OnSite Healthcare & Wellness

Assisted Living Service Request/Patient Consent

Part 1: Patient Demographic/Billing Information

Facility Name: Legacy at Southpointe Date: 5/5/2021

Patient Name: Webb (Last Name) Apt A6 Charles (First Name) (MI)

Previous Adress: Raleigh NC 27612 Previous Phone Number: 919-579-9861

DOB: SSN: Phone # 919-579-9861

Gender: ☑M ☐F Marital Status: married Race: Black

Emergency Contact: Shena Webb Phone Number: 919-579-9861
Tory Breece (Stepson) 919-

Is patient capable of making his/her own healthcare decisions? ☑Yes ☐No

If no, does patient have Surrogate Decision Maker (Family Member, Legal Guardian, POA)? ☑Yes* ☐No

Name: Shena D. Webb Relationship to Patient: spouse

Phone: 919 579-9861 Email: shenawebb@icloud.com

*Note: Surrogate listed here should be same as Surrogate signing on next page

INSURANCE INFORMATION: please attach a copy of:

- **YOUR FACILITY FACE SHEET**
- **PRIMARY AND SECONDARY INSURANCE CARDS**
- **HISTORY AND PHYSICAL**
- **DISCHARGE SUMMARY**

without these items, we cannot see patient

SERVICES REQUESTED:

☑	Primary Care	To include all primary care services
☑	Acute Care	To include acute visits only
☑	Mental Health	To include psychiatry and psychotherapy, for the purposes of managing emotional, behavioral, or cognitive problems, and/or psychotropic medication management
☑	Podiatry/Foot Care	Requested for management of foot care *
☑	Optometry	Requested for management of diagnosis, prevention, and treatment of ophthalmic diseases and visual disorders *
☑	Audiology	Requested for management of diagnosis, prevention, and treatment of auditory diseases and hearing impairment *

* May not be available in all areas.

[Consent and Acknowledgement Follow on Next Page]

When complete, please email to referrals@ohw-sc.com or fax to 864.442.4126 along with Facility Face Sheet and Insurance Cards, AND legal documentation of Surrogate Decision Maker.
Patient cannot be seen until all documentation is received.

OnSite Healthcare & Wellness

Part 2: Patient Consent and Acknowledgement Form

Patient Name: Charles Webb **Facility:** Legacy at Southpointe

DOB: [redacted]

Consent for Services and Acknowledgement of Receipt of Policies:

By signing below:

- I request and consent for the healthcare services indicated above to be provided to me by Onsite Healthcare and Wellness, LLC.
- I authorize the release of any medical or other information necessary to determine available health care benefits and to remit and process third party payment claims for services rendered on my behalf.
- I understand that my insurance company may assign a portion of a bill for services as patient liability.
- I understand that my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record
- I authorize the release of information to my Attending Provider and/or facility as applicable.
- I agree that my responsible party (financial agent) may be informed that I am receiving services for billing purposes unless I request otherwise.
- I also consent to receive Chronic Care Management (CCM) Services from Onsite, which includes my acknowledgment that
    - Electronic communication of my medical information will be made with other treating providers as part of coordination of my care.
    - Cost-sharing will apply to CCM Services, so I may be billed for a portion of CCM Services even though CCM Services will not necessary involve a face-to-face meeting with the Provider.

Charles Webb

Patient Signature

Printed Name: Charles Webb

Date: ~~5/5/2021~~ 6/23/2021

Surrogate Decision Maker Signature

Printed Name: _____

Date: _____

Surrogate's Designation: (Family Member, POA, Legal Guardian, etc.)**

***If a legally appointed surrogate, please include copy of documents verifying relationship / legal capacity.*

Incapacity to Sign: **Patient consents to the terms set forth herein, but was unable to sign this Consent and Acknowledgement Form due to (please be specific and include two Witness Signatures (one of which may be the healthcare provider):**

_____

Witness Signature / Date

Witness Signature / Date

When complete, please email to referrals@ohw-sc.com or fax to 864.442.4126 along with Facility Face Sheet and Insurance Cards, AND legal documentation of Surrogate Decision Maker. Patient cannot be seen until all documentation is received.

OnSite Healthcare & Wellness

Name: Charles Webb DOB: / / Date: 5/5/2021

Allergies:					
Medical Condition:	**Yes**	**No**	**Relative**	**Unk**	**Add'l Comments**
Musculoskeletal/Neuromuscular					
Rheumatoid arthritis		✓			
Osteoarthritis		✓			
Gout		✓			
Scoliosis		✓			
Osteoporosis		✓			
Multiple Sclerosis		✓			
Cerebral palsy		✓			
Seizures		✓			
Parkinson's		✓			
Neuropathy		✓			
Other:					
Audio/Visual					
Glaucoma		✓			
Blindness		✓			
Hearing loss		✓			
Other:	✓				left side neglect from Stroke 6/14/2018
Internal Organs					
Hepatitis		✓			
Cirrhosis		✓			
Kidney Disease		✓			
Kidney stones		✓			
Urinary retention		✓			
Inflammatory bowels		✓			
GERD/Reflux		✓			
Constipation		✓			
Diarrhea		✓			
GI bleeding	✓				
Thyroid disease		✓			
Diabetes type					Type 1 or 2
Other:					
Cardiovascular/Respiratory					
Heart attack	✓				6/2018
Stroke		✓			
Heart failure (CHF)	✓				
High blood pressure		✓			
Orthostasis		✓			
Afib / Irregular Heart rate		✓			
Anticoagualtion		✓			
Bleed disorder		✓			
COPD		✓			
Asthma		✓			
Emphysema	✓				Pacemaker 6/2018
Other:					

