

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM HORRY COUNTY  
Court of Common Pleas

Nate Fata, Special Referee

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Lower Court Case No. 2016-CP-26-8032  
Court of Appeals Case No. 2017-001817

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DANIEL ERIC KNIGHT,

Respondent,

v.

PHILLIP RAY CAUSEY,

Appellant.

---

**RECORD ON APPEAL**

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**VOLUME 4 OF 4**

Joseph D. Thompson, III, S.C. Bar No. 66580  
111 Coleman Boulevard  
Suite 301  
Mount Pleasant, South Carolina 29464  
Telephone: (843) 720-3460  
[JThompson@hallboothsmith.com](mailto:JThompson@hallboothsmith.com)

*Attorney for Appellant Phillip Ray Causey*

**RECEIVED**  
MAY 08 2018  
SC Court of Appeals

**INDEX**

**ORDERS**

Order of Default entered February 24, 2017 .....	2
Order of Referral entered March 22, 2017 .....	3
Order Granting Judgment (Damages Hearing) entered May 30, 2017 .....	5
Order Denying Defendant's Motions entered August 3, 2017 .....	10

**JUDGMENTS**

Nate Fata's Letter Rendering His Decision on Damages dated April 26, 2017 .....	39
---	----

**PLEADINGS**

Notice of Appeal .....	41
Plaintiffs Summons and Complaint filed December 16, 2016 .....	81

**TRANSCRIPTS**

Transcript of Damages Hearing April 18, 2017 .....	90
Transcript of Motions Hearing June 29, 2017 .....	139

**MOTIONS**

Affidavit of Default as to Defendant Phillip Ray Causey filed February 14, 2017 .....	321
Motion for Default Judgment and Certificate of Service filed February 16, 2017 .....	323
Notice of Motion and Motion for Referral to Special Referee filed March 2, 2017 .....	327
Defendant's Motion to Set Aside Default filed April 25, 2017 .....	331

**POST-JUDGMENT MOTIONS**

Defendant's Post Judgment Motions and Memorandum in Support filed June 08, 2017 .....	332
Defendant's Motion for Relief from Judgment Pursuant to SCRCP 60 filed June 13, 2017 .....	345

**EXHIBITS AND OTHER MATERIALS**

Plaintiff's Exhibit 15 — Damages Hearing .....	347
Plaintiff's Exhibit 19 — Damages Hearing .....	417
Nate Fata's Letter Setting Hearing on Defendant's Motion to Set Aside Default for June 2, 2017 dated May 16, 2017 .....	1573
Nate Fata's Email Agreeing to Reschedule Motion to Set Aside Default Hearing to June 13, 2017 dated May 18, 2017 .....	1574
Defendant's Exhibit 1 - Motions Hearing .....	1577
Affidavit of Phillip Ray Causey filed June 22, 2017 .....	1578
Affidavit of Shawana Palsey-Shaw (filed June 29, 2017 .....	1584

Amedisys Home Health of Conway

PAGE: 1/2  
Department of Health And Human Services  
Health Care Financing Administration

<<<L14E5456 /20160603/485 /xx/R>>

Form Approved  
OMB No. 0938-0357

Home Health Certification and Plan of Treatment



6. Patient's Name and Address KNIGHT, DANIEL 206 KCV CECOM DR CONWAY, SC 29527		7. Provider's Name and Address Amedisys Home Health of Conway 176 Waccamaw Medical Park Court Conway, SC 29526-8965	
230-719-8030		(P)843-347-8899 (F)843-347-8885	

8. Date of Birth: 09/26/1974		9. Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
11. ICD-CM 248.815	Principal Diagnosis Encntr for surgical after following surgery on the	Date 05/15/16 (O)	10. Medications: Dose/Route/Frequency/Dura. (New) (Changed) ORXCODONE HCL DOSE:10 MG ORAL FOUR TIMES DAILY FOUR TIMES DAILY FOR PAIN AS NEEDED (New) FROFAC DOSE:20 MG ORAL DAILY (New)
15. ICD-CM 243.2	Other Pertinent Diagnosis Encounter for attention t o ileostomy	Date 05/15/16 (O)	
F41.9	Anxiety disorder, unspeci fied	Date 05/15/16 (R)	

14. DME and Supplies Box of Gloves, Normal Saline, 4x4's, 2x2's, ABC pads, Tape, Alcohol Wipes, Wound Care/Dressing Supplies, Large Gauze, CONWAY ON 487	13. Safety Measures Keep pathways clear, Standard precautions / Infection control, Bathroom Safety, Fire Safety, Medication Safety, CONWAY ON 487
16. Nutritional Requirements Regular diet	17. Allergies Penicillin, Sulfa

18a. Functional Limitations 1[] Amputation 5[] Paralysis 9[] Legally Blind 2[] Bowel/Bladder SKX Endurance A[] Dyspnea W/Min Exert 3[] Contracture 7[] Ambulation B[] Other 4[] Hearing 8[] Speech	18b. Activities Permitted 1[] Complete Bedrest 6[] Part Wt Bearing A[] Wheelchair 2[] Bedrest SPP 7[] Ind. at Home B[] Walker 3[] SKX Up as Tolerated 8[] Crutches C[] No Rest 4[] Transfer Bed/Chair 9[] Cann D[] Other 5[] Exercises Prescribed
--	--

19. Mental Status 1[X] Oriented 3[] Forgetful 5[] Disoriented 7[] Agitated 9[] Other 2[] Comatose 4[] Depressed 6[] Lethargic	20. Prognosis 1[] Poor 2[] Guarded 3[] Fair 4[X] Good 5[] Excellent
---	--

21. Orders for Discipline and Treatments ( Specify Amount/Frequency/Duratio)  
SN: SN9 EFFECTIVE 5/30/2016  
May take orders from: RACHEL COLLINS  
SN ORDERS  
Patient treatment for ABDOMINAL WOUND will be monitored by SN and modified by physician.  
SN to instruct patient, caregiver on pain management.  
SN to evaluate pain each visit.

SN to instruct patient, caregiver in wound care to include signs and symptoms of infection and when to report physician.  
SN to instruct patient, caregiver in wound care/proper disposal of soiled dressings.  
SN to instruct patient, caregiver in proper nutrition/hydration to facilitate wound healing.  
SN to perform wound care as ordered by physician. SN to clean wound(s) abdomen with normal saline or wound cleanser;  
CONWAY ON 487

22. Goals/Rehabilitation Potential/Discharge Plans SN GOALS Patients symptoms will be well controlled with current therapy within 60 days. Patient/ caregiver able to verbalize understanding of	measures to mitigate pain and when to call MD by 7/28/16. Patient's wound/incision will be healed without signs of infection within 60 days. Patient/ caregiver able to verbalize understanding of fall CONWAY ON 487
---	--

21. Verbal Start of Care and Nurse's Signature and Date Where Applicable: 05/30/2016 *[Signature]* 25. Date HRA Received Signed POZ

24. Physician's Name and Address RINKUS, GILBERTAS 2361 CYPRESS CIRCLE CONWAY, SC 29526- 843/347-7291 UPIN: 877713 MPI: 1328126301	25. I [X] certify [] recertify that this patient is confined to his or her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
--	---

27. Attending Physician's Signature (Required on Date Signed 485 kept on file in medical records of HRA)	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment on federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.
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PAGE: 2/2

Department of Health And Human Services  
Health Care Financing Administration

<<21453456 /26160603/487 /xx/0>>

Form Approved  
OMB No. 0910-0357

Appendix to Home Health Certification and Plan of Treatment

6. Patient's Name  
KNIGHT, DANIEL

7. Provider's Name  
Amedys Home Health of Conway

8. Item No.

14. DME and Supplies

WOUND VAC SUPPLIES Sterile cotton tipped applicators, normal saline, 4x4's, rolled gauze, paper tape for fragile skin, tube dressing, stomahesive pasts, hydrocolloid strips,

skin prep, non-adhering dressing, alginate, Aquacel, adhesive remover foam, drapes, thin film, Makin seals.

15. Safety Measures

Slow position change

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

may prep periwound tissue with skin prep. Fill cavity(ies) with VAC foam: granules/foam (black) for large cavity(ies), versifoam (white) for tunnel(s) or track(s); may use versifoam for small or surface lesions. Cover with film dressing (drape); cut a hole in drape approx. 2 cm, apply the T.R.A.C. pad directly over the opening. Connect tubing, release all clamps and turn VAC on. May use hydrocolloid dressing or transparent film (drape) around opening to protect skin from breakdown. Teach CG/patient how to change out canister per, troubleshoot, and seal leaks. VAC should remain on a minimum of 12 hours per day. SN may use non-adhering dressing to wound bed as needed, to aide in ease of foam removal. May saturate foam with NS for easier, less painful foam removal. In case of VAC malfunction/power outage, str. PP/CC/SN may apply the appropriate moist wound healing dressing to the wound, and change per. SN to change VAC dressing 3week & per for leakage or complications.  
VAC Pump Setting: Continuous therapy at 125 (75mmHg - 175

mmHg) or Intermittent therapy \_\_\_\_\_ (75mmHg - 175 mmHg).  
SN to monitor vital signs, mads, chest/heart auscultation.  
SN to instruct patient in all aspects of medication regimen inc. schedule dosage, side effects, drug/food interactions.  
BR TO INSTRUCT ON FALL PRECAUTIONS  
SN TO INSTRUCT ON SKIN CARE AND PRESSURE RELIEF MEASURES  
SN TO INSTRUCT ON S/S OF DEPRESSION AND WAYS TO MANAGE  
CLINICIANS TO OBTAIN VS AND REPORT OUT OF THE FOLLOWING  
PARAMETERS TO MD  
>SB 160/90 <90/60  
TEMP >101 <98  
RR >120 <60  
RESP >24 <12  
MAY OBTAIN O2 SAT FOR DYSPNEA AND REPORT LESS THAN 90%  
LBN may see patient under supervision of RN.

22. Goals/Rehabilitation Potential/Discharge Plans

prevention by end of cert period  
Patient free of falls/ injuries through end of certification period.  
Patient will remain free of any pressure related skin breakdown this certification period.  
Patient will be free of symptoms of Depression and will remain compliant with medications this certification period.  
Patient's VS to be within MD acceptable parameters.  
Patient/caregiver knowledgeable of parameters to call MD

REHAB POTENTIAL  
Good for full recovery.

DISCHARGE PLANS  
Patient will be discharged when goals are met to an independent level & to follow up with Dr. at scheduled appointment.

9. Signature of Physician

10. Date

6/14/16

11. Optional Name/Signature of Nurse/Therapist

12. Date

Home Health Certification and Plan of Treatment



6. Patient's Name and Address KNIGHT, DANIEL 206 ECU CECUM DR  CONWAY, SC 29527                      330-719-5830		7. Provider's Name and Address Amedisys Home Health of Conway 176 Waccamaw Medical Park Court  Conway, SC 29526-8965                      (P)843-347-5899                      (F)843-347-5885	
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8. Date of Birth: 09/26/1974		9. Sex: XX M <input type="checkbox"/> F		10. Medications: Dose/Route/Frequency/Dir. (N)ew (C)hanged OXYCODONE HCL DOSE:10 MG ORAL FOUR TIMES DAILY FOUR TIMES DAILY FOR PAIN AS NEEDED (New) PROZAC DOSE:20 MG ORAL DAILY (New)	
11. ICD-CM Z48.815	Principal Diagnosis Encntr for surgical after following surgery on the	Date 05/15/16 (O)			
13. ICD-CM Z43.2	Other Pertinent Diagnoses Encounter for attention to ileostomy	Date 05/15/16 (O)			
F41.9	Anxiety disorder, unspecified	05/15/16 (E)			

14. DME and Supplies Box of Gloves, Normal Saline, 4x4's, 2x2's, ABD pads, Tape, Alcohol Wipes, Wound Care/Dressing Supplies, Large Gauze, * CONT ON 487 *	15. Safety Measures Keep pathways clear, Standard precautions / Infection control, Bathroom Safety, Fire Safety, Medication Safety, * CONT ON 487 *
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16. Nutritional Requirements Regular diet	17. Allergies Paniceillin, Sulfa
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18a. Functional Limitations 1[] Amputation    5[] Paralysis    9[] Legally Blind 2[] Bowel/Bladder 6XX Endurance    A[] Dyspnea W/Min Exert 3[] Contracture    7[] Ambulation    B[] Other 4[] Hearing            8[] Speech	18b. Activities Permitted 1[] Complete Bedrest            6[] Part Wt Bearing    A[] Wheelchair 2[] Bedrest BRP                    7[] Ind. at Home        B[] Walker 3XX Up as Tolerated                8[] Crutches            C[] No Rest 4[] Transfer Bed/Chair              9[] Cane                 D[] Other 5[] Exercises Prescribed
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19. Mental Status    1XX Oriented    3[] Forgetful    5[] Disoriented    7[] Agitated    9[] Other 2[] Comatose    4[] Depressed    6[] Lethargic
--

20. Prognosis            1[] Poor            2[] Guarded            3[] Fair            4XX Good            5[] Excellent
---

21. Orders for Discipline and Treatments ( Specify Amount/Frequency/Duration) SN: 3W9 EFFECTIVE 5/30/2016 May take orders from: RACHEL COLLINS, NP  SN ORDERS Patient treatment for ABDOMINAL WOUND will be monitored by SN and modified by physician. SN to instruct patient, caregiver on pain management. SN to evaluate pain each visit.	SN to instruct patient, caregiver in wound care to include signs and symptoms of infection and when to report physician. SN to instruct patient, caregiver in wound care/proper disposal of soiled dressings. SN to instruct patient, caregiver in proper nutrition/hydration to facilitate wound healing. SN to perform wound care as ordered by physician. SN to clean wound(s) abdomen with normal saline or wound cleanser; * CONT ON 487 *
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22. Goals/Rehabilitation Potential/Discharge Plans SN GOALS Patients symptoms will be well controlled with current therapy within 60 days. Patient/ caregiver able to verbalize understanding of	measures to mitigate pain and when to call MD by 7/28/16. Patient's wound/incision will be healed without signs of infection within 60 days. Patient/ caregiver able to verbalize understanding of fall * CONT ON 487 *
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23. Verbal Start of Care and Nurse's Signature and Date Where Applicable: 05/30/2016	25. Date HHA Received Signed POT
--	----------------------------------

24. Physician's Name and Address RIMKUS, GILBERTAS 2361 CYPRESS CIRCLE CONWAY, SC 29526-  843/347-7291    UPIN: H77713    NPI: 1326126301	26. I XX certify <input type="checkbox"/> recertify that this patient is confined to his or her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
--	--

27. Attending Physician's Signature (Required on Date Signed 485 Kept on File in Medical Records of HHA)	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment on Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.
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Addendum to Home Health Certification and Plan of Treatment

6. Patient's Name  
KNIGHT, DANIEL

7. Provider's Name  
Amedisys Home Health of Conway

8. Item No.

14. DME and Supplies

WOUND VAC SUPPLIES Sterile cotton tipped applicators, normal saline, 4x4's, rolled gauze, paper tape for fragile skin, tube dressing, stomahesive paste, hydrocolloid strips,

skin prep, non-adhering dressing, alginate, Aquacel, adhesive remover foam, drape, thin film, Eakin seals, wound cleanser

15. Safety Measures

Slow position change

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

may prep periwound tissue with skin prep. Fill cavity(ies) with VAC foam: granulafoam (black) for large cavity(ies), versafoam (white) for tunnel(s) or track(s); may use versafoam for small or surface lesions. Cover with film dressing (drape); cut a hole in drape approx. 2 cm, apply the T.R.A.C. pad directly over the opening. Connect tubing, release all clamps and turn VAC on. May use hydrocolloid dressing or transparent film (drape) around opening to protect skin from breakdown. Teach CG/patient how to change out canister prn, troubleshoot, and seal leaks. VAC should remain on a minimum of 22 hours per day. SN may use non-adhering dressing to wound bed as needed, to aide in ease of foam removal. May saturate foam with NS for easier, less painful foam removal. In case of VAC malfunction/power outage, etc. PT/CG/SN may apply the appropriate moist wound healing dressing to the wound, and change prn. SN to change VAC dressing 3xweek & prn for leakage or complications.

mmHg) or Intermittent therapy \_\_\_\_\_ (75mmHg - 175 mmHg). SN to monitor vital signs, meds, chest/heart auscultation. SN to instruct patient in all aspects of medication regimen inc. schedule dosage, side effects, drug/food interactions. SN TO INSTRUCT ON FALL PRECAUTIONS SN TO INSTRUCT ON SKIN CARE AND PRESSURE RELIEF MEASURES SN TO INSTRUCT ON S/S OF DEPRESSION AND WAYS TO MANAGE CLINICIANS TO OBTAIN VS AND REPORT OUT OF THE FOLLOWING PARAMETERS TO MD  
>BP 180/90 <90/60  
TEMP >101 <96  
HR >120 <60  
RESP >24 <12  
MAY OBTAIN O2 SAT FOR DYSPNEA AND REPORT LESS THAN 90%  
LBN may see patient under supervision of RN.

VAC Pump Setting: Continuous therapy at 125 (75mmHg - 175

22. Goals/Rehabilitation Potential/Discharge Plans

prevention by end of cert period  
Patient free of falls/ injuries through end of certification period.

REHAB POTENTIAL  
Good for full recovery.

Patient will remain free of any pressure related skin breakdown this certification period.  
Patient will be free of symptoms of Depression and will remain compliant with medications this certification period.  
Patient's VS to be within MD acceptable parameters.  
Patient/caregiver knowledgeable of parameters to call MD

DISCHARGE PLANS  
Patient will be discharged when goals are met to an independent level & to follow up with Dr. at scheduled appointment.

[END IN SIGHT: 06/28/2016]

9. Signature of Physician

10. Date

10. Optional Name/Signature of Nurse/Therapist

12. Date

Page: 1 / 1

Patno: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 06/09/2016

SUPPLEMENTAL ORDER

[msptorder/rpptord/3.0]

Amedisys Home Health of Conway  
176 Waccamaw Medical Park Court

Conway, SC 29526-8965

(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS  
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECUM DR

CONWAY, SC 29527  
DOB : 09/26/1974



ORDER 06/01/2016

[06012016]

MAY TAKE ORDERS FROM DR. PAUL RICHARDSON/RACHEL COLLINS NP

DR. GILBERTAS RIMKUS/KATIE CANNON, RN

SN Signature	<i>Katie Cannon</i>	Date	6/1/16
Physician Signature	<i>[Signature]</i>	Date	6/14/16

48632592

*10*

Page: 1 / 1  
Patno: I1455456  
Patient: KNIGHT, DANIEL  
Location: 2223

Date: 06/06/2016

SUPPLEMENTAL ORDER

[nsptorder/rpptord/3.0]

Amedisys Home Health of Conway  
176 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(F) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

RICHARD EISENMAN  
2376 CYPRESS CIRCLE, STE 100  
CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECOM DR  
CONWAY, SC 29527  
DOB : 09/26/1974



ORDER 06/03/2016

[06032016]  
ORDER REASON:  
LAB

ORDER:  
SN to obtain CBC with diff and CMP via venipuncture eff w/o 6/06/16

WO: DR RICHARD EISENMAN/RACHEL COLLINS FNP/Natalie Ruckman RN

GOAL:  
Patients labs will remain within therapeutic levels throughout cert.

Clinician Name: NATALIE RUCKMAN RN Date: 06/03/2016

Physician  
Signature

Date

48603090

Electronically signed by PAUL RICHARDSON, MD  
on 07/05/2016 at 10:14::38 PM

From:

06/07/2016 10:20

#426 P.004/005

Page: 1 / 1

PatNo: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 06/07/2016

SUPPLEMENTAL ORDER

[msptorder/rpptord/3.0]

Amedisys Home Health of Conway  
176 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

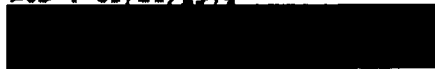
GILBERTAS RINKUS  
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECUM DR

CONWAY, SC 29527  
DOB : 09/26/1974



ORDER 06/07/2016

[06072016]

Please hold the wound vac for one week. SN to apply wet to dry dressing on SN visit days and instruct caregiver on how to apply on non SN visit days. Dressing needs to be changed daily. Patient to follow up with Dr. Rinkus on 6/16/16. wound needs to be changed daily. SN to instruct caregiver on how to apply wet to dry dressing.

TO Dr. Rinkus/Connie/Amy Allison, RN

Clinician Signature: AMY ALLISON RN Date: 06/07/2016

Physician  
Signature

Date

6/8/16

48619651

No. 9026 P. 5

ASSOC IN SURGERY

Jun. 8. 2016 11:35AM

Page: 1 / 1

Patno: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 06/10/2016

SUPPLEMENTAL ORDER

[msptorder/rpptord/3.0]

Amedisys Home Health of Conway  
176 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS  
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECUM DR

CONWAY, SC 29527  
DOB : 09/26/1974



ORDER 06/08/2016

[06082016]

ORDER REASON:  
PRN VISIT

ORDER:

SN to perform prn visit for leaking colostomy bag and wound care eff 6/08/16

3 prn visits for colostomy complications or wound vac complications eff 6/08/16

DR. RIMKUS/Natalie Ruckman RN

GOAL:

Patient will remain safe throughout cert period.

Clinician Name: NATALIE RUCKMAN RN Date: 06/08/2016

Physician  
Signature

Date

6/29/16

48628623

Page: 1 / 1

Pano: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 06/16/2016

SUPPLEMENTAL ORDER

[msptorder/rpportord/3.0]

Amedisys Home Health of Conway  
175 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS  
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECUM DR

CONWAY, SC 29527  
DOB : 09/26/1974

ORDER 06/16/2016

(06162016)

Effective 6/16/16, please discontinue wound vac to abdominal incision. Wound care to be performed as follows: Cleanse wound with normal saline or wound cleanser. Pat dry with 4x4 gauze. Apply wet to dry dressing with light packing. Dressing to be changed daily and as needed. SN to perform on regularly scheduled SN visit days. SN to instruct patient/caregiver to perform on non SN visit days.

TO Dr. Rimkus/Connie/Amy Allison, RN

Clinician Signature: AMY ALLISON RN Date: 06/16/2016

Physician  
Signature

Date

6/29/16

46672471

Page: 1 / 1  
Patno: I1455456  
Patient: KNIGHT, DANIEL  
Location: 2222

Date: 06/20/2016

SUPPLEMENTAL ORDER

[msptorder/rpptord/3.0]

Amedisys Home Health of Conway  
176 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

PAUL RICHARDSON  
2367B CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECUM DR

CONWAY, SC 29527  
DOB : 09/26/1974

ORDER 06/17/2016

[06172016]

ORDER REASON:

LABS

ORDER:

effective week of 6/20/16

EN to obtain hepatic function panel w/o 6/20/16 via VP.

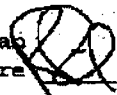
orders per Dr. Paul Richardson/Rachel Collins RNP, Kimberly Atwell, LPN

GOAL:

labs will be therapeutic

Clinician Name: KIMBERLY ATWELL LPN Date: 06/17/2016

Physician  
Signature



Electronically signed by PAUL RICHARDSON, MD  
on 06/22/2016 at 09:44:27 PM

Date

48684367



Page: 1 / 1

Patno: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 06/28/2016

SUPPLEMENTAL ORDER

[msptorder/rpportord/3.0]

Amedisys Home Health of Conway  
176 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS  
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL  
206 ECU CECUM DR

CONWAY, SC 29527  
DOB : 09/26/1974

ORDER 06/20/2016

[06202016]

ORDER REASON:  
DECREASED VISIT

ORDER:

SN 2W5

Effective: Week Of 06/27/2016

effective w/o 6/21/16

Decrease SN visits, due to, d/c wound vac

orders per Dr. Gilbertas Rimkus/Kimberly Atwell, LPN

GOAL:

patient will continue to heal with no complications

Clinician Name: KIMBERLY ATWELL LPN Date: 06/20/2016

Physician  
Signature

Date

7/6/16

48721789

08/02/2016 17:21

(FAX)

P.008/027

From:

07/16/2016 12:12

#847 P.002/002

Page: 1 / 1

Patno: 11455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 07/08/2016

SUPPLEMENTAL ORDER

[msptorder/rptord/3.0]

Amedisys Home Health of Conway  
175 Waccamaw Medical Park Court

Conway, SC 29526-8965  
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS  
2361 CYPRESS CIRCLE  
CONWAY, SC 29526-

PATIENT : 11455456

KNIGHT, DANIEL  
306 ECU CECOM DR  
CONWAY, SC 29527  
DOB : 09/26/1974

ORDER 07/07/2016

[07072016]

ORDER REASON:

DISCONTINUE WOUND CARE

ORDER:

EFFECTIVE 7/7/16

DISCONTINUE WOUND CARE

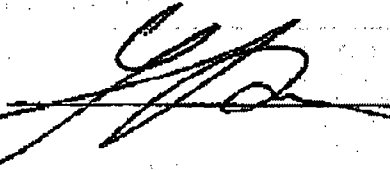
PER DR. RIMKUS/AMANDA SOLES LPN

*Kate Cannon, LPN*

Clinician Name: AMANDA SOLES LPN

Date: 07/07/2016

Physician  
Signature



Date

*7/29/16*

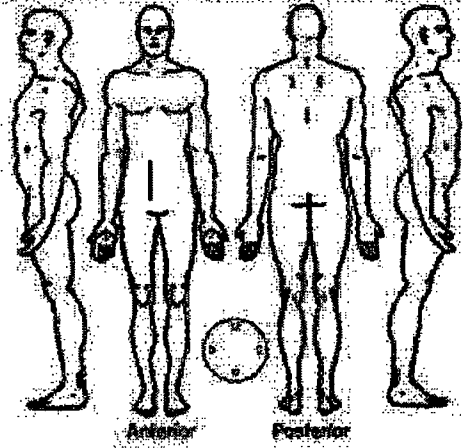
48788062

*CD*

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 05/30/2016 MR#: I1455456  
 Agentcode: FRED00245

Denote location of specific skin conditions/wounds by number(s) appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include color(s).



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Clean: ASEPTIC		Surgical	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Type of Support Surface

- Preventative  Treatment  Wheelchair Cushion
- Mattress:
- Other:

Description of Wound Locations

Location 1: MID ABDOMIN  
 Location 3:

Location 2:  
 Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)	12.5 *2 *1.5 cm			
Drainage Amount/Type	T: SS A: SM	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)				
Surrounding Tissue	WNL			
Edema/Color				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 05/30/2016 MR#: 11455456

Agent Code: FFE000245 Agent Name: FREDERICK, KIMBERLY, RN

Time In: 09:00 Time Out: 11:00

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Skilled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WOUND CLEANSER

 Wound irrigated with (specify): Wound packed with (specify):

BLACK FOAM

 Wound dressing applied (specify):

DRAPE, WOUND VAC

 Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: SCA Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

PATIENT HOME BOUND DUE TO ABDOMINAL WOUND. SKILLED NURSE FOR ADMISSION ASSESSMENT AND WOUND CARE AND EDUCATION. WOUND CARE PERFORMED TO MID ABDOMIN. WOUND VAC TURNED OFF, SOILED DRESSING REMOVED, BLACK FOAM REMOVED, WOUND BED CLEANSED WITH WOUND CLEANSER AND PAT DRY, DRAPE APPLIED AND BLACK FOAM APPLIED TO WOUND BED, COVERED WITH DRAPE AND WOUND VAC APPLIED AT 125 CONTINUOUS. EDUCATION PROVIDED FOR INCREASED PROTEIN FOR WOUND HEALING AND MUSCLE STRENGTH. PATIENT VERBALIZED UNDERSTANDING. WILL CONTINUE TO MONITOR. PATIENT EDUCATION PROVIDED FOR WOUND VAC MUST BE ON FOR MINIMUM OF 22 HOURS, IF NOT WORKING FOR 2 HOURS, REMOVE AND APPLY WET TO DRY DRESSING. WET WITH NORMAL SALINE, SQUEEZE EXCESS COTI FLUFF IN WOUND AND COVER WITH 4X4 AND SECURE WITH TAPE. VERBALIZED UNDERSTANDING. WILL MONITOR. ENCOURAGED TO CALL IF UNABLE TO PERFORM WET TO DRY. REINFORCED SKILLED NURSE VISIT FREQUENCY AND 24 HOUR ON CALL NURSE.

Record on Appeal 1365

Signature: KIMBERLY FREDERICK, RN

Date: 05/30/2016

Page: 1 SOC/ROC ASSESSMENT  
Date: 05/30/2016 Patient: KNIGHT, DANIEL (I1455456) Agent: FREDERICK, KIMBERLY, RN (FR0000245)  
Time in: 09:00 Time Out: 11:00

TYPE OF VISIT:  Skilled <Planned> / PRN / Infusion / <Wound care>  Skilled & Supervisory  Supervisory Only  
 Other  
DATE 05/30/2016 TIME IN TIME OUT  
Agency: Anedisys Home Health of Conway (2222) 09:00 11:00

AGENCY INFORMATION

(M0010) CMS Certification Number:

Branch Identification (Optional, for Agency Use)  
(M0014) Branch State: (M0015) Branch ID Number: MSA Code

PATIENT TRACKING

(M0020) Patient ID Number: I1455456

Cert From: 05/30/2016 Cert To: 07/28/2016

(M0030) Start of Care Date: 05/30/2016 (M0032) Resumption of Care Date:

NA - Not Applicable

(M0040) Patient's Name:

DANIEL

KNIGHT

Patient Phone:  
330-719-5830

(First) (MI) (Last) (Suffix)

Patient's Address:

206 ECU CIRCUM DR

CONWAY

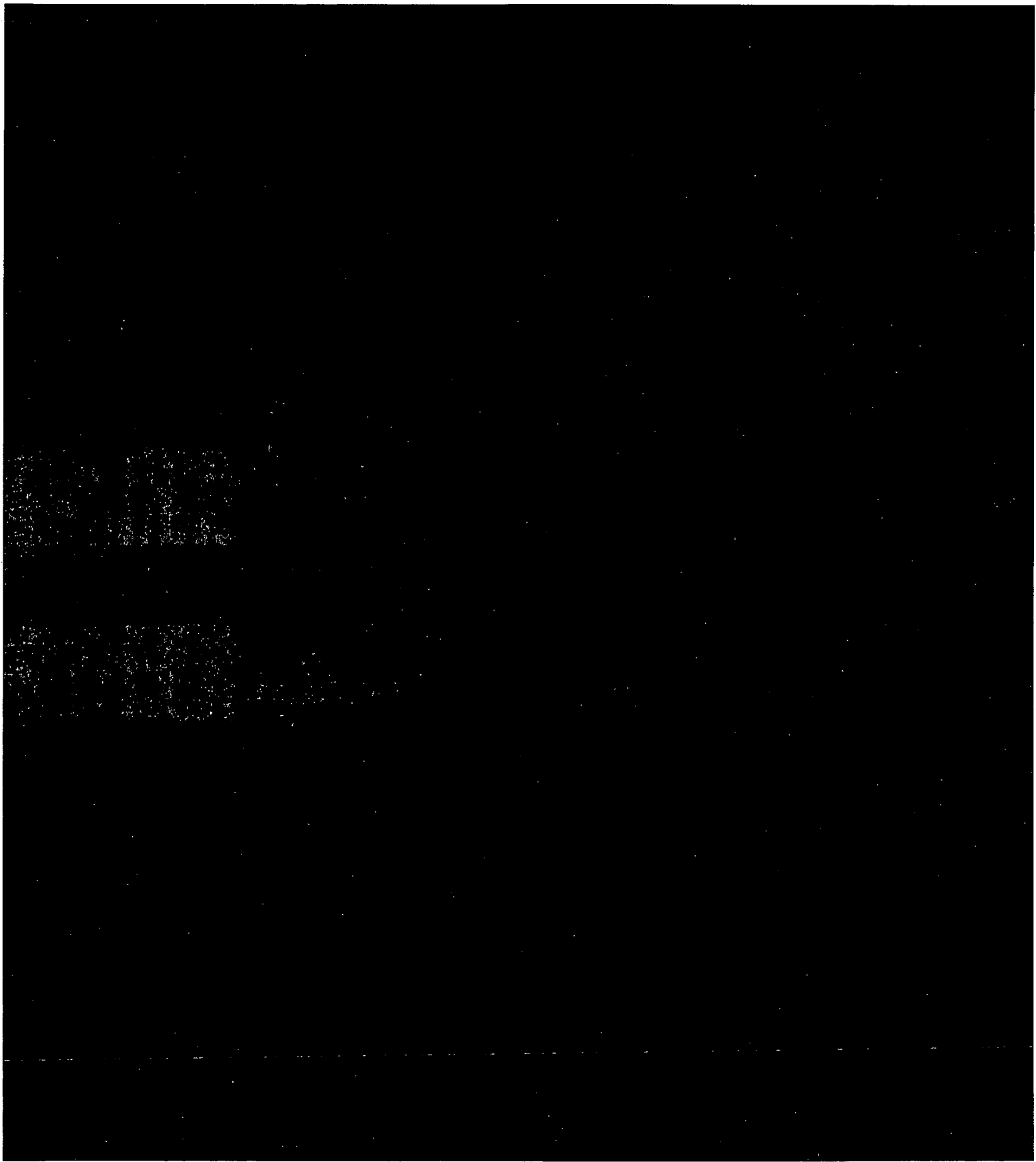
(Street / Apt. No.) (City)

(M0050) Patient State of Residence: SC (M0060) Patient ZIP Code: 29527

(M0140) RACE / ETHNICITY

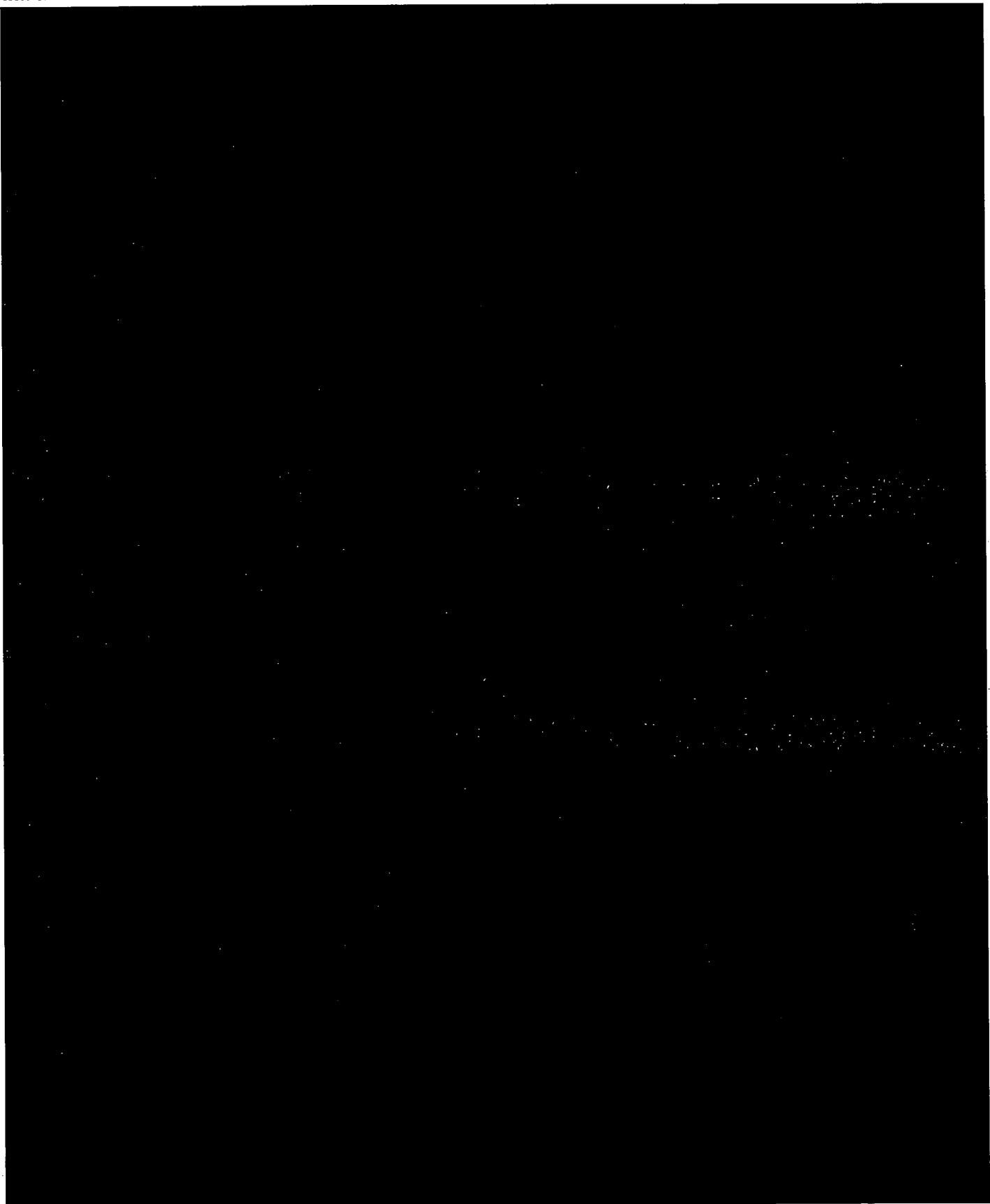
Race/Ethnicity : (Mark all that apply)

- 1 - American Indian or Alaska Native
- 2 - Asian
- 3 - Black or African-American
- 4 - Hispanic or Latino
- 5 - Native Hawaiian or Pacific Islander
- 6 - White



Page: 3      SOC/ROC ASSESSMENT  
Date: 05/30/2016      Patient: KNIGHT, DANIEL (11455456) Agent: FREDERICK, KIMBERLY, RN (FR0000245)  
Time in: 09:00 Time Out: 11:00

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UK - Unknown

(M0018) PHYSICIAN INFO

National Provider Identifier (NPI) for the attending physician who has signed the plan of care:

1326126301

UK - Unknown or Not Available

Phone: 843/347-7291

Name: RIMKUS, GILBERTAS  
Address: [Street / Apt. No.]

