOM & BED NO.
Brown, Robert	Smith		

ST 118843 1PLY UB-92

NOSTALGIC VIEW
KENT TOWN, WA 98331

APPROVED OMB NO. 0938-0279

1 PATIENT CONTROL NO. PAGE 1 OF 1 — 093246161A

4 TYPE OF BILL: 211

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 072201 THROUGH 072901

7 COV D. 007

8 N-C D. 9 C-H D. 10 L-R D. 11

12 PATIENT NAME: BROWN, ROBERT

13 PATIENT ADDRESS

14 BIRTHDATE: 04151920 | 15 SEX: M | 16 MS | 17 ADMISSION DATE: 072201 | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT: 01 | 23 MEDICAL RECORD NO.

24–30 CONDITION CODES | 31

32–35 OCCURRENCE CODE / DATE

36 OCCURRENCE SPAN CODE: 70 FROM 7/19/01 THROUGH 7/22/01

37 BROWN, ROBERT

38

39–41 VALUE CODES / AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0022	HIPPS RATE CODE	RHB11	072601	7	0.00		
2	0120	R & B SEMIPVT 2BD (GENER	155.00	072901	7	1085.00		
3	0250	PHARMACY			0	57.31		
4	0270	MEDICAL SURGICAL/SUPPLIE			0	22.33		
5	0300	LABORATORY			0	9.00		
6	0420	PHYSICAL THERAPY			15	450.00		
7	0424	EVALUATION/RE-EVALUATION			1	72.00		
8	0430	OCCUPATIONAL THERAPY			13	390.00		
9	0434	EVALUATION/RE-EVALUATION			1	72.00		
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	** TOTALS **				2157.64		

50 PAYER: 52 MEDICARE | 51 PROVIDER NO. | 52 REL. OF BEN. | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME: BROWN, ROBERT | 59 P. REL.: 01 | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.: V548 | OTHER DIAG. CODES: 68 CODE 71595 | 69 CODE 4019 | 70 CODE 71596 | 71 CODE 3669 | 72 CODE 3899 | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C.: 9 | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE: A | OTHER PROCEDURE CODE / DATE: B | OTHER PROCEDURE CODE / DATE: C | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID: DR. SMITH

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE: X | 86 DATE: 11/07/2002

UB-92 HCFA-1450 OCR/ORIGINAL

7/ 9/2004