OnSite Healthcare & Wellness

Mental Health/Cognitive Impairments/Dementias					
Depression		✓			
Anxiety		✓			
Bipolar disorder		✓			
Anorexia		✓			
Learning disability		✓			
Visual hallucinations		✓			
Auditory hallucinations		✓			
Panic attacks		✓			
Behavioral issues		✓			
Difficulty sleeping		✓			
Stress		✓			
Alzheimer's disease		✓			
Vascular Dementia	✓				
Frontotemporal dementia		✓			
Lewy-body dementia		✓			
Parkinson's dementia		✓			
Parkinson's psychosis		✓			
Wernekie Korsakoff		✓			
Delirium		✓			
Encephalopathy		✓			
Mild Cognitive Impairment		✓			
Sundowning		✓			
Other:					

Other					
Cancer		✓			Type:
Bleeding disorder		✓			
High Cholesterol		✓			
Poor appetite		✓			
Weight loss		✓			
Other:					

Surgeries					
Type	**Yes**	**No**	**Year**	**Unk**	**Add'l Comments**
Pacemaker	✓		2018		

Social					
Type	**Yes**	**No**	**Years**	**Unk**	**Add'l Comments**
Married	✓				
Smoker		✓			
Tobacco		✓			
Alcohol		✓			
Drugs		✓			

Immunizations					
Type	**Yes**	**No**	**Year**	**Unk**	**Add'l Comments**
Flu vaccine	✓		2020		
Pneumovax 23		✓			
Prevnar 13		✓			
TDaP		✓			
Varicella		✓			
Hep B	✓		5/2021		
Other:					

NAVION

Resident and Care Signature Page

BY THEIR SIGNATURES, the Resident, his/her Legal Representative, and the Community ("Parties") have executed this Resident and Care Agreement to be effective as of this 23 day of June, 2021 and acknowledge that they have read and understand all of the terms and conditions of this Agreement, including any terms and conditions contained in the Appendices to this Agreement. The Parties to this Agreement also each acknowledge that their express acceptance of all of the terms and conditions of this Resident and Care Agreement, including any terms and conditions contained in the Appendices and Addendums to this Agreement, will also be legally evidenced through each parties' respective performances under this Agreement.

Resident:

Charles Webb 6/23/2021

Printed Name (Date)

Signature of Resident

Resident's Legal Representative:

Printed Name (Date)

Signature of Resident's Legal Representative

Signature of Legal Representative in his/her Individual Capacity

The Community Representative:

6/23/21

NAVION
SENIOR SOLUTIONS

Appendix A

Residence Description, Occupancy Date, Community Fee And Primary And Total Monthly Fees

Residence Descriptions, Occupancy Date and Community Fee	
Name of Resident: Charles Webb	Apartment Number:
Occupancy Date: June 25, 2021	One-time Community Fee: $ 1000.00

Primary Monthly Fee, Level of Care Fee and Total Monthly Fee	
Primary Monthly Fee:	$ 1795
Level of Care Fee for Level 3 Care: Complex Meds	$ 995 $ 300
Total Monthly Fee as of 6/25/21: $300 per month discount for 6 months beginning June 2021	$ 3150

With limited exceptions, fees and services are subject to change upon thirty (30) days advance notice to the Resident. In the event of changes to the fees listed above, the Community will update Appendix A and provide a copy of the same to the Resident, his or her Responsible Party, if any, and/or any other individual that has assumed responsibility for the Resident's financial obligations to the Community.

NAVION

Appendix D

Residents' Bill of Rights

Each resident or the resident's designated representative will be given a copy of the resident's rights and responsibilities before move-in. The Bill of Rights must state that residents have the right:

- To be treated with dignity and respect.
- To be given informed choices and opportunities to select or refuse service and to accept responsibility for the consequences.
- X To participate in their initial care/service plan and any revisions or updates at the time changes occur. Level III - shouldn't have been left alone
- To receive information about the method for evaluating their service needs and assessing costs for the services provided.
- To exercise individual rights that do not infringe upon the rights or safety of others.
- To be free from neglect, financial exploitation, verbal, mental, physical or sexual abuse.
- To receive services in a manner that protects privacy and dignity.
- To have prompt access to review all of their records and given photocopies. Photocopied records to be provided promptly, but in no case more than two business days (excluding weekends and holidays).
- To have medical and other records kept confidential except as otherwise prohibited by law.
- To associate and communicate privately with any individual of choice, to send and receive personal mail unopened and to have reasonable access to the private use of a telephone.
- To be free from physical restraints and inappropriate use of psychoactive medications.
- To manage personal financial affairs unless legally restricted.
- To have access to and participate in social activities.
- To be encouraged and assisted to exercise rights as a citizen.
- To be free of any written contract or agreement language with the facility that purports to waive their rights or the facility's liability for negligence.
- To voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of retaliation.
- To be free of retaliation after they have exercised their rights provided by law or rule.
- X To have a safe and homelike environment. - At home he was never alone, and was assisted when he needed help.
- To be free of discrimination in regard to race, color, national origin, gender, sexual orientation, or religion.
- To receive proper notification if requested to move out of the facility and be required to move out only for reasons stated in 50-State Assisted Living Facilities law.

Initials of Resident/Legal Representative: _____ (Acknowledging receipt of this Appendix).

NAVION SENIOR SOLUTIONS

Appendix E

Motorized Vehicles and Cart Policy

Motorized carts, including motorized wheelchairs and similar motor vehicles, may be operated at the Community subject to the following:

- The cart is needed by the resident due to a disability, as determined by the Community's health care professionals and/or the president's personal physician, including but not limited to a determination made in conjunction with a physical and or occupational therapy evaluation.
- Your operation of the vehicle does not pose a threat to the health and safety of yourself or others.
- The vehicle is operated at a low speed setting.
- You agree to abide by our safety guidelines for the use of motorized vehicles on the premises, which may be modified from time to time.

Reasonable accommodations will be made to the rules, policies and practices (upon a showing of necessity) so long as the requested accommodation does not constitute a threat to the health or safety of you, the other residents, our associates or visitors.

You agree to pay for all damages to others or to the community, which are caused by you or your motorized vehicle and that we may invoice you for such costs. You further understand and agree that we may, at our sole discretion, prohibit your further use of an electric scooter or similar vehicle at any time.

I understand and agree to all of the terms contained in this Motorized Cart Policy.

_____	_____
Resident Signature	Date
_____	_____
Legal Representative	Date
_____	_____
Community Representative	Date

Omnicare
a CVSHealth company

Resident Pharmacy Enrollment Form

Community Name* Legacy at Southpointe Room Number (IF AVAILABLE) _____

Move-in Date* _____ Future Admit Yes No

Resident Information

*Required field

Webb Charles

Last Name* (PLEASE PRINT) First Name* Middle Initial

/ / 919-579-9861 M

Date of Birth* (MM / DD / YYYY) Phone Number* Gender

_____, Raleigh NC 27612

Street Address (FOR BILLING PURPOSES) City State Zip Code

_____

Social Security Number* Medicare ID Number

Is Omnicare the Resident's primacy pharmacy? ● Yes No

If no, what is their emergency pharmacy?* (SERVICE CHARGE MAY APPLY) _____

Are the Resident's medications managed by community? ● Yes No (SELF ADMINISTERED)

Is the Resident responsible for all pharmacy services, including the bill and any other finances?

● Yes No (IF NO, PLEASE COMPLETE THE NEXT SECTION BELOW)

Financially Responsible Party

Only complete if there is a Responsible Party, other than the Resident, who agrees to be responsible for payment of all amounts owed by the Resident for prescription drug products and services provided to the Resident by Omnicare.

_____

Responsible Party Last Name* Responsible Party First Name*

_____

Email Phone Number*

_____

Billing Address* City State Zip Code

People involved in the Resident's health care

The following people are involved in the Resident's health care and have permission to manage the Resident's prescriptions.

Full Name* Shena D. Webb Phone Number* 919-579-9861

Check all that apply:

Same as financially responsible party Legal Guardian by power of attorney Legal Guardian by court order

● Spouse Child Other _____

Payment sources for pharmacy products and services

Does the Resident have prescription insurance coverage?* ● Yes ○ No

If yes, please check all pay sources that apply:

Medicare Part B
Effective Date: 7/01/2017
Medicare Part B Number:

Medicare Part D or Rx Insurance (Commercial) Plan Name
Plan Name: TriCare For Life
ID Number:
Group Number:
BIN/PCN:
Phone Number:

Medicaid
Number:
State:
Date:

Hospice
Hospice Name:
Phone Number:

Veteran Drug Benefit
Name:

Signature

By signing below, the Resident or Resident's Representative acknowledges and agrees as set forth below.