2361 CYPRESS CIRCLE

City: CONWAY State: SC Zip Code: 29526

Secondary Referring Physician I.D.:

Phone:

Name:  
Address: [Street / Apt. No.]

City: State: Zip Code:

May take orders from:

RACHEL COLLINS

(M0880/M0890/M0100) CLINICAL RECORD ITEMS

(M0880) Discipline of Person Completing Assessment: (M0890) Date Assessment Completed:  
 1 - RN  2 - PT  3 - SLP/ST  4 - OT 05/30/2016

(M0100) This Assessment is currently Being Completed for the Following Reason: Start of Care

Medical Record No. (if different than PATIENT TRACKING SHEET'S M0920): 11455456

(M0102) DATE OF PHYSICIAN-ORDERED SOC

Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care

(Resumption of care) date when the patient was referred for home health services, record the date specified.  
(Go to M0110, if date entered)

NA No specific SOC date ordered by physician

(M0104) DATE OF REFERRAL

Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.  
05/29/2016



VITAL SIGNS  
Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred Prior Weight:  Right / Previous Weight:  Right /

Sitting  Left 102 / 60 Standing  Left / Lying  Left /

Temperature:  Refused / Unable To Assess / Deferred 98.3  ORAL  AXILLARY  RECTAL  TYPANIC

Pulse:  Refused / Unable To Assess / Deferred

Apical 84  Brachial  <Regular> / Irregular  Radial  Carotid  Rest  Activity  
 Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
 Respirations:  Refused / Unable To Assess / Deferred  
 16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
 Documentation of Skilled intervention / instruction / management problems:

Patient Demonstration Pool

Casis Questions	Have Patient Demonstrate These Tasks PRIOR to Opening the QASIS Set	Clinician Education
M1200 Vision	1. Have the patient READ the numbers on the medication bottles.	'In order to be scored "0" - Normal vision, the patient must be able to see/read medication labels and / or newspaper with prescription or drugstore reading glasses. If requires magnifying glass or other device, vision is impaired.'
M1830, M1840 and M1850 Transferring	2. Ask the patient to sit down in a chair, then ask them to stand up by themselves. In the bathroom, ask the patient to step in and out of the tub. Observe the patient during transfers and determine the amount of assistance required for transfer from bed to chair. (If bedfast, have patient turn and position self).	'In order to be scored "0", must complete ALL transfers safely, effectively, and efficiently without any kind of human intervention. In/out of chair, on/off toilet, and in/out of tub safe'
M1860 Amputation & M1400 Dyspnea	3. Once standing, have the patient walk to the bathroom or at least 20 feet. (if unable to ambulate, assess bed or chair mobility, transfers or other activities able to perform & determine level of exertion which creates shortness of breath)	'M1860 - To score a "0", must be able to safely ambulate on all surfaces at all times by self without supervision or assist from a device or person. If WC used for mobility, determine if help needed to propel self to get around. 'M1400-To score a "1", must ambulate at a pace that creates more than moderate exertion without becoming short of breath. A person who walks very slowly at own pace may not be creating greater than moderate exertion.'
M1830 Bathing	4. Once in the tub, ask the patient to bend down and wash feet, and then reach to wash back.	Medical restrictions, location of tub/shower and presence of wounds, dressing and PAD may restrict bathing in tub or shower. 'Preference and habit are not being scored here. To score a "0", patient is independent in tub/shower bathing without human assistance of safety or assistive devices. If the patient requires standby assistance to bathe or shower or requires verbal cueing/reminders, then select Response 2 or Response 3, depending on whether the assistance 'needed is intermittent ("2") or continuous ("3").' safely in the tub
M1840 Toilet Transferring	5. Determine what device is used for toileting. Have the patient get to and use device.	'Scores of "0" and "1" reflect getting to toilet, score of "2" reflects 'ability to use BSC, score of "3" reflects ability to use bedpan/urinal' and score of "4" indicates dependence for all toileting activities.' This also helps to provide answer to M1850.
M1810 & M1820 Dressing	6. Have patient take off and put back on shirt and shoes and socks during physical assessment.	Observe cognition, fine motor function, general appearance and any modifications to wardrobe. If the patient has modified his/her wardrobe to accommodate a limitation, he/she may not be independent in the task if the improvement is needed.
M1350 Wounds	7. Inspect the patient's total body for presence of wounds and lesions	'Lesion' is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, etc., are considered lesions. All alterations in skin integrity are considered to be lesions, except for bowel ostomies (which are reported in QASIS item M1630). Persistent redness without a break in the skin is also considered a lesion. Skin lesions or open wounds that are not receiving clinical intervention from the home health agency should not be

MI322	8. Assess stage of pressure ulcers and determine healing status of all wounds. Observe ALL wounds unless covered by a cast or dressing not to be removed by physician order.	considered when responding to this question. Ostomies, other than bowel ostomies, (e.g., tracheostomy, thoracostomy, urostomy) ARE considered to be skin lesions or open wounds if clinical interventions (e.g., cleansing, dressing changes) are being provided by the home health agency during the home health care episode. PICC lines and peripheral IV sites are considered skin lesions/open wounds.  These questions indicate staging and healing status of wounds. Obtain wound history to determine etiology and correct labeling of pressure ulcer stage. Describe wound, wound bed, and presence of healing ridge, if applicable. Use WOCN and NPURP guidelines to determine wound status and staging. Infection, necrosis, lack
Number of Stage I Pressure Ulcers		'of wound progress, all may indicate "non-healing" status. A stage 1 pressure ulcer is not healing.
MI308 Number of Unhealed Stage II or Higher Pressure Ulcers MI326 & MI324		
Most Problematic Pressure Ulcer MI334		
Stasis Ulcer Status MI342 Surgical Wound Status	9. Thoroughly assess pain (acute or chronic which may interfere with activity or movement).	Assess for presence of acute and chronic pain. (Consider neoplasms, orthopedic procedures, musculoskeletal disorders, surgical interventions, paresthesia and neuropathy.) Evaluate medication regimen. Pain medications might be taken regularly but
MI242 Pain		pain could still interfere with activity or movement. Determining factors that aggravate pain may help identify pain that interferes.
MI740 Behavior Problems	10. Assess closely for behavior problems during the Admission Visit.	Patient requiring supervision of medications or prompting to perform tasks may be due to memory deficits or impaired decision making. A patient identified as a fall risk may be due to impaired decision making.

CRISIS DOCUMENTATION TIPS:

A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for all items. All tasks must be assessed considering cognition, emotional and behavioral state and physical function and its effects on safety, effectiveness and efficiency of task completion. If patient requires improvement in any of these areas to reach maximum potential or benefit, then he does not meet the 'standard of independence'. If patient needs human intervention by supervision (prompting, cueing, reminders or standby) or assistance (touching, contact guarding or participation) the standard of independence is not met.

Safety is a MUST! If a patient is unsafe to perform a task/ADL, he/she must be scored at the level for him/her to perform it SAFELY. Score ability not compliance. If a patient is not safe to ambulate without an assistive device, but has been doing so, you must score the patient at the safety level.

Score ability not preference. If a patient prefers a sponge bath, you must score the patient's ability to get in and out of tub or shower safely. Score according to medical restrictions. For example, if a patient is on bedrest with bathroom privileges, he/she cannot be scored independent

in most functional questions, regardless of compliance. If a patient has a wound, consider this when scoring (i.e., can the patient get in the tub with wound on lower extremity?). Often a patient that is limited in certain functional tasks is also limited in others (i.e., patients who need assistance in bathing, often need assistance in dressing).

(M1000) INPATIENT FACILITY DISCHARGE

From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)

- 1 - Long-term nursing facility (LNF)
- 2 - Skilled nursing facility (SNF / ICU)
- 3 - Short-stay acute hospital (IPPS)
- 4 - Long-term care hospital (LTCM)
- 5 - Inpatient rehabilitation hospital or unit (IRF)
- 6 - Psychiatric hospital or unit

7 - Other (specify)  
 NA - Patient was not discharged from an inpatient facility [Go to M1017]

(M1005) INPATIENT DISCHARGE DATE  
 Inpatient Discharge Date (most recent):  
 05/29/2016  
 UK - Unknown

(M1011) INPATIENT DIAGNOSES  
 List each Inpatient Diagnosis and ICD-10-C M code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):  
 Inpatient Facility Diagnosis ICD-10-C M Code

a. Peritonitis, unspecified K65.9  
 b. Perforation of intestines (nontrauma) K63.1  
 c.  
 d.  
 e.  
 f.  
 NA - Not applicable (patient was not discharged from an inpatient facility) [Omit "NA" option on SOC, ROC]

(M1017) MEDICAL DIAGNOSES  
 Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):  
 Changed Medical Regimen Diagnosis: ICD-10-C M Code

a. Peritonitis, unspecified K65.9  
 b. Perforation of intestines (nontrauma) K63.1  
 c.  
 d.  
 e.  
 f.  
 NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

PRIOR HISTORY

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Infection	<input type="checkbox"/> Cancer (site):
<input type="checkbox"/> CHF	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Immunosuppressed	<input type="checkbox"/> Surgeries:
<input type="checkbox"/> Other Cardiac	<input type="checkbox"/> Fractures	<input type="checkbox"/> Open Wound	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> CVA	<input type="checkbox"/> Mastectomy, date:

R / L

<input type="checkbox"/> Menopause	<input type="checkbox"/> Falls	<input type="checkbox"/> Hysterectomy, date:
<input type="checkbox"/> Chronic Vertigo	<input type="checkbox"/> Recurrent Syncope	

IMMUNIZATIONS

Flu Date: 10/01/2015  
 Pneumonia Date:  
 Tetanus Date:  
 Other: Date:

PREVIOUS OUTCOMES  
 PRIOR HOSPITALIZATION(S)  No  Yes Number of times:  
 Reason(s) / Date(s):

PRIOR EMERGENCY CARE:  No  Yes Number of times:  
 Reason(s) / Date(s):

PREVIOUS THERAPY:  No  Yes Number of times:  
 Reason(s) / Date(s):  
 / Outcomes

05/29/2016

PHYSICIAN: Date last contacted: \_\_\_\_\_ Date last visited: \_\_\_\_\_  
PRIMARY REASON FOR HOME HEALTH: WOUND CARE  
PRESENT ILLNESS / NURSING / THERAPY / DIAGNOSIS: SMALL INTESTINE RESECTION AND ILSOSTOMY

(M1016) CONDITIONS PRIOR

Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:

If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen.

(Mark all that apply.)

- 1 - Urinary incontinence
- 2 - Indwelling/suprapubic catheter
- 3 - Intractable pain
- 4 - Impaired decision-making
- 5 - Disruptive or socially inappropriate behavior
- 6 - Memory loss to the extent that supervision required
- 7 - None of the above
- NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days.
- UK - Unknown

(M1030) THERAPIES

Therapies the patient receives at home: (Mark all that apply.)

- 1 - Intravenous or infusion therapy (excludes TPN)
- 2 - Parental nutrition (TPN or lipids)
- 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- 4 - None of the above

(M1033) RISK FOR HOSPITALIZATION

Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization?

(Mark all that apply.)

- 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- 3 - Multiple hospitalizations (2 or more) in the past 6 months
- 4 - Multiple emergency department visits (2 or more) in the past 6 months
- 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- 7 - Currently taking five or more medications
- 8 - Currently reports exhaustion
- 9 - Other risk(s) not listed in 1 - 8
- 10 - None of the above

(M1034) OVERALL STATUS

Overall Status: Which description best fits the patient's overall status? (Check one)

- 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).
- 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- 3 - The patient has serious progressive conditions that could lead to death within a year.
- UK - The patient's situation is unknown or unclear.

PROGNOSIS

Poor  Guarded  Fair  Good  Excellent

ADVANCE DIRECTIVES

ADVANCE DIRECTIVES

- Living will  Do not resuscitate  Do not hospitalize  Durable power of attorney
- Organ donor  Funeral arrangements made  Education needed  Copies on file

Description of patient's wishes if no copies of Advanced Directives on file:

FULL CODE

Comments:

(M1036) RISK FACTORS

Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)

- 1 - Smoking
- 2 - Obesity
- 3 - Alcohol dependency
- 4 - Drug dependency
- 5 - None of the above
- 0X - Unknown

(M1100) PATIENT LIVING SITUATION

Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance?

(Check one box only.)

Living Arrangement	Availability of Assistance			Occasional / short-term assistance	
	Around the clock	Regular daytime	Regular nighttime	No assistance available	
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input checked="" type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

CAREGIVER ASSISTANCE

- Capable  Able  Willing caregiver available
- limited caregiver support (ability/willingness)
- no caregiver available

Primary Caregiver (name) ELIZABETH ENGLISH

Primary Language of patient/caregiver  
 Language barrier  Needs interpreter

Phone Number (if different from patient)

Relationship/Health status

Able to safely care for patient  Yes  No  
 Other (specify)

Other organizations providing services

EMERGENCY CODE

Emergency Code: D3

ENVIRONMENTAL SAFETY

Steps  
 Exterior No.  Railing  Right  Left  None  Interior No.  Railing  Right  Left  None

ENVIRONMENTAL/SAFETY ASSESSMENT

Safety Hazards in the home

Unsound Structure  Y  N  N/A No telephone available and/or unable to use phone  Y  N  N/A

Unsafe functional barriers (i.e. stairs)	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	Insects/Rodents	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A
Improper bathroom accessibility	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A	Residence poorly maintained	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A
Uneven floor surfaces / entry	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	Ramp present	<input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A
Unsafe placement of rugs/cords furniture, etc.	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	At risk for falls	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
Inadequate heating/cooling/electricity	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	Stairs inside home	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A
Inadequate sanitations/plumbing	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A	Cluttered soiled area	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A
Inadequate refrigeration	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A	Emergency planning/fire safety/equipment maintenance:	
Unsafe gas/electric appliances or outlets	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	Smoke detectors on all levels of home	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
Inadequate running water	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	More than one exit	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
Inadequate lighting	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A	Plan for power failure	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
Unsafe storage of supplies/equipment	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A	Oxygen in use - signs posted	<input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A
Oxygen back-up:	<input type="checkbox"/> Available	Handles smoking materials safely	<input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A
	<input type="checkbox"/> Knows how to use	Lack of fire safety devices	<input type="checkbox"/> Y <input type="checkbox"/> S <input type="checkbox"/> N <input type="checkbox"/> N/A
	<input type="checkbox"/> Electrical/fire safety	Fire extinguishers	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A

Comments::

Documentation of Skilled Intervention/Instruction/Management Problems:

SAFETY MEASURES

Safety Measures:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 1 - Anticoagulant precautions       | <input type="checkbox"/> 8 - Direct patient supervision / Safety in ADL's                | <input checked="" type="checkbox"/> 14 - Bathroom Safety      |
| <input type="checkbox"/> 2 - Oxygen safety measures          | <input checked="" type="checkbox"/> 9 - Keep pathways clear                              | <input checked="" type="checkbox"/> 15 - Fire Safety          |
| <input type="checkbox"/> 3 - Seizure precautions             | <input type="checkbox"/> 10 - Support during transfer and ambulation                     | <input type="checkbox"/> 16 - Immunosuppression precautions   |
| <input type="checkbox"/> 4 - Fall prevention safety measures | <input checked="" type="checkbox"/> 11 - Standard precautions / Infection control        | <input checked="" type="checkbox"/> 17 - Medication Safety    |
| <input type="checkbox"/> 5 - Aspiration precautions          | <input type="checkbox"/> 12 - Ambulate with assistive devices (wheelchair, walker, cane) |   |
| <input type="checkbox"/> 6 - Keep siderails up               | <input type="checkbox"/> 13 - Assistance with ADL's                                      | <input checked="" type="checkbox"/> 18 - Slow position change |
| <input type="checkbox"/> 7 - HOB elevated                    | <input type="checkbox"/> 19 - Other  |   |

(M1200) VISION

Vision: (with corrective lenses if the patient usually wears them):

- 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
- 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

EYES

No Problem Identified

- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract

- Infections
- Any surgeries
- Other

Documentation of skilled intervention / instruction / management problems:

(M1210) HEARING

Ability to Hear (with hearing aid or hearing appliance if normally used):

- 0 - Adequate: hears normal conversation without difficulty.
- 1 - Mildly to Moderately impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- 2 - Severely impaired: absence of useful hearing.

UK - Unable to assess hearing.

EARS

No Problem Identified

Hearing Loss

Aid used R / L

Deaf: R / L

Ear pain

Vertigo

Tinnitus R / L

Other:

Documentation of skilled intervention / instruction / management problems:

NOSE

No Problem Identified

Congestion

Sinus Infection

Epistaxis

Impaired sense of smell

Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

No Problem Identified

Dentures: Upper / Lower

Difficulty swallowing

Lesions

Hoarse

Ulcerations

Toothache

Gum problems

Chewing problems

Other:

Documentation of skilled intervention / instruction / management problems:

(M1220) UNDERSTANDING OF VERBAL CONTENT

Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

0 - Understands: clear comprehension without cues or repetitions.

1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

3 - Rarely/Never Understands

UK - Unable to assess hearing.

(M1230) SPEECH AND ORAL (VERBAL) EXPRESSION

Speech and Oral (Verbal) Expression of language (in patient's own language)

0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice,

- grammar or speech intelligibility; needs minimal prompting or assistance).
- 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).
- 5 - Patient nonresponsive or unable to speak.

PAIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABDOMEN any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

- Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

- Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying

Frequency of pain:

- Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

- Movement  
 Anxiation  
 Immobility  
 Other:  
DRESSING CHANGE

- Localized  
 Radiates

- Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:

Non Pharmacological Interventions:

- Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

- Medication: OXYCODONE  
TELS AM

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A

Duration of Relief: VARIES

How often is medication needed for breakthrough pain?

- Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

(M1240) PAIN ASSESSMENT

using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

Has this patient had a formal Pain Assessment

- 0 - No standardized, validated assessment conducted  
 1 - Yes, and it does not indicate severe pain  
 2 - Yes, and it indicates severe pain

(M1242) FREQUENCY OF PAIN

Frequency of Pain Interfering with patient's activity or movement:

- 0 - Patient has no pain  
 1 - Patient has pain that does not interfere with activity or movement  
 2 - Less often than daily  
 3 - Daily, but not constantly  
 4 - All of the time  
Decline Reason:

ENDOCRINE/HEMATOLOGY

No Problem

Deferred (Explain)  
(Circle all applicable items)

Diabetes: Type I Juvenile /Type I /Type II

Onset of diabetes

Blood sugar ranges  Patient /Caregiver Report

Monitored by:  Self  Caregiver  Nurse  Patient

Other

Frequency of monitoring

Patient/caregiver competency with use of Glucometer  ADEQUATE  NEEDS FURTHER INSTRUCTION

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine /Excessive Urination /Excessive Thirst /Dry Skin /Drowsiness

Low Blood Sugar: Anxiety /Diaphoresis /Intense Hunger /Weakness /Faint /Stupor /Nausea /Tremor /Irritable /Palpitations

Diet control (specify)

Oral medication

Patient /caregiver ability to draw up and administer insulin:  ADEQUATE  NEEDS FURTHER INSTRUCTION

Insulin dose/frequency (specify)

On insulin since How long has the patient been insulin dependent?

Document any Diabetes Related Diagnosis:

Neurologic  
Neuropathy  
Ophthalmic

Peripheral Vascular Disease  
Radiculopathy

Renal  
Other

Additional Endocrine Disease Assessments:

Thyroid Disease:  Hyperthyroidism  Hypothyroidism

Symptoms exhibited related to Thyroid Disease:

Patient fatigues easily  Increased sensitivity to cold /heat  Unexplained weight gain  Unexplained weight loss

Enlarged thyroid gland  Excessive sweating  Rapid heart rate

Other

Anemia (specify if known)

Secondary bleed: GI /GU /GYN /Unknown  Hemophilia

Other

Venipuncture for drawn from space using  aseptic  sterile technique.

Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Specs transported to

laboratory via OSHA protocol.

Universal precautions / infection control maintained

Documentation of Skilled intervention / instruction / management problems:

SEMMES WEINSTEIN

Semmes Weinstein Monofilament 5.07

Right 5 /5  NA - patient Right LE amputee

Left 5 /5  NA - patient Left LE amputee

INTERCUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: <Pale> / Jaundice / Redness

Skin Turgor: Good / <Fair> / Poor

Skin: <Cool> / Cyanotic / <Dry> / Diaphoretic / Warm

Highlight all applicable conditions listed:

Abrasions / Bruises / Fistulas / <Incision> / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
 Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

RISK FACTOR	BRADEN SCALE - For Predicting Pressure Sore Risk				SCORE
* fill out per organizational policy	[ ] Deferred	HIGH RISK: score < 12	MODERATE RISK: score 13 - 14	LOW RISK: score 15 - 18	
<b>SENSORY PERCEPTION</b>	1. COMPLETELY LIMITED	2. VERY LIMITED	3. SLIGHTLY LIMITED	4. NO IMPAIRMENT	
Ability to respond meaningfully to pressure-related discomfort	Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation.	Responds only to painful stimuli. Cannot communicate or restlessness	Responds to verbal commands, but cannot always communicate discomfort or the need to be turned.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
	OR limited ability to feel pain over most of body	OR has a sensory impairment which limits the ability to feel pain or discomfort over 2 areas of the body.	OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.		
					<u>3</u>
<b>MOISTURE</b>	1. CONSTANTLY MOIST	2. OFTEN MOIST	3. OCCASIONALLY MOIST	4. RARELY MOIST	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always moist. Linen must be changed as often as 3 times in 24 hours.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry; Linen only requires changing at routine intervals.	
					<u>3</u>
<b>ACTIVITY</b>	1. BEDFAST	2. CHAIRFAST	3. WALKS OCCASIONALLY	4. WALKS FREQUENTLY	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of day in bed or chair.	Walks outside bedroom twice a day and inside room at least once every two hours during waking hours.	
					<u>3</u>
<b>MOBILITY</b>	1. COMPLETELY IMMOBILE	2. VERY LIMITED	3. SLIGHTLY LIMITED	4. NO LIMITATION	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
					<u>3</u>
<b>NUTRITION</b>	1. VERY POOR	2. PROBABLY INADEQUATE	3. ADEQUATE	4. EXCELLENT	
Usual food intake pattern	Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement	Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	Eats over half of most meals. Eats a total of 4 servings of protein (meat), dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered	Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require	
					<u>3</u>

OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.  
 OR receives less than optimum amount of liquid diet or tube feeding.  
 is on a tube feeding or TPN regimen which probably meets most of nutritional needs.  
 supplementation.

FRICITION & SHEAR

1. PROBLEM	2. POTENTIAL PROBLEM	3. NO APPARENT 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 or agitation leads to almost constant friction.	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.	Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.

3

Total score of 12 or less represents HIGH RISK  
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TOTAL SCORE:

18

(M1300) PRESSURE ULCER ASSESSMENT

Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?  
 0 - No assessment conducted [ Go to M1306 ]  
 1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool  
 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

(M1302) RISK OF DEVELOPING PRESSURE ULCERS

Does this patient have a Risk of Developing Pressure Ulcers?  
 0 - No  
 1 - Yes

(M1322) CURRENT NUMBER OF STAGE I PRESSURE ULCERS

Current Number of Stage I Pressure Ulcers:  
 Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.  
 0  1  2  3  4 or more

(M1306) PRESSURE ULCER

Does this patient have at least one or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)  
 Unhealed Pressure Ulcer at Stage II or Higher  
 0 - No [ Go to M1322 ]  
 1 - Yes

(M1308) PRESSURE ULCERS AT EACH STAGE (2-4)

Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:  
 (Enter 0 if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage descriptions - unhealed pressure ulcers	Number Currently Present
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	

- b. Stage III:  
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- c. Stage IV:  
Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
- d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device.
- d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.
- d.3 Unstageable: Suspected deep tissue injury in evolution.

M1320, M1334, M1342 Wound Guidance

Newly epithelialized: When epithelial tissue has completely covered the wound surface of the pressure ulcer, regardless of how long the pressure ulcer has been re-epithelialized. This is an appropriate response for Stage III and IV pressure ulcers, but not for Stage II ulcers as fully epithelialized Stage II ulcers should not be reported.

Fully Granulating: Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium, no dead space, no avascular tissue (eschar and/or slough), no signs or symptoms of infection, wound edges are open. This is the appropriate response for a Stage III or IV pressure ulcer that is fully granulated, but epithelial tissue has not completely covered the wound surface.

Early/Partial Granulation: > 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (eschar and/or slough) (i.e., < 25% of the wound bed is covered with avascular tissue); may have dead space, no

Not healing: signs or symptoms of infection; wound edges are open. Wound with > 25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

Note: A new Stage 1 pressure ulcer is reported on OASIS as Not healing. Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for Stage II ulcers is 3 - Not healing.

NA: "No observable" pressure ulcer includes only those that cannot be observed due to the presence of a dressing or device that cannot be removed (including casts). (When determining the healing status of a pressure ulcer for answering M1320, the

presence of necrotic tissue does NOT make the pressure ulcer NA - No observable pressure ulcer.)

A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 - Early/partial granulation if necrotic or avascular tissue covers <25% of the wound bed, or Response 3 - Not

healing, if the wound has > 25% necrotic or avascular tissue.

M1320) STATUS OF MOST PROBLEMATIC PRESSURE ULCER

Status of Most Problematic Pressure Ulcer that is Observable:  
(Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

M1324) STAGE OF MOST PROBLEMATIC PRESSURE ULCER

Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - Patient has no pressure ulcers or no stageable pressure ulcers

M1330) STAGIS ULCER

Does this patient have a Stasis Ulcer?  
 0 - No [ Go to M1340 ]

- 1 - Yes, patient has BOTH observable and unobservable stasis ulcers  
 2 - Yes, patient has observable stasis ulcers ONLY  
 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device)  
[ Go to M1340 ]

(M1332) NUMBER OF STASIS ULCERS

Current Number of Stasis Ulcer(s) that are Observable:

- 1 - One  
 2 - Two  
 3 - Three  
 4 - Four or more

(M1334) STATUS OF MOST PROBLEMATIC STASIS ULCER

Status of Most Problematic Stasis Ulcer that is Observable:

- 1 - Fully granulating  
 2 - Early/partial granulation  
 3 - Not healing

(M1340) SURGICAL WOUND

Does this patient have a Surgical Wound?

- 0 - No (At SOC/ROC, go to M1350; At FU/DC, go to M1400)  
 1 - Yes, patient has at least one observable surgical wound  
 2 - Surgical wound known but not observable due to non-removable dressing/device

(At SOC/ROC, go to M1350; At FU/DC, go to M1400)

(M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

Status of Most Problematic Surgical Wound that is Observable

- 0 - Newly epithelialized  
 1 - Fully granulating  
 2 - Early/partial granulation  
 3 - Not healing

(M1350) SKIN LESION OR OPEN WOUND

Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?

- 0 - No  
 1 - Yes

(M1400) DYSPNEIC / SHORT OF BREATH

When is the patient dyspneic or noticeably Short of Breath?

- 0 - Patient is not short of breath  
 1 - When walking more than 20 feet, climbing stairs  
 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)  
 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation

- 4 - At rest (during day or night)

Decline Reason:

- Observed  Reported

(M1410) RESPIRATORY TREATMENTS

Respiratory Treatments utilized at home: (Mark all that apply.)

- 1 - Oxygen (intermittent or continuous)  
 2 - Ventilator (continually or at night)  
 3 - Continuous / Bi-level positive airway pressure  
 4 - None of the above

CARDIOPULMONARY

- No Problem

Heart Sounds:  <Regular> / Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/Duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date  
Pacemaker: Date Type  
 No Edema

Edema:  Lower Extremities Right /Left  Sacral  Dependent:  
 Upper Extremities Right /Left  
 Pitting +1 /+2 /+3 /+4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec /> 3 sec

Breath Sounds:

Anterior: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior: Clear  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Accessory muscles used  Right lower: Clear

Cough: Dry /Acute /Chronic  
 Productive: Thick /Thin /Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 @ \_\_\_\_\_ lpm per  
O2 saturation 98 %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

Gastrointestinal 4

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals 3 MEALS DAILY  
Diets  Low sodium diet  Calorie ADA diet  Sland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids amt.  Restrict fluids amt.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis(blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral:

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:

Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?

Documentation of Skilled intervention / instruction / management problems:

Nutrition Health Screen

Directions: Mark each area with a check to assessment, then total score to determine additional risk.

Has an illness or condition that changed the kind and / or amount of food eaten	<input checked="" type="checkbox"/>	2
Eats fewer than 2 meals per day	<input type="checkbox"/>	3
Eats few fruits, vegetables or milk products	<input type="checkbox"/>	2
Has 3 or more drinks of beer, liquor or wine almost everyday	<input type="checkbox"/>	2
Has tooth or mouth problems that make it hard to eat	<input type="checkbox"/>	2
Does not always have enough money to buy the food needed	<input type="checkbox"/>	4
Eats alone most of the time	<input type="checkbox"/>	1
Takes 3 or more different prescribed or over-the-counter drugs a day	<input type="checkbox"/>	1
Without wanting to, has lost or gained 10 pounds in the last 6 months	<input type="checkbox"/>	2
Not always physically able to shop, cook and / or feed self	<input checked="" type="checkbox"/>	2
<input type="checkbox"/> No Problem		
		TOTAL

Interpretation

- 0-2 Good As appropriate reassess and / or provide information based on situation
  - 3-5 Moderate Risk Educate, refer, monitor and reevaluate based on patient situation and organization policy
  - 6 or >High Risk Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health
- Reassess nutritional status and educate based on plan of care

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent X quads  Other

Last BM 05/30/2016 Usual Frequency Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal Stools: Blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful  
 Current Treatment  
 Ostomy:  Colostomy Date  
 Sigmoid  Transverse  
 Assessment of Site:

Documentation of Skilled Intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:  
Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):

Amount ml Frequency

Patient tolerated procedure well  YES  NO

returns

Other (specify)

Documentation of Skilled Intervention / instruction / management problems:

M1609 GENITOURINARY (Cont'd.)

Has this patient been treated for a Urinary Tract Infection in the past 14 days?

- 0 - No  
 1 - Yes  
 NA - Patient on prophylactic treatment  
 UK - Unknown (Omit "UK" option on DC)

M1610 GENITOURINARY (Cont'd.)

Urinary Incontinence or Urinary Catheter Presence:

- 0 - No incontinence or catheter (includes amuria or ostomy for urinary drainage) [ Go to M1620 ]  
 1 - Patient is incontinent  
 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [ Go to M1620 ]  
Decline Reason:

M1615 GENITOURINARY (Cont'd.)

When does Urinary Incontinence occur?

- 0 - Timed-voiding defers incontinence
- 1 - Occasional stress incontinence
- 2 - During the night only
- 3 - During the day only
- 4 - During the day and night

(M1626) BOWEL INCONTINENCE FREQUENCY

Bowel Incontinence Frequency:

- 0 - Very rarely or never has bowel incontinence
- 1 - Less than once weekly
- 2 - One to three times weekly
- 3 - Four to six times weekly
- 4 - On a daily basis
- 5 - More often than once daily
- NA - Patient has ostomy for bowel elimination
- UK - Unknown (Omit "UK" option on PU, DC)

(M1630) OSTOMY FOR BOWEL ELIMINATION

Ostomy for Bowel Elimination:

Does the patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

- 0 - Patient does not have an ostomy for bowel elimination.
- 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
- 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

GENITALIA

No Problem  Deferred (explain):

- Discharge (describe):
- Drainage (describe): Date last PAP: Results:
- Lesions  Blisters
- Masses  Cysts
- Inflammation  Breast self-exam Frequency:
- Surgical Alteration  Discharge: R / L
- Prostate Problem: BPH / TURP Date: Frequency:
- Self-testicular exam  Other (specify):

Documentation of Skilled Interventions / Instructions / Management Problems:

MENTAL STATUS

- 1 - Oriented  2 - Comatose  3 - Forgetful  4 - Depressed  5 - Disoriented  6 - Lethargic  7 - Agitated
- 8 - Other

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>

- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
- Aphasia: Receptive / Expressive
- Motor change: Fine / Gross Site
- Hand grips: Equal / Unequal
- Weakness: UE / LE Location
- Tremor: Fine / Gross
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE

R / L

- Inappropriate response to caregiver / clinician
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

(M1700) COGNITIVE FUNCTIONING

Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractability.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710/M1720) MENTAL STATUS

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly

4 - Constantly

NA - Patient nonresponsive

(M1720) When Anxious (Reported or observed Within the Last 14 Days):

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

(M1730) DEPRESSION SCREENING

Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

- 0 - No
- 1 - Yes, patient was screened using the PHQ-2 \* scale.

Instructions for this two-question tool: Ask patient:

"Over the last two weeks, how often have you been bothered by any of the following problems?\*

PHQ-2	Not at all	several days	More than half of the days	Nearly every day	NA
	0 - 1 day	2 - 5 days	6 - 11 days	12 - 14 days	Unable to respond
a) Little interest or pleasure in doing things	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
b) Feeling down, depressed, or hopeless?	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA

- 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

- 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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(M1740) BEHAVIORS DEMONSTRATED

Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required.
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions.
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects).
- 5 - Disruptive, infantile or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior.
- 7 - None of the above behaviors demonstrated.

(M1745) FREQUENCY OF BEHAVIOR PROBLEMS

Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never  
 1 - Less than once a month  
 2 - Once a month  
 3 - Several times each month  
 4 - Several times a week  
 5 - At least daily

PSYCHOSOCIAL

- No Problem  
 Learning barrier: Functional / Mental / Physical / Psychosocial

Able to <read> / <write>  Inability to read / write

Education level COLLEGE GRADUATE

Spiritual/Cultural implications that impact care:

Spiritual resource

Depression History:  Chronic / Long term  Recent / Acute

Current treatment:

Exhibited behaviors / factors associated with Depression:

- Lack of coping skills  Lack of motivation / loss of interest  Denial  Inability to recognize problems withdrawn  
 Chronic pain / persistent bodily symptoms  Unrealistic expectations

Evidence of abuse:

Potential Detail:

Actual Detail:

Financial Detail:

Physical Detail:

Verbal/Emotional Detail:

Documentation of skilled intervention / instruction / management problems:

(M1750) PSYCHIATRIC NURSING SERVICES

Is the Patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

- 0 - No  
 1 - Yes

MUSCULOSKELETAL

No Problem  New Falls Reported

Joint problems (specify)

Symptoms:  Pain  Swollen Joints  Stiffness

Contractures:

Location

Muscle Atrophy Location:  Poor conditioning  Muscle wasting  Decreased muscle tone

Limited ROM

Location:

Skin Numbness / Tingling

Decreased mobility LIMITED  Decreased endurance WEAKNESS

Prosthesis: RUE / RLE / LUR / LLE / Other

Fracture (location)

Shuffling / Wide-based gait  Weakness GENERALIZED

Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify)  Other

Hemiplegia  Paraplegia  Quadriplegia

Other (specify)

Documentation of skilled intervention / instruction / management problems:

FUNCTIONAL LIMITATIONS

(Locator #18A)

- |   |  |
|---|--|
| <input type="checkbox"/> 1 - Amputation                   | <input type="checkbox"/> 7 - Ambulation                    |
| <input type="checkbox"/> 2 - Bowel/Bladder (Incontinence) | <input type="checkbox"/> 8 - Speech                        |
| <input type="checkbox"/> 3 - Contracture                  | <input type="checkbox"/> 9 - Legally blind                 |
| <input type="checkbox"/> 4 - Hearing                      | <input type="checkbox"/> A - Dyspnea with minimal exertion |
| <input type="checkbox"/> 5 - Paralysis                    | <input type="checkbox"/> B - Other (Specify)               |

6 - Endurance

ACTIVITIES PERMITTED

- |   |   |  |                                    |
|---|---|--|------------------------------------|
| <input type="checkbox"/> 1 - Complete bedrest           | <input type="checkbox"/> 5 - Exercises prescribed   | <input type="checkbox"/> 9 - Cane            | <input type="checkbox"/> D - Other |
| <input type="checkbox"/> 2 - Bedrest/BRP                | <input type="checkbox"/> 6 - Partial weight bearing | <input type="checkbox"/> A - Wheelchair      |                                    |
| <input checked="" type="checkbox"/> 3 - Up as tolerated | <input type="checkbox"/> 7 - Independent at home    | <input type="checkbox"/> B - Walker          |                                    |
| <input type="checkbox"/> 4 - Transfer bed/chair         | <input type="checkbox"/> 8 - Crutches               | <input type="checkbox"/> C - No restrictions |                                    |

(M1800) GROOMING

Grooming:

Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make-up, teeth or denture care, fingernail care).

- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 - Someone must assist the patient to groom self.
- 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) ABILITY TO DRESS UPPER BODY

Current

safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Ability to Dress Upper Body

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2 - Someone must help the patient put on upper body clothing
- 3 - Patient depends entirely upon someone else to dress the upper body.

Decline Reason:

(M1820) ABILITY TO DRESS LOWER BODY

Current

safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Ability to Dress Lower Body

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

(M1830) BATHING

Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:

- (a) for intermittent supervision or encouragement or reminders, OR
- (b) to get in and out of the shower or tub, OR
- (c) for washing difficult to reach areas.

- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink,

- in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.

- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

Decline Reason:

(M1840) TOILET TRANSFERRING

Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 - Able to get to and from the toilet and transfer independently with or without a device.  
 1 - When reminded, assisted or supervised by another person, able to get to and from the toilet and transfer.  
 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).  
 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.  
 4 - Is totally dependent in toileting.

(M1845) TOILETING HYGIENE

Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 - Able to manage toileting hygiene and clothing management without assistance.  
 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.  
 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.  
 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) TRANSFERRING

Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.  
 1 - Able to transfer with minimal human assistance or with use of an assistive device  
 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.  
 3 - Unable to transfer self and unable to bear weight or pivot when transferred by another person.  
 4 - Bedfast, unable to transfer but is able to turn and position self in bed.  
 5 - Bedfast, unable to transfer and is unable to turn and position self.

Decline Reason:

(M1860) AMBULATION / LOCOMOTION

Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).  
 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.  
 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.  
 3 - Able to walk only with the supervision or assistance of another person at all times.  
 4 - Chairfast, unable to ambulate but is able to wheel self independently.  
 5 - Chairfast, unable to ambulate and is unable to wheel self.  
 6 - Bedfast, unable to ambulate or be up in a chair.

Decline Reason:

(M1870) FEEDING OR EATING

Feeding or Eating: Current ability to feed self meals and snacks safely.

Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.  
 1 - Able to feed self independently but requires:  
(a) meal set-up; OR  
(b) intermittent assistance or supervision from another person; OR  
(c) a liquid, pureed or ground meat diet.  
 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack  
 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.  
 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.  
 5 - Unable to take in nutrients orally or by tube feeding.

(M1880) PLANNING AND PREPARING LIGHT MEALS

Current Ability to Plan and Prepare Light Meals: (for example, cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission)  
 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.

2 - Unable to prepare any light meals or reheat any delivered meals.

(M1990) ABILITY TO USE TELEPHONE

Ability to Use Telephone:

Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

0 - Able to dial numbers and answer calls appropriately and as desired.

1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.

2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.

3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.

4 - Unable to answer the telephone at all but can listen if assisted with equipment.

5 - Totally unable to use the telephone.

NA - Patient does not have a telephone

(M1900) PRIOR FUNCTIONING ADL/IADL

Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most

recent illness, exacerbation, or injury. Check only one box in each row.

Functional Area	Independent	Needed Some		Dependent
			Help	
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 2
b. Ambulation	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 2
c. Transfer	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1		<input type="checkbox"/> 2

MANC 10 - Fall Risk Assessment Tool

Required Core Elements

'Assess one point for each core element "yes".'

Points

Information may be gathered from medical record, assessment and if applicable, the patient/caregiver.

Beyond protocols listed below, scoring should be based on your clinical judgment.

Age 65 +  0  1  
 Diagnosis (3 or more co-existing)  0  1

Includes only documented medical diagnosis  0  1  
 Prior history of falls within 3 months

An unintentional change in position resulting in coming to rest on the ground or at a lower level  0  1  
 Incontinence

Inability to make it to the bathroom or commode in timely manner  0  1  
 Includes frequency, urgency, and/or nocturia.  
 Visual impairment

Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.  0  1  
 Impaired functional mobility

May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.  0  1  
 Environmental hazards

May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.  0  1  
 Poly Pharmacy (4 or more prescriptions - any type)

All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk

include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.

Pain affecting level of function  0  1  
Pain often affects an individual's desire or ability to move or pain can be a factor in depression or  
compliance with safety recommendations.  0  1  
Cognitive impairment  
Could include patients with dementia, Alzheimer's or stroke patients or patients who are  
confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits.  
Consider patients ability to adhere to the plan of care.  
A score of 4 or more is considered at risk for falling Total 3

Missouri Alliance for HOME CARE  
2426 Hyde Park, Suite A, Jefferson City, MO 65109-4731 - (573) 634-7772 - (573) 634-4374 Fax

(M1910) FALL RISK ASSESSMENT

Has this patient had a multi-factor Fall Risk Assessment using a standardized, validated assessment tool?  
 0 - NO.  
 1 - Yes, and it does not indicate a risk for falls.  
 2 - Yes, and it does indicate a risk for falls.

ALLERGIES

NKA  
Food allergies:  
 Peanuts  Shellfish  Eggs  Milk products Other:  
Medication allergies:  
 Penicillin  Codeine  Sulfa  Aspirin  Iodine Other:  
Other allergies:  
 Latex  Insect Bites  Tape  Pollen  
Please document specific signs and symptoms related to the above listed allergies/past allergic reactions:

MEDICATIONS

Medication change since last visit?  Yes  No  
Medication (include name, dose, route, freq, N/C, start/change date)

Effective:  Yes  No  Other

Orders obtained  
Skilled Medication Instruction:

- Drug/drug interactions
- Drug/food interactions
- Duration of therapy
- Medication(s) names
- Missed doses/what to do
- Other
- Proper disposal of sharps
- S/E contraindications

S/S allergic reaction  
Administered by:  Self  Family/Caregiver  Nurse  
 Other:

Skilled intervention: Medication administered during this skilled visit etc.

MEDICATIONS REVIEW

Drug Review completed per agency policy.

Medication regimen  completed  reviewed

Patient / caregiver knowledge deficits?  No  Yes, explain:

WHEN AND WHY TAKING MEDICATIONS

Presence of significant side effects?  No  Yes, explain:

Indications of noncompliance with medications?  No  Yes, explain:

Indications of ineffective drug therapy  No  Yes, explain:

Potential duplicate drug therapy?  No  Yes, explain:

Potential drug interactions?  No  Yes, explain:

(M2000) DRUG REGIMEN REVIEW

Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues

(for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance [non-adherence])?

- 0 - Not assessed/reviewed [ Go to M2010 ]
- 1 - No problems found during review [ Go to M2010 ]
- 2 - Problems found during review
- NA - Patient is not taking any medications [ Go to M2040 ]

(M2002) MEDICATION FOLLOW-UP

Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- 0 - No
- 1 - Yes

(M2010) PATIENT/CAREGIVER HIGH RISK DRUG EDUCATION

Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

- 0 - No
- 1 - Yes
- NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) MEDICATIONS

Management of Oral Medications:

Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
  - (a) individual dosages are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.
- 3 - Unable to take medication unless administered by another person.

NA - No oral medications prescribed.

Decline Reason:

Financial ability to pay for medications: Yes  Yes  No

(M2030) INJECTABLE MEDICATIONS

Management of Injectable Medications:

Patient's current ability to prepare and take all prescribed injectable medications reliably

and safely, including administration of correct dosage at the appropriate times/intervals.

Excludes IV medications.

- 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take injectable medication(s) at the correct times if:
  - (a) individual syringes are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection.
- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.

(M2046) PRIOR MEDICATION MANAGEMENT

Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation, or injury. Check only one box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> NA
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> NA

(M2192) TYPES AND SOURCES OF ASSISTANCE

Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. (Check only one box in each row.)

0 - No assistance needed patient is independent or does not have needs in this area  
 1 - Non-agency caregiver(s) currently provide assistance  
 2 - Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance  
 3 - Non-agency caregiver(s) need training/ supportive services to provide assistance  
 4 - Assistance needed, but no non-agency caregiver(s) available

Type of Assistance

a. <del>ADL assistance</del> transfer/ ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. IADL assistance (for example, meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. Medication administration (for example, oral, inhaled or injectable)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. Medical procedures/ treatments (for example, changing wound dressing, home exercise program)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e. Management of Equipment (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f. Supervision and safety (for example, due to cognitive impairment)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
g. Advocacy or facilitation of patient's participation in appropriate medical care (for example, transportation to or from appointments)	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

(M2110) ADL OR IADL ASSISTANCE

How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?  
 1 - At least daily  
 2 - Three or more times per week  
 3 - One to two times per week  
  
 4 - Received, but less often than weekly  
 5 - No assistance received  
 UX - Unknown

(M2200) THERAPY NEED

Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? [Enter zero ("000") if no therapy visits indicated.]  
Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).  
 NA - Not applicable: No case mix group defined by this assessment.

(M1021/M1023/M1025) DIAGNOSES, SYMPTOM CONTROL, AND OPTIONAL DIAGNOSES

Diagnoses, Symptom Control, and Optional Diagnoses: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-C M code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.  
Code each row according to the following directions for each column. Review the OASIS Guidance Manual for additional directions

on how to complete M1021, M1023, and M1025.

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.  
Column 2: Enter the ICD-10-C M code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-C M coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-C M codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care. Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

- 0 - Asymptomatic; no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty; affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of

the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.  
(OPTIONAL) There is no requirement that HRAs enter a diagnosis code in M1025 (Columns 3 and 4).

Diagnoses reported in M1025 will not impact payment.  
agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

a Z-code is reported in Column 2 AND

the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a

resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a

resolved underlying condition that requires multiple diagnosis codes under ICD-10-C M coding guidelines,

enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1021 Primary Diagnosis & (M1023) Other Diagnoses) (M1025) Optional Diagnoses (OPTIONAL) (not used for payment)  
 Column 1 Column 2 Column 3 Column 4  
 Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided) ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses  
 May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved  
 Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)

Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. <u>Encntr for surgical after following</u>	V, W, X, Y codes NOT allowed <u>Z48.815</u>	V, W, X, Y, Z codes NOT allowed a.	V, W, X, Y, Z codes NOT allowed a.
05/15/2016 [X] Onset [ ] Exac	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM
(M1023) Other Diagnoses	All ICD-10-CM codes allowed <u>Z43.2</u>	V, W, X, Y, Z codes NOT allowed b.	V, W, X, Y, Z codes NOT allowed b.
b. <u>Encounter for attention to ileostom</u>	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM
05/15/2016 [X] Onset [ ] Exac	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM
c. <u>Anxiety disorder, unspecified</u>	<u>F41.9</u>	c.	c.
05/15/2016 [ ] Onset [X] Exac	[ ] 0 [ ] 1 [X] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM
d.	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	d.	d.
[ ] Onset [ ] Exac	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM
e.	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	e.	e.
[ ] Onset [ ] Exac	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM
f.	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	f.	f.
[ ] Onset [ ] Exac	[ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4	ICD-10-CM	ICD-10-CM

(M2250) PLAN OF CARE SYNOPSIS  
 Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs/other clinical findings	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Patient does not have diabetes or does not have lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Falls risk assessment indicates patient has no risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2)

has some symptoms of depression but does

not meet criteria for further evaluation of depression based on screening tool used.

- e. Intervention(s) to monitor and mitigate pain  0  1  NA Pain assessment indicates patient has no pain.
- f. Intervention(s) to prevent pressure ulcers  0  1  NA Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
- g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing as requested by physician pressure ulcers for which moist wound healing is indicated.

APPLIANCES / SPECIAL EQUIPMENT / ORGANIZATIONS

Supportive Services / Assistance

- Lifeline  
 Meals on wheels

Appliances / Special Equipment

- Hospital bed  
 Transfer bench  
 Hoyer lift

- Grab bars: Bathroom / Other

- Bedside commode  
 Transfer board  
 Needs:

Home Medical Equipment

- DME Company Name Equipment Phone Number  
 DME Company Name Equipment Phone Number  
 Oxygen HME Co. Phone Number

Other organizations providing service

- Name Phone Number

INDICATIONS FOR SERVICES

- Indications For: Refused / Orders Obtained  
 Skilled Nursing ORDERS OBTAINED  
 Home Health Aide  
 Physical Therapy REFUSED  
 Occupational Therapy REFUSED

- Medical Social Worker  
 Speech Therapy  
 Dietician  
 Respiratory Therapist  
 Chaplain

Referrals Made  
 Service refused, refused reason and physician notification:

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

PATIENT HOME BOUND DUE TO ABDOMINAL WOUND. SKILLED NURSE FOR ADMISSION ASSESSMENT AND WOUND CARE AND EDUCATION. WOUND CARE PERFORMED TO MID ABDOMIN. WOUND VAC TURNED OFF, SOILED DRESSING REMOVED, BLACK FOAM REMOVED, WOUND BED CLEANSER WITH WOUND CLEANSER AND PAT DRY, DRAPE APPLIED AND BLACK FOAM APPLIED TO WOUND BED, COVERED WITH DRAPE AND D WOUND VAC APPLIED AT 125 CONTINUOUS. EDUCATION PROVIDED FOR INCREASED PROTEIN FOR WOUND HEALING AND MUSCLE STRENGTH. PATIENT VERBALIZED UNDERSTANDING. WILL CONTINUE TO MONITOR. PATIENT EDUCATION PROVIDED FOR WOUND VAC MUST BE ON FOR MINIMUM OF 24 HOURS, IF NOT WORKING FOR 2 HOURS, REMOVE AND APPLY NET TO DRY DRESSING. NET WITH NORMAL GALLI NE, SQUEEZE EXCESS OUT FLUFF IN WOUND AND COVER WITH ASA AND SECURE WITH TAPE. VERBALIZED UNDERSTANDING. WILL MONITOR. ENCOURAGED TO CALL IF UNABLE TO PERFORM NET TO DRY. REINFORCED SKILLED NURSE VISIT FREQUENCY AND 24 HOUR ON CALL NURSE.

LAB INTERVENTIONS

SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 via \_\_\_\_\_ (access device or port): using clean no touch technique, access device,  
 withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT 0 INR 0 PTT 0  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).  
 SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained urine via straight cath with 0 Fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_  
 Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input checked="" type="checkbox"/> Patient	<input checked="" type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- |  |   |  |
|--|---|--|
| <input checked="" type="checkbox"/> Medication regimen/administration      | <input checked="" type="checkbox"/> Universal precautions/handwashing | <input checked="" type="checkbox"/> Advance directives                                       |
| <input checked="" type="checkbox"/> Pain levels                            | <input checked="" type="checkbox"/> Basic home safety                 | <input checked="" type="checkbox"/> DNR/DNI  |
| <input checked="" type="checkbox"/> Treatment options                      | <input checked="" type="checkbox"/> Rights and responsibilities       | <input checked="" type="checkbox"/> Confidentiality  |
| <input checked="" type="checkbox"/> Disease progression                    | <input checked="" type="checkbox"/> HIPAA privacy                     | <input checked="" type="checkbox"/> Emergency planning in the event if service is disrupted. |
| <input checked="" type="checkbox"/> Agency phone number/after hours number | <input checked="" type="checkbox"/> State hotline number              |  |

Other

HOMEBOUND REASON

Unable to leave home without assistance due to:

Confusion / Dementia

Severe weakness

Fatigues easily

SOB with exertion

Medical restrictions

Physical Limitations

Unsteady gait

Balance issues

Mobility restrictions, Reason:

Pain with mobility

Environmental Barriers, Reason:

Psychiatric condition

Paranoia

Depression

Agoraphobia

Anxiety

Schizophrenia

Alzheimer's

Other:

REHAB POTENTIAL

REHAB POTENTIAL:

Patient will probably be able to perform ADL's and meet therapy needs independently.

Patient will not be able to meet therapy needs independently.

Good for full recovery.

Good for partial recovery.

Fair for full recovery.

Fair for partial recovery.

DISCHARGE PLANS

DISCHARGE PLANS:

Patient will be discharged when goals are met to an independent level & to follow up with Dr. at scheduled appointment.

Patient will be discharged to spouse/family care & to follow up with Dr. at scheduled appointment.

Patient will be discharged to the care of

when goals are met.

Discharge not anticipated at this time due to

COORDINATION OF CARE

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement

Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name GILBERTAS RINKUS

PT  OT  SLP  SS  SN  Aide

Other (specify)

CLINICAL MANAGER

<Goals> /Rehab. discussed with patient?

Yes

No

Discharge planning discussed with patient?

Verbal Order obtained 05/30/2016

YES  NO  N/A

PRN Order obtained

REFERRAL TO:

Next physician visit

Not Yet scheduled

Last physician visit

05/29/2016

Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit

Medically necessary home health services

SN

PT

ST

FTF Doctor

FTF Visit Reason

Physician's clinical findings to support above services

Page: 35 SOC/ROC ASSESSMENT  
Date: 05/30/2016 Patient: KNIGHT, DANIEL (11455656) Agent: FREDERICK, KIMBERLY, RN (FRE000245)  
Time In: 09:00 Time Out: 11:00

---

Physician's clinical findings to support homebound status

---

DIRECTIONS TO PATIENT'S HOME

701 SOUTH TOWARDS GEORGETOWN. LIVES IN MEMPHILL HOUSE NEAR END OF ROAD ON RIGHT. HAS BIG DOGS

---

Medication Tracking

Pharmacy: CMC OUTPATIENT PHARMACY

Phone: 843-347-8123

Allergies: PCN, SULFA

Profiles Initiated By: KIMBERLY FREDERICK

Date: 05/30/2016

Updated By:

Date:

---

Medication Profile

Medication 1

Start Date: 05/29/2016 D/C Date: New/Change: N Priority: 0

Drug: OXYCODONE HCL, OR, TABS, 10 MG

Dose: 10 MG

Route: ORAL

Frequency: FOUR TIMES DAILY

Instructions: FOUR TIMES DAILY FOR PAIN AS NEEDED

Medication 2

Start Date: 01/01/2016 D/C Date: New/Change: N Priority: 0

Drug: PROZAC, OR, CAPS, 20 MG

Dose: 20 MG

Route: ORAL

Frequency: DAILY

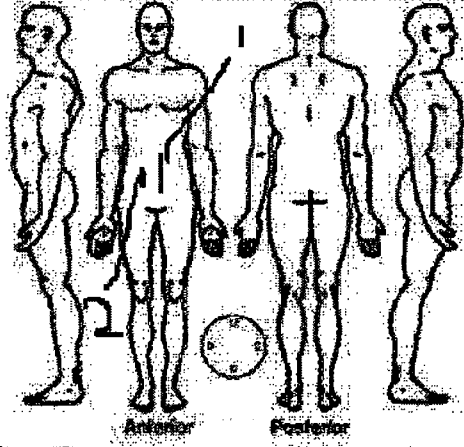
Instructions:

Signature: KIMBERLY FREDERICK, RN Date: 05/30/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/01/2016 MR#: I1455456  
 Agentcode: CUN000089

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site so that to include location.



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Clean: ASEPTIC		Surgical	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Type of Support Surface

- Preventative  Treatment  Wheelchair Cushion
- Mattress:
- Other:

Description of Wound Locations

Location 1: ABDOMEN Location 2: STOMA  
 Location 3: Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: SS A: SM	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	SP			
Undermining/Tunnelling (Y/N):	N			
Surrounding Tissue	WNL			
Edema/CGC				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/01/2016 MR#: I1455456

Agentcode: CUN000089 Agent Name: CUNNINGHAM, PATRICIA, LPN

Time in: 15:45 Time Out: 17:15

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	O = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
PP = Foul Purulent	L = Large	EP = Epithelialization	I = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

WOUND INTERVENTIONS

Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT

Wound cleaned with (specify):

NS/ WOUND CLEANSER

Wound irrigated with (specify):

Wound packed with (specify):

BLACK FOAM

Wound dressing applied (specify):

VAC DRAPE

Patient tolerated procedure well

Other (specify):

WOUND VAC CONNECTED AT 125 MM/HG CONTINUOUS SUCTION.

Satisfactory return demo:  Yes  No

Wound debridement

Drainage collection container emptied. Volume:

Medicated prior to wound care

Education:  Yes  No

Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing

Patient / Family / Caregiver to perform wound care / dressing change

Other:

Interventions/Instructions

PATIENT RESTING IN CHAIR WHEN SN INTO HOME. HAD APPT WITH SURGEON TODAY HAS ON WET TO DRY DSG AT THIS TIME. WOUND CARE DONE SEE WOUND ADDENDUM. COLOSTOMY CARE INSTRUCTED TO CAREGIVER AND SHE PERFORMED COLOSTOMY CARE WELL. INSTRUCTED TO GATHER ALL SUPPLIES WASH HANDS PUT ON GLOVES REMOVE POUCH AND DISPOSE. REMOVE GLOVES WASH HANDS REAPPLY GLOVES CLEAN AROUND STOMA AND THE STOMA ITSELF RINSE WELL PAT DRY APPLY BARRIER POWDER, USE BARRIER SPRAY THEN APPLY STOMAREHESIVE AROUND STOMA LEFT AIR DRY, ATTACH BAG TO BARRIER WAFFER APPLY AROUND STOMA, PRESS DOWN AROUND STOMA FIRMLY TO MAKE SURE BARRIER IS ATTACHED. CAN APPLY TAPE AROUND BARRIER RING FOR EXTRA SECURITY. CAREGIVER DID WELL FOLLOWING INSTRUCTIONS FOR OSTOMY CARE AND OSTOMY BAG APPLICATION. SN INSTRUCTED EAT WELL BALANCED DIET INCLUDING VEGETABLES, FRESH FRUITS. NEED START FOOD DIARY AND DOCUMENT ALL FOODS EATEN DAILY. TO HELP SEE WHICH FOODS CAN EAT WITH CUT PROBLEMS. NEED EAT SLOWLY, CHEW FOOD THOROUGHLY, AVOID GUM, SMOKING OR DRINKING THROUGH STRAW. TRY YOGURT OR BUTTERMILK TO HELP DECREASE GAS. AVOID FOODS LIKE FISH, ONIONS, GARLIC, BROCCOLI, ASPARAGAS AND CABBAGE. SN INSTRUCTED 24/7 ON

Record on Appeal 1402

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Pt. Name: KNIGHT, DANIEL Visit Date: 06/01/2016 MR#: T1455456

Agentcode: CUN000089 Agent Name: CUNNINGHAM, PATRICIA, LPN

Time in: 15:45 Time Out: 17:15

**WOUND INTERVENTIONS**

Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT

Wound cleaned with (specify):

NS/ WOUND CLEANSER

Wound irrigated with (specify):

Wound packed with (specify):

BLACK FOAM

Wound dressing applied (specify):

VAC DRAPE

Patient tolerated procedure well

Other (specify):

WOUND VAC CONNECTED AT 125 MM/HG CONTINUOUS SUCTION.

Satisfactory return demo:  Yes  No

Wound debridement

Drainage collection container emptied. Volume:

Medicated prior to wound care

Education:  Yes  No

Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing

Patient / Family / Caregiver to perform wound care / dressing change

Other:

CALL NURSE AND TO CALL IF PROBLEMS OCCUR.

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/01/2016 Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN000089)  
Time in: 15:45 Time Out: 17:15

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/01/2016 TIME IN [ ] AM [ ] PM 15:45 TIME OUT [ ] AM [ ] PM 17:15  
TYPE OF VISIT: [X] Skilled <Planned> / PRN / Infusion / <Wound care> [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: OBSERVATION AND HED EDUCATION

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract
- Infections
- Any surgeries
- Other
- Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
- Hearing Loss
- Aid used R / L
- Deaf: R / L
- Ear pain
- Tinnitus R / L
- Other:
- Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
- Dentures: Upper / Lower
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:
- Documentation of Skilled intervention / instruction / management problems:

**PAIN**  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:  
Check all that apply:

Description of pain:  
 Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying  
  
 Irritability  
 Tense  
 Restlessness  
 Vital signs changes  
 Diaphoresis

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
 Other:

Localized  
 Radiates

Pain Relieved By:  
Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:  
Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief:

How often is medication needed for breakthrough pain?  
 Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

**ENDOCRINE/HEMATOLOGY**

No Problem  
 Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse  
 Other:

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Venipuncture for  drawn from  space using  aseptic  sterile technique.  
 Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:  
Labs transported to laboratory via OSHA protocol.  
 Universal precautions / infection control maintained

**INTEGUMENTARY SYSTEM**

No problem  See wound addendum  New Wound

Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: <Good> / Fair / Poor  
Skin: Cool / Cyanotic / <Dry> / Diaphoretic / <Warm>

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS  
Height:  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual  
Blood Pressure:  Refused / Unable To Assess / Deferred Prior Weight:  Reported  Actual  
 Right /  Right Previous Weight:  Right /  Right  
Sitting  Left 102 / 72 Standing  Left / Lying  Left /  
Temperature:  Refused / Unable To Assess / Deferred  
Pulse: 98.6  Refused / Unable To Assess / Deferred  ORAL  AXILLARY  RECTAL  TYMPANIC  
 Apical  Brachial  <Regular> / Irregular  Radial 86  Carotid  Rest  Activity  
Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred 18  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals  
Diets  Low sodium diet  3 MEALS DAILY  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids  Restrict fluids  Restrict fluids

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (ant./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <active> / Hyperactive / Hypoactive X 4 quadrants

Absent X  Other

Last BM: 06/01/2016 Usual Frequency: Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal Stools: Blood / Gray / Tarry  
 Hemorrhoids:  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Bite:

HAS OSTOMY

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date  
Face/ankle: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 /+2 /+3 /+4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec /> 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior: Clear  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry /Acute /Chronic  
 Productive: Thick /Thin /Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 @ lpm per  
O2 saturation %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other: DENIES UTI S/S

Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency /frequency  Burning /pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):

Amount ml Frequency Returns  
Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
- Aphasia: Receptive / Expressive
- Motor change: Fine / Gross Site
- Hand grips: Equal / Unequal
- Weakness: UE / LE Location
- Tremors: Fine / Gross
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
- Inappropriate follow through in the past
- Documentation of Skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:
- Location
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
- Amputation: Right: BK / BK / UE Left: BK / BK / UE (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of Skilled intervention / instruction / management problems:

MEDICATIONS

Medication change since last visit?  Yes  No  
Medication (include name, dose, route, freq, N/C, start/change date)

Effective  Yes  No  Other  
 Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/E contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

PATIENT RESTING IN CHAIR WHEN SN INTO HOME. HAD APPT WITH SURGEON TODAY HAS ON WET TO DRY DSG AT THIS TIME. WOUND CARE DONE SEE WOUND ADDENDUM. COLOSTOMY CARE INSTRUCTED TO CAREGIVER AND SHE PERFORMED COLOSTOMY CARE WELL. INSTRUCTED TO GATHER ALL SUPPLIES WASH HANDS PUT ON GLOVES REMOVE POUCH AND DISPOSE. REMOVE GLOVES WASH HANDS REAPPLY GLOVES CLEAN AROUND STOMA AND THE STOMA ITSELF RINSE WELL PAT DRY APPLY BARRIER POWDER, USE BARRIER SPRAY THEN APPLY STOMACHESTIVE AROUND STOMA LEFT AIR DRY, ATTACH BAG TO BARRIER W APER APPLY AROUND STOMA, PRESS DOWN AROUND STOMA FIRMLY TO MAKE SURE BARRIER IS ATTACHED. CAN APPLY TAPE AROUND BARRIER RING FOR EZTRA SECURITY. CAREGIVER DID WELL FOLLOWING INSTRUCTIONS FOR OSTOMY CARE AND OSTOMY BAG APPLICATION. SN INSTRUCTED EAT WELL BALANCED DIET INCLUDING VEGETABLES, FRESH FRUITS. NEED START FOOD DIARY AND DOCUMENT ALL FOODS EATEN DAILY. TO HELP SEE WHICH FOODS CAN EAT WITH OUT PROBLEMS. NEED EAT SLOWLY, CHEW FOOD THOROUGHLY. ATOLD GUM, SMOKING OR DRINKING THROUGH STRAW. TRY YOGURT OR BUTTE RMLK TO HELP DECREASE GAS. AVOID FOODS LIKE FISH, ONIONS, GARLIC, BROCCOLI, ASPARAGAS AND CABBAGE. SN INSTRUCTED 24/7 ON CALL NURSE AND TO CALL IF PROBLEMS OCCUR.

LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBAIC  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBAIC  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 via \_\_\_\_\_ (access device or port): using clean no touch technique, \_\_\_\_\_ access device,  
 withdraw and discard \_\_\_\_\_ ml of blood, draw lab specimen, flush device with \_\_\_\_\_ ml SNS followed by \_\_\_\_\_ ml Heparin.
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT \_\_\_\_\_ INR \_\_\_\_\_ PTT \_\_\_\_\_  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained urine via straight cath with \_\_\_\_\_ in cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input checked="" type="checkbox"/> Patient <b>SEE BY</b>	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**HOMEBOUND REASON**

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
  - Unsteady gait
  - Balance issues
  - Mobility restrictions, Reason:
  - Pain with mobility
  - Environmental Barriers, Reason:
- Psychiatric condition
  - Paranoia
  - Depression
  - Agoraphobia
  - Anxiety
  - Schizophrenia
  - Alzheimer's
- Other:

**WRITTEN INSTRUCTIONS/MATERIALS PROVIDED**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Medication regimen/administration      | <input type="checkbox"/> Universal precautions/handwashing | <input type="checkbox"/> Advance directives                                       |
| <input type="checkbox"/> Pain levels                            | <input type="checkbox"/> Basic home safety                 | <input type="checkbox"/> DNR/DNI  |
| <input type="checkbox"/> Treatment options                      | <input type="checkbox"/> Rights and responsibilities       | <input type="checkbox"/> Confidentiality  |
| <input type="checkbox"/> Disease progression                    | <input type="checkbox"/> HIPAA privacy                     | <input type="checkbox"/> Emergency planning in the event if service is disrupted. |
| <input type="checkbox"/> Agency phone number/after hours number | <input type="checkbox"/> State hotline number              |   |
- Other

**SUPERVISORY VISIT (Complete if applicable.)**

- AIDE  PTA  CTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify \_\_\_\_\_  
 Staff was contacted regarding updated careplan If staff not present, specify date \_\_\_\_\_

**OBSERVATION OF**

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain: \_\_\_\_\_  
 TEACHING/TRAINING OF \_\_\_\_\_

NEXT SCHEDULED SUPERVISORY VISIT \_\_\_\_\_

**COORDINATION OF CARE**

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify) PATIENT CARE CONFERENCE  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?

Verbal Order obtained  YES  NO  N/A

PRN Order obtained

REFERRAL TO:

Next physician visit  Not Yet Scheduled Last physician visit 06/01/2016  Unknown

Billable supplies recorded

FACE TO FACE

Date of FTP Visit Medically necessary home health services  SN  PT  ST  
FTP Doctor  
FTP Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

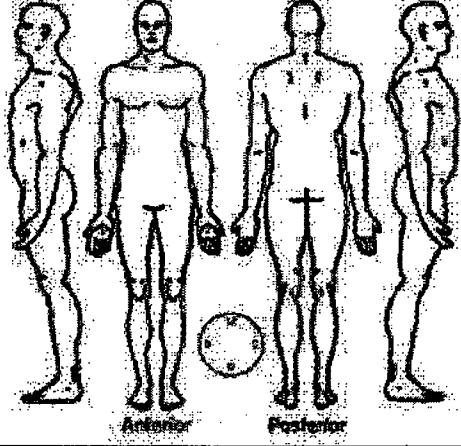
Signature: PATRICIA CUNNINGHAM, LPN Date: 06/01/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/03/2016 MR#: I1455456

Agencycode: RUC000016

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing appropriate information for each numbered site so that to include anatomy.



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[X] Clean: ASEPTIC		Surgical	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[ ] Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[ ] No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OTEEB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Type of Support Surface

Preventative  Treatment  Wheelchair Cushion

Mattress:

Other:

Description of Wound Locations

Location 1: MID ABD

Location 2:

Location 3:

Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: SS A: SM	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	E			
Undermining/Tunnelling (Y/N):	N			
Surrounding Tissue	WNL			
Edema/CGcr				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/03/2016 MR#: I1455456

Agent Code: RUC000018 Agent Name: RUCKMAN, NATALIE, RN

Time in: 14:00 Time Out: 14:51

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WOUND CLEANSER

 Wound irrigated with (specify): Wound packed with (specify):

1 PIECE OF BLACK SPONGE

 Wound dressing applied (specify):

DRAPE, SKIN PREP, WOUND VAC AT 125MM HG

 Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: 250 Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Homebound status: taxing effort to leave home, generalized weakness

Medical necessity: wound care, education

SN into see patient. Patient A+Cx3, VSS, sitting in chair. Lung sounds diminished to left side. Patient states this is normal for him since accident. Abd soft and nontender. Patient has new colostomy bag in place no leaks, stoma beefy red, brown liquid stool in bag. Wound care performed to abd no signs of infection noted. Reviewed signs of infection with patient such as fever, purulent drainage, odor or redness around site. Wound vac in place at 125mm hg and patient reminded to call for leaks and remove vac if not operating at 125mm hg for two hours and place wet to dry dressing. Patient educated on the need for protein for healing and to drink boost for additional protein patient had recent weight loss. Patient aware of 24hour on call nurse

Record on Appeal 1414

Signature: NATALIE RUCKMAN, RN

Date: 06/03/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/03/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0900018)  
Time in: 14:00 Time Out: 14:51

NURSING VISIT NOTE

Agency: Amadys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/03/2016 TIME IN: [ ] AM [ ] PM 14:00 TIME OUT: [ ] AM [ ] PM 14:51  
TYPE OF VISIT: [X] Skilled <Planned> / PRN / Infusion / <Wound care> [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: WOUND CARE, EDUCATION

EYES

[ ] No Problem Identified  
[ ] Contacts:  
[X] Glasses  
[ ] Blurred vision  
[ ] Glaucoma  
[ ] Cataract  
  
[ ] Infections  
[ ] Any surgeries  
[ ] Other  
  
[ ] Documentation of skilled intervention / instruction / management problems:

EARS

[X] No Problem Identified  
[ ] Hearing Loss  
[ ] Aid used R / L  
[ ] Deaf: R / L  
  
[ ] Ear pain  
[ ] Vertigo  
[ ] Tinnitus R / L  
  
[ ] Other:  
  
Documentation of skilled intervention / instruction / management problems:

NOSE

[X] No Problem Identified  
[ ] Congestion  
[ ] Sinus Infection  
[ ] Epistaxis  
[ ] Impaired sense of smell  
[ ] Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

[X] No Problem Identified  
[ ] Dentures: Upper / Lower  
  
[ ] Difficulty swallowing  
[ ] Lesions  
[ ] Hoarse  
[ ] Ulcerations  
[ ] Toothache  
[ ] Gum problems  
[ ] Chewing problems  
[ ] Other:  
  
[ ] Documentation of Skilled intervention / instruction / management problems:

PAIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABD any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
 Other:

Localized  
 Radiates

Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication: PERCOSET  
WELL PRESENT

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief: VARIES

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem  
 Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse  
 Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: / Other  
Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations  
/ Other

Venipuncture for  drawn from  space using  aseptic  sterile technique.  
 Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Specs transported to Laboratory via CSHA protocol.  
 Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: <Pale> / Jaundice / Redness  
Skin Turgor: Good / <Fair> / Poor  
Skin: Cool / Cyanotic / <Dry> / Diaphoretic / <Warm>

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred  
 Right 100 / 67  Left /  Right /  
Prior Weight: Previous Weight:

Sitting  Left / Standing  Left / Lying  Left /

Temperature:  Refused / Unable To Assess / Deferred  
97.1 F  ORAL  AXILLARY  RECTAL  TYMPANIC

Pulse:  Refused / Unable To Assess / Deferred  
 Apical 94  Brachial  <Regular> / Irregular  Radial  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred  
18  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals: 2-3 MEALS PER DAY  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other: LOW RESIDUAL  
 Increase fluids  Restrict fluids

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting  
 Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (ant./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds:  Active /  Hyperactive /  Hypoactive X 4 quadrants

Absent X  Other

Last BM 06/02/2016 Usual Frequency

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence

Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal Stools: Blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Site:

Documentation of skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> /  Irregular  Murmur

Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date

Pacemaker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Diminished  Right upper: Clear  
 Left lower: Diminished  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Diminished  Right upper: Clear  
 Left lower: Diminished  Right middle: Clear  
 Right lower: Clear  
 Accessory muscles used

Cough: Dry / Acute / Chronic  
 Productive: Thick / Thin / Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 @ \_\_\_\_\_ lpa per.  
O2 saturation 97 %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/Family

Other:  
 Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:  
Urinary Catheter:

Patient has catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):  
Amount ml Frequency Returns  
Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
  - Alert
  - Oriented <person> / <place> / <time>
  - Disoriented
  - Forgetful
  - Headaches
  - Comatose
  - Lethargic
  - Agitated
  - Anxiety
  - Difficulty coping with altered status
  - Pupils:  PERRLA  Unequal R / L
  - Aphasia: Receptive / Expressive
  - Motor change: Fine / Gross site
  - Hand grips: Equal / Unequal
  - Weakness: UE / LE Location
  - Tremors: Fine / Gross
  - Paralysis R / L Site
  - Hallucinations
  - Sleep / Rest  ADEQUATE  INADEQUATE
  - Inappropriate response to caregiver / clinician
  - Inappropriate follow through in the past
- Documentation of Skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:
- Location
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
- Amputation: Right: BK / BK / UE Left: BK / BK / UE (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of Skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)

- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/E contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Homebound status: taxing effort to leave home, generalized weakness Medical necessity: wound care, education SN into see patient. Patient R-0X3, V66, sitting in chair. Lung sounds diminished to left side. Patient states this is normal for him since accident. Abd soft and nontender. Patient has new colostomy bag in place no leaks, stoma beefy red, brown liquid stool in bag. Wound care performed to abd no signs of infection noted. Reviewed signs of infection with patient such as fever, purulent drainage, odor or redness around site. Wound vac in place at 125mm hg and patient reminded to call for leaks and remove vac if not operating at 125mm hg for two hours and place wet to dry dressing. Patient educated on the need for protein for healing and to drink boost for additional protein patient had recent weight loss. Patient aware of 24hour on call nurse

LAB INTERVENTIONS

- SN performed venipuncture to (location) using (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 to monitor

Specimen brought to Lab. Results to be forwarded to Dr.  
 SN obtained  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 via (access device or port): using clean no touch technique, access device,  
 withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 Specimen brought to Lab. Results to be forwarded to Dr.

- SN obtained PT-INR / PTT via finger stick using Coagulation Machine:  
 Results: PT 0 INR 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).

- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Specimen brought to Lab. Results to be forwarded to Dr.  
 SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Patient response  
 Specimen brought to Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications(list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / CG	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0006419)

Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
	<u>WOUND VAC AT 125MM HG AND REMOVE IF HOT AT 125MM HG FOR 2 HOURS PLACE WET TO DRY</u>					
Diet / Fluid management	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
	<u>BOOST FOR NUTRITION AND HEALING, PREVENT WEIGHT LOSS</u>					
Activity Guidelines	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's
- Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

SUPERVISORY VISIT (Complete if applicable.)

AIDS  PTA  CTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify  
 Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:  
 TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

Page: 9  
Date: 06/03/2016  
Time in: 14:00 Time Out: 14:51  
SKILLED NURSE VISIT NOTE  
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)

Reviewed / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit  Not Yet Scheduled Last physician visit 06/03/2016  Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

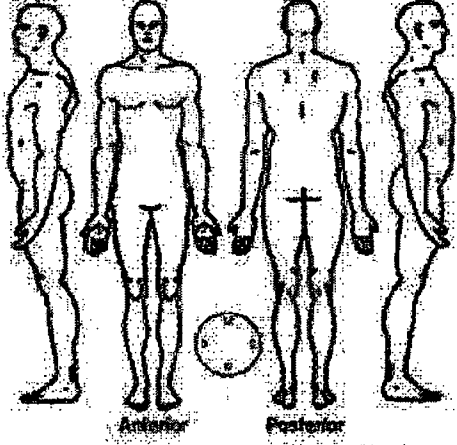
Physician's clinical findings to support homebound status

Signature: NATALIE RUCKMAN, RN Date: 06/03/2016

**WOUND ADDENDUM**

Pt. Name: KNIGHT, DANIEL Visit Date: 06/06/2016 MR#: I1455456  
 Agentcode: ATND00009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include color(s).



<input type="checkbox"/> NO WOUND	LOCATION#:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	[ ]	[ ]	[ ]
<input type="checkbox"/> Clean:		Surgical	[ ]	[ ]	[ ]
<input type="checkbox"/> Sterile		Skin Tear	[ ]	[ ]	[ ]
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	[ ]	[ ]	[ ]
		Arterial Ulcer	[ ]	[ ]	[ ]
		Neuropathic (Diab)	[ ]	[ ]	[ ]
		Stoma	[ ]	[ ]	[ ]
	OTHER	[ ]	[ ]	[ ]	

Type of Support Surface

- Preventative  Treatment  Wheelchair Cushion  
 Mattress:  
 Other:

Description of Wound Locations

Location 1: ABDOMEN Location 2:  
 Location 3: Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)	12.5 *2.0 *1.3 cm			
Drainage Amount/Type	T: SS A: C	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N):				
Surrounding Tissue	WNL			
Edema/CGer				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/06/2016 MR#: T1455456

AgentCode: ATW000009 Agent Name: ATWELL, KIMBERLY, LPN

Time in: 10:15 Time Out: 11:00

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	O = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC

 Wound irrigated with (specify): Wound packed with (specify):

MOISTENED GAUZE, COVERED WITH ABD PAD SECURED WITH TAPE.

 Wound dressing applied (specify): Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag; patient/wife changes colostomy bag and wafer with no complications. wound vac was removed and disposed of, a 3.2x3.2 opening in the middle of the mid abdominal surgical wound is draining copious amounts of SS drainage, no odor, no elevated temp, Dr. Rinkus office was notified, patient will go for a f/u appoint in the morning, orders not to reapply the wound vac, however to apply wet/dry dressing, bid. patient voiced understanding. labs will be obtained at the next visit, d/t patient has already ate & drank this AM. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

Record on Appeal 1425

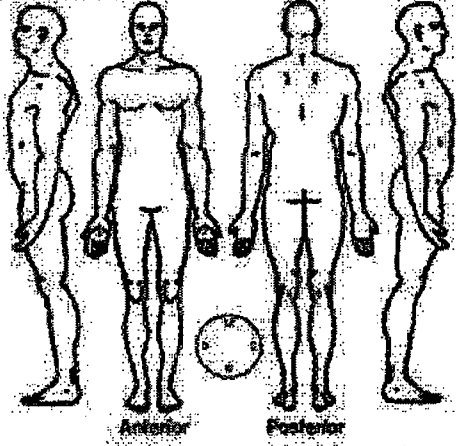
Signature: KIMBERLY ATWELL, LPN

Date: 08/06/2016

**WOUND ADDENDUM**

Pt. Name: KNIGHT, DANIEL Visit Date: 06/08/2016 MR#: I1455456  
 Agentcode: RUC000018

Denote location of specific skin conditions/wounds by number(s) appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include column(s).



<input type="checkbox"/> NO WOUND	<b>LOCATION:</b>	#1	#2	#3	#4
Technique used for wound care:	<b>TYPE OF WOUND</b>	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Clean: ASEPTIC		Surgical	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Type of Support Surface**

- Preventative  Treatment  Wheelchair Cushion
- Mattress:
- Other:

**Description of Wound Locations**

Location 1: ABD Location 2:  
 Location 3: Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: P A: SM	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)	Y			
Surrounding Tissue	WNL			
Edema/Color				

Other:

**Stage of Wound / Thickness**

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/09/2016 MR#: T1455456

Agentcode: RUC000018 Agent Name: RUCKMAN, NATALIE, RN

Time in: 11:10 Time Out: 11:45

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Sciled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC AND SALINE

 Wound irrigated with (specify): Wound packed with (specify):

SALINE DAMP GAUZE

 Wound dressing applied (specify):

ADD PAD AND TAPE

 Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of sciled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Homebound status: generalized weakness

medical necessity: prn visit for colostomy care and wound care

SN into see patient. Patient A+CX3, the patient called very anxious because his colostomy bag was leaking and his wife who usually places the bag for him is not home. Upon arriving patient had stool leaking over abd and legs. Patient's dressing to abd has stool in it. SN cleaned patient with wound cleanser and saline. New colostomy bag attached no leaks present. Wet to dry dressing placed in abd wound per new orders from doctor. Patient has yellow, thick drainage but reports doctor has not started antibiotic treatment at this time. Patient saw doctor on Monday. Patient to return on 6/14 for re eval from doctor. SN reviewed wet to dry dressing and change instructions with patient and packing wound. Patient aware of 24hour on call nurse

Record on Appeal 1427

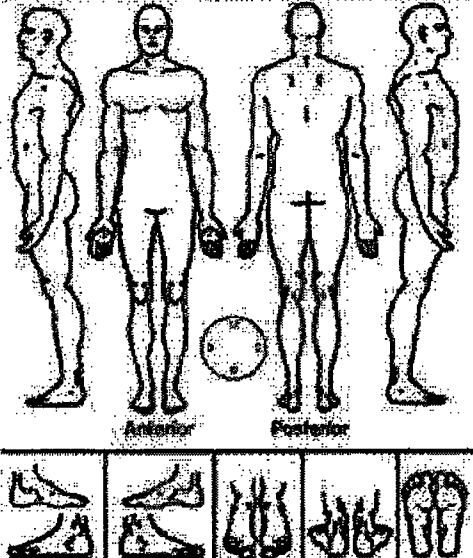
Signature: NATALIE RUCKMAN, RN

Date: 06/08/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/08/2016 MR#: I1455456  
 Agent code: ATW000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include color/size.



<input type="checkbox"/> NO WOUND	LOCATION #:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clean:		Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Support Surface						
<input type="checkbox"/> Preventative <input type="checkbox"/> Treatment <input type="checkbox"/> Wheelchair Cushion <input type="checkbox"/> Mattress: <input type="checkbox"/> Other:						

Description of Wound Locations

Location 1: ABDOMEN Location 2:  
 Location 3: Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: SS A: MOD	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)				
Surrounding Tissue	WNL			
Edema/CGer				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/08/2016 MR#: T1455456

Agentcode: ATW000009 Agent Name: ATWELL, KIMBERLY, LPN

Time in: 09:00 Time Out: 10:00

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odeur	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC

 Wound irrigated with (specify): Wound packed with (specify):

MOISTENED GAUZE COVERED WITH ABD PAD

 Wound dressing applied (specify): Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications, however he ask would I change it today so his wife would not have to do it tonight. wound vac was d/e d/t infection in the opening of the wound, no antibiotics were given, only to clean area with WC, change wet/dry dressing bid until return appointment in 1 week. (see wound addendum) continues draining SS drainage, no odor, no elevated temp, labs to obtain abc, cmp was drawn from the right AC and transported to CMC. educated on diet high in protein to promote the healing process. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

Record on Appeal 1429

Signature: KIMBERLY ATWELL, LPN

Date: 06/08/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/09/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC090610)  
Time in: 11:10 Time Out: 11:45

NURSING VISIT NOTE

Agency: Amadys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/08/2016 TIME IN: 11:10 TIME OUT: 11:45  
TYPE OF VISIT:  Skilled Planned /<PRN> /infusion /<Wound care>  Skilled & Supervisory  Supervisory Only  
 Other  
Reason for visit: PRN COLOSTOMY AND WOUND VISIT

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract
- Infections
- Any surgeries
- Other:

Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
- Hearing Loss
- Aid used R / L
- Deaf: R / L
- Ear pain
- Vertigo
- Tinnitus R / L
- Other:

Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
- Dentures: Upper / Lower
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:

Documentation of Skilled intervention / instruction / management problems:

**PAIN**  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Stabbing  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying  
  
 Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
 Other:

Localized  
 Radiates

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A

Duration of Relief:

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

**ENDOCRINE/HEMATOLOGY**

No Problem  
 Blood sugar ranges  Patient /Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Venipuncture for drawn from space using  aseptic  sterile techniques.

Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Leads transported to

laboratory via CSMR protocol.

Universal precautions / infection control maintained

**INTEGUMENTARY SYSTEM**

No problem  See wound addendum  New Wound

Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: <Pale> / Jaundice / Redness  
Skin Turgor: Good / <Fair> / Poor  
Skin: Cool / Cyanotic / <Dry> / Diaphoretic / <Warm>

Highlight all applicable conditions listed:  
Abrasions / <Bruises> / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred Prior Weight:  
 Right /  Right Previous Weight:  
 Right /

Sitting  Left 102 / 60 Standing  Left / Lying  Left /

Temperature:  Refused / Unable To Assess / Deferred  
98.2 F  ORAL  AXILLARY  RECTAL  TYMPANIC

Pulse:  Refused / Unable To Assess / Deferred  
 Apical 102  Brachial  <Regular> / Irregular  Radial  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred  
16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals  
Diets  Low sodium diet  3 MEALS PER DAY  
 Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids ant.  Restrict fluids ant.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Readings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <active> / Hyperactive / Hypoactive X 4 quadrants

Absent X quadrants  Other

Last BM 06/08/2016 Usual Frequency

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence

Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction

Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: blood / Gray / Tarry

Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  Sigmoid  Transverse

Assessment of Bite:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur

Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date

Face/ankle: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior: Clear  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry / Acute / Chronic  
 Productive: Thick / Thin / Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 @ lpm per %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify): Amount ml Frequency Returns

Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / gross site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
  
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
  
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
  
- Contractures:
- Location
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
  
- Amputation: Right: BK / BK / UE Left: BL / BK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

Medication change since last visit?  Yes  No  
Medication (include name, dose, route, freq, N/C, start/change date)

Effective  Yes  No  Other  
 Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/E contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Homebound status: generalized weakness medical necessity: n/n visit for colostomy care and wound care SN into see patient. Patient A/Cx3, the patient called very anxious because his colostomy bag was leaking and his wife who usually places the bag for him is not home. Upon arriving patient had stool leaking over abd and legs. Patient's dressing to abd has stool in it. SN cleaned patient with wound cleanser and saline. New colostomy bag attached no leaks present. Wet to dry dressing placed in abd wound per new orders from doctor. Patient has yellow, thick drainage but reports doctor has not started antibiotic treatment at this time. Patient saw doctor on Monday. Patient to return on 6/14 for re eval from doctor. SN reviewed wet to dry dressing and change instructions with patient and packing wound. Patient aware of 24hour on call nurse

LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_

Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_

via \_\_\_\_\_ (access device or port): using clean no touch technique, access device, withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.

- SN obtained PT-INR / PTT via finger stick using Coagulation Machine. Lab. Results to be forwarded to Dr.

Results: PT 0 INR 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).

- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_

Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_

Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

WET TO DRY DRESSING CHANGE, COLOSTOMY BAG CHANGE

	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet / Fluid management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activity Guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADL's / Self-care tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety Factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifestyle adjustments/Coping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical limitations
- Unsteady gait  Balance issues  Mobility restrictions, Reason:
- Pain with mobility  Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia  Depression  Agoraphobia  Anxiety  Schizophrenia  Alzheimer's
- Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other:

SUPERVISORY VISIT (Complete if applicable.)

- AIDS  PTA  CIA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify  Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:

TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit 06/16/2016  Not Yet Scheduled Last physician visit  Unknown

Billable supplies recorded

FACE TO FACE  
Date of FTF Visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

Signature: NATALIE RUCKMAN, RN Date: 06/08/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/09/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)  
Time In: 09:00 Time Out: 10:00

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/08/2016 TIME IN [ ] AM [ ] PM 09:00 TIME OUT [ ] AM [ ] PM 10:00  
TYPE OF VISIT: [X] skilled <Planned> / PRN / Infusion / Wound care [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: WOUND VAC

EYES

- No Problem Identified
  - Contacts:
  - glasses
  - Blurred vision
  - Glaucoma
  - Cataract
  - Infections
  - Any surgeries
  - Other
- Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
  - Hearing Loss
  - Aid used R / L
  - Deaf: R / L
  - Ear pain
  - Vertigo
  - Tinnitus R / L
  - Other:
- Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
  - Congestion
  - Sinus Infection
  - Epistaxis
  - Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
  - Dentures: Upper / Lower
  - Difficulty swallowing
  - Lesions
  - Hoarse
  - Ulcerations
  - Toothache
  - Gum problems
  - Chewing problems
  - Other:
- Documentation of Skilled intervention / instruction / management problems:



Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:

Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred Prior Weight:  
 Right 102 / 60  Right / Previous Weight:  
 Right /

Sitting  Left / Standing  Left / Lying  Left /

Temperature:  Refused / Unable To Assess / Deferred  
98.3 F  ORAL  AXILARY  RECTAL  TYMPANIC  
Pulse:  Refused / Unable To Assess / Deferred

Apical  Brachial  <Regular> / Irregular  Radial 92  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc

Respirations:  Refused / Unable To Assess / Deferred  
16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.

Documentation of skilled intervention / instruction / management problems:

978

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals THREE TIMES PLUS SNACKS  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet

Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids ant.  Restrict fluids ant.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis/blood / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other

Frequency of Abnormal Symptoms

Enteral

N/A  No Problem

Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Bite care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds:  Active / Hyperactive  Hypoactive X 4 quadrants

Absent X  Other

Last BM 06/08/2016 Usual Frequency Every day

Incontinence of stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Site:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  Regular / Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 e Date  
Pacemaker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:  
 Upper Extremities Right / Left

Pitting +1 /+2 /+3 /+4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec /> 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry /Acute /Chronic  Unable to cough up secretions  
 Productive: Thick /Thin /Frothy Sputum Color Amount

Oxygen:

O2 @ \_\_\_\_\_ lpm per \_\_\_\_\_  
O2 saturation \_\_\_\_\_ %  N/A  
Does this patient have a trach?  YES  NO  
Who manages?  Self  RN  Cg/family

Other:  
 Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency /frequency  Burning /pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria  
 Incontinence (details if applicable)

Diapers/other:  
Urinary Catheter:

Patient has Catheter

Type:  
 Foley  
 Suprapubic  
 Intermittent  
 Condon  
 Other:  
 Skilled catheter care with French  
 Foley inserted (date) \_\_\_\_\_  
 Skill / Foley catheter care / Change \_\_\_\_\_  
Inflated balloon with \_\_\_\_\_ ml  without difficulty

Irrigation solution: Type (specify): \_\_\_\_\_ Returns  
Amount \_\_\_\_\_ ml Frequency \_\_\_\_\_  
Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / Gross Site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
  
- Inappropriate follow through in the past
- Documentation of Skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
  
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
  
- Contractures:
- Location
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALISED
  
- Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)
  
- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications, however he ask would I change it today so his wife would not have to do it tonight. wound was d/c d/t infection in the opening of the wound, no antibiotics were given, only to clean area with WC, change wet/dry dressing bid until return appointment in 1 week. (see wound addendum) continues draining SS drainage, no odor, no elevated temp, labs to obtain cbc, cmp was drawn from the right AC and transported to CMC. educated on diet high in protein to promote the healing process. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

LAB INTERVENTIONS

SN performed venipuncture to RT AC (location) using BUTTERFLY (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other

to monitor LABS

Specimen brought to CMC Lab. Results to be forwarded to Dr. RACHEL COLLINS  
 SN obtained  PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other

via (access device or port): using clean no touch technique, access device, withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 Specimen brought to Lab. Results to be forwarded to Dr.  
 SN obtained PT-INR / PTT via finger stick using Coagulation Machine.

Results: PT 0 INR 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).

SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Specimen brought to Lab. Results to be forwarded to Dr.  
 SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Patient response Lab. Results to be forwarded to Dr.  
 Specimen brought to

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning s/s to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000909)

Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<b>AS TOLERATED</b>		<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's
- Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

SUPERVISORY VISIT [Complete if applicable.]

AIDS  PTA  CTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify  
 Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:  
 TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals /Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit  Not Yet Scheduled Last physician visit 06/07/2016  Unknown

Billable supplies recorded

FACE TO FACE  
Date of FTF visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

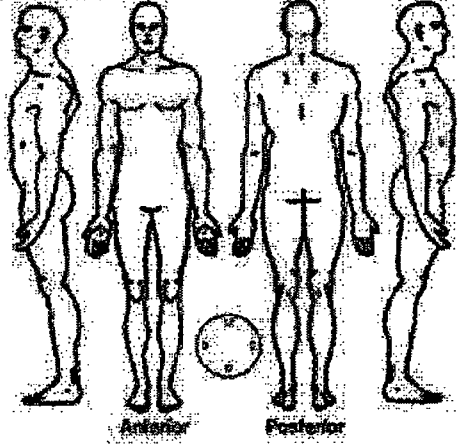
Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/08/2016

**WOUND ADDENDUM**

Pt. Name: KNIGHT, DANIEL Visit Date: 06/10/2016 MR#: I1455456  
 Agentcode: ATW000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing appropriate information for each numbered site on chart to include column(s).



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care: <input type="checkbox"/> Clean: <input type="checkbox"/> Sterile <input type="checkbox"/> No Touch:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Type of Support Surface

Preventative  Treatment  Wheelchair Cushion

Mattress:

Other:

**Description of Wound Locations**

Location 1: ABDOMEN Location 2:  
 Location 3: Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)	12.0 *1.0 *1.0 cm			
Drainage Amount/Type	T: SS A: SM	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)				
Surrounding Tissue	WNL			
Edema/Color				

Other:  
 opening in center of surgical wound 0.2 x 0.2 x 2.0

**Stage of Wound / Thickness**

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/10/2016 MR#: T1455456

Agentcode: ATW000009 Agent Name: ATWELL, KIMBERLY, LPN

Time in: 09:00 Time Out: 09:30

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odeor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	I = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

WOUND INTERVENTIONS

Wound care done: [ ] Yes [X] No

Location(s) if patient has more than one wound site:

[X] Soiled dressing removed By: [ ] Patient [ ] Caregiver [ ] Family [X] RN/PT

[X] Wound cleaned with (specify):

WC

[ ] Wound irrigated with (specify):

[X] Wound packed with (specify):

MOIST WET/DRY DRESSING

[ ] Wound dressing applied (specify):

[X] Patient tolerated procedure well

[ ] Other (specify):

Satisfactory return demo: [ ] Yes [ ] No

[ ] Wound debridement

[ ] Drainage collection container emptied. Volume:

[ ] Medicated prior to wound care

Education: [ ] Yes [ ] No

[ ] Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing

[ ] Patient / Family / Caregiver to perform wound care / dressing change

[ ] Other:

Interventions/Instructions

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. dressing was removed and disposed of, a 0.2x0.2 opening in the middle of the mid abdominal surgical wound is draining small amounts of SS drainage, no odor, no elevated temp, Dr. Rimkus office is aware of this, did not wish to use antibiotics at this time, did order the wound vac not be placed back on until he comes back to the office for f/u. He and his wife are educated to change wet/dry dressing. labs will be obtained next week. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/10/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000091)  
Time in: 09:00 Time Out: 09:30

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/10/2016 TIME IN: [ ] AM [ ] PM 09:00 TIME OUT: [ ] AM [ ] PM 09:30  
TYPE OF VISIT: [X] Skilled <Planned> / PRN / Infusion / Wound care [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: WOUND CARE

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract
  
- Infections
- Any surgeries
- Other:
  
- Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
- Hearing Loss
- Aid used R / L
- Deaf: R / L
- Ear pain
- Vertigo
- Tinnitus R / L
- Other:
  
- Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
- Dentures: Upper / Lower
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:
  
- Documentation of Skilled intervention / instruction / management problems:

PAIN

No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)

0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying  
  
 Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Imobility  
 Other:

Localized  
 Radiates

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A

Duration of Relief:

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem

Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: / Other  
Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Venipuncture for drawn from space using  aseptic  sterile technique.

Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Specs transported to laboratory via OSHA protocol.

Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem

See wound addendum  New Wound

Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred  Right 128 / 78  Left  Right  
Prior Weight:  Reported  Actual  
Previous Weight:  Right

Sitting  Left  Right Standing  Left  Right Lying  Left  Right

Temperature:  Refused / Unable To Assess / Deferred 99.2 F  ORAL  AXILLARY  RECTAL  TYMPANIC  
Pulse:  Refused / Unable To Assess / Deferred

Apical  Brachial  <Regular> / Irregular  Radial 98  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred 16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

98t

Gastrointestinal

Nutritional status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals: SEVERAL SMALL MEALS DAILY  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids ant.  Restrict fluids ant.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Bite care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: [amt./specify]

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> /Hyperactive /Hypoactive X 4 quadrants

Absent X quads  Other

Last BM: 06/10/2016 Usual Frequency: Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery /Black /Mucous /Pain /Odor Amount

Current treatment:

Abnormal Stools: Blood /Gray /Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Bite:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> /Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date  
Pacemaker: Date Type  
 No Edema

Edema:  Lower Extremities Right /Left  Sacral  Dependent:  
 Upper Extremities Right /Left

Pitting +1 /+2 /+3 /+4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used  
 Cough:

Dry / Acute / Chronic

Productive: Thick / Thin / Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 @ \_\_\_\_\_ lpm per \_\_\_\_\_  
O2 saturation \_\_\_\_\_ %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condon  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):

Amount ml Frequency

Returns

Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxious
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / gross site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
  
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:
- Location:
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
  
- Amputation: Right: BK / BK / UE Left: BK / BK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

Medication change since last visit?  Yes  No  
Medication (include name, dose, route, freq, N/C, start/change date)

Effective  Yes  No  Other  
 Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. Dressing was removed and disposed of, a 0.2x0.2 opening in the middle of the mid abdominal surgical wound is draining small amounts of SS drainage, no odor, no elevated temp, Dr. Rinkus office is aware of this, did not wish to use antibiotics at this time, did order the wound vac not be placed back on until he comes back to the office for f/u. He and his wife are educated to change wet/dry dressing. Labs will be obtained next week. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 via \_\_\_\_\_ (access device or port): using clean no touch technique, access device,  
 withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_
- SN obtained PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT 0 INR 0 PTT 0  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_  
 Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient <u>NO PAIN NOTED</u>	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<b>AS TOLERATED</b>		<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
  - Unsteady gait
  - Pain with mobility
  - Psychiatric condition
    - Paranoia
    - Depression
    - Agoraphobia
    - Anxiety
    - Schizophrenia
    - Alzheimer's
  - Other:
- Balance issues
- Mobility restrictions, Reason:
- Environmental Barriers, Reason:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

SUPERVISORY VISIT (Complete if applicable.)