Resident Signature / Representative Signature*

Charles Webb — Printed Name

5/5/2021 — Date

Omnicare Prescription Medication Service Terms

1. Prescription Containers: Resident understands that the prescription drug products provided by Omnicare will be dispensed in containers that are not child resistant.
2. Legal Representative: Any individual signing on behalf of Resident and representing that they are the Resident's Guardian or Legal Representatives ("Representative") will provide Omnicare with documentation establishing his/her legal authority to enter into this Agreement. If this Agreement is executed by the Representative, the Representative hereby affirms that s/he has the authority to enter into Agreements on the Resident's behalf. References in these Service Terms to "Resident" will include the Representative, as appropriate.
3. Assignment of Benefits: Resident hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Resident. Resident will immediately notify Omnicare in writing of any change to the Resident's ability to make health care decisions independently or change in Representative.
4. Payment: Payment in full amount owed by Resident is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law may accrue on all delinquent accounts beginning on the day after the payment is due.
5. Fees and Expenses: The Resident and/or Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this Agreement, including without limitation, attorneys' fees, court costs and expenses.
6. Delinquent Payment: The Resident and/or Financially Responsible Party acknowledge that if the Resident is delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, (a) condition its continued provision of products and services to the Resident upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Resident. Such suspension or termination will in no way affect the obligation to pay all amounts owed under this Agreement, including costs of collection.
7. Successors: This Agreement shall inure to the benefits of, and be binding upon, each party and its respective affiliates, successors and assigns, heirs, executors, and administrators.
8. Disclosure or Use of Resident Information for Treatment, Payment, and Healthcare Operations. The Resident or Legal Representative hereby acknowledges Omnicare has made available a copy of its Notice of Privacy Practices and that Omnicare may use and disclose Resident's personal health information in compliance with Federal and state laws.
9. People listed as being involved in resident's healthcare have permission to perform activities necessary to manage resident's prescriptions, including, but not limited to, submitting prescriptions to be filled, viewing resident's prescription records and medical profile, discussing resident's care with Omnicare pharmacists, accessing financial information related to resident's prescriptions, providing guidance and direction to Omnicare pharmacy in connection with resident's prescriptions, and/or undertaking any activity that resident personally could undertake to manage resident's prescriptions. Resident's Caregiver may manage resident's prescriptions in person at Omnicare pharmacy, telephonically, or through any other channel that Omnicare pharmacy makes available. This consent is valid until revoked on by telephonically calling 866-397-8935.

STATEMENT DATE	DUE DATE	ACCOUNT NO.
08/01/2021	UPON RECEIPT	913687

RESIDENT
Webb, Charles (1658)

AMOUNT DUE	AMOUNT PAID
$2,845.00	

Please make checks payable to: The Legacy at Southpointe

The Legacy at Southpointe
23 Southpointe Drive
Greenville, SC 29607

Shena Webb

Clayton, NC 27520

The Legacy at Southpointe
23 Southpointe Drive
Greenville, SC 29607

Please detach and return with your payment. Payment due upon receipt. A late fee will be applied to the account if payment is received after the 10th of the month.

Account Details

Resident: Webb, Charles

Date	Description	Charges	Credits	Balance
	BALANCE FORWARD			$0.00
06/29/2021	Payment		$1,000.00	
07/07/2021	Payment		$3,684.98	
06/24/2021	Room & Board charges Jun 24-30 2021 (STD)	$418.81		
07/01/2021	Room & Board charges Jul 01-31 2021 (STD)	$1,795.00		
08/01/2021	Room & Board charges Aug 01-31 2021 (STD)	$1,795.00		
06/24/2021	Community Fees - AL	$1,000.00		
06/24/2021	Complex Medication Management - AL	$84.00		
06/24/2021	Level III AL	$232.17		
06/24/2021	Miscellaneous		$105.00	
07/01/2021	Complex Medication Management - AL	$360.00		
07/01/2021	Concessions - AL		$200.00	
07/01/2021	Level III AL	$995.00		
08/01/2021	Complex Medication Management - AL	$360.00		
08/01/2021	Concessions - AL		$200.00	
08/01/2021	Level III AL	$995.00		
	BALANCE DUE			**$2,845.00**

Internal Medicine
& Pediatrics Associates, P.A.
Doctors for Adults and Children

224 High House Road
Suite 100
Cary, NC 27513

Phone: (919) 380-7531
Fax: (919) 380-0686
www.carymedpeds.com

Date: 5/7/21

To Whom It May Concern:

Our patient Charles Webb DOB: / / had a PPD placed on 5/5/21 and was read on 5/7/21. The PPD reading was ~~5/7/21~~ 10 0 mm negative. Please feel free to contact our office if there are any questions regarding the PPD reading.

Thank you,

Internal Medicine and Pediatrics

K Shuler RN

NAVION Senior Solutions

PHYSICIAN ADMISSION ORDERS (SC)

Resident:	Charles Webb			**Date:**	5/5/2021
DOB:		**Physician:**	MEMBER GROUP	**Physician Phone:**	919 384-7531
May admit to Assisted Living level of care:				☑ Yes	☐ No
Allergies:	Septra, Bystolic (Fatigue), Metformin (Nausea)				
Additional Medication/Treatment Orders:					

May use generic substitutions:	☑ Yes	☐ No
May give annual flu shot:	☑ Yes	☐ No
May self-administer meds:	☐ Yes	☑ No
May give PPD test in accordance with state regulations:	☑ Yes	☐ No
Date of last pneumonia vaccine:	8/10/204	

ANCILLARY ORDERS:		
Podiatrist:	☐ Yes	☐ No
Dentist:	☐ Yes	☐ No
Optometrist / Ophthalmologist:	☐ Yes	☐ No