- AIDE
- PTA
- CNA
- LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify \_\_\_\_\_  
 Staff was contacted regarding updated careplan If staff not present, specify date \_\_\_\_\_

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain: \_\_\_\_\_  
 TEACHING/TRAINING OF \_\_\_\_\_

NEXT SCHEDULED SUPERVISORY VISIT \_\_\_\_\_

COORDINATION OF CARE

PLAN OF CARE: \_\_\_\_\_

**SKILLED NURSE VISIT NOTE**

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name

PT  OT  SLP  SS  SN  Aide  Other (specify)

Goals /Rehab. discussed with patient?

Yes  No

Discharge planning discussed with patient?

Verbal Order obtained

YES  NO  N/A

PRN Order obtained

REFERRAL TO:

Next physician visit

Not Yet Scheduled

Last physician visit

Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit

Medically necessary home health services

SN  PT  ST

FTF Doctor

FTF Visit Reason

Physician's clinical findings to support above services

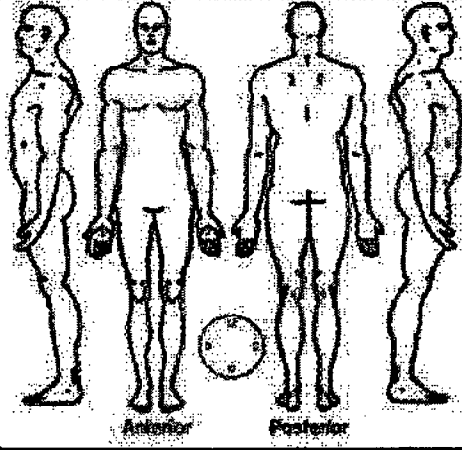
Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/10/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/13/2016 MR#: I1455456  
 Agentcode: ATN000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include etiology.



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clean:		Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Support Surface

- Preventative  Treatment  Wheelchair Cushion
- Mattress:
- Other:

Description of Wound Locations

Location 1: ABD Location 2:  
 Location 3: Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: SS A: SC	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)	N			
Surrounding Tissue	WNL			
Edema/Color				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/13/2016 MR#: I1455456

Agentcode: ATN000009 Agent Name: ATWELL, KIMBERLY, LPN

Time in: 09:40 Time Out: 10:15

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odor	R = Red
SS = Serousanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	I = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC

 Wound irrigated with (specify): Wound packed with (specify):

MOISTENED GAUZE, 4X4, ABD PAD SECURED WITH TAPE

 Wound dressing applied (specify): Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changed colostomy bag and wafer with no complications. dressing was removed and disposed of, a 0.2x0.2 opening in the middle of the mid abdominal surgical wound is draining small amounts of SS drainage, no odor, no elevated temp, Dr. Rimkus office is aware of this, did not wish to use antibiotics at this time, did order the wound vac not be placed back on until he comes back to the office for f/u. He and his wife are educated to change wet/dry dressing. labs will be obtained next week. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

Record on Appeal 1460

Signature: KIMBERLY ATWELL, LPN

Date: 06/13/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/13/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)  
Time in: 09:40 Time Out: 10:15

NURSING VISIT NOTE

Agency: Anadisy's Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/13/2016 TIME IN: [ ] AM [ ] PM 09:40 TIME OUT: [ ] AM [ ] PM 10:15  
TYPE OF VISIT: [X] Skilled <Planned> / PRN / Infusion / Wound care [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: SN VISIT AND WOUND CARE

EYES

[ ] No Problem Identified  
[ ] Contacts:  
[X] glasses  
[ ] Blurred vision  
[ ] Glaucoma  
[ ] Cataract  
[ ] Infections  
[ ] Any surgeries  
[ ] Other  
[ ] Documentation of skilled intervention / instruction / management problems:

EARS

[X] No Problem Identified  
[ ] Hearing Loss  
[ ] Aid used R / L  
[ ] Deaf: R / L  
[ ] Ear pain  
[ ] Vertigo  
[ ] Tinnitus R / L  
[ ] Other:  
Documentation of skilled intervention / instruction / management problems:

NOSE

[X] No Problem Identified  
[ ] Congestion  
[ ] Sinus Infection  
[ ] Epistaxis  
[ ] Impaired sense of smell  
[ ] Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

[X] No Problem Identified  
[ ] Dentures: Upper / Lower  
[ ] Difficulty swallowing  
[ ] Lesions  
[ ] Hoarse  
[ ] Ulcerations  
[ ] Toothache  
[ ] Gum problems  
[ ] Chewing problems  
[ ] Other:  
[ ] Documentation of Skilled intervention / instruction / management problems:

PRIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:  
Check all that apply:

Description of pain:	Effect on patient:	Frequency of pain:	Aggravating factors:
<input type="checkbox"/> Dull ache	<input type="checkbox"/> Appetite	<input type="checkbox"/> Occasional	<input type="checkbox"/> Movement
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Activity	<input type="checkbox"/> Always present	<input type="checkbox"/> Ambulation
<input type="checkbox"/> Pressure/heaviness	<input type="checkbox"/> Sleep	<input type="checkbox"/> Comes and goes	<input type="checkbox"/> Immobility
<input type="checkbox"/> Burning	<input type="checkbox"/> Anger	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Shooting	<input type="checkbox"/> Moaning		
<input type="checkbox"/> Sharp	<input type="checkbox"/> Crying		
<input type="checkbox"/> Localized	<input type="checkbox"/> Irritability		
<input type="checkbox"/> Radiates	<input type="checkbox"/> Tense		
	<input type="checkbox"/> Restlessness		
	<input type="checkbox"/> Vital sign changes		
	<input type="checkbox"/> Diaphoresis		

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication: N/A LAST NIGHT

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief: N/A

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem  
 Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse  
 Other

Frequency of monitoring

Competency with use of Glucometer  lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness  
/ Other  
 Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations  
/ Other

Venipuncture for drawn from space using  aseptic  sterile technique.  
 Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:  
labs transported to laboratory via CSHA protocol.  
 Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound  
 Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS -  
Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred Prior Weight:  
 Right 102 / 60  Right / Previous Weight:  
Sitting  Left / Standing  Left / Lying  Left /  
Temperature:  Refused / Unable To Assess / Deferred  
Pulse:  Refused / Unable To Assess / Deferred  ORAL  AXILLARY  RECTAL  TYMPANIC  
 Apical  Brachial  <Regular> / Irregular  Radial 90  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred  
16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

938

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic  
Eating Patterns / Frequency of Meals  
Diets  Low sodium diet  TERRE MEALS PLUS SNACKS  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids  Restrict fluids  Restrict fluids

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis/blood / Coffee Grounds / Bile (green / yellow) / Fecal vomiting  
 Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (ant./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent X quads  Other

Last BM: 06/13/2016 Usual Frequency Every day

Incontinence of stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence

Measurements of Ascites: Inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction

Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Site:

Documentation of skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur

Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date

Pacemaker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Accessory muscles used  Right lower: Clear

Cough: Dry / Acute / Chronic  
 Productive: Thick / Thin / Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 % lpm per %  N/A  
O2 saturation %  YES  NO  
Does this patient have a trach?  
Who manages?  Self  RN  Cg/family

Other:  
 Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's  
 Orthopnea  Other:  
 Blackouts  Fainting  Dizziness  
Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged  
 Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)  
Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria  
 Incontinence (details if applicable)

Diapers/other:  
Urinary Catheter:  
 Patient has Catheter

Type:  
 Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):  
Amount ml Frequency Returns  
Patient tolerated procedure well  YES  NO  
 Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / Gross Site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
  
- Inappropriate follow through in the past
- Documentation of Skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
  
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
  
- Contractures:
- Location
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
  
- Amputation: Right: BK / BK / UE Left: BK / BK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of Skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)
  
- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional skilled intervention / skilled instruction

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LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 via \_\_\_\_\_ (access device or port): using clean no touch technique, access device,  
 withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_
- SN obtained PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT 0 INR 0 PTT 0  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_  
 Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
<b>NO S/S OF INFECTION</b>						
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW00009)

Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
	<b>AS TOLERATED</b>					
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**HOMEBOUND REASON**

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's
- Other:

**WRITTEN INSTRUCTIONS/MATERIALS PROVIDED**

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other:

**SUPERVISORY VISIT (Complete if applicable.)**

- AIDE
- PTA
- OTA
- LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify \_\_\_\_\_  
 Staff was contacted regarding updated careplan If staff not present, specify date \_\_\_\_\_

**OBSERVATION OF**

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain: \_\_\_\_\_  
 TEACHING/TRAINING OF \_\_\_\_\_

NEXT SCHEDULED SUPERVISORY VISIT \_\_\_\_\_

**COORDINATION OF CARE**

PLAN OF CARE: \_\_\_\_\_

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name

PT  OT  SLP  SS  SN  Aide  Other (specify)

Goals / Rehab. discussed with patient?

Yes  No

Discharge planning discussed with patient?

Verbal Order obtained

YES  NO  N/A

PRN Order obtained

REFERRAL TO:

Next physician visit

Not Yet Scheduled

Last physician visit

Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit

Medically necessary home health services

SN  PT  ST

FTF Doctor

FTF Visit Reason

Physician's clinical findings to support above services

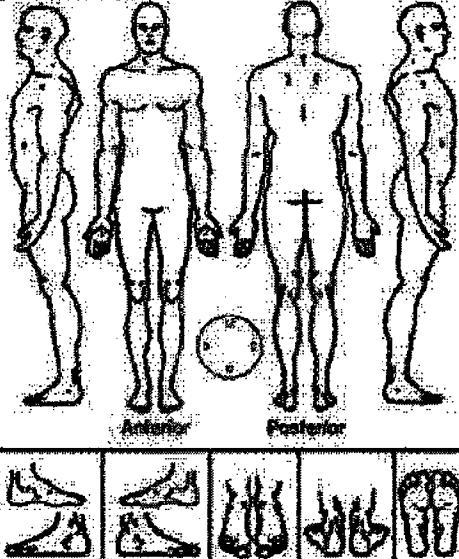
Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/13/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/15/2016 MR#: I1455456  
 Agentcode: ATW000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include color(s).



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care: <input type="checkbox"/> Clean: <input type="checkbox"/> Sterile <input type="checkbox"/> No Touch:	TYPE OF WOUND	Pressure Ulcer	[ ]	[ ]	[ ]	[ ]
		Surgical	[ ]	[ ]	[ ]	[ ]
		Skin Tear	[ ]	[ ]	[ ]	[ ]
		Venous Ulcer (Sta)	[ ]	[ ]	[ ]	[ ]
		Arterial Ulcer	[ ]	[ ]	[ ]	[ ]
		Neuropathic (Diab)	[ ]	[ ]	[ ]	[ ]
		Stoma	[ ]	[ ]	[ ]	[ ]
OTHER	[ ]	[ ]	[ ]	[ ]		

Type of Support Surface

Preventative  Treatment  Wheelchair Cushion

Mattress:

Other:

Description of Wound Locations

Location 1: MID LINE ABDOMEN  
 Location 3:

Location 2:  
 Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: SS A: MOD	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)	Y			
Surrounding Tissue	WNL			
Edema/Color				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/15/2016 MR#: 11455456

AgentCode: ATW000009 Agent Name: ATWELL, KIMBERLY, LPN

Time in: 10:45 Time Out: 11:50

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC:

 Wound irrigated with (specify): Wound packed with (specify):

MOISTENED GAUZE, ABD PAD SECURED WITH TAPE

 Wound dressing applied (specify): Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications., patient ask would I change the wafer and bag today so his wife wouldnt have to, removed and disposed of, stoma was cleaned, prepped with skin prep, stoma paste applied to the wafer, dressing was removed and disposed of, a 0.2x0.2 opening in the middle of the mid abdominal surgical wound is draining small amounts of SS drainage, no odor, no elevated temp, Dr. Rimkus office is aware of this, did not wish to use antibiotics at this time, did order the wound vac not be placed back on until he comes back to the office for f/u, which is tomorrow, He and his wife are educated to change wet/dry dressing. labs will be obtained next week. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

Record on Appeal 1471

Signature: KIMBERLY ATWELL, LPN

Date: 06/15/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/15/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)  
Time in: 10:45 Time Out: 11:50

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/15/2016 TIME IN: 10:45 TIME OUT: 11:50  
TYPE OF VISIT:  Skilled <Planned> / PRN / Infusion / Wound care  Skilled & Supervisory  Supervisory Only  
 Other  
Reason for visit: SN VISIT

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract
- Infections
- Any surgeries
- Other
- Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
- Hearing Loss
- Aid used R / L
- Deaf: R / L
- Ear pain
- Vertigo
- Tinnitus R / L
- Other:
- Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
- Dentures: Upper / Lower
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:
- Documentation of Skilled intervention / instruction / management problems:

PAIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABDOMEN any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:  
Check all that apply:  
Description of pain:  Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp  
 Localized  
 Radiates  
Effect on patient:  
 Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying  
 Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis  
Frequency of pain:  
 Occasional  
 Always present  
 Comes and goes  
Other:  
Aggravating factors:  
 Movement  
 Ambulation  
 Immobility  
Other:

Pain Relieved By:  
Non Pharmacological Interventions:  
 Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:  
 Medication: OXYCODONE  
10AM

Pain Medication Last Given:  
Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief: VARIABLE

How often is medication needed for breakthrough pain?  
 Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY  
 No Problem  
 Blood sugar ranges  Patient / Caregiver Report  
Monitored by:  Self  Caregiver  Nurse  
 Other

Frequency of monitoring  
Competency with use of Glucometer  lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:  
 High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness  
 Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations  
 Other  
 venipuncture for drawn from space using  aseptic  sterile technique.  
 Pressure applied to site site:  with  without evidence of complications.  
 Patient tolerated procedure well  Other:  
Labs transported to laboratory via OSHA protocol.  
 Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM  
 No problem  See wound addendum  New Wound  
 Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic... / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable to Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable to Assess / Deferred  Right 102 / 68  Left /  Right /  Left /  
Prior Weight:  Reported  Actual  
Previous Weight:  Reported  Actual

Sitting  Left / Standing  Left / Lying  Left /

Temperature:  Refused / Unable to Assess / Deferred 99.6 F  ORAL  AXILLARY  RECTAL  TYMPANIC

Pulse:  Refused / Unable to Assess / Deferred  Apical  Brachial  <Regular> / Irregular  Radial 80  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable to Assess / Deferred 0  ac  pc

Respirations:  Refused / Unable to Assess / Deferred 16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.

Documentation of Skilled Intervention / Instruction / Management problems:

978

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Feeding Patterns / Frequency of Meals THREE TIMES PLUS SNACKS  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet

Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids amt.  Restrict fluids amt.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other

Frequency of Abnormal Symptoms

Enteral

N/A  No Problem

Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)



Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior: Clear  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry / Acute / Chronic  Unable to cough up secretions  
 Productive: Thick / Thin / Frothy Sputum Color Amount

Oxygen:

O2 @ lpm per %  N/A  
O2 saturation %  YES  NO  
Does this patient have a trach?

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL/s

Orthopnea  Other:

Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:

Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):  
Amount ml Frequency Returns

Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
  - Alert
  - Oriented <person> / <place> / <time>
  - Disoriented
  - Forgetful
  - Headaches
  - Comatose
  - Lethargic
  - Agitated
  - Anxiety
  - Difficulty coping with altered status
  - Pupils:  PERRLA  Unequal R / L
  - Aphasia: Receptive / Expressive
  - Motor change: Fine / Gross site
  - Hand grips: Equal / Unequal
  - Weakness: UE / LE Location
  - Tremors: Fine / Gross
  - Paralysis R / L Site
  - Hallucinations
  - Sleep / Rest  ADEQUATE  INADEQUATE
  - Inappropriate response to caregiver / clinician
  - Inappropriate follow through in the past.
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)  
Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:  
Location
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
- Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

Medication change since last visit?  Yes  No  
Medication (include name, dose, route, freq, N/C, start/change date)

Effective  Yes  No  Other  
 Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications, patient ask would I change the wafer and bag today so his wife wouldnt have to, removed and disposed of, stoma was cleaned, prepped with skin prep, stoma paste applied to the wafer, dressing was removed and disposed of, a 0.2X0.2 opening in the middle of the mid abdominal surgical wound is draining small amounts of SS drainage, no odor, no elevated temp, Dr. Rimkus office is aware of this, did not wish to use antibiotics at this time, did order the wound vac not be placed back on until he comes back to the office for f/u, which is tomorrow, He and his wife are educated to change wet/dry dressing. labs will be obtained next week. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBAIC  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBAIC  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 via \_\_\_\_\_ (access device or port): using clean no touch technique, access device, withdraw and discard \_\_\_\_\_ ml of blood, draw lab specimen, flush device with \_\_\_\_\_ ml SNS followed by \_\_\_\_\_ ml Heparin.
- SN obtained PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT 0 INR 0 PTT 0  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained urine via straight cath with \_\_\_\_\_ in cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
<u>S/S OF INFECTION</u>						
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
<u>PAIN IN THE INCISION</u>						
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Caregiver		<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
	<u>NEEDS ASSISTANCE WITH ADL'S</u>					
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

Confusion / Dementia

Severe weakness

Fatigues easily

SOB with exertion

Medical restrictions

Physical Limitations

Unsteady gait

Balance issues

Mobility restrictions, Reason:

Pain with mobility

Environmental Barriers, Reason:

Psychiatric condition

Paranoia

Depression

Agoraphobia

Anxiety

Schizophrenia

Alzheimer's

Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

Medication regimen/administration

Pain levels

Treatment options

Disease progression

Agency phone number/after hours number

Other:

Universal precautions/handwashing

Basic home safety

Rights and responsibilities

HIPAA privacy

State hotline number

Advance directives

DNR/DNI

Confidentiality

Emergency planning in the event if service is disrupted.

SUPERVISORY VISIT (Complete if applicable.)

AIDE  PTA  CTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify

Staff was contacted regarding updated careplan

If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:

TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

Page: 9  
Date: 06/15/2016  
Time in: 10:45 Time Out: 11:50  
SKILLED NURSE VISIT NOTE  
Patient: KNIGHT, DANIEL (11455455) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician  PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit 06/16/2016  Not yet scheduled Last physician visit  Unknown

Billable supplies recorded

FACE TO FACE

Date of FTP visit Medically necessary home health services  SN  PT  ST  
FTP Doctor  
FTP Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/15/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/17/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)  
Time in: 11:00 Time Out: 12:00

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/17/2016 TIME IN: 11:00 TIME OUT: 12:00  
TYPE OF VISIT:  Skilled <Planned> / PRN / Infusion / Wound care  Skilled & Supervisory  Supervisory Only  
 Other  
Reason for visit: WOUND CARE

EYES

No Problem Identified  
 Contacts:  
 Glasses  
 Blurred vision  
 Glaucoma  
 Cataract  
  
 Infections  
 Any surgeries  
 Other  
  
 Documentation of skilled intervention / instruction / management problems:

EARS

No Problem Identified  
  
 Hearing Loss  
 Aid used R / L  
 Deaf: R / L  
  
 Ear pain  
 Vertigo  
 Tinnitus R / L  
  
 Other:  
  
Documentation of skilled intervention / instruction / management problems:

NOSE

No Problem Identified  
 Congestion  
 Sinus Infection  
 Epistaxis  
 Impaired sense of smell  
 Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

No Problem Identified  
 Dentures: Upper / Lower  
  
 Difficulty swallowing  
 Lesions  
 Hoarse  
 Ulcerations  
 Toothache  
 Gum problems  
 Chewing problems  
 Other:  
  
 Documentation of Skilled intervention / instruction / management problems:

Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABDOMEN any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:  
Check all that apply:  
Description of pain:  Dull ache  
 Throbbing  
 Pressure heaviness  
 Burning  
 Shooting  
 Sharp  
Effect on patient:  Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying  
Frequency of pain:  Occasional  
 Always present  
 Comes and goes  
 Other:  
Aggravating factors:  Movement  
 Ambulation  
 Imobility  
 Other:  
 Localized  
 Radiates  
 Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:  
Non Pharmacological Interventions:  
 Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:  
 Medication: OTYCUDONE  
YESTERDAY

Pain Medication Last Given:  
Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief: VARIES

How often is medication needed for breakthrough pain?  
 Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem  
 Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse  
 Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness  
/ Other  
 Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations  
/ Other

Venipuncture for  drawn from  space using  aseptic  sterile technique.  
 Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:  
Labs transported to  laboratory via OSHA protocol.  
 Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS  
Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual  
Blood Pressure:  Refused / Unable To Assess / Deferred  Right 100 / 60  Left /  Right /  Left /  Right /  Left /  
Sitting  Left / Standing  Left / Lying  Left /  
Temperature:  Refused / Unable To Assess / Deferred 98.5  ORAL  AXILLARY  RECTAL  TYMPANIC  
Pulse:  Refused / Unable To Assess / Deferred  Apical  Brachial  <Regular> / Irregular  Radial 97  Carotid  Rest  Activity  
Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred 16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of skilled intervention / instruction / management problems:

978

Gastrointestinal

Nutritional Status  
Appetite  Good  Fair  Poor  NPO  Anorexic  
Eating Patterns / Frequency of Meals THREE TIMES PLUS SNACKS  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids ant.  Restrict fluids ant.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting  
 Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral  
 N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds:  Active / Hyperactive  Hypoactive X 4 quadrants

Absent X  Other

Last BM 06/17/2016 Usual Frequency Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: Blood / Gray / Tarry  
 Hemorrhoids:  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Bite:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  Regular  Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date

Pace-maker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry / Acute / Chronic  Unable to cough up secretions  
 Productive: Thick / Thin / Frothy Sputum Color Amount

Oxygen:

O2 @ \_\_\_\_\_ lpm per \_\_\_\_\_  
O2 saturation \_\_\_\_\_ %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Dispens/other:  
Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care \_\_\_\_\_ with \_\_\_\_\_ French  
 Foley inserted (date) \_\_\_\_\_  
 Skill / Foley catheter care \_\_\_\_\_ / Change \_\_\_\_\_  
Inflated balloon with \_\_\_\_\_ ml  without difficulty

Irrigation solution: Type (specify): \_\_\_\_\_ Returns

Amount \_\_\_\_\_ ml Frequency \_\_\_\_\_  
Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / gross site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
  
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
  
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
  
- Contractures:
- Location:
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
  
- Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)
  
- Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

Medication change since last visit?  Yes  No  
Medication (include name, dose, route, freq, N/C, start/change date)

Effective  Yes  No  Other  
 Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/E contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear. Bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. Ostomy care was complete by wife with no questions or complications. Dressing was removed and disposed of; a 0.2x0.2 opening in the middle of the mid abdominal surgical wound is draining small amounts of SS drainage, no odor, no elevated temp. Dr. Rimkus office is aware of this, did not wish to use antibiotics at this time, wound vac was d/c wet/dry dressing only. He and his wife are educated to change wet/dry dressing. Labs will be obtained next week for hepatic function test. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

LAB INTERVENTIONS

- SN performed venipuncture to (location) using (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 to monitor  
 Specimen brought to Lab. Results to be forwarded to Dr.
- SN obtained (location) using (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 via (access device or port): using clean no touch technique, access device,  
 withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 Specimen brought to Lab. Results to be forwarded to Dr.
- SN obtained PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT 0 INR 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other  
 Specimen brought to Lab. Results to be forwarded to Dr.
- SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other  
 Patient response  
 Specimen brought to Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O3	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000009)

Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
  - Unsteady gait
  - Balance issues
  - Mobility restrictions, Reason:
  - Pain with mobility
  - Environmental Barriers, Reason:
  - Psychiatric condition
    - Paranoia
    - Depression
    - Agoraphobia
    - Anxiety
    - Schizophrenia
    - Alzheimer's
  - Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- ENR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

SUPERVISORY VISIT [Complete if applicable.]

AIDE  PTA  OTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify  
 Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:  
 TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals /Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit  Not Yet Scheduled Last physician visit  Unknown

Billable supplies recorded

FACE TO FACE  
Date of FTF Visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

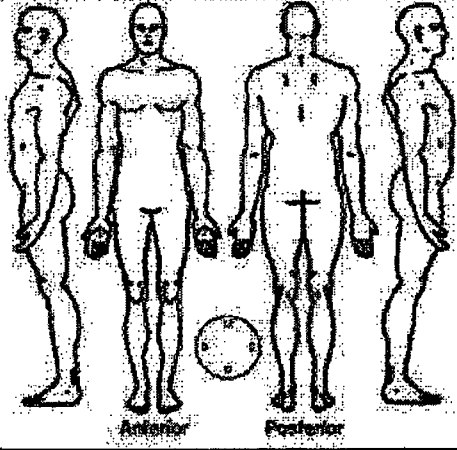
Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/17/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/20/2016 MR#: I1455456  
 Agentcode: ATN000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart to include color(s).



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clean:		Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Support Surface

Preventative  Treatment  Wheelchair Cushion

Mattress:

Other:

Description of Wound Locations

Location 1: MID LINE ABDOMEN

Location 2:

Location 3:

Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: N A: N	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)	Y			
Surrounding Tissue	WNL			
Edema/Color				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/20/2016 MR#: I1455456

Agentcode: ATN000009 Agent Name: ATWELL, KIMBERLY, LPN

Time in: 10:30 Time Out: 11:45

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	O = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC

 Wound irrigated with (specify): Wound packed with (specify):

DRY ABD PAD SECURED WITH TAPE.

 Wound dressing applied (specify): Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications, he reported he now has a hernia around the stoma, this was reported to on calls surgeon this weekend and was told it was a common occurrence. Dressing was removed and disposed of, the opening was not packed with gauze over the weekend and therefore closed up, patient was tunneled in several areas Friday and was educated on the importance of keeping the opening patent. Dr. Rimkus/Connie was notified of this and this patient was given an appointment Wednesday 2pm, therefore no visit will be made by SN Wednesday, patient was notified of this. no odor, temp 99.3 labs to obtain hepatic function panel was drawn from right SC with no complication and transported to OMC. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

Record on Appeal 1491

Signature: KIMBERLY ATWELL, LPN

Date: 08/20/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/20/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW0000091)  
Time in: 10:30 Time Out: 11:45

NURSING VISIT NOTE

Agency: Anadisy's Ems Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/20/2016 TIME IN: [ ] AM [ ] PM 10:30 TIME OUT: [ ] AM [ ] PM 11:45  
TYPE OF VISIT: [X] Skilled <Planned> / PRN / infusion / Wound care [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: WOUND CARE AND LABS

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract
  
- Infections
- Any surgeries
- Other:

[ ] Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
- Hearing Loss
- Aid used R / L
- Deaf: R / L
  
- Ear pain
- Vertigo
- Tinnitus R / L
  
- Other:

Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
- Dentures: Upper / Lower
  
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:

[ ] Documentation of skilled intervention / instruction / management problems:

PAIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABDOMEN any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:  
Check all that apply:

Description of pain:  
 Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying  
  
 Irritability  
 Tense  
 Restlessness  
 Vital signs changes  
 Diaphoresis

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
 Other:

Localized  
 Radiates

Pain Relieved By:  
Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication: OXYCODONE 9AM

Pain Medication Last Given:  
Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief: VARIABLE

How often is medication needed for breakthrough pain?  
 Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem  
 Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse  
 Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: / Other  
Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Venipuncture for  drawn from  space using  aseptic  sterile technique.  
 Pressure applied to site site:  with  without evidence of complications.

Patient tolerated procedure well  Other:  
Labs transported to laboratory via OSHA protocol.  
 Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS  
Height: 5' 8"  Reported  Actual Weight:  Refused /  Unable To Assess /  Deferred  Reported  Actual

Blood Pressure:  Refused /  Unable To Assess /  Deferred Prior Weight:  Reported  Actual  
 Right 106 / 62  Right /  Right /  Right /  
Sitting  Left / Standing  Left / Lying  Left /  
Temperature:  Refused /  Unable To Assess /  Deferred  
Pulse:  Refused /  Unable To Assess /  Deferred  
 Apical  Brachial  <Regular> / Irregular  Radial 88  Carotid  Rest  Activity

Blood Sugar:  Refused /  Unable To Assess /  Deferred 0  ac  pc  
Respirations:  Refused /  Unable To Assess /  Deferred  
16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

978

Gastrointestinal

Nutritional Status

Appetite:  Good  Fair  Poor  NPO  Anorexic

Feeding Patterns / Frequency of Meals: THREE TIMES PLUS SNACKS  
Diets:  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids amt.  Restrict fluids amt.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent X  Other

Last BM 06/20/2016 Usual Frequency Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain:  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal Stools:  Blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Site:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Vise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date  
Pacemaker: Date Type  
 No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:  
 Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough:

Dry / Acute / Chronic

Productive: Thick / Thin / Frothy Sputum Color Amount

Unable to cough up secretions

Oxygen:

O2 @ lpm per

O2 saturation %  N/A

Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:

Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:

Clarity:  Clear  Cloudy  Sediment  Mucus

Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condon  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):

Amount ml Frequency

Returns

Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / gross site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis R / L Site
- Hallucinations
- sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
  
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
  
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
  
- Contractures:
- Location
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
  
- Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)

- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. he reported he now has a hernia around the stoma, it was reported to on call surgeon this weekend and was told it was a common occurrence. dressing was removed and disposed of, the opening was not packed with gauze over the weekend and therefore closed up, patient was tunneled in several areas Friday and was educated on the importance of keeping the opening patent. Dr. Rinkus/Commie was notified of this and this patient was given an appointment Wednesday 2pm, therefore no visit will be made by SN Wednesday, patient was notified of this. no odor, temp 99.3  
 Labs to obtain hepatic function panel was drawn from right SC with no complication and transported to CMC. reinforced 24 hour nurse line and frequency. no other questions or concerns at this time.

LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBAIC  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_ to monitor
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBAIC  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_
- via \_\_\_\_\_ (access device or port): using clean no touch technique, access device,  
 withdraw and discard \_\_\_\_\_ ml of blood, draw lab specimen, flush device with \_\_\_\_\_ ml SNS followed by \_\_\_\_\_ ml Heparin.  
 specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.
- SN obtained \_\_\_\_\_ PT-INR / PTT via finger stick using Coagulation Machine.  
 Results: PT \_\_\_\_\_ INR \_\_\_\_\_ PTT \_\_\_\_\_  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.  
 SN obtained urine via straight cath with \_\_\_\_\_ in cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
<b>NO S/S OF INFECTION</b>						
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Caregiver		<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
	<u>NEEDS ASSISTANCE WITH ADLs</u>					
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**HOMEBOUND REASON**

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's
- Other:

**WRITTEN INSTRUCTIONS/MATERIALS PROVIDED**

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Other
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.

**SUPERVISORY VISIT (Complete if applicable.)**

AIDE  PTA  CTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify

Staff was contacted regarding updated careplan If staff not present, specify date

**OBSERVATION OF**

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:  
 TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

**COORDINATION OF CARE**

PLAN OF CARE:

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No

Discharge planning discussed with patient?

Verbal Order obtained

YES  NO  N/A

PRN Order obtained

REFERRAL TO:

Next physician visit

Not Yet Scheduled

Last physician visit

Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit

Medically necessary home health services

SN  PT  ST

FTF Doctor

FTF Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

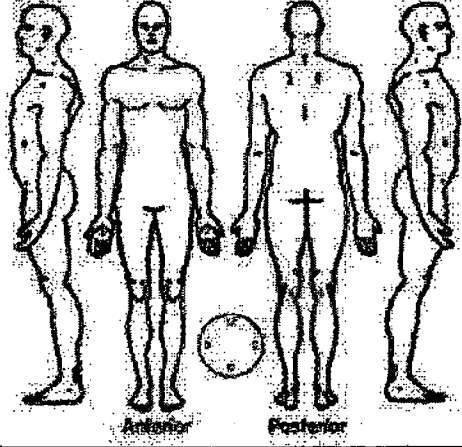
Signature: KIMBERLY ATWELL, LPN

Date: 06/20/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/23/2016 MR#: I1455456  
 Agentcode: ATW000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing appropriate information for each numbered site as client to include estimates.



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	[ ]	[ ]	[ ]	[ ]
<input type="checkbox"/> Clean:		Surgical	[ ]	[ ]	[ ]	[ ]
<input type="checkbox"/> Sterile		Skin Tear	[ ]	[ ]	[ ]	[ ]
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	[ ]	[ ]	[ ]	[ ]
		Arterial Ulcer	[ ]	[ ]	[ ]	[ ]
		Neuropathic (Diab)	[ ]	[ ]	[ ]	[ ]
		Stoma	[ ]	[ ]	[ ]	[ ]
	OTHER	[ ]	[ ]	[ ]	[ ]	

Type of Support Surface

- Preventative  Treatment  Wheelchair Cushion  
 Mattress:  
 Other:

Description of Wound Locations

Location 1: MID LINE ABDOMEN  
 Location 3:

Location 2:  
 Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: SS A: SM	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N):				
Surrounding Tissue	WNL			
Edema/Color				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/23/2016 MR#: I1455456

Agent Code: ATW000009 Agent Name: ATWELL, KIMBERLY, LPN

Time In: 10:00 Time Out: 10:45

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	O = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
PP = Foul Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

**WOUND INTERVENTIONS**Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC

 Wound irrigated with (specify): Wound packed with (specify):

MOISTENED GAUZE COVERED WITH ABD SECURED TAPE

 Wound dressing applied (specify): Patient tolerated procedure well Other (specify):Satisfactory return demo:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:**Interventions/Instructions**

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. he reported he now has a hernia around the stoma, when he went to the MD yesterday, Dr. Rimkus discussed reversal surgery in 3 weeks, MD was not concerned with the top of the wound being closed with tunneling noted, also will repair the hernia. patient was notified of this. no odor, temp 99.3 concerns at this time.

Record on Appeal 1502

Signature: KIMBERLY ATWELL, LPN

Date: 06/23/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/23/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LEN (ATW000009)  
Time in: 10:00 Time Out: 10:45

NURSING VISIT NOTE

Agency: Amadivys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/23/2016 TIME IN: 10:00 TIME OUT: 10:45  
TYPE OF VISIT:  Skilled  Planned  PRN  Infusion  Wound care  Skilled & Supervisory  Supervisory Only  
 Other  
Reason for visit: WOUND CARE

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract
  
- Infections
- Any surgeries
- Other

Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified
- Hearing Loss
- Aid used R / L
- Deaf: R / L
  
- Ear pain
- Vertigo
- Tinnitus R / L
  
- Other:

Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified
- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified
- Dentures: Upper / Lower
  
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:

Documentation of skilled intervention / instruction / management problems:

PAIN

No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)

0  1  2  3  4  5  6  7  8  9  10  
 PAIN Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
 Other:

Localized  
 Radiates

Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief:

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem

Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness  
/ Other  
 Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations  
/ Other

Venipuncture for drawn from space using  aseptic  sterile technique.  
 Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:  
Labs transported to laboratory via OSHA protocol.  
 Universal precautions / Infection control maintained

INTEGUMENTARY SYSTEM

No problem

Skin breakdown Location:  New Wound

Highlight all applicable skin assessment:

SKILLED NURSE VISIT NOTE

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:

Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable to Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable to Assess / Deferred  
 Right 122 / 76  Left /  Right /  
Prior Weight: Previous Weight:

Sitting  Left / Standing  Left / Lying  Left /

Temperature:  Refused / Unable to Assess / Deferred  
97.6 F  ORAL  AXILARY  RECTAL  TYMPANIC

Pulse:  Refused / Unable to Assess / Deferred  
 Apical  Brachial  <Regular> / Irregular  Radial 72  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable to Assess / Deferred 0  ac  pc

Respirations:  Refused / Unable to Assess / Deferred  
16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.

Documentation of Skilled intervention / instruction / management problems:

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Feeding Patterns / Frequency of Meals

Diet  Low sodium diet  THREE TIMES PLUS SNACKS  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids  Restrict fluids  ant.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other

Frequency of Abnormal Symptoms

Enteral

N/A  No Problem

Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Wound care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: [amt./specify]

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent  Normal  Other

Last BM 06/23/2016 Usual Frequency Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: Blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Gastomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Site:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur  
 Chest Pain:  Ache  Angular  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 Date  
Pacemaker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry / Acute / Chronic  Unable to cough up secretions  
 Productive: Thick / Thin / Frothy Sputum Color Amount

Oxygen:

O2 @ \_\_\_\_\_ lpm per \_\_\_\_\_  
O2 saturation %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/Family

Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)

(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):  
Amount ml Frequency Returns

Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
- Aphasia: Receptive / Expressive
- Motor charge: Fine / Gross Site
- Hand grips: Equal / Unequal
- Weakness: UE / LE Location
- Tremors: Fine / Gross
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:
- Location
- Muscle Atrophy Location:  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
- Amputation: Right: BK / AK / UE Left: BL / AL / UL (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)
- Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)

- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
- Drug/food interactions
- Duration of therapy
- Medication(s) names
- Missed doses/what to do
- Other
- Proper disposal of sharps

S/S contraindications

S/S allergic reaction

Administered by:  Self  Family/Caregiver  Nurse  
 Other:

Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. He reported he now has a hernia around the stoma, when he went to the MD yesterday, Dr. Riskue discussed reversal surgery in 3 weeks, MD was not concerned with the top of the wound being closed with tunneling noted, also will repair the hernia. patient was notified of this. no odor, temp 99.3 concerns at this time.

LAB INTERVENTIONS

SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_

Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_

via \_\_\_\_\_ (access device or port): using clean no touch technique, access device, withdraw and discard \_\_\_\_\_ ml of blood, draw lab specimen, flush device with \_\_\_\_\_ ml SNS followed by \_\_\_\_\_ ml Heparin.

SN brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

SN obtained PT-INR / PTT via finger stick using Coagulation Machine.

Results: PT 0 INR 0 PTT 0  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).

SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_

Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

SN obtained urine via straight cath with \_\_\_\_\_ fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_

Patient response \_\_\_\_\_  
 Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

TEACHING/TRAINING

SUBJECT INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning s/s to report	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
<b>NO S/S OF INFECTION</b>						
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11456456) Agent: ATWELL, KIMBERLY, LFN (RTW000091)

Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> <input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
  - Unsteady gait
  - Pain with mobility
  - Psychiatric condition
    - Paranoia
    - Depression
    - Agoraphobia
    - Anxiety
    - Schizophrenia
    - Alzheimer's
  - Other:
- Balance issues
- Mobility restrictions, Reason:
- Environmental Barriers, Reason:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other:

SUPERVISORY VISIT (Complete if applicable.)

AIDE  PTA  OTA  LFN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify

Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:

TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

Reviewed / Revised with patient / caregiver involvement  Outcome achieved

Page: 9  
Date: 06/23/2016  
Time in: 10:00 Time Out: 10:45

SKILLED NURSE VISIT NOTE

Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

Revised:  
COORDINATION OF CARE:

Physician Physician name  
PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No

Discharge planning discussed with patient?

Verbal Order obtained

YES  NO  N/A

PRN Order obtained

REFERRAL TO:

Next physician visit 07/06/2016  Not Yet Scheduled Last physician visit  Unknown

Billable supplies recorded:

FACE TO FACE

Date of FTF Visit Medically necessary home health services  SN  PT  ST

FTF Doctor

FTF Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/23/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/27/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)  
Time in: 08:15 Time Out: 08:55

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/27/2016 TIME IN: 08:15 TIME OUT: 08:55  
TYPE OF VISIT:  Skilled  Planned  PRN  Infusion  Wound care  Skilled & Supervisory  Supervisory Only  
 Other  
Reason for visit: WOUND CARE

EYES

- No Problem Identified
- Contacts:
- Glasses
- Blurred vision
- Glaucoma
- Cataract

- Infections
- Any surgeries
- Other

Documentation of skilled intervention / instruction / management problems:

EARS

- No Problem Identified

- Hearing Loss
- Aid used R / L
- Deaf: R / L

- Ear pain
- Vertigo
- Tinnitus R / L
- Other:

Documentation of skilled intervention / instruction / management problems:

NOSE

- No Problem Identified

- Congestion
- Sinus Infection
- Epistaxis
- Impaired sense of smell
- Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

- No Problem Identified

- Dentures: Upper / Lower
- Difficulty swallowing
- Lesions
- Hoarse
- Ulcerations
- Toothache
- Gum problems
- Chewing problems
- Other:

Documentation of skilled intervention / instruction / management problems:

PRIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABDOMEN any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
Other:

Localized  
 Radiates

Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication: OPICODONE N/A

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A

Duration of Relief: N/A

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem

Blood sugar ranges  Patient  Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Other

Venipuncture for drawn from space using  aseptic  sterile technique.

Pressure applied to site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Specimens transported to laboratory via OSHA protocol.

Universal precautions / infection control maintained

INTEGRUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Inch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS  
Height: 5' 8"  Reported  Actual Weight:  Refused /  Unable To Assess /  Deferred  Reported  Actual

Blood Pressure:  Refused /  Unable To Assess /  Deferred  
 Right 118 / 74  Left  Right  
Prior Weight:  Reported  Actual  
Previous Weight:  Reported  Actual

Sitting  Left  Right Standing  Left  Right Lying  Left  Right

Temperature:  Refused /  Unable To Assess /  Deferred  
99.0  ORAL  AXILLARY  RECTAL  TYMPANIC

Pulse:  Refused /  Unable To Assess /  Deferred  
 Apical  Brachial  <Regular> / Irregular  Radial 16  Carotid  Rest  Activity

Blood Sugar:  Refused /  Unable To Assess /  Deferred 0  ac  pc  
Respirations: 16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled Intervention / Instruction / Management problems:

90% RA

Gastrointestinal

Nutritional status  
Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals  
Diets:  Low sodium diet  THREE TIMES PLUS SNACKS Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids amt.  Restrict fluids amt.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Page: 04  
Date: 06/27/2016  
Time in: 08:15 Time Out: 08:55  
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

SKILLED NURSE VISIT NOTE

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (ant./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds:  <active> / Hyperactive  Hypoactive X 4 quadrants

Absent X  quads  Other

Last BM: 06/27/2016 Usual Frequency: Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description:  Watery  Black  Mucous  Pain  Odor Amount

Current treatment:

Abnormal Stools:  Blood  Gray  Tarry  
 Hemorrhoids:  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Bite:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0.0 Date  
Pacemaker: Date Type

No Edema  
 Edema:  Lower Extremities Right / Left  Sacral  Dependent

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec  
Breath Sounds:  
 Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior: Clear  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Accessory muscles used  
 Cough: Dry / Acute / Chronic  
 Productive: Thick / Thin / Frothy Sputum Color Amount  Unable to cough up secretions  
Oxygen:  
O2 @ \_\_\_\_\_ lpm per \_\_\_\_\_ %  N/A  
Does this patient have a trach?  YES  NO  
Who manages?  Self  RN  Cg/family  
 Other:  
 Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's  
 Orthopnea  Other:  
 Blackouts  Fainting  Dizziness  
Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged  
 Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No  
 Deferred (explain)  
(Highlight all applicable items)  
Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria  
 Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):

Amount ml Frequency Returns

Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
- Aphasia: Receptive / Expressive
- Motor change: Fine / gross site
- Hand grips:  Equal / Unequal
- Weakness: RUE / LE Location
- Tremors: Fine / Gross
- Paralysis: R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:  
Location
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness: GENERALIZED
- Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)
- Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)
- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. He reported he now has a hernia around the stoma, when he went to the MD yesterday, Dr. Riskus discussed reversal in a couple weeks, MD was not concerned with the top of the wound being closed with tunneling noted, also will repair the hernia. patient was notified of this. no odor, temp 99.0 no concerns at this time. reinforced 24 hour nurse line and frequency. No other questions or concerns at this time.

LAB INTERVENTIONS

- SN performed venipuncture to (location) using (venipuncture device and size) via sterile technique for the following labs:
  - PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR
  - Other
 to monitor

Specimen brought to Lab. Results to be forwarded to Dr.

- SN obtained
  - PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR
  - Other

via (access device or port): using clean no touch technique, access device, withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.

Specimen brought to Lab. Results to be forwarded to Dr.

- SN obtained PT-INR / PTT via finger stick using Coagulation Machine.

Results: PT 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).

- SN obtained urine via clean catch for:
  - Urinalysis  Culture and Sensitivity  Urine Albumin
  - Other

Specimen brought to Lab. Results to be forwarded to Dr.

- SN obtained urine via straight cath with 0 fr cath, using sterile technique for:
  - Urinalysis  Culture and Sensitivity  Urine Albumin
  - Other

Specimen brought to Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
	Patient	Caregiver	Verbalized	Questionable	Compliant	Return Demonstration
Disease processes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early warning S/S to report	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NO S/S OF INFECTION</b>						
Medications (list meds taught)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapy: IV / Parenteral / O2	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatments (Resp, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> <input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
  - Paranoia
  - Depression
  - Agoraphobia
  - Anxiety
  - Schizophrenia
  - Alzheimer's
- Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

SUPERVISORY VISIT (complete if applicable.)

- AIDS
- PTA
- OTA
- LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify  
 Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:

TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

Page: 9  
Date: 06/27/2016  
Time in: 08:15 Time Out: 08:55  
SKILLED NURSE VISIT NOTE  
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

<Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised

COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit 07/06/2016  Not Yet Scheduled Last physician visit  Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

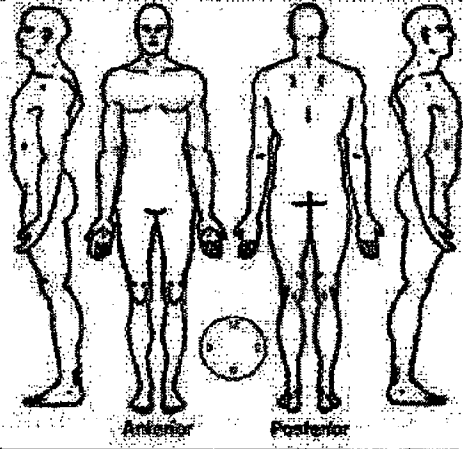
Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/27/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/30/2016 MR#: I1455456  
 Agentcode: ATN000009

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site in order to include location.



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Clean:		Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Type of Support Surface

- Preventative  Treatment  Wheelchair Cushion
- Mattress:
- Other:

Description of Wound Locations

Location 1: MID LINE ABDOMEN

Location 2:

Location 3:

Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)				
Drainage Amount/Type	T: A:	T: A:	T: A:	T: A:
S / S of Infection				
Wound Bed Tissue				
Undermining/Tunnelling (Y/N)				
Surrounding Tissue				
Edema/Color				

Other:

Stage of Wound / Thickness

- Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved
  - Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater
  - Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue
  - Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone.
- U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 06/30/2016 MR#: I1455458

Agent Code: ATW000009 Agent Name: ATWELL, KIMBERLY, LPN

Time In: 10:00 Time Out: 10:45

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	O = Odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
FP = Foul Purulent	L = Large	EP = Epithelialization	I = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

WOUND INTERVENTIONS

Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

Soiled dressing removed By:  Patient  Caregiver  Family  RN/PT

Wound cleaned with (specify):

Wound irrigated with (specify):

Wound packed with (specify):

Wound dressing applied (specify):

GAUZE, ABD PAD AND TAPE

Patient tolerated procedure well

Other (specify):

Satisfactory return demc:  Yes  No

Wound debridement

Drainage collection container emptied. Volume:

Medicated prior to wound care

Education:  Yes  No

Patient / Family / Caregiver instructed on wound care / disposal of soiled dressing

Patient / Family / Caregiver to perform wound care / dressing change

Other:

Interventions/Instructions

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. dressing was removed from mid line abd. and disposed of, cleaned with NS, moistened gauze was applied and covered with abd pad secured with tape. scheduled for reversal surgery in the next couple weeks. no odor, temp 99.0 no concerns at this time. reinforced 24 hour nurse line and frequency. No other questions or concerns at this time.

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 06/30/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LFN (RTW000009)  
Time In: 10:00 Time Out: 10:45

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)  
Patient: KNIGHT, DANIEL (11455456) Start of Care Date: 05/30/2016  
DATE: 06/30/2016 TIME IN: 10:00 TIME OUT: 10:45  
TYPE OF VISIT:  skilled  Planned  PRN  Infusion  Wound care  Skilled & Supervisory  Supervisory Only  
 Other  
Reason for visit: WOUND CARE

EYES

No Problem Identified  
 Contacts:  
 Glasses  
 Blurred vision  
 Glaucoma  
 Cataract  
 Infections  
 Any surgeries  
 Other  
 Documentation of skilled intervention / instruction / management problems:

EARS

No Problem Identified  
 Hearing Loss  
 Aid used R / L  
 Deaf R / L  
 Ear pain  
 Vertigo  
 Tinnitus R / L  
 Other  
 Documentation of skilled intervention / instruction / management problems:

NOSE

No Problem Identified  
 Congestion  
 Sinus Infection  
 Epistaxis  
 Impaired sense of smell  
 Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

No Problem Identified  
 Dentures: Upper / Lower  
 Difficulty swallowing  
 Lesions  
 Hoarse  
 Ulcerations  
 Toothache  
 Gum problems  
 Chewing problems  
 Other  
 Documentation of skilled intervention / instruction / management problems:

PAIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: ABDOMEN any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
Other:

Localized  
 Radiates

Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:  
Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication: OTYCODONE  
LAST NIGHT

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief: VARIES

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem  
 Blood sugar ranges  Patient /Caregiver Report

Monitored by:  Self  Caregiver  Nurse  
 Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness  
/ Other  
 Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations  
/ Other

Venipuncture for drawn from space using  aseptic  sterile technique.  
 Pressure applied to site site:  with  without evidence of complications.

Patient tolerated procedure well  Other:  
Labs transported to laboratory via OSHA protocol.  
 Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound  
 Skin breakdown Location:  
Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:

Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS

Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred  Right 118 / 68  Left  
Prior Weight:  Right / Previous Weight:  Right

Sitting  Left / Standing  Left / Lying  Left

Temperature:  Refused / Unable To Assess / Deferred 97.6  ORAL  AXILARY  RECTAL  TYMPANIC

Pulse:  Refused / Unable To Assess / Deferred  Apical  Brachial  <Regular> / Irregular  Radial 90  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred 16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of skilled intervention / instruction / management problems:

Gastrointestinal

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids amt.  Restrict fluids amt.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other

Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Wound care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: [amt./specify]

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent X quads  Other

Last BM 06/29/2016 Usual Frequency Every day

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence  
 Measurements of Ascites: Inches

Frequency of Distention:

Constipation: Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction  
 Diarrhea: Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: Blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Rite:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur  
 Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like  
Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date

Pace-maker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used  
 Cough: Dry / Acute / Chronic  
 Productive:  Unable to cough up secretions  
Thick / Thin / Frothy Sputum Color Amount

Oxygen: O2: O2 saturation %  N/A  
Does this patient have a trach?  YES  NO  
Who manages?  Self  RN  Cg/family  
 Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's  
 Orthopnea  Other:  
 Blackouts  Fainting  Dizziness  
Documentation of skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Bloodstinged  
 Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No  
 Deferred (explain)  
(Highlight all applicable items)  
Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria  
 Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:  
 Patient has Catheter

Type:  
Foley  
Suprapubic  
Intermittent  
Condon  
Other:  
Skilled catheter care with French  
Foley inserted (date) / Change  
Skill / Foley catheter care / ml / without difficulty  
Inflated balloon with ml  
Irrigation solution: Type (specify):  
Amount ml Frequency  
Patient tolerated procedure well  YES  NO  
 Other (specify)

Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
- Aphasia: Receptive / Expressive
- Motor changes: Fine / gross Site
- Hand grips: Equal / Unequal
- Weakness: UE / LE Location
- Tremors: Fine / Gross
- Paralysis R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:
- Location
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
- Amputation: Right: BK / AK / UE Left: BL / AL / UL (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)
- Effective:  Yes  No  Other
- Orders obtained

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11459456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

Skilled Medication Instruction:

- Drug/drug interactions
- Drug/food interactions
- Duration of therapy
- Medication(s) names
- Missed doses/what to do
- Other
- Proper disposal of sharps

S/S contraindications

S/S allergic reaction

Administered by:  Self  Family/Caregiver  Nurse  
 Other:

Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional skilled intervention / Skilled instruction

Male patient was sitting at the kitchen table when I arrived to the home, after vitals were obtained, assessment was complete. Lung sounds were clear, bowel sounds were active, liquid stools drain into a colostomy bag, patient/wife changes colostomy bag and wafer with no complications. dressing was removed from mid line abd. and disposed of, cleaned with NS, moistened gauze was applied and covered with abd pad secured with tape. scheduled for reversal surgery in the next couple weeks. no odor, temp 99.0 no concerns at this time. reinforced 24 hour nurse line and frequency. No other questions or concerns at this time.

LAB INTERVENTIONS

SN performed venipuncture to (location) using (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 to monitor

Specimen brought to Lab. Results to be forwarded to Dr.

SN obtained  PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other

via (access device or port): using clean no touch technique, access device, withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.

Specimen brought to Lab. Results to be forwarded to Dr.

SN obtained PT-INR / PTT via finger stick using Coagulation Machine.

Results: PT 0 INR 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).

SN obtained urine via clean catch for:

- Urinalysis  Culture and Sensitivity  Urine Albumin
- Other

Specimen brought to Lab. Results to be forwarded to Dr.

SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Specimen brought to Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
early warning S/S to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Caregiver		<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Pain with mobility
- Psychiatric condition
- Paranoia
- Other:
- Balance issues
- Environmental Barriers, Reason:
- Mobility restrictions, Reason:
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Other
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/ONR
- Confidentiality
- Emergency planning in the event if service is disrupted.

SUPERVISORY VISIT (Complete if applicable.)

ADR  PTA  OTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify \_\_\_\_\_  
 If staff not present, specify date \_\_\_\_\_

OBSERVATION OF

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain: \_\_\_\_\_

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:  
 <Reviewed> / Revised with patient / caregiver involvement  Outcome achieved

Revised  
COORDINATION OF CARE:

Physician Physician name  
PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:  
Next physician visit  Not Yet Scheduled Last physician visit  Unknown

Billable supplies recorded  
FACE TO FACE  
Date of FTF Visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

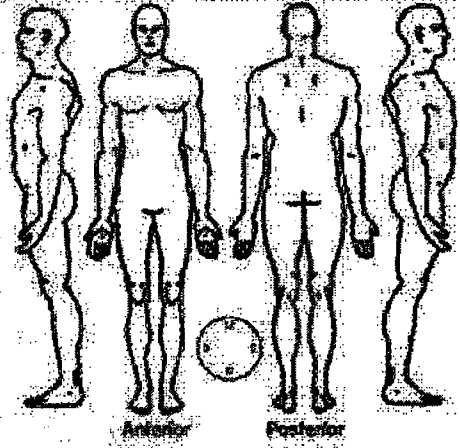
Physician's clinical findings to support homebound status

Signature: KIMBERLY ATWELL, LPN Date: 06/30/2016

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 07/05/2016 MR#: I1455456  
 Agentcode: RUC000018

Denote location of specific skin conditions/wounds by number (1-4) corresponding to illustrations below. Proceed by completing applicable information for each numbered site on chart to include estimates.



<input type="checkbox"/> NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Clean: ASEPTIC		Surgical	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sterile		Skin Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Touch:		Venous Ulcer (Sta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Arterial Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Neuropathic (Diab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Stoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Type of Support Surface

Preventative  Treatment  Wheelchair Cushion

Mattress:

Other:

Description of Wound Locations

Location 1: MID LINE ABD

Location 2:

Location 3:

Location 4:

	LOCATION #1	LOCATION #2	LOCATION #3	LOCATION #4
Stage of Pressure Ulcer				
Thickness of Other Wounds				
Measurement (LxWxD)	3 *0.3 *0.1			
Drainage Amount/Type	T: N A: N	T: A:	T: A:	T: A:
S / S of Infection	N			
Wound Bed Tissue	G			
Undermining/Tunnelling (Y/N)	N			
Surrounding Tissue	WNL			
Edema/Color				

Other:

Stage of Wound / Thickness

Stage 1: An Area of Skin Redness (Without a Break in Skin) that Does Not Disappear When Pressure is Relieved  
 Stage 2: A Partial Thickness Loss of Skin Layers that Looks Like an Abrasion, Blister or Shallow Crater  
 Stage 3: A Full Thickness of the Skin is Lost, Able to See Subcutaneous Tissue, Looks Like a Deep Crater With or Without Undermining Adjacent Tissue  
 Stage 4: A Full Thickness of Skin and Subcutaneous Tissue is Lost, Able to See Muscle or Bone  
 U = Unstageable: Necrotic Tissue Grayish / Yellow Slough Present or Soft / Hard Eschar is Present  
 Thickness F = Full P = Partial

Pt. Name: KNIGHT, DANIEL Visit Date: 07/05/2016 MR#: 11455456

Agent Code: REC000010 Agent Name: RUCKMAN, NATALIE, RN

Time in: 11:06 Time Out: 11:36

Drainage Type	Drainage Amount	Wound Bed Tissue	S / S Infection	Surrounding Tissue
N = None	N = None	SP = Slick Pink	N = None	WNL
S = Serous	SC = Scant	G = Granulating	C = odor	R = Red
SS = Serosanguineous	SM = Small	SL = Slough	ER = Erythema	W = White
P = Purulent	MOD = Moderate	E = Eschar	W = Warmth	F = Firm
EP = Foul/Purulent	L = Large	EP = Epithelialization	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

## WOUND INTERVENTIONS

Wound care done:  Yes  No

Location(s) if patient has more than one wound site:

 Scaled dressing removed By:  Patient  Caregiver  Family  RN/PT Wound cleaned with (specify):

WC

 Wound irrigated with (specify): Wound packed with (specify):

SALINE DAMP GAUZE

 Wound dressing applied (specify):

ABD. PAD. AND TAPE

 Patient tolerated procedure well Other (specify):Satisfactory return demc:  Yes  No Wound debridement Drainage collection container emptied. Volume: Medicated prior to wound careEducation:  Yes  No Patient / Family / Caregiver instructed on wound care / disposal of scaled dressing Patient / Family / Caregiver to perform wound care / dressing change Other:

## Interventions/Instructions

Homebound status: taxing effort to leave home

Medical necessity: disease management, wound care and education

SN into see patient. Patient A+Cx3, VSS, Lung sounds clear, bowel sounds x4. Ostomy bag in place draining brown liquid stool, stoma is beefy red. Patient is to see doctor tomorrow concerning reversal. Patient denies any drainage from wound, no signs of infection no fever, redness or odor. Wound cleaned and wet to dry dressing applied. Discussed reversal with patient. SN educated patient on reasons for liquid stool and signs of dehydration. Patient aware of 24hour on call nurse

Record on Appeal 1533

Signature: NATALIE RUCKMAN, RN

Date: 07/05/2016

Page: 1  
Date: 07/05/2016  
Time in: 11:06 Time Out: 11:36

**SKILLED NURSE VISIT NOTE**

Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC090010)

**NURSING VISIT NOTE**

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 07/05/2016

TIME IN

AM  PM

Start of Care Date:

05/30/2016

11:06

TIME OUT

AM  PM

11:36

TYPE OF VISIT:  Skilled  Planned  PRN  Infusion  Wound care

Skilled & Supervisory

Supervisory Only

Other

Reason for visit: SLP, SN VISIT

**EYES**

No Problem Identified

Contacts:

Glasses

Blurred vision

Glaucoma

Cataract

Infections

Any surgeries

Other:

Documentation of skilled intervention / instruction / management problems:

**EARS**

No Problem Identified

Hearing Loss

Aid used R / L

Deaf: R / L

Ear pain

Vertigo

Tinnitus R / L

Other:

Documentation of skilled intervention / instruction / management problems:

**NOSE**

No Problem Identified

Congestion

Sinus Infection

Epistaxis

Impaired sense of smell

Documentation of Skilled Intervention / Instructions / Management Problems:

**MOUTH / THROAT**

No Problem Identified

Dentures: Upper / Lower

Difficulty swallowing

Lesions

Hoarse

Ulcerations

Toothache

Gum problems

Chewing problems

Other:

Documentation of Skilled intervention / instruction / management problems:

PAIN  
 No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)  
 0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:  
Check all that apply:

Description of pain:	Effect on patient:	Frequency of pain:	Aggravating factors:
<input type="checkbox"/> Dull ache	<input type="checkbox"/> Appetite	<input type="checkbox"/> Occasional	<input type="checkbox"/> Movement
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Activity	<input type="checkbox"/> Always present	<input type="checkbox"/> Anxiation
<input type="checkbox"/> Pressure heaviness	<input type="checkbox"/> Sleep	<input type="checkbox"/> Comes and goes	<input type="checkbox"/> Immobility
<input type="checkbox"/> Burning	<input type="checkbox"/> Anger	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Shooting	<input type="checkbox"/> Moaning		
<input type="checkbox"/> Sharp	<input type="checkbox"/> Crying		
<input type="checkbox"/> Localized	<input type="checkbox"/> Irritability		
<input type="checkbox"/> Radiates	<input type="checkbox"/> Tense		
	<input type="checkbox"/> Restlessness		
	<input type="checkbox"/> Vital sign changes		
	<input type="checkbox"/> Diaphoresis		

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A  
Duration of Relief:

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem  
 Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: / Other  
Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Venipuncture for drawn from space using  aseptic  sterile technique.  
 Pressure applied to site site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Leads transported to

laboratory via OSHA protocol.

Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: Good / Fair / Poor  
Skin: Cool / Cyanotic / Dry / Diaphoretic / Warm

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incision / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS  
Height: 5' 8"  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred  
 Right  Left  
Prior Weight:  Reported  Actual  
Previous Weight:  Right  Left

Sitting  Left 97 / 68 Standing  Left  Right Lying  Left  Right

Temperature:  Refused / Unable To Assess / Deferred  
97.1 F  ORAL  AXILLARY  RECTAL  TYMPANIC  
Pulse:  Refused / Unable To Assess / Deferred

Apical 85  Brachial  <Regular> / Irregular  Radial  Carotid  Rest  Activity

Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc

Respirations:  Refused / Unable To Assess / Deferred  
18  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.

Documentation of skilled intervention / instruction / management problems:

Gastrointestinal

Nutritional Status  
Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals: 3 MEALS PER DAY  
Diets:  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids amt.  Restrict fluids amt.

Abnormal Symptoms  
 Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral  
 N/A  No Problem  
 Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of Skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent  X quads  Other

Last BM: 07/05/2016 Usual Frequency

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence

Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction

Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal Stools: Blood / Gray / Tarry

Hemorrhoids  External  Internal  Painful

Current Treatment

Stoma:  Colostomy Date  Sigmoid  Transverse

Assessment of Site:

Documentation of Skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur

Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 e Date

Pacemaker: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 /+2 /+3 /+4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior:  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used  
 Cough: Dry / Acute / Chronic  
 Productive: Thick / Thin / Frothy Sputum Color Amount  Unable to cough up secretions

Oxygen:

O2 @ 1pm per  
O2 saturation %  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:  
 Dyspnea:  Rest  Exertion  Ambulation feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of skilled intervention / instruction / management problems:

GENITOURINARY  
 No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)  
(Highlight all applicable items)  
Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria  
 Incontinence (details if applicable)

Diapers/other:  
Urinary Catheter:  
 Patient has Catheter

Type:  
 Foley  
 Suprapubic  
 Intermittent  
 Condon  
 Other:  
 Skilled catheter care  
 Foley inserted (date) with French  
 Skill / Foley catheter care / Change ml  without difficulty  
Inflated balloon with ml  without difficulty

Irrigation solution: Type (specify):  
Amount ml Frequency Returns  
Patient tolerated procedure well  YES  NO

Other (specify)  
Documentation of skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
- Alert
- Oriented <person> / <place> / <time>
  
- Disoriented
- Forgetful
- Headaches
- Comatose
- Lethargic
- Agitated
- Anxiety
- Difficulty coping with altered status
- Pupils:  PERRLA  Unequal R / L
  
- Aphasia: Receptive / Expressive
  
- Motor change: Fine / gross site
  
- Hand grips: Equal / Unequal
  
- Weakness: UE / LE Location
- Tremors: Fine / Gross
  
- Paralysis: R / L Site
- Hallucinations
- Sleep / Rest  ADEQUATE  INADEQUATE
- Inappropriate response to caregiver / clinician
- Inappropriate follow through in the past
- Documentation of skilled intervention / instruction / management problems:

R / L

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
  
- Contractures:
- Location
  
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
  
- Amputation: Right: BK / BK / UE Left: BK / BK / UE (specify)  Other
  
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)
- Documentation of skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)

- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
  - Drug/food interactions
  - Duration of therapy
  - Medication(s) names
  - Missed doses/what to do
  - Other
  - Proper disposal of sharps
  - S/S contraindications
  - S/S allergic reaction
- Administered by:  Self  Family/Caregiver  Nurse  
 Other:
- Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Homebound status: taxing effort to leave home Medical necessity: disease management, wound care and education SN into see patient. Patient R-003, 766, Lung sounds clear, bowel sounds x1. Ostomy bag in place draining brown liquid stool, stoma is beefy red. Patient is to see doctor tomorrow concerning reversal. Patient denies any drainage from wound, no signs of infection no fever, redness or odor. Wound cleaned and wet to dry dressing applied. Discussed reversal with patient. SN educated patient on reasons for liquid stool and signs of dehydration. Patient aware of 24hour on call nurse

LAB INTERVENTIONS

- SN performed venipuncture to \_\_\_\_\_ (location) using \_\_\_\_\_ (venipuncture device and size) via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 to monitor \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained \_\_\_\_\_  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other \_\_\_\_\_  
 via \_\_\_\_\_ (access device or port): using clean no touch technique, access device,  
 withdraw and discard \_\_\_\_\_ ml of blood, draw lab specimen, flush device with \_\_\_\_\_ ml SNS followed by \_\_\_\_\_ ml Heparin.
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained PT-INR / PTT via finger stick using Coagulation Machine.
- Results: PT 0 INR 0 PTT 0  
 Reported to Dr. \_\_\_\_\_ (must answer PT and INR or PTT for results).
- SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_  
 SN obtained urine via straight cath with \_\_\_\_\_ fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other \_\_\_\_\_
- Patient response \_\_\_\_\_
- Specimen brought to \_\_\_\_\_ Lab. Results to be forwarded to Dr. \_\_\_\_\_

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning s/s to report	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
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Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Diet / Fluid management	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

HOMEBOUND REASON

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's
- Other:

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

SUPERVISORY VISIT (Complete if applicable.)

ATR  PTA  CTR  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify

Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF **XIM**

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:

TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

COORDINATION OF CARE

PLAN OF CARE:

<Revised> / Revised with patient / caregiver involvement  Outcome achieved

COORDINATION OF CARE:

Revisit  
 Physician Physician name  
 PT  OT  SLP  SS  SN  Aide  Other (specify)  
Goals /Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit 07/06/2016  Not Yet Scheduled Last physician visit  Unknown

Billable supplies recorded

FACE TO FACE  
Date of FTP Visit Medically necessary home health services  SN  PT  ST  
FTP Doctor  
FTP Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

Signature: NATALIE RUCKMAN, RN Date: 07/05/2016

Page: 1 SKILLED NURSE VISIT NOTE  
Date: 07/07/2016 Patient: KNIGHT, DANIEL (11455456) Agent: SOLES, AMANDA, LPN (SOL009079)  
Time In: 10:40 Time Out: 11:15

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222) Start of Care Date: 05/30/2016  
Patient: KNIGHT, DANIEL (11455456) TIME IN: 10:40 TIME OUT: 11:15  
DATE: 07/07/2016 [ ] AM [ ] PM [ ] AM [ ] PM  
TYPE OF VISIT: [X] Skilled <Planned> / PRN / Infusion / Wound care [ ] Skilled & Supervisory [ ] Supervisory Only  
[ ] Other  
Reason for visit: REG VISIT

EYES

[ ] No Problem Identified  
[ ] Contacts:  
[X] Glasses  
[ ] Blurred vision  
[ ] Glaucoma  
[ ] Cataract  
[ ] Infections  
[ ] Any surgeries  
[ ] Other  
[ ] Documentation of skilled intervention / instruction / management problems:

EARS

[X] No Problem Identified  
[ ] Hearing Loss  
[ ] Aid used R / L  
[ ] Deaf: R / L  
[ ] Ear pain  
[ ] Vertigo  
[ ] Tinnitus R / L  
[ ] Other:  
Documentation of skilled intervention / instruction / management problems:

NOSE

[X] No Problem Identified  
[ ] Congestion  
[ ] Sinus Infection  
[ ] Epistaxis  
[ ] Impaired sense of smell  
[ ] Documentation of Skilled Intervention / Instructions / Management Problems:

MOUTH / THROAT

[X] No Problem Identified  
[ ] Dentures: Upper / Lower  
[ ] Difficulty swallowing  
[ ] Lesions  
[ ] Hoarse  
[ ] Ulcerations  
[ ] Toothache  
[ ] Gum problems  
[ ] Chewing problems  
[ ] Other:  
[ ] Documentation of Skilled intervention / instruction / management problems:

PAIN

No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)

0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

Dull ache  
 Throbbing  
 Pressure/heaviness  
 Burning  
 Shooting  
 Sharp

Effect on patient:

Appetite  
 Activity  
 Sleep  
 Anger  
 Moaning  
 Crying

Frequency of pain:

Occasional  
 Always present  
 Comes and goes  
 Other:

Aggravating factors:

Movement  
 Ambulation  
 Immobility  
 Other:

Localized  
 Radiates

Irritability  
 Tense  
 Restlessness  
 Vital sign changes  
 Diaphoresis

Pain Relieved By:

Non Pharmacological Interventions:

Diversion  Heat  Ice  Massage  
 Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A

Duration of Relief:

How often is medication needed for breakthrough pain?