LABS/TESTING (if applicable)

Test/Frequency:

PT/INR: ☐ Yes ☑ No **Frequency:**

Pacemaker Checks: ☐ Yes ☑ No **Frequency:**

Location for pacemaker checks: Office ☐ Yes ☐ No **Community** ☐ Yes ☐ No

DIET:

☑ Regular	☐ Reduced Carb		☐ Mechanical Soft	
☐ Low Saturated Fat/Low Cholesterol	☐ No Added Salt	☐ Puree	☐ Nectar	☐ Honey

May consume alcohol:	☐ Yes	☑ No
May have alcohol in Apartment:	☐ Yes	☑ No
May have alcohol at residence functions/events – two drink limit	☐ Yes	☑ No

Nourishment / Supplement (if applicable) ***Amount and Frequency*:**

Community VS Parameters: Unless Otherwise Stated these parameters will be followed;

Temp; Call MD if >100.5, or < 97 Degrees Orally **Pulse; Call MD if < 90, or < 60**

Resp; Call MD if > 24, or < 16
B/P; Call MD if Systolic BP > 180 or < 85 or Diastolic BP > 100 or < 50 ☑ Yes ☐ No

If NO, include desired specific parameters:

I have examined this person and find no evidence to support the need for continuous skilled nursing care at this time. The person's needs can be met in the community residential care facility setting. Additionally, the person does not pose a threat to themselves or others.

Physician's Signature:		**Date:**	5/5/2021

Diet Order

Resident's Name: Charles Webb DOB:

The diets listed below are provided by Carolina Reserve. Please indicate **ONE** diet for the resident referenced above. **(Please note that diets can't be combined)**

✓ **Regular** This diet supplies approximately 5 grams of sodium. This menu is based on avoiding the use of convenience foods, using spices instead of salt and using fresh/frozen vegetables instead of canned. Modified diets are built from this regular diet.

_____ **No Added Salt** This diet supplies 3 – 4 grams of sodium by restricting table salt and foods with a high sodium content (smoked meats, breakfast meats, cheeses, salty snacks).

_____ **Low Fat/Low Cholesterol** Based on the American Heart Association Step 1 diet. The regular diet is modified in portions and selection to 70 or less grams of fat, 20 or less grams of saturated fat and less than 300mg of cholesterol.

_____ **Reduced Carbohydrate** This diet is designed to provide consistent calories and carbohydrates. Some portions differ from those in the regular diet. Restricted foods are concentrated sweets and other foods high in simple carbohydrates. Provides about 2,000 calories/day and includes sugar substitute and 2% skim milk.

_____ **Modification:** _____ **Mechanical Soft**

_____ **Pureed**

_____ **Thickened Liquids:** _____ **Honey**

_____ **Nectar**

✓ **Resident allowed to participate in diets that are associated with holidays, special events and birthdays.**

_____ **Resident is permitted to have alcohol at social events. Not to exceed 6 ounces in a day.**

MICHAEL GADD

5/5/2024

Physician's Signature **Date**

CL_RS_402.6 Diet Order

NAVION Senior Solutions

PHYSICIAN ADMISSION ORDERS (SC)

Resident:	Charles Webb			**Date:**	6/23/2021
DOB:		**Physician:**	Michael Capps	**Physician Phone:**	919-380-7531
May admit to Assisted Living level of care:				☑ Yes	☐ No
Allergies:	Septra, Bystolic (Fatigue), metformin (diarrhea)				
Additional Medication/Treatment Orders:					

May use generic substitutions:	☑ Yes	☐ No
May give annual flu shot:	☑ Yes	☐ No
May self-administer meds:	☐ Yes	☑ No
May give PPD test in accordance with state regulations:	☑ Yes	☐ No
Date of last pneumonia vaccine:	1/4/2019	

ANCILLARY ORDERS:		
Podiatrist:	☐ Yes	☐ No
Dentist:	☐ Yes	☐ No
Optometrist / Ophthalmologist:	☐ Yes	☐ No

LABS/TESTING (if applicable)

Test/Frequency:

PT/INR: ☐ Yes ☑ No **Frequency:**

Pacemaker Checks: ☐ Yes ☑ No **Frequency:**

Location for pacemaker checks: Office ☐ Yes ☐ No **Community** ☐ Yes ☐ No

DIET:

☑ Regular	☐ Reduced Carb		☐ Mechanical Soft	
☐ Low Saturated Fat/Low Cholesterol	☐ No Added Salt	☐ Puree	☐ Nectar	☐ Honey

May consume alcohol:	☐ Yes	☑ No
May have alcohol in Apartment:	☐ Yes	☑ No
May have alcohol at residence functions/events – two drink limit	☐ Yes	☑ No
Nourishment / Supplement (if applicable) ***Amount and Frequency*****:**		

Community VS Parameters: Unless Otherwise Stated these parameters will be followed;

Temp; Call MD if >100.5, or < 97 Degrees Orally **Pulse; Call MD if < 90, or < 60**

Resp; Call MD if > 24, or < 16
B/P; Call MD if Systolic BP > 180 or < 85 or Diastolic BP > 100 or < 50 ☑ Yes ☐ No

If NO, include desired specific parameters:

I have examined this person and find no evidence to support the need for continuous skilled nursing care at this time. The person's needs can be met in the community residential care facility setting. Additionally, the person does not pose a threat to themselves or others.