Current pain control medications adequate  More than 3 times/day  
 2-3 times/day  Less than daily  Never  
 Other:

Documentation of Pain Management Interventions / Instructions:

ENDOCRINE/HEMATOLOGY

No Problem

Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer  Lancet use  Reading results  Calibration  Other

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Other

Venipuncture for drawn from space using  aseptic  sterile technique.

Pressure applied to site Site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Specs transported to

laboratory via OSHA protocol.

Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

No problem  See wound addendum  New Wound

Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: Pale / Jaundice / Redness  
Skin Turgor: <Good> / Fair / Poor  
Skin: Cool / Cyanotic / <Dry> / Diaphoretic / <Warm>

Highlight all applicable conditions listed:  
Abrasions / Bruises / Fistulas / Incisions / Itch / Lacerations / Lesions / Pressure Ulcer / Rash / Scaling / Wounds  
Other (specify, incl. pertinent hx)

Documentation of Skilled Interventions / Instructions / Management problems:

VITAL SIGNS  
Height: 5' 8"  Reported  Actual Weight:  Refused  Unable To Assess  Deferred  Reported  Actual

Blood Pressure:  Refused  Unable To Assess  Deferred Prior Weight:  
 Right  Left  Right Previous Weight:  
 Right  Left

Sitting  Left 108 / 70 Standing  Left Lying  Left

Temperature:  Refused  Unable To Assess  Deferred  
98.6  ORAL  AXILLARY  RECTAL  TYMPANIC

Pulse:  Refused  Unable To Assess  Deferred  
 Apical 80  Brachial  <Regular> / Irregular  Radial  Carotid  Rest  Activity

Blood Sugar:  Refused  Unable To Assess  Deferred 0  ac  pc

Respirations:  Refused  Unable To Assess  Deferred  
16  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.

Documentation of Skilled Intervention / Instruction / Management problems:

Gastrointestinal

Nutritional Status:  
Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals: 3 MEALS PER DAY  
Diets:  Low sodium diet  Low calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet

Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids  Restrict fluids

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis (blood) / Coffee Grounds / Bile (green / yellow) / Recal vomiting

Difficulty Swallowing  Other

Frequency of Abnormal Symptoms

Enteral

N/A  No Problem

Tube Feedings  
 Other (specify)

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:

Patient / Caregiver competent to perform:  Yes  No

Dressing/Site care: (specify)

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (ant./specify)

Interventions/Instructions/Comments:

Who manages?  
Documentation of skilled intervention / instruction / management problems:

Abdomen / G.I.

No Problem

Bowel Sounds: <Active> / Hyperactive / Hypoactive X 4 quadrants

Absent X quadrants  Other

Last BM 07/07/2016 Usual Frequency Every day

Incontinence of stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence

Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction

Diarrhea Frequency:  >3x/day  <3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal stools: Blood / Gray / Tarry  
 Hemorrhoids  External  Internal  Painful

Current Treatment

Stomy:  Colostomy Date  
 Sigmoid  Transverse

Assessment of Site:

Documentation of skilled intervention / instruction / management problems:

CARDIOPULMONARY

No Problem

Heart Sounds:  <Regular> / Irregular  Murmur

Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily Chest pain relieved by:

LVEF assessment: 0 % Date

Edema: Date Type

No Edema

Edema:  Lower Extremities Right / Left  Sacral  Dependent:

Upper Extremities Right / Left

Pitting +1 / +2 / +3 / +4  Non-pitting Site:  
 Cramps  Claudication  Capillary refill: < 3 sec / > 3 sec

Breath Sounds:

Anterior:  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Posterior: Clear  Right lower: Clear  
 Left upper: Clear  Right upper: Clear  
 Left lower: Clear  Right middle: Clear  
 Right lower: Clear

Accessory muscles used

Cough: Dry / Acute / Chronic  
 Productive: Thick / Thin / Frothy Sputum Color: Amount:  Unable to cough up secretions

Oxygen:

O2 @ \_\_\_\_\_ lpm per \_\_\_\_\_  
O2 saturation: \_\_\_\_\_  N/A  
Does this patient have a trach?  YES  NO

Who manages?  Self  RN  Cg/family

Other:

Dyspnea:  Rest  Exertion  Ambulation  feet  During ADL's

Orthopnea  Other:  
 Blackouts  Fainting  Dizziness

Documentation of Skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged

Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No

Deferred (explain)

(Highlight all applicable items)

Symptoms:  Urgency / frequency  Burning / pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria

Incontinence (details if applicable)

Diapers/other:

Urinary Catheter:

Patient has Catheter

Type:

Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care with French  
 Foley inserted (date) / Change  
 Skill / Foley catheter care / Change  
Inflated balloon with \_\_\_\_\_ ml  without difficulty

Irrigation solution: Type (specify): \_\_\_\_\_ Returns

Amount \_\_\_\_\_ ml Frequency \_\_\_\_\_  
Patient tolerated procedure well  YES  NO

Other (specify)

Documentation of Skilled intervention / instruction / management problems:

NEURO/EMOTIONAL

- No Problem
  - Alert
  - Oriented <person> / <place> / <time>
  - Disoriented
  - Forgetful
  - Headaches
  - Comatose
  - Lethargic
  - Agitated
  - Anxiety
  - Difficulty coping with altered status
  - Pupils:  PERRLA  Unequal R / L
  - Aphasia: Receptive / Expressive
  - Motor change: Fine / gross site
  - Hand grips: Equal / Unequal
  - Weakness: UE / LE Location
  - Tremors: Fine / Gross
  - Paralysis: R / L Site
  - Hallucinations
  - Sleep / Rest  ADEQUATE  INADEQUATE
  - Inappropriate response to caregiver / clinician
  - Inappropriate follow through in the past
- Documentation of Skilled intervention / instruction / management problems:

MUSCULOSKELETAL

- No Problem  New Falls Reported
- Joint problems (specify)
- Symptoms:  Pain  Swollen Joints  Stiffness
- Contractures:
- Location
- Muscle Atrophy  Poor conditioning  Muscle wasting  Decreased muscle tone
- Limited ROM Location:
- Skin Numbness / Tingling:
- Decreased mobility  Decreased endurance
- Prosthesis: RUE / RLE / LUE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait  Weakness GENERALIZED
- Amputation: Right: BK / AK / UE Left: BL / AL / UL (specify)  Other
- Hemiplegia  Paraplegia  Quadriplegia
- Other (specify)

Documentation of Skilled intervention / instruction / management problems:

MEDICATIONS

- Medication change since last visit?  Yes  No
- Medication (include name, dose, route, freq, N/C, start/change date)

- Effective  Yes  No  Other
- Orders obtained

Skilled Medication Instruction:

- Drug/drug interactions
- Drug/food interactions
- Duration of therapy
- Medication(s) names
- Missed doses/what to do
- Other
- Proper disposal of sharps
- S/S contraindications
- S/S allergic reaction

Administered by:  Self  Family/Caregiver  Nurse

Other:  Other:  
 Skilled intervention: Medication administered during this skilled visit etc.

INTERVENTIONS/INSTRUCTIONS

Additional Skilled Intervention / Skilled Instruction

Diane/Dr Rinkus/Amanda Soles LPN Discontinue wound care, verbal order written. sn let in by pt. alert and oriented times 3. no medication changes vital signs stable. pt reports 0/10 pain. pt having surgery tomorrow to reverse ileostomy. homebound due to ileostomy and taxing effort to leave home. medical necessity is education on medication and disease process. on reinforced nursing frequency and 24 hour on call. on assessed surgical site no redness, swelling or purulent drainage.

LAB INTERVENTIONS

SN performed venipuncture to [location] using [venipuncture device and size] via sterile technique for the following labs:  
 PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 to monitor

Specimen brought to Lab. Results to be forwarded to Dr.  
 SN obtained  PT-INR  PTT  CBC  BMP  CMP  Thyroid  HGBA1C  Lipid Panel  Est. GFR  
 Other  
 via (access device or port): using clean no touch technique, access device, withdraw and discard 0 ml of blood, draw lab specimen, flush device with 0 ml SNS followed by 0 ml Heparin.  
 SN obtained PT-INR / PTT via finger stick using Coagulation Machine.

Results: PT 0 INR 0 PTT 0  
 Reported to Dr. (must answer PT and INR or PTT for results).

SN obtained urine via clean catch for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Specimen Brought to Lab. Results to be forwarded to Dr.  
 SN obtained urine via straight cath with 0 fr cath, using sterile technique for:  
 Urinalysis  Culture and Sensitivity  Urine Albumin  
 Other

Patient response  
 Specimen brought to Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE					
Disease processes	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Early warning S/S to report	<input checked="" type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input checked="" type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
	<u>SEE ABOVE</u>					
Medications (list meds taught)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Pain	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Therapy: IV / Parenteral / O2	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Treatments (Resp, etc)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Equipment Use/Management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

Diet / Fluid management	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Activity Guidelines	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
ADL's / Self-care tasks	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Safety Factors	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Lifestyle adjustments/Coping	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Community Resources	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration
Other (Specify)	<input type="checkbox"/> Patient	<input type="checkbox"/> Caregiver	<input type="checkbox"/> Verbalized	<input type="checkbox"/> Questionable	<input type="checkbox"/> Compliant	<input type="checkbox"/> Return Demonstration

**HOMEBOUND REASON**

Unable to leave home without assistance due to:

- Confusion / Dementia
- Severe weakness
- Fatigues easily
- SOB with exertion
- Medical restrictions
- Physical Limitations
- Unsteady gait
- Balance issues
- Mobility restrictions, Reason:
- Pain with mobility
- Environmental Barriers, Reason:
- Psychiatric condition
- Paranoia
- Depression
- Agoraphobia
- Anxiety
- Schizophrenia
- Alzheimer's
- Other:

**WRITTEN INSTRUCTIONS/MATERIALS PROVIDED**

- Medication regimen/administration
- Pain levels
- Treatment options
- Disease progression
- Agency phone number/after hours number
- Universal precautions/handwashing
- Basic home safety
- Rights and responsibilities
- HIPAA privacy
- State hotline number
- Advance directives
- DNR/DNI
- Confidentiality
- Emergency planning in the event if service is disrupted.
- Other

**SUPERVISORY VISIT (Complete if applicable.)**

- AIDE
- PTA
- CTA
- LFN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify: \_\_\_\_\_  
 If staff not present, specify date: \_\_\_\_\_

**OBSERVATION OF**

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain: \_\_\_\_\_  
 TEACHING/TRAINING OF \_\_\_\_\_

NEXT SCHEDULED SUPERVISORY VISIT \_\_\_\_\_

**COORDINATION OF CARE**

PLAN OF CARE:

- <Reviewed> / Revised with patient / caregiver involvement
- Outcome achieved

Page: 9  
Date: 07/07/2016  
Time in: 10:40 Time Out: 11:15  
SKILLED NURSE VISIT NOTE  
Patient: KNIGHT, DANIEL (11455456) Agent: SOLES, AMANDA, LPN (SOL000079)

Revised  
COORDINATION OF CARE:

Physician Physician name  
 PT  OT  SLP  SR  SN  Aide  Other (specify)  
Goals / Rehab. discussed with patient?  Yes  No Discharge planning discussed with patient?  
 Verbal Order obtained  YES  NO  N/A  
 PRN Order obtained

REFERRAL TO:

Next physician visit 07/08/2016  Not Yet Scheduled Last physician visit 07/06/2016  Unknown

Billable supplies recorded

FACE TO FACE

Date of FTF Visit Medically necessary home health services  SN  PT  ST  
FTF Doctor  
FTF Visit Reason

Physician's clinical findings to support above services

Physician's clinical findings to support homebound status

Signature: AMANDA SOLES, LPN Date: 07/07/2016

Page: 1 SUPERVISORY VISIT  
Date: 07/12/2016 Patient: KNIGHT, DANIEL (11455455) Agent: RUCKMAN, NATALIE, RN (RUC000016)  
Time in: 11:49 Time Out: 12:29

DATE 07/12/2016 TIME IN [ ] AM [ ] PM 11:49 TIME OUT [ ] AM [ ] PM 12:29

SUPERVISORY VISIT [Complete if applicable.]

AIDE  PTA  OTA  LPN / LVN

STAFF:  PRESENT  NOT PRESENT

CARE PLAN UPDATED?  YES  NO If Yes, specify

Staff was contacted regarding updated careplan If staff not present, specify date

OBSERVATION OF

XIB

IS FAMILY/PATIENT SATISFIED WITH CARE?  YES  NO Explain:

TEACHING/TRAINING OF

NEXT SCHEDULED SUPERVISORY VISIT

Signature: NATALIE RUCKMAN, RN Date: 07/12/2016

Page: 1  
Date: 07/12/2016  
Time in: 11:49 Time Out: 12:29  
SKILLED DISCHARGE OASIS  
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)

TYPE OF VISIT:  Skilled  Planned / PRN / Infusion / Wound care  Skilled & Supervisory  Supervisory only

DATE: 07/12/2016 [X] Other DISCHARGE  
TIME IN: 11:49 TIME OUT: 12:29  
Agency: Amedisys Home Health of Conway (2222)

AGENCY INFORMATION

(M0010) CMS Certification Number:  
(M0014) Branch State: (Optional, for Agency Use) (M0015) Branch ID Number: MSA Code

PATIENT TRACKING

(M0020) Patient ID Number: 11455456  
(M0030) Start of Care Date: 05/30/2016 (M0032) Resumption of Care Date: [X] NA - Not Applicable  
(M0040) Patient's Name: DANIEL KNIGHT Patient Phone: 330-719-5830

(M0050) Patient State of Residence: SC (M0060) Patient ZIP Code: 29527  
Patient's Address: 206 ECU CIRCUM DR CONWAY  
(Street / Apt. No.) (City)

(M0063) Medicare Number: [X] NA - No Medicare  
(M0064) Social Security Number: 408-45-6569 [X] NA - No Medicaid  
(M0065) Birth Date: 09/26/1974 [X] UK - Unknown or Not Available  
(M0069) Gender: Male [X] NA - No Medicaid

(M0150) CURRENT PAYMENT SOURCES

Current Payment Sources for Home Care: (Mark all that apply)  
0 - None; no charge for current services  
1 - Medicare (traditional fee-for-service)  
2 - Medicare (HMO/managed care/Advantage plan)  
3 - Medicaid (traditional fee-for-service)  
4 - Medicaid (HMO/managed care)  
5 - Workers' compensation  
6 - Title programs (for example, Title III, V or XVI)  
7 - Other government (for example, TriCare, VA)  
[X] 8 - Private insurance  
9 - Private HMO/managed care  
10 - Self-pay  
11 - Other (specify):  
UK - Unknown

(M0010) PHYSICIAN INFO

National Provider Identifier (NPI) for the attending physician who has signed the plan of care:  
1326126301 [X] UK - Unknown or Not Available Phone: 843/347-7291  
Name: RIMKUS, GILBERTAS  
Address: 2361 CYPRUS CIRCLE  
City: CONWAY State: SC Zip Code: 29526

Secondary Referring Physician I.D.: Phone:  
Name:  
Address: [Street / Apt. No.]  
City: State: Zip Code:

May take orders from:

(M0080/M0090/M0100) CLINICAL RECORD ITEMS  
(M0080) Discipline of Person Completing Assessment: (M0090) Date Assessment Completed:  
 1 - RN  2 - PT  3 - SLP/ST  4 - OT 07/12/2016

(M0100) This Assessment is currently Being Completed for the Following Reason: Discharge From Agency

Medical Record No. (if different than PATIENT TRACKING SHEET'S M0020): 11455456

VB001 (Herpes Zoster Vaccine)  
(VB001) Did the patient report ever receiving the Herpes Zoster (Shingles) vaccine?  No  Yes  
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VB008, VB009, VB010 (Advance Care Plan)  
(VB008) Does the patient have an Advance Care Plan documented in the Home Health Medical Record?  
 No  
(VB009) Indicate Discussions Regarding Advance Care Plan Type:

- 1) The patient had a discussion with Home Health Agency staff but did not wish to provide an Advance Care Plan.
- 2) The patient had a discussion with Home Health Agency staff but was unable to provide an Advance Care Plan.
- 3) The patient did not have any discussion with Home Health Agency staff related to an Advance Care Plan.

Yes  
(VB010) Indicate information documented in the Advance Care Plan:  
 1) Medical Treatment Preferences  
 2) Mental Health/Behavioral Treatment Preferences  
(VB010-B) Indicate Mental Health/Behavioral Treatment Preferences:  
 3) Cultural/Social Preferences

4) Spiritual/Religious Preferences

(VB010-C) Indicate Cultural/Social Preferences Type:

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VB011, VB012 (Surrogate Decision Maker)  
(VB011) Does the patient have a surrogate decision maker documented in the home health medical record?  
 No  
(VB012) Indicate discussions regarding name of surrogate decision maker type:

- 1) The patient had a discussion with home health agency staff but did not wish to provide name of surrogate decision maker.
- 2) The patient had a discussion with home health agency staff but was unable to provide name of surrogate decision maker.
- 3) The patient did not have any discussion with home health agency staff related to surrogate decision maker.

Yes  
(VB011-B) Indicate name of surrogate decision maker:

**HIS WIFE**  
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VITAL SIGNS  
Height: 5 ' 8 "  Reported  Actual Weight:  Refused / Unable To Assess / Deferred  Reported  Actual

Blood Pressure:  Refused / Unable To Assess / Deferred Prior Weight: Previous Weight:  
 Right /  Right

Sitting Standing Lying

Left 94 / 75  Left /  Left /  
Temperature:  Refused / Unable To Assess / Deferred  
Pulse: 99.2 F  ORAL  AXILLARY  RECTAL  TYMPANIC  
 Refused / Unable To Assess / Deferred  
 Apical 60  Brachial  <Regular> / Irregular  Radial  Carotid  Rest  Activity  
Blood Sugar:  Refused / Unable To Assess / Deferred 0  ac  pc  
Respirations:  Refused / Unable To Assess / Deferred 15  <Regular> / Irregular  Cheyne-Stokes  Death rattle  Apnea periods sec.  
Documentation of Skilled intervention / instruction / management problems:

(M1041) INFLUENZA VACCINE  
Influenza Vaccine Data Collection Period:  
Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?  
 0 - No [Go to M1051]  
 1 - Yes

(M1046) INFLUENZA VACCINE RECEIVED  
Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?  
 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)  
 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)  
 3 - Yes; received from another health care provider (for example: physician, pharmacist)  
 4 - No; patient offered and declined  
 5 - No; patient assessed and determined to have medical contraindication(s)  
 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine  
 7 - No; inability to obtain vaccine due to declared shortage  
 8 - No; patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

(M1051) PNEUMOCOCCAL VACCINE  
Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?  
Pneumococcal Vaccine:  
 0 - No  
 1 - Yes [Go to M1500 at TRN; Go to M1230 at DC]

(M1056) REASON PNEUMOCOCCAL VACCINE NOT RECEIVED  
Reason Pneumococcal Vaccine not received:  
If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:  
pneumovax), state reason:  
 1 - Offered and declined  
 2 - Assessed and determined to have medical contraindication(s)  
 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine  
 4 - None of the above

CAREGIVER ASSISTANCE  
 Capable  Able  Willing caregiver available  
 Limited caregiver support (ability/willingness)  
 No caregiver available  
Primary Caregiver (name)  
Primary Language of patient/caregiver  
 Language barrier  Needs interpreter  
Phone Number (if different from patient)  
Relationship/Health status  
Able to safely care for patient  Yes  No  
Other (specify)

Other organizations providing services

EMERGENCY CODE  
Emergency Code: D3

(M1230) SPEECH AND ORAL (VERBAL) EXPRESSION

Speech and Oral (Verbal) Expression of Language (in patient's own language)

- 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).
- 5 - Patient nonresponsive or unable to speak.

PAIN

No Problem  
Is patient experiencing pain?  Yes  No  Unable to communicate

Primary site: any additional sites:

Intensity: (using scales below)

0  1  2  3  4  5  6  7  8  9  10  
 FACES Scale  0-10 Scale (subjective reporting)

Collected using:

Check all that apply:

Description of pain:

- Dull ache
- Throbbing
- Pressure/heaviness
- Burning
- Shooting
- Sharp

Effect on patient:

- Appetite
- Activity
- Sleep
- Anger
- Moaning
- Crying

Frequency of pain:

- Occasional
- Always present
- Comes and goes
- Other:

Aggravating factors:

- Movement
- Ambulation
- Imobility
- Other:

- Localized
- Radiates

- Irritability
- Tense
- Restlessness
- Vital sign changes
- Diaphoresis

Pain Relieved By:

Non Pharmacological Interventions:

- Diversion  Heat  Ice  Massage
- Repositioning  Rest/Relaxation  Other:

Pharmacological Interventions:

Medication:

Pain Medication Last Given:

Pain relieved according to patient goal:  Yes  No  N/A

Duration of Relief:

How often is medication needed for breakthrough pain?

- Current pain control medications adequate  More than 3 times/day
- 2-3 times/day  Less than daily  Never
- Other:

Documentation of Pain Management Interventions / Instructions:

(M1242) FREQUENCY OF PAIN

Frequency of Pain Interfering with patient's activity or movement:

- 0 - Patient has no pain
  - 1 - Patient has pain that does not interfere with activity or movement
  - 2 - Less often than daily
  - 3 - Daily, but not constantly
  - 4 - All of the time
- Decline Reason:

ENDOCRINE/HEMATOLOGY

No Problem

Deferred (Explain)  
(Circle all applicable items)

Diabetes: Type I Juvenile / Type I / Type II

Onset of diabetes

Blood sugar ranges  Patient / Caregiver Report

Monitored by:  Self  Caregiver  Nurse

Other

Frequency of monitoring

Competency with use of Glucometer

Patient exhibits the following signs and symptoms:

High Blood Sugar: Excessive Sugar in Urine / Excessive Urination / Excessive Thirst / Dry Skin / Drowsiness

Low Blood Sugar: Anxiety / Diaphoresis / Intense Hunger / Weakness / Faint / Stupor / Nausea / Tremor / Irritable / Palpitations

Diet control (specify)

Oral medication

Patient / Caregiver ability to draw up and administer insulin:  ADEQUATE  NEEDS FURTHER INSTRUCTION

Insulin dose/frequency (specify)

On insulin since \_\_\_\_\_ How long has the patient been insulin dependent?

Document any Diabetes Related Diagnosis:

Neurologic  
Neuropathy  
Ophthalmic

Peripheral Vascular Disease

Radiculopathy

Renal

Other

Additional Endocrine Disease/Assessments:

Thyroid Disease:  Hyperthyroidism  Hypothyroidism

Symptoms exhibited related to Thyroid Disease:

Patient fatigues easily  Increased sensitivity to cold/heat  Unexplained weight gain  Unexplained weight loss

Enlarged thyroid gland  Excessive sweating  Rapid heart rate

Other

Anemia (specify if known)

Secondary bleed: GI / GU / GYN / Unknown  Hemophilia

Other

Venipuncture for \_\_\_\_\_ drawn from \_\_\_\_\_ space using  aseptic  sterile technique.

Pressure applied to site site:  with  without evidence of complications.

Patient tolerated procedure well  Other:

Specs transported to \_\_\_\_\_ laboratory via OSHA protocol.

Universal precautions / infection control maintained

Documentation of Skilled intervention / instruction / management problems:

(M1322) CURRENT NUMBER OF STAGE I PRESSURE ULCERS

Current Number of Stage I Pressure Ulcers:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

0  1  2  3  4 or more

(M1306) PRESSURE ULCER

Does this patient have at least one

or designated as unstageable? (Excludes Stage I pressure

re ulcers and healed Stage II pressure ulcers)

Unhealed Pressure Ulcer at Stage II or Higher

0 - No | Go to M1322 |  
 1 - Yes

(M1307) OLDEST STAGE II PRESENT @ DC

The Oldest Stage II Pressure Ulcer that is present at discharge: (Excludes healed Stage II Pressure Ulcers)

- 1 - Was present at the most recent SOC/ROC assessment
- 2 - Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified:

month / day / year

NA - No Stage II pressure ulcers are present at discharge

(M1308) PRESSURE ULCERS AT EACH STAGE (2-4)

Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable:

(Enter 0 if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Number Currently

Stage descriptions - unhealed pressure ulcers

Present

a. Stage II:

Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

b. Stage III:

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

c. Stage IV:

Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

d.1 Unstageable: Known or likely but Unstageable due to non-removable dressing or device.

d.2 Unstageable: Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.

d.3 Unstageable: Suspected deep tissue injury in evolution.

(M1309) WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC

Instructions for a, b, c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage

since the most recent SOC/ROC

Enter Number

(Enter 0 if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)

a. Stage II:

b. Stage III:

c. Stage IV:

Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I

or II at the most recent SOC/ROC

Enter Number

(Enter 0 if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)

Unstageable due to coverage of wound bed by slough or eschar

M1320, M1334, M1342 Wound Guidance

Newly epithelialized: When epithelial tissue has completely covered the wound surface of the pressure ulcer, regardless of how long the pressure ulcer has been re-epithelialized. This is an appropriate response for Stage III and IV pressure ulcers, but not for Stage II ulcers as fully epithelialized Stage II ulcers should not be reported.

Fully Granulating: Wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium, no dead space, no avascular tissue (eschar and/or slough), no signs or symptoms of infection, wound edges are open. This is the

appropriate response for a Stage III or IV pressure ulcer that is fully granulated, but epithelial tissue has not completely covered the wound surface.

Early/Partial Granulation: > 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (eschar and/or slough) (i.e., < 25% of the wound bed is covered with avascular tissue); may have dead space, no

signs or symptoms of infection; wound edges are open.

Not healing: Wound with > 25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

Note: A new Stage I pressure ulcer is reported on CASIS as Not healing. Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for Stage II ulcers is 3 - Not healing.

NA: "No observable" pressure ulcer includes only those that cannot be observed due to the presence of a dressing or device that cannot be removed (including casts). (When determining the healing status of a pressure ulcer for answering M1320, the

presence of necrotic tissue does NOT make the pressure ulcer NA - No observable pressure ulcer.)

A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 - Early/partial granulation if necrotic or avascular tissue covers <25% of the wound bed, or Response 3 - Not

healing, if the wound has > 25% necrotic or avascular tissue.

(M1320) STATUS OF MOST PROBLEMATIC PRESSURE ULCER

Status of Most Problematic Pressure Ulcer that is Observable:

(Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

(M1324) STAGE OF MOST PROBLEMATIC PRESSURE ULCER

Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable:

(Excludes pressure ulcer that cannot be staged due to a

non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - Patient has no pressure ulcers or no stageable pressure ulcers

(M1330) STASIS ULCER

Does this patient have a Stasis Ulcer?

0 - No [ Go to M1340 ]

- 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
- 2 - Yes, patient has observable stasis ulcers ONLY
- 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device)

[ Go to M1340 ]

(M1332) NUMBER OF STASIS ULCERS

Current Number of Stasis Ulcer(s) that are Observable:

- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

(M1334) STATUS OF MOST PROBLEMATIC STABIS ULCER

Status of Most Problematic Stabis Ulcer that is Observable:

- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing

(M1340) SURGICAL WOUND

Does this patient have a Surgical Wound?

0 - No [At SOC/ROC, go to M1350; At FU/DC, go to M1400]

1 - Yes, patient has at least one observable surgical wound

2 - Surgical wound known but not observable due to non-removable dressing/device

[At SOC/ROC, go to M1350; At FU/DC, go to M1400]

(M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

Status of Most Problematic Surgical Wound that is Observable

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing

(M1400) DYSPNEIC / SHORT OF BREATH

When is the patient dyspneic or noticeably

Short of Breath?

0 - Patient is not short of breath

1 - When walking more than 20 feet, climbing stairs

2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)

3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation

4 - At rest (during day or night)

Decline Reason:

Observed  Reported

CARDIOPULMONARY

No Problem

Heart Sounds:  Regular  Irregular  Murmur

Chest Pain:  Ache  Anginal  Dull  Localized  Postural  Radiating  Sharp  Substernal  Wise-like

Associated with:  SOB  Exertion  Diaphoresis

Frequency/duration:

Palpitations  Fatigues Easily

Chest pain relieved by:

LVEF assessment: 0 % Date

Pacemaker: Date Type

No Edema

Edema:  Lower Extremities: Right / Left  Sacral  Dependent:

Upper Extremities: Right / Left

Pitting: +1 / +2 / +3 / +4  Non-pitting Site:

Cramps  Claudication  Capillary refill < 3 sec / > 3 sec

Breath Sounds:

Anterior:

Left upper: Clear  Right upper: Clear

Left lower: Clear  Right middle: Clear

Posterior:  Right lower: Clear

Left upper: Clear  Right upper: Clear

Left lower: Clear  Right middle: Clear

Right lower: Clear

Accessory muscles used

Cough:  Dry / Acute / Chronic

Productive:

Thick / Thin / Frothy

Sputum Color

Amount

Unable to cough up secretions

Oxygen:

O2 @ lpm per  
O2 saturation: %  N/A  
Does this patient have a trach?  YES  NO  
Who manages?  Self  RN  Cg/family  
 Other:

Dyspnea:  Rest  Exertion  Ambulation feet  During ADL/s  
 Orthopnea  Other:  
 Blackouts  Fainting  Dizziness  
Documentation of Skilled intervention / instruction / management problems:

(M1500) CARDIAC STATUS

Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?

- 0 - No  Go to M2004 at TRN;  Go to M1500 at DC |  
 1 - Yes  
 2 - Not assessed  Go to M2004 at TRN;  Go to M1500 at DC |  
 NA - Patient does not have diagnosis of heart failure  Go to M2004 at TRN;  Go to M1500 at DC |

(M1510) CARDIAC STATUS

Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the previous OASIS assessment, what action(s) has (have) been taken to respond?

- (Mark all that apply.)  
 0 - No action taken  
 1 - Patient's physician (or other primary care practitioner) contacted the same day  
 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)  
 3 - Implement physician-ordered patient-specific established parameters for treatment  
 4 - Patient education or other clinical interventions  
 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

Gastrointestinal

0

Nutritional Status

Appetite  Good  Fair  Poor  NPO  Anorexic

Eating Patterns / Frequency of Meals 3 MEALS PER DAY  
Diets  Low sodium diet  Calorie ADA diet  Bland diet  Protein diet  High carbohydrate diet  
 Low carbohydrate diet  Mechanical diet  Soft diet  Regular diet  Other:  
 Increase fluids ant.  Restrict fluids ant.

Abnormal Symptoms

Nausea  Heartburn / indigestion  Vomiting  Continuous  Intermittent  
Hematemesis(blood) / Coffee Grounds / Bile (green / yellow) / Fecal vomiting

Difficulty Swallowing  Other  
Frequency of Abnormal Symptoms

Enteral

N/A  No Problem  
 Tube Feedings  
 Other (specify):

Pump: (type/specify)

Product:

Strength:

Feedings:  Bolus  Continuous Frequency of feedings:  
Patient / Caregiver competent to perform:  Yes  No

Dressing/site care: (specify)

Page: 10 SKILLED DISCHARGE CASES  
 Date: 07/12/2016 Patient: KNIGHT, DANIRE (114554561) Agent: RUCKMAN, NATALIE, RN (RUC000019)  
 Time in: 11:49 Time Out: 12:29

Performed by:  Self  Nurse  Caregiver  Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?

Documentation of Skilled intervention / instruction / management problems:

Nutrition/Health Screen

Directions: Mark each area with a check to assessment, then total score to determine additional risk.

Has an illness or condition that changed the kind and / or amount of food eaten	2
Eats fewer than 2 meals per day	3
Eats few fruits, vegetables or milk products	2
Has 3 or more drinks of beer, liquor or wine almost everyday	2
Has tooth or mouth problems that make it hard to eat	2
Does not always have enough money to buy the food needed	4
Eats alone most of the time	1
Takes 3 or more different prescribed or over-the-counter drugs a day	1
Without wanting to, has lost or gained 10 pounds in the last 6 months	2
Not always physically able to shop, cook and / or feed self	2
<b>[X] No Problem</b>	<b>TOTAL</b>

Interpretation

0-2 Good As appropriate reassess and / or provide information based on situation  
 3-5 Moderate Risk Educate, refer, monitor and reevaluate based on patient situation and organization policy  
 6 or >High Risk Coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health

Reassess nutritional status and educate based on plan of care

Abdomen / G.I.