Physician's Signature:		**Date:**	6/23/2021

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_____ **Low Fat/Low Cholesterol** Based on the American Heart Association Step 1 diet. The regular diet is modified in portions and selection to 70 or less grams of fat, 20 or less grams of saturated fat and less than 300mg of cholesterol.

_____ **Reduced Carbohydrate** This diet is designed to provide consistent calories and carbohydrates. Some portions differ from those in the regular diet. Restricted foods are concentrated sweets and other foods high in simple carbohydrates. Provides about 2,000 calories/day and includes sugar substitute and 2% skim milk.

_____ **Modification:** _____ **Mechanical Soft**

_____ **Pureed**

_____ **Thickened Liquids:** _____ **Honey**

_____ **Nectar**

✓ **Resident allowed to participate in diets that are associated with holidays, special events and birthdays.**

_____ **Resident is permitted to have alcohol at social events. Not to exceed 6 ounces in a day.**

Physician's Signature – 6/23/2021 **Date**

CL_RS_402.6 Diet Order

AFTER VISIT SUMMARY

UNC HEALTH

Charles Webb MRN: 100002584256

4/22/2021 10:30 AM NC HEART AND VASCULAR RALEIGH BLUE RIDGE RD SUITE 400 919-787-5380

Instructions from Joseph M Falsone, MD

Today's medication changes

CHANGE how you take:
amLODIPine (NORVASC)

Accurate as of April 22, 2021 10:48 AM.
Review your updated medication list below.

Echocardiogram W Colorflow Spectral Doppler
Scheduled for 6/1/2021

Return in about 6 months
(around 10/22/2021).

5/10/21 @8:00

What's Next

JUN 1 2021 **ECHOCARDIOGRAM W COLORFLOW SPECTRAL DOPPLER**
Tuesday June 1 11:30 AM (Arrive by 11:15 AM)
4201 Suite 102 Lake Boone Trail

IMG NC HV REX MOB
2800 BLUE RIDGE ROAD
STE 400
RALEIGH NC
27607-6478
919-787-5380

OCT 28 2021 **UNCHCS RETURN with Joseph M Falsone, MD**
Thursday October 28 1:00 PM (Arrive by 12:45 PM)

NC HEART AND VASCULAR RALEIGH BLUE RIDGE RD SUITE 400
2800 Blue Ridge Rd
STE 400
RALEIGH NC
27607-6478
919-787-5380

Today's Visit

You saw Joseph M Falsone, MD on Thursday April 22, 2021. The following issues were addressed:

- Heart murmur
- Complete heart block
- High blood pressure disorder
- High cholesterol or triglycerides
- Stroke

Blood Pressure 105/64	BMI 30.04
Weight 175 lb	Height 5' 4"
Pulse 72	

Health Maintenance Summary

Recommended Procedures	Due Date	Last Completed
Retinal Eye Exam	**Never done**	---
Diabetes Urine Protein Test	**10/23/2016**	10/23/2015
Hemoglobin A1C	**12/11/2018**	6/11/2018
Pneumonia Vaccine (2 of 2 - PPSV23)	**06/16/2019**	6/16/2018
Flu Vaccine (Season Ended)	09/01/2021	---

Health Maintenance Summary (continued)

Recommended Procedures	Due Date	Last Completed
Colonoscopy - colon cancer screening	07/30/2023	7/30/2013

Allergies

	Reactions	Comment
Ace Inhibitors		
Sulfa (sulfonamide Antibiotics)		

My UNC Chart allows you to manage your health, send messages to your provider, view your test results, schedule and manage appointments, and request prescription refills securely and conveniently from your computer or mobile device.

To activate your account, go to **MyUNCChart.org** and click **Use Your Activation Code**. Enter your My UNC Chart Activation Code exactly as it appears below along with your Date of Birth to complete the activation process.

My UNC Chart Activation Code: PDCM7-XTQQ5-J3FWK
Expires: 7/2/2021 3:19 PM

If you need assistance with My UNC Chart, call UNC HealthLink at (888) 996-2767.

Care Everywhere CEID

UNC-527-8652 : This CEID can be used in the Request Outside Records activity when querying UNC from another organization that uses Epic software.

Your Medication List as of April 22, 2021 10:48 AM

ⓘ If you have any questions, ask your nurse or doctor.

CHANGE	**amLODIPine** 10 MG tablet Commonly known as: NORVASC Changed by: Joseph M Falsone, MD	Take 0.5 tablets (5 mg total) by mouth daily. What changed: **how much to take**
	aspirin 81 MG tablet Commonly known as: ECOTRIN	Take 81 mg by mouth daily.
	* **atorvastatin** 10 MG tablet Commonly known as: LIPITOR	Take 10 mg by mouth daily.
	* **atorvastatin** 20 MG tablet Commonly known as: LIPITOR	Take 1 tablet (20 mg total) by mouth daily with evening meal.
	baclofen 10 MG tablet Commonly known as: LIORESAL	Take 10 mg by mouth daily as needed.
	brimonidine 0.2 % ophthalmic solution Commonly known as: ALPHAGAN	Administer 2 drops to both eyes two (2) times a day.
	cetirizine 10 MG tablet Commonly known as: ZyrTEC	Take 10 mg by mouth daily.
	clopidogreL 75 mg tablet Commonly known as: PLAVIX	Take 1 tablet (75 mg total) by mouth daily.
	donepeziL 10 MG tablet Commonly known as: ARICEPT	Take 10 mg by mouth daily.
	fluticasone propionate 50 mcg/actuation nasal spray Commonly known as: FLONASE	1 spray by Each Nare route daily.
	hydrALAZINE 25 MG tablet Commonly known as: APRESOLINE	Take 4 tablets (100 mg total) by mouth every eight (8) hours.
	* **levothyroxine** 125 MCG tablet Commonly known as: SYNTHROID	Take 125 mcg by mouth daily.
	* **levothyroxine** 100 MCG tablet Commonly known as: SYNTHROID	Take 1 tablet (100 mcg total) by mouth daily at 0600.
	melatonin 3 mg Tab	Take 1 tablet (3 mg total) by mouth nightly.
	memantine 10 MG tablet Commonly known as: NAMENDA	Take 10 mg by mouth Two (2) times a day.
	metoprolol tartrate 50 MG tablet Commonly known as: LOPRESSOR	Take 25 mg by mouth Two (2) times a day.

*** This list has 4 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

Questions About Your Visit?

If you have any questions about any information included in this visit summary, please contact your provider by sending a secure message using My UNC Chart or by phone at the number listed above. Bring this form with you to your next scheduled appointment as a reminder to discuss with your provider. Use this form to make notes about any medications, including over-the-counter medications, you have stopped or started taking, or any questions you have about any test or procedure results.

AFTER VISIT SUMMARY

UNC HEALTH CARE

Charles Webb MRN: 100002584256

10/1/2019 1:30 PM NC HEART AND VASCULAR RALEIGH BLUE RIDGE RD SUITE 400 919-787-5380

Instructions from Joseph M Falsone, MD

Return in about 6 months
(around 4/1/2020).

What's Next

APR 14 2020 **Device Check with Joseph M Falsone, MD**
Tuesday April 14 1:30 PM (Arrive by 1:15 PM)

NC HEART AND VASCULAR RALEIGH
BLUE RIDGE RD SUITE 400
2800 BLUE RIDGE RD
RALEIGH NC
27607-6478
919-787-5380

Health Maintenance Summary

Recommended Procedures	Last Completed
Retinal Eye Exam	---
Hepatitis C Test	---
Diabetes Urine Protein Test	10/23/2015, 3/4/2015, 3/4/2015, 11/18/2014
Hemoglobin A1C	6/11/2018, 6/11/2018, 3/3/2016, 10/23/2015
Flu Vaccine (1)	---
Pneumonia Vaccine (2 of 2 - PPSV23)	6/16/2018
Colonoscopy - colon cancer screening	7/30/2013

Allergies

	Reactions	Comment
Ace Inhibitors		
Sulfa (sulfonamide Antibiotics)		

Today's Visit

You saw Joseph M Falsone, MD on Tuesday October 1, 2019. The following issues were addressed:

- Sick sinus syndrome
- High cholesterol or triglycerides
- High blood pressure disorder
- Stroke
- Coronary heart disease

Blood Pressure 120/80
BMI 29.86
Weight 185 lb
Height 5' 6"
Pulse 60

Your Medication List as of October 1, 2019 2:06 PM

ⓘ If you have any questions, ask your nurse or doctor.

amLODIPine 10 MG tablet Commonly known as: NORVASC	Take 10 mg by mouth daily.
aspirin 81 MG tablet Commonly known as: ECOTRIN	Take 81 mg by mouth daily.
atorvastatin 20 MG tablet Commonly known as: LIPITOR	Take 1 tablet (20 mg total) by mouth daily with evening meal.
baclofen 10 MG tablet Commonly known as: LIORESAL	Take 10 mg by mouth daily as needed.
brimonidine 0.2 % ophthalmic solution Commonly known as: ALPHAGAN	Administer 2 drops to both eyes two (2) times a day.
clopidogrel 75 mg tablet Commonly known as: PLAVIX	Take 1 tablet (75 mg total) by mouth daily.
donepezil 10 MG tablet Commonly known as: ARICEPT	Take 10 mg by mouth daily.
hydrALAZINE 25 MG tablet Commonly known as: APRESOLINE	Take 4 tablets (100 mg total) by mouth every eight (8) hours.
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Additional Plan of Care Education

Preventing Falls: After Your Visit
Your Care Instructions:

Additional Plan of Care Education (continued)

Getting around your home safely can be a challenge if you have injuries or health problems that make it easy for you to fall. Loose rugs and furniture in walkways are among the dangers for many older people who have problems walking or who have poor eyesight. People who have conditions such as arthritis, osteoporosis, or dementia also have to be careful not to fall.