No Problem

Bowel Sounds: <Active / Hyperactive / Hypoactive 4 quadrants

Absent  X  quads  Other

Last BM 07/12/2016 Usual Frequency

Incontinence of Stool: Frequency

Abnormal Symptoms:

Abdominal Distention:  Pain  Cramps  Tenderness  Firm  Flatulence

Measurements of Ascites: inches

Frequency of Distention:

Constipation Frequency:  Occasional  Acute  Chronic

Current treatment:  Enema  Laxative Product Frequency

Impaction

Diarrhea Frequency:  >3x/day  < 3x/day  Other

Description: Watery / Black / Mucous / Pain / Odor Amount

Current treatment:

Abnormal Stools: Blood / Gray / Tarry

Hemorrhoids  External  Internal  Painful

Current Treatment

Ostomy:  Colostomy Date

Sigmoid  Transverse

Assessment of Bite:

Documentation of Skilled intervention / instruction / management problems:

GENITOURINARY

No Problem  
Color:  Yellow  Straw  Amber  Brown  Grey  Blood-tinged  
 Other:  
Clarity:  Clear  Cloudy  Sediment  Mucus  
Odor:  Yes  No  
 Deferred (explain)  
(Highlight all applicable items)  
Symptoms:  Urgency /frequency  Burning /pain  Hesitancy  Nocturia  Hematuria  Oliguria / anuria  
 Incontinence (details if applicable)

Diapers/other:  
Urinary Catheter:

Patient has Catheter

Type:  
 Foley  
 Suprapubic  
 Intermittent  
 Condom  
 Other:  
 Skilled catheter care  
Foley inserted (date) with French  
 Skill / Foley catheter care / Change  
Inflated balloon with ml without difficulty

Irrigation solution: Type (specify):  
Amount ml Frequency  
Patient tolerated procedure well  YES  NO

Returns

Other (specify):  
Documentation of skilled intervention / instruction / management problems:

M1500 GENITOURINARY (Cont'd.)  
Has this patient been treated for a Urinary Tract Infection in the past 14 days?  
 0 - No

NA - Patient on prophylactic treatment  
 UK - Unknown (omit "UK" option on DCI)

M1510 GENITOURINARY (Cont'd.)  
Urinary Incontinence or Urinary Catheter Presence:  
 0 - No incontinence or catheter (includes amuria or ostomy for urinary drainage) [ Go to M1520 ]

1 - Patient is incontinent  
 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) [ Go to M1520 ]  
Decline Reason:

M1515 GENITOURINARY (Cont'd.)  
When does Urinary Incontinence occur?  
 0 - Timed voiding defers incontinence  
 1 - Occasional stress incontinence  
 2 - During the night only  
 3 - During the day only  
 4 - During the day and night

(M1620) BOWEL INCONTINENCE FREQUENCY

Bowel Incontinence Frequency:

- 0 - Very rarely or never has bowel incontinence
- 1 - Less than once weekly
- 2 - One to three times weekly
- 3 - Four to six times weekly
- 4 - On a daily basis
- 5 - More often than once daily
- NA - Patient has ostomy for bowel elimination
- UK - Unknown      [Omit "UK" option on FU, DC]

(M1700) COGNITIVE FUNCTIONING

Cognitive Functioning:      Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710/M1720) MENTAL STATUS

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly

- 4 - Constantly
- NA - Patient nonresponsive

(M1720) When Anxious (Reported or observed Within the Last 14 Days):

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

(M1740) BEHAVIORS DEMONSTRATED

Cognitive, behavioral, and psychiatric symptoms      that are demonstrated at least once a week      (Reported or Observed):

(Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required.
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions.
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects).
- 5 - Disruptive, infantile or socially inappropriate behavior (      excludes      verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior.
- 7 - None of the above behaviors demonstrated.

(M1745) FREQUENCY OF BEHAVIOR PROBLEMS

Frequency of Disruptive Behavior Symptoms (Reported or Observed)      Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

MUSCULOSKELETAL

- No Problem      (      New Falls Reported)
- Joint problems (specify)  
Symptoms:       Pain       Swollen Joints       Stiffness
- Contractures:

Location

- Muscle Atrophy
- Limited ROM
- Skin Numbness / Tingling
- Decreased mobility
- Prosthesis: RUE / RLE / LOE / LLE / Other
- Fracture (location)
- Shuffling / Wide-based gait
- Amputation: Right: BK / AK / UE Left: BK / AK / UE (specify) Other
- Hemiplegia
- Paraplegia
- Quadriplegia
- Other (specify)

Documentation of Skilled intervention / instruction / management problems:

(M1800) GROOMING

Grooming:

Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make-up, teeth or denture care, fingernail care).

0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.

- 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 - Someone must assist the patient to groom self.
- 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) ABILITY TO DRESS UPPER BODY

Current

safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Ability to Dress Upper Body

0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2 - Someone must help the patient put on upper body clothing
- 3 - Patient depends entirely upon someone else to dress the upper body.

Decline Reason:

(M1820) ABILITY TO DRESS LOWER BODY

Current

safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Ability to Dress Lower Body

0 - Able to obtain, put on, and remove clothing and shoes without assistance.

- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

(M1830) BATHING

Bathing:

Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:

- (a) for intermittent supervision or encouragement or reminders, OR
- (b) to get in and out of the shower or tub, OR
- (c) for washing difficult to reach areas.

3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for

assistance or supervision.

4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink,

in chair, or on commode.

5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.

5 - Unable to participate effectively in bathing and is bathed totally by another person.

Decline Reason:

(M1840) TOILET TRANSFERRING

Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted or supervised by another person, able to get to and from the toilet and transfer.
  - 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
  - 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
  - 4 - Is totally dependent in toileting.

(M1845) TOILETING HYGIENE

Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 - Able to manage toileting hygiene and clothing management without assistance.
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
  - 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
  - 3 - Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) TRANSFERRING

Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device
  - 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
  - 3 - Unable to transfer self and unable to bear weight or pivot when transferred by another person.
  - 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
  - 5 - Bedfast, unable to transfer and is unable to turn and position self.

Decline Reason:

(M1850) AMBULATION / LOCOMOTION

Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
  - 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
  - 3 - Able to walk only with the supervision or assistance of another person at all times.
  - 4 - Chairfast, unable to ambulate but is able to wheel self independently.
  - 5 - Chairfast, unable to ambulate and is unable to wheel self.
  - 6 - Bedfast, unable to ambulate or be up in a chair.

Decline Reason:

(M1870) FEEDING OR EATING

Feeding or Eating: Current ability to feed self meals and snacks safely.

Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
    - (a) meal set-up; OR
    - (b) intermittent assistance or supervision from another person; OR
    - (c) a liquid, pursed or ground meat diet.
  - 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack
  - 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
  - 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
  - 5 - Unable to take in nutrients orally or by tube feeding.

(M1880) PLANNING AND PREPARING LIGHT MEALS

Current Ability to Plan and Prepare Light Meals: (for example, cereal, sandwich) or reheated delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR  
(b) is physically, cognitively, and manually able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission)
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.  
 2 - Unable to prepare any light meals or reheat any delivered meals.

(M1890) ABILITY TO USE TELEPHONE

Ability to Use Telephone:

Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone.

(M2004) MEDICATION INTERVENTION

Medication Intervention:

If there were any clinically significant medication issues at the time of, or at any time since the

previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day to resolve any identified clinically significant medication issues, including reconciliation?

- 0 - No  
 1 - Yes  
 NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment

(M2015) PATIENT/CAREGIVER DRUG EDUCATION INTERVENTION

Patient/Caregiver Drug Education Intervention:

At the time of, or at any time since the previous OASIS assessment, was the

patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- 0 - No  
 1 - Yes  
 NA - Patient not taking any drugs

(M2020) MEDICATIONS

Management of Oral Medications:

Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.

Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
- (a) individual dosages are prepared in advance by another person; OR
- (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.
- 3 - Unable to take medication unless administered by another person.

NA - No oral medications prescribed.

Decline Reason:

Financial ability to pay for medications:      Yes  Yes       No

(M2030) INJECTABLE MEDICATIONS

Management of Injectable Medications:

Patient's current ability to prepare and take all prescribed injectable medications reliably

and safely, including administration of correct dosage at the appropriate times/intervals.

Excludes IV medications.

- 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take injectable medication(s) at the correct times if:
- (a) individual syringes are prepared in advance by another person; OR
- (b) another person develops a drug diary or chart
- 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection.

**SKILLED DISCHARGE CASES**

Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)

- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.

**(M2102) TYPES AND SOURCES OF ASSISTANCE**

Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. (Check only one box in each row.)

No assistance needed patient is independent or does not have needs in this area  
 Non-agency caregiver(s) currently provide assistance

Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance

Non-agency caregiver(s) need training/ supportive services to provide assistance

Assistance needed, but no non-agency caregiver(s) available

Type of Assistance

a. Assistance with transfer/ambulation, bathing, dressing, toileting, eating/feeding	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. IADL assistance (for example, meals, housekeeping, laundry, telephones, shopping, finances)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. Medication administration (for example, oral, inhaled or injectable)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. Medical procedures/ treatments (for example, changing wound dressing, home exercise program)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
e. Management of Equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
f. Supervision and safety (for example, due to cognitive impairment)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
g. Advocacy or facilitation of patient's participation in appropriate medical care (for example, transportation to or from appointments)	<input checked="" type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

**(M2300/M2310) EMERGENT CARE**

(M2300) Emergent Care: At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/ observation status)?

- 0 - No [ Go to M2400 ]
- 1 - Yes, used hospital emergency department WITHOUT hospital admission.
- 2 - Yes, used hospital emergency department WITH hospital admission.
- UK - Unknown [ Go to M2400 ]

Decline Reason:

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? (Mark all that apply.)

- 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall

**SKILLED DISCHARGE OASIS**

Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC900010)

- 3 - Respiratory infection (for example, pneumonia, bronchitis)
- 4 - Other respiratory problem
- 5 - Heart failure (for example, fluid overload)
- 6 - Cardiac dysrhythmia (irregular heartbeat)
- 7 - Myocardial infarction or chest pain
- 8 - Other heart disease
- 9 - Stroke (CVA) or TIA
- 10 - Hypo/hyperglycemia, diabetes out of control
- 11 - GI bleeding, obstruction, constipation, impaction
- 12 - Dehydration, malnutrition
- 13 - Urinary tract infection
- 14 - IV catheter-related infection or complication
- 15 - Wound infection or deterioration
- 16 - Uncontrolled pain
- 17 - Acute mental/behavioral health problem
- 18 - Deep vein thrombosis, pulmonary embolus
- 19 - Other than above reasons
- 20 - Reason unknown

**(M2400) INTERVENTION SYNOPSIS**

(Box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? (Check only one)

the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputees).
b. Falls prevention interventions	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

**(M2410) INPATIENT FACILITY ADMISSION**

To which Inpatient Facility has the patient been admitted?

- 1 - Hospital [ Go to M2430 ]
- 2 - Rehabilitation Facility [ Go to M0903 ]
- 3 - Nursing Home [ Go to M0903 ]
- 4 - Hospice [ Go to M0903 ]

NA - No inpatient facility admission [omit "NA" option on TRN]  
 Decline Reason:

**(M2420) DISCHARGE DISPOSITION**

Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)

- 1 - Patient remained in the community (without formal assistive services).
- 2 - Patient remained in the community (with formal assistive services).
- 3 - Patient transferred to a noninstitutional hospice.
- 4 - Unknown because patient moved to a geographic location not served by this agency.
- UK - Other unknown
- Go to M0903

**M0903 & M0906**

(M0903) Date of Last (Most Recent) Home Visit:

07/12/2016

(M0906) Discharge/Transfer/Death Date:

Enter the date of the discharge, transfer, or death (at home) of the patient.

07/12/2016

**INTERVENTIONS/INSTRUCTIONS**

Additional Skilled Intervention // Skilled Instruction

Sp into see patient. Patient A+OX3, VSS, Patient had reversal last week of ostomy. Incision is closed to abd no open areas. No redness, drainage, or fever. Patient aware of signs of infection. Patient has incision with nonremovable dressing to abd and to see doctor later today. Patient was released by Dr Rimkus, and denies any further need for home health. Patient is having regular bowel movements. Bowel sounds x4 abd soft. Patient is ambulating. Patient has no new medications, is eating without nausea. Patient denies any depression, and has no hx of falls. Patient discharged from HH.

**SUMMARY OF CARE / TREATMENT / SERVICES PROVIDED**

ATTENTION PHYSICIAN: The care Summary is for your records.

Date of last home visit 07/12/2016

Physician Notified

Dear Doctor

**DR RIMKUS**

07/12/2016

PGT 485 Attached for Signature

Discharge Date 07/12/2016

Transfer Date

Death Date

Copy sent

**DISCIPLINES INV.**

**MET OUTCOMES**

**COMMENTS**

- SN
- HHA
- PT
- OT
- SPE
- MSW
- Other
- Other

**MET**

**STABLE**

Complete this Section for Care Summary purposes (Unless Summary is written elsewhere)

**REASON FOR ADMISSION (describe condition)**

Patient for surgical aftercare, for ileostomy, anxiety, wound vac care ADMIT CONDITION: (M1017) Changed Medical Regimen Diagnosis (a): - K53.9, Peritonitis, unspecified  
 - K53.1, Perforation of intestine (nontrauma) (M1930) Therapies the patient receives at home: - None of the above (M1200) Vision: - Normal vision: sees adequately in most situations; can see medication labels, newspaper (M1306) Unhealed Pressure Ulcer at Stage II or Higher or designated as "unstageable":  
 - No (M1350) Skin Lesion or Open Wound: - Yes (M1520) Bowel Incontinence Frequency: - NA - Patient has ostomy for bowel elimination (M1530) Ostomy for Bowel Elimination: - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen (M1740) Cognitive, behavioral, and psychiatric symptoms: - None of the above behaviors demonstrated. (M1806) Grooming: - Grooming utensils must be placed within reach before able to complete grooming activities. (M1810) Ability to Dress Upper Body: - Able to dress upper body without assistance if clothing is laid out or handed to the patient. (M1820) Ability to Dress Lower Body: - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. (M1830) Bathing: - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath. (M1840) Toilet Transferring: - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. (M1850) Transferring: - Able to transfer with minimal human assistance or with use of an assistive device. (M1860) Ambulation/Locomotion: - Able to walk only with the supervision or assistance of another person at all times. (M1870) Feeding or Eating: - Able to independently feed self.

SUMMARY OF CARE (including progress toward goals to date)

Patient received assessment and monitoring, wound care and teaching, signs infection, when to contact doctor, pain management, medication education, colostomy education and diet, pressure ulcer prevention, fall prevention education

DISCHARGE PLANNING (specify future follow-up, referrals, etc.)

Patient discharged, patient's wife assists with care and patient is independent

DISCHARGE

If Discharge Summary checked in upper right, indicate reason and date below.

- Goals met 07/12/2016
- Expired / Death
- Relocation / Moved out of service area
- Refused care

Transfer/Admit to other agency/organization/facility

Patient no longer home bound

Referred to hospice

Referred to outpatient

Noncompliance with POC

Patient/Family request

Physician request

Failure to maintain services of an attending physician

Agency/Organization decision

Other

Explain:

Specify:

CONDITION AT DISCHARGE (describe)

stable, A+OX3, ves FUNCTIONAL LIMITATIONS: (M1810) Ability to Dress Upper Body: - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. (M1820) Ability to Dress Lower Body: - Able to obtain, put on, and remove clothing and shoes without assistance. (M1830) Bathing: - Unable to use the shower or tub, but able to bathe self independently, with or without the use of devices, at the sink, in chair, or on commode. (M1840) Toilet Transferring: - Able to get to and from the toilet and transfer independently with or without a device. (M1845) Toileting Hygiene: - Able to manage toileting hygiene and clothing management without assistance. (M1850) Transferring: - Able to independently transfer. (M1860) Ambulation/Locomotion: - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).

INSTRUCTIONS

Written instructions given to patient / caregiver:

Yes  No, explain:

Patient / Caregiver demonstrates understanding of instructions:

Yes  No, explain:

Signature: NATALIE RUCKMAN, RN Date: 07/12/2016

**Home Health Agency:**  
Amedisys Home Health of Conway

**Patient Name:** KNIGHT, DANIEL

**Address:**  
176 Waccamaw Medical Park Court,  
Conway, SC 29526-8965

**Patient Identification:** I1455456

**Phone:** (843) 347-5899, TTY users should call 711.

## Home Health Change of Care Notice (HHCCN)

**Your home health care is going to change.** Starting on 07/12/2016, your home health agency will change the following items and/or services for the reasons listed below.

Items/services:	Reason for change:
sn assessment and service	discharge from hh

**Read the information next to the checked box below.** Your home health agency is giving you this information because:

**Your doctor's orders for your home care have changed.**



The home health agency must follow physician orders to give you care.  
The home health agency can't give you home care without a physician's order.  
If you don't agree with this change, discuss it with your home health agency or the doctor who orders your home care.

**Your home health agency has decided to stop giving you the home care listed above.**



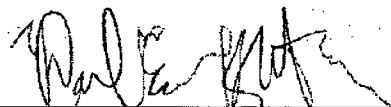
You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.  
If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care.  
If you get care from a different home health agency, you can ask it to bill Medicare.

**If you have questions about these changes, you can contact your home health agency and/or the doctor who orders your home care.**

You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed.

**Additional Information:**

**Please sign and date below** to show that you received and understand this notice. Return this signed notice to your home health agency in person or by mailing it to them at the address listed at the top of this notice.

Signature of the Patient or of the Authorized Representative*	Date:
	07/12/2016 12:04:00 PM

\*If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

**NATE FATA, P.A.**  
**ATTORNEY AT LAW**

P.O. Box 16620  
THE COURTYARD, SUITE 215  
SURFSIDE BEACH, SOUTH CAROLINA 29587  
TELEPHONE (843) 238-2676  
TELECOPIER (843) 238-0240

**VIA EMAIL**

May 16, 2017

P. Brooke Eaves, Esq.  
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Charleston, SC 29401  
[jthompson@hallboothsmith.com](mailto:jthompson@hallboothsmith.com)


Re: Daniel Eric Knight vs. Phillip Ray Causey  
Civil Action No. 2016-CP-26-8032

Counselors:

I have set the hearing on Defendant's Motion to Set Aside Default for Friday, June 2, 2017 at 11:00 a.m. here in my office in Surfside Beach. Trey please file a Notice of Hearing with the Court and I look forward to seeing everyone on June 2<sup>nd</sup>.

With best regards, I remain

Very truly yours,  
NATE FATA, P.A.



Nate Fata  
NF/sh

---

**From:** Nate Fata <nfata@fatalaw.com>  
**Sent:** Thursday, May 18, 2017 3:53 PM  
**To:** 'Brooke Eaves'; 'Sally Huffman'  
**Cc:** Joseph Thompson, III; ian@maguirelawfirm.com  
**Subject:** RE: Knight v Causey [IWOV-chdms.FID37636]

All,

Lets reschedule the hearing for 10 am on June 13, 2017 at my office. Please provide any briefs relating to the Motion to me by June 6, 2017. Mr. Thompson, please get a court reporter for the hearing.

Thanks,

Nate

Nate Fata, P.A.  
P.O. Box 16620  
Surfside Beach, SC-29587  
(843) 238-2676

**AV Preeminent, Martindale-Hubbell**

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**From:** Brooke Eaves [mailto:eaves@maguirelawfirm.com]  
**Sent:** Thursday, May 18, 2017 10:57 AM  
**To:** 'Nate Fata'; 'Sally Huffman'  
**Cc:** jthompson@hallboothsmith.com; ian@maguirelawfirm.com  
**Subject:** RE: Knight v Causey [IWOV-chdms.FID37636]

Dear Honorable Special Referee Nate Fata,

I hope you are doing well. Mr. Maguire and I are available on June 13. We believe that Special Referee Nate Fata has complete jurisdiction to hear this matter per the applicable statutes and Order of Referral. Please let us know if you are available to conduct the hearing on June 13, 2017, and if so what time the hearing will be held. If you are not available on June 13, then please let us know other dates you are available. Thank you.

Sincerely,

**P. Brooke Eaves, Esq.**

Litigation Attorney  
**MAGUIRE LAW FIRM**  
1600 North Oak Street, Suite B  
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Direct Dial: 843.663.1410  
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Supervising Attorney: Ian D. Maguire, Esquire  
Visit us on the web: [www.MaguireLawFirm.com](http://www.MaguireLawFirm.com)

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---

**From:** Joseph Thompson, III [<mailto:JThompson@hallboothsmith.com>]  
**Sent:** Thursday, May 18, 2017 10:33 AM  
**To:** 'Sally Huffman'; [eaves@maguirelawfirm.com](mailto:eaves@maguirelawfirm.com); [ian@maguirelawfirm.com](mailto:ian@maguirelawfirm.com)  
**Cc:** Nate Fata  
**Subject:** RE: Knight v Causey [IWOV-chdms.FID37636]  
**Importance:** High

Nate:

My paralegal and I miscommunicated and I am unavailable for a hearing on June 2. Without waiving, and specifically preserving my objection to the hearing being conducted by the special referee (as opposed to the circuit court), I am available the week of June 12, including the dates that Brooke suggested she was available (specifically June 13, 15 and 16).

That said, I again, respectfully, maintain that the Motion should be heard by the Circuit Court and, in consideration of judicial economy and conserving time and resources, I respectfully request the special referee consider deferring action on the motion until the motion is heard by the Circuit Court. If the Circuit Court disagrees with the Defendant's position, we can then schedule the hearing before you.

I understand your position on the latter but hope to hear from you regarding the rescheduling of the motion hearing the week of June 12. Many thanks!

---

**From:** Sally Huffman [<mailto:shuffman@fatalaw.com>]  
**Sent:** Tuesday, May 16, 2017 2:25 PM  
**To:** [eaves@maguirelawfirm.com](mailto:eaves@maguirelawfirm.com); [ian@maguirelawfirm.com](mailto:ian@maguirelawfirm.com); Joseph Thompson, III  
**Cc:** Nate Fata; Lindsay Moten  
**Subject:** Knight v Causey

Good afternoon Counselors:

Please see the attached.

Thank you.

Sally

Sally J. Huffman  
Legal Assistant  
Nate Fata, P.A.  
P.O. Box 16620  
Surfside Beach, SC 29587  
843-238-2676  
843-238-0240 (fax)

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**Joseph Thompson, III**

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**From:** Joseph Thompson, III  
**Sent:** Tuesday, April 25, 2017 1:07 PM  
**To:** 'nfata@fatalaw.com'  
**Cc:** 'Ian Maguire'; 'Brook@maguirelawfirm.com'; 'eaves@maguirelawfirm.com'  
**Subject:** Knight v Causey (Motion to Set Aside Default)  
**Attachments:** Knight-FiledMotion.pdf  
**Importance:** High

**Note:**

Attached please find the Defendant Causey's Motion to Set Aside Default which was filed this morning in Horry County (and served electronically). As a result of this filing, the Defendant Causey respectfully requests that an Order/Judgment of the Special Referee should not be issued/held in abeyance until after the Circuit Court disposes of the now pending motion.

Under the circumstances, I respectfully ask that Ian consent to this request and that no Order/Judgment be issued until after the Motion to Set Aside Default is heard by the Circuit Court.

I appreciate your kind consideration and attention.

**Joseph D. (Trey) Thompson, III**

**Hall Booth Smith, P.C.**

40 Calhoun Street

Suite 550

Charleston, SC 29401

D: 843.720.3469 C: 843-475-9508

O: 843.720.3460 F: 843.720.3458

[jthompson@hallboothsmith.com](mailto:jthompson@hallboothsmith.com) [www.hallboothsmith.com](http://www.hallboothsmith.com)

**Please Note New Address and Phone Numbers**

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**DEFENDANT'S  
EXHIBIT**

STATE OF SOUTH CAROLINA )  
 )  
COUNTY OF HORRY )  
  
DANIEL ERIC KNIGHT, )  
 )  
Plaintiff, )  
 )  
v. )  
 )  
PHILLIP RAY CAUSEY, )  
 )  
Defendant. )

IN THE COURT OF COMMON PLEAS  
FOR THE 15TH JUDICIAL CIRCUIT  
CASE NO.: 2016-CP-26-8032

AFFIDAVIT PHILLIP RAY CAUSEY

Personally appeared before me Phillip Ray Causey and, after being duly sworn, deposes and says:

1) I am Phillip Ray Causey and I am over the age of eighteen (18) years. I currently live at 325 M W Stroud Road in Nichols, South Carolina.

2) I graduated Hancock High School in Mississippi in 1995. I have not received any additional formal education since high school. I have no legal training, have never been employed in any job in the law or legal field, and have no family members or relatives in the law or legal field.

3) On April 27, 2016, I did not own any vehicles or real property and had no insurance policies issued in my name. In April 2016, I did not have a permanent address but more often than not I stayed at my father's house at 325 M W Stroud Road.

4) On April 27, 2016, I had my father Ottis Causey's permission to use his 1994 Ford pickup truck. Since the pickup truck had a current license tag, I figured that it must have been covered by liability insurance. Prior to the accident on April 27, 2016, I did not know what insurance company provided insurance on my father's pickup truck. However, I believed my father Ottis Causey had insurance coverage on the pickup truck.



5) I was involved in an automobile accident with Daniel Eric Knight on April 27, 2016 on Highway 701 in Horry County, South Carolina. The accident with Mr. Knight occurred around 5:20 P.M. as I was headed to a friend's home. I did not drink any alcohol or use any drugs, prescription or otherwise, on April 27, 2016.

6) Just prior to the impact with Mr. Knight's vehicle, I was operating my father's pickup truck completely within my lane of travel on Highway 701. I was not using my cell phone, was not texting, and was not otherwise distracted. While my father's pickup truck was located in the left-most portion of my lane of travel toward the center line of Highway 701, it did not cross the center line prior to the impact with Mr. Knight's vehicle.

7) When I saw Mr. Knight approaching from the opposite direction on Highway 701, he appeared to be driving his vehicle toward the left-most portion of his lane of travel and toward the center line. Very quickly thereafter, our vehicles came into contact in a sideswipe manner. It is my belief and testimony that my father's pickup truck never crossed the center line of Highway 701 prior to the impact.

8) After the accident, I went to check on Mr. Knight and the other driver involved in the accident. There were no apparent serious or life threatening injuries to anyone involved.

9) I provided a copy of the insurance card in the pickup truck to the police officer at the scene of the accident. I did not pay any particular attention to the information on the insurance card or the insurance company name.

10) At no time since the accident occurred have I ever said that my father's pickup truck crossed the center line. At no time have I ever admitted or conceded that my actions caused the accident with Mr. Knight. To the contrary, I have always maintained that I was not at fault for causing the accident with Mr. Knight.

- 2 - 

11) I left the scene of the accident with the tow truck driver who transported my father's pickup truck back to 325 M W Stroud Road in Nichols, South Carolina. Since it was not my pickup truck, I did not have any follow up with any insurance company regarding the damage to it or whether it would be repaired. It was my understanding that my father would report it to the insurance company and then the insurance company would take care of it after that.

12) I do not recall ever being involved in any other automobile accidents as a driver. I have not previously been involved in reporting an automobile accident to an insurance company.

13) I did not contact the insurance company for my father's pickup truck after the accident. Again, it was my understanding that my father would report whatever needed to be reported to the insurance company. I figured that if the insurance company needed anything from me, someone from the insurance company would call me.

14) Eventually, my father's insurance company called me and interviewed me about what happened in the accident on April 27, 2016. As I recall, the only things that were discussed were the facts of the accident. I do not recall whether the company said the statement was being recorded but, regardless, I have never been provided a copy of any recorded statement. I do not believe that I was provided any information by the insurance company regarding any claims being made by anybody involved in the accident in the telephone call.

15) After my telephone call with the insurance company, I figured that the insurance company was taking care of whatever needed to be taken care of.

16) I eventually received papers in the mail concerning Mr. Knight. When I read the papers, I believed that Mr. Knight was coming after me personally. I did not see anything in the papers that the insurance company was being sued and, therefore, I believed that the insurance company was not involved.

- 3 - PRC

17) I have never been sued by anyone for any automobile accident before Mr. Knight. I was not aware, and did not understand, that I needed to contact my father's insurance company if I was sued for the accident with Mr. Knight. I was not aware that my father's insurance company would provide me a lawyer if I was sued for the accident with Mr. Knight.

18) I did not have the financial means to hire a lawyer to assist me with Mr. Knight's lawsuit. However, at all times, I intended to contest Mr. Knight's case and I expected that I would eventually have an opportunity to defend myself in court. Since I did not own anything of value, I figured that even if I lost the case I would not have to pay a lawyer and there would be nothing for Mr. Knight to collect anyway.

19) I did not understand that I needed to file anything or otherwise respond to the papers that I received. I did not know what default meant and I did not understand that I would not be able to contest Mr. Knight's case if a default happened. Again, I believed that there would eventually be a court hearing and I would have the opportunity to defend myself.

20) I received a second set of papers regarding Mr. Knight which included a notice of a hearing on April 18, 2017. I believed the hearing would be the court hearing where I would be able to explain my side of the story and dispute the cause of the accident.

21) From the time that I received the first set of papers regarding Mr. Knight through the time when I appeared for what I thought would be a court hearing on April 18, 2017, I did not contact my father's insurance company. Throughout that time period, I did not believe that the insurance company was involved but instead thought that Mr. Knight was coming after me personally. I was not aware, and did not understand, that I needed to contact my father's insurance company about the court hearing with Mr. Knight.

22) My father Ottis Causey drove me to the hearing location on April 18, 2017. I simply told him that it was a court date about the wreck. We were both surprised when we arrived and found that the hearing was going to be held in a lawyer's office instead of a courthouse.

23) Shortly after arriving, I was addressed by Mr. Knight's attorney Brooke Eaves. In the course of our brief contact, Attorney Eaves told me that the hearing was not about me personally, but was about the insurance company because the insurance company had not done something it was supposed to sometime prior. While I did not understand anything that she was trying to tell me, I wondered why the insurance company was not at the hearing if it was all about the insurance company and not me. This was the first moment that I learned that my father's insurance company might somehow be involved.

24) At the time of the hearing, I did not understand how or why a lawyer was holding the hearing, instead of a judge. It became more concerning when the lawyer excluded my father from the hearing without any explanation. While I still believed that I had the opportunity to dispute the accident, it became clear to me that I would not be allowed to say much of anything or to defend myself. In fact, throughout the hearing, the lawyer judge interrupted me or cut me off when I tried to participate. Many records, medical records, and other documents (some over 1,100 pages) were handed to me to review for the first time during the hearing. I was never offered an opportunity to review them to even understand what they were, much less come up with some objection to them. On more than one occasion, I perceived the lawyer judge to be smirking at me. In short, by the time the hearing was concluded, I was convinced that I had not participated in a fair process held before a fair judge.

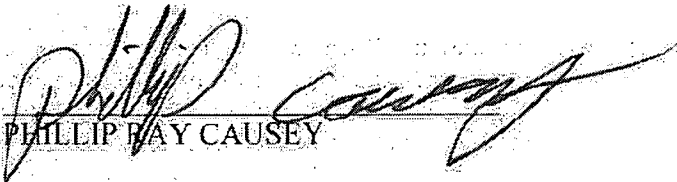
PRC

25) I am not sure why Attorney Eaves would tell me that the hearing was not about me but the insurance company when the result of the hearing was a judgment entered against me for almost \$3.5 million. A judgment was not entered against my father's insurance company.

26) When I received the first set of papers regarding Mr. Knight, I did everything that I thought I could financially afford to do to dispute Mr. Knight's case. While I figured the court would eventually set a hearing where I could defend myself, that never happened.

27) I believe my action, or inaction, was controlled by a mistake, inadvertence or excusable neglect and, therefore, I respectfully request that the default judgment be set aside; the entry of default be set aside; and that I be allowed to contest Mr. Knight's case in full, especially given the fact that I did not contribute to the cause of the accident.

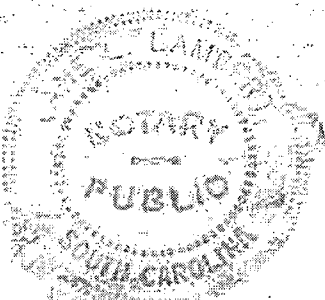
FURTHER AFFIANT SAYETH NOT!

  
PHILLIP RAY CAUSEY

Sworn to and subscribed before me  
this 21<sup>st</sup> day of June, 2017

  
Notary Public

My commission expires: 2/22/2018



STATE OF SOUTH CAROLINA

COUNTY OF HORRY

Daniel Eric Knight,

Plaintiff,

vs.

Phillip Ray Causey,

Defendant.

IN THE COURT OF COMMON PLEAS  
FIFTEENTH JUDICIAL CIRCUIT

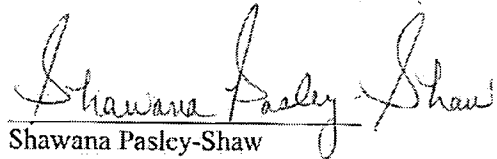
Docket No.: 16-CP-26-8032

**AFFIDAVIT OF  
SHAWANA PASLEY-SHAW**

Shawana Pasley-Shaw, resident of Horry County, files this, her Affidavit, and states as follows:

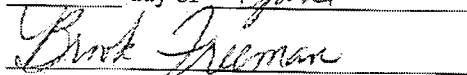
1. I, Shawana Pasley-Shaw, am a resident and citizen of Loris, South Carolina.
2. On April 27, 2016, I witnessed a collision on or about Highway 701 in Loris, SC, at approximately 5:20p.m.
3. A Ford PK, driven by Phillip Ray Causey, was traveling north on Highway 701.
4. I was driving my vehicle behind the Ford PK, driven by Phillip Ray Causey.
5. The Ford PK, driven by Phillip Ray Causey, crossed the center line and struck the Honda driven by Daniel Eric Knight.
6. The Ford PK, driven by Phillip Ray Causey, crossed the center line many times and kept drifting into the other lane before he finally crossed the center line and struck the Honda driven by Daniel Eric Knight.
7. When Phillip Ray Causey struck Daniel Eric Knight's Honda, the impact caused Daniel Eric Knight's Honda to crash head-on into a GMC SUV.
8. Immediately after the collision, I witnessed Phillip Ray Causey get out of the Ford PK he was driving, run around to the passenger side of the Ford PK, and begin throwing items out of the passenger side of his vehicle into the nearby ravine.

FURTHER THE AFFIANT SAYETH NOT.

  
 Shawana Pasley-Shaw

SWORN to before me this

28<sup>th</sup> day of June, 2017



Notary Public for South Carolina

My Commission Expires: 5/29/18