Preventing Falls at Home:

- Remove raised doorway thresholds, throw rugs, and clutter. Repair loose carpet or raised areas in the floor.
- Move furniture and electrical cords to keep them out of walking paths.
- Use nonskid floor wax, and wipe up spills right away, especially on ceramic tile floors.
- If you use a walker or cane, put rubber tips on it. If you use crutches, clean the bottoms of them regularly with an abrasive pad, such as steel wool.
- Keep your house well lit, especially stairways, porches, and outside walkways. Use night-lights in areas such as hallways and bathrooms.
- Install sturdy handrails on stairways.
- Move items in your cabinets so that the things you use a lot are on the lower shelves (about waist level).
- Keep a cordless phone and a flashlight with new batteries by your bed. If possible, put a phone in each of the main rooms of your house.carry a cell phone in case you fall and cannot reach a phone.
- Wear low-heeled shoes that fit well and give your feet good support. Use footwear with nonskid soles.
- Do not wear socks without shoes on wood floors.
- Walk on the grass when the sidewalks are slippery. If you live in an area that gets snow and ice in the winter, sprinkle salt on slippery steps and sidewalks.

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my UNC Chart™

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My UNC Chart Activation Code: K9NH3-PW46X-SMPF9
Expires: 12/30/2019 1:16 PM

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Additional Plan of Care Education (continued)

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This is the Company that monitors the pacemaker that Charles had. This Company is connected to his Cardiologist office Dr. Joseph Falzone.

I am enrolled in
BIOTRONIK
Home
Monitoring®

Customer Support Line
(800) 547-0394

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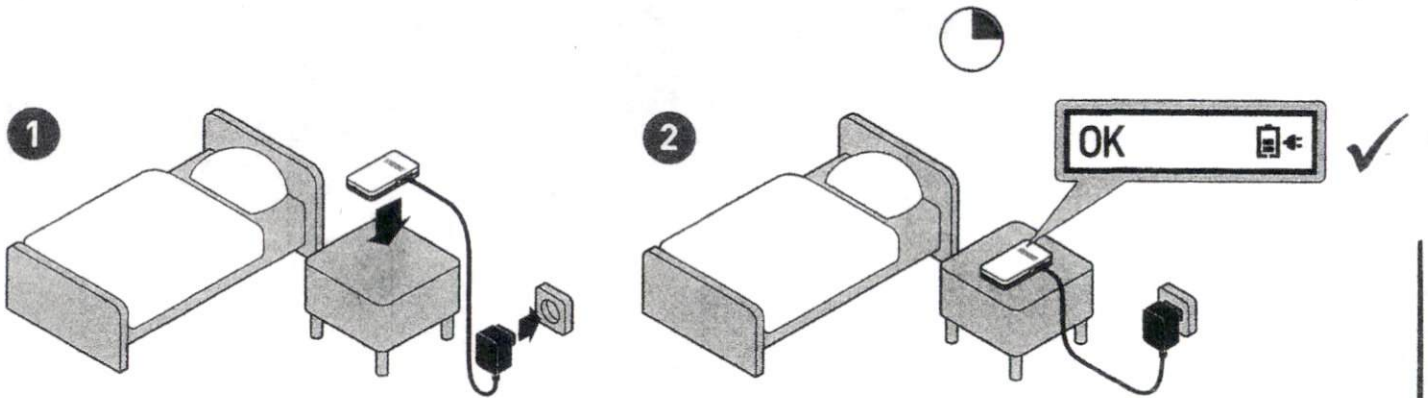
This is the setup that the pacemaker monitoring system was setup in this Room.

CardioMessenger® Smart
Quick Start Guide



BIOTRONIK

Patient Information Verification and Identification Cards

69087664

If all information shown below is correct, please check this box: [ ]

Make any necessary changes or additions in the **CORRECTIONS** spaces below. Please print clearly using black or dark blue ink only.

CHARLES WEBB

CLAYTON, NC 27520

CORRECTIONS

Telephone Number **919-822-4962**

Date of Birth

Social Security Number _____ - ____ - _____

Physician checking your device:

Name **JOSEPH M. FALSONE, MD**

Address **2800 BLUE RIDGE RD #400**
RALEIGH, NC 27607

Telephone Number **(919) 787-5380**

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Please return completed form to BIOTRONIK in the enclosed postage-paid envelope.
Please remove and keep the cards attached below.

PATIENT I.D. CARD

BIOTRONIK
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WEBB, CHARLES

Edora 8 DR-T	**69087664**	**06/14/2018**
Solia S 53	49911690	06/14/2018
Solia S 60	49758661	06/14/2018

Physician/Facility to contact:
(919) 787-5380
JOSEPH FALSONE, MD

IMPLANTABLE CARDIAC PACEMAKER