

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Nate Fata, Special Referee

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

RECEIVED
MAY 08 2018
SC Court of Appeals

DANIEL ERIC KNIGHT,

Respondent,

v.

PHILLIP RAY CAUSEY,

Appellant.

RECORD ON APPEAL

VOLUME 4 OF 4

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Columbia, SC 29202
(803) 779-7599

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Attorney for Appellant Phillip Ray Causey

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Amedisys Home Health of Conway

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Department of Health And Human Services
Health Care Financing Administration

<<<11455456 /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

330-719-5930

7. Provider's Name and Address

Amadys Home Health of Conway
176 Waccamaw Medical Park Court

Conway, SC 29826-8965

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

8. Date of Birth: 09/26/1974

9. Sex: XX M () F

11. ICD-CM
248.815Principal Diagnosis
Encnter for surgical after
following surgery on theDate
05/15/16 (O)13. ICD-CM
243.2Other Pertinent Diagnosis
Encounter for attention t
o ileostomyDate
05/15/16 (O)

F41.9

Anxiety disorder, unspeci
fiedDate
05/15/16 (R)10. Medications: Dose/Route/Frequency/Dura. (New) (C) changed
ORXCODONE HCL DOSE:10 MG ORAL FOUR TIMES DAILY FOUR TIMES
DAILY FOR PAIN AS NEEDED (New)
FROLANC DOSE:20 MG ORAL DAILY (New)

14. DME and Supplies

Box of Gloves, Normal Saline, 4x4's, 2x2's, ABC pads, Tape,
Alcohol Wipes, Wound Care/Dressing Supplies, Large Gauze,
CONV ON 483

15. Safety Measures

Keep pathways clear, Standard precautions / Infection
control, Bathroom Safety, Fire Safety, Medication Safety,
CONV ON 483

16. Nutritional Requirements

Regular diet

17. Allergies

Penicillin, Sulfis

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 SPP 7[] Ind. at Home B[] Walker
3XX Up as Tolerated 8[] Crutches C[] No Rest
4[] Transfer Bed/Chair 9[] Cann D[] Other
5[] Exercises Prescribed19. 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)

SM: SW9 EFFECTIVE 5/30/2016

May take orders from: RACHEL COLLINS

SM ORDERS

Patient treatment for ABDOMINAL WOUND will be monitored by
SM and modified by physician.
SM to instruct patient, caregiver on pain management.
SM to evaluate pain each visit.SM to instruct patient, caregiver in wound care to include
signs and symptoms of infection and when to report
physician.SM to instruct patient, caregiver in wound care/proper
disposal of soiled dressings.SM to instruct patient, caregiver in proper
nutrition/hydration to facilitate wound healing.SM to perform wound care as ordered by physician. SM to
clean wound(s) abdomen with normal saline or wound cleanser;
CONV ON 483

22. Goals/Rehabilitation Potential/Discharge Plans

SM 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
CONV ON 483

23. Verbal Start of Care and Review's

Signature and Date Where Applicable: 05/30/2016



25. Date HRA Received Signed 802

24. Physician's Name and Address

RINKUS, GILBERTAS
2361 CYPRESS CIRCLE
CONWAY, SC 29526-

843/347-7291 UPIN: 877713 MPI: 1328126301

26. I XX 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 in-
formation required for payment on federal funds may be subject to
fine, imprisonment, or civil penalty under applicable federal laws.

Form HCFA-485 (C41) (02-94)

PAGE: 2/2

Department of Health And Human Services
Health Care Financing Administration

<<21453456 / 20160503/487 /xx/0>>

Form Approved
OMB No. 0910-0357

Addendum to Home Health Certification and Plan of Treatment

6. Patient's Name
KNIGHT, DANIEL7. Provider's Name
Amesbury 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, 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), versaflex (white) for tunnel(s) or track(s); may use versaflex 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. AM 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/AM may apply the appropriate moist wound healing dressing to the wound, and change per. AM to change VAC dressing 3xweek & per for leakage or complications.

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

mmHg) or Intermittent therapy _____ (75mmHg - 175 mmHg).
 AM to monitor vital signs, meds, chest/heart auscultation.
 AM to instruct patient in all aspects of medication regimen inc. schedule dosage, side effects, drug/food interactions.
 AM TO INSTRUCT ON FALL PRECAUTIONS
 AM TO INSTRUCT ON SKIN CARE AND PRESSURE RELIEF MEASURES
 AM 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%
 LSW 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

Form HCFA-487 (C6) (4-87)

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

8. Date of Birth: 09/26/1974

9. Sex: XX M ☐ F10. Medications: Dose/Route/Frequency/Dir. (N)ew (C)hanged
OXYCODONE HCL DOSE:10 MG ORAL FOUR TIMES DAILY FOUR TIMES
DAILY FOR PAIN AS NEED (New)
PROZAC DOSE:20 MG ORAL DAILY (New)11. ICD-CM
Z48.815Principal Diagnosis
Encntr for surgical after
following surgery on theDate
05/15/16 (O)13. ICD-CM
Z43.2Other Pertinent Diagnoses
Encounter for attention t
o ileostomyDate
05/15/16 (O)

F41.9

Anxiety disorder, unspeci
fied

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 *

16. Nutritional Requirements

Regular diet

17. Allergies

Penicillin, Sulfa

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 Prescribed19. 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 *

22. Goals/Rehabilitation Potential/Discharge Plans

SN GOALS

Patient's 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 *

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 ☐ 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 in-
formation required for payment on Federal funds may be subject to
fine, imprisonment, or civil penalty under applicable Federal laws.

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), versafom (white) for tunnel(s) or track(s); may use versafom 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.

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

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%
LEN 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.

[END IN SIGHT: 06/28/2016]

9. Signature of Physician

10. Date

10. Optional Name/Signature of Nurse/Therapist

12. Date

From:

06/10/2016 16:56

#584 P.002/003

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
Physician
Signature

Katie Cannon
[Signature]

Date

6/1/16

Date

6/14/16

48632592

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 CourtConway, SC 29526-8965
(F) (843) 347-5899 (F) (843) 347-5885PHYSICIANRICHARD EISENMAN
2376 CYPRESS CIRCLE, STE 100

CONWAY, SC 29526-

PATIENT : I1455456KNIGHT, DANIEL
206 ECU CECOM DRCONWAY, SC 29527
DOB : 09/26/1974
ORDER 06/03/2016

[06032016]

ORDER REASON:

LAB

ORDER:

EN 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:

06/06/2016 10:20

#426 P.004/005

Page: 1 / 1

Patho: 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 CRECOM 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

48619651

No. 9026 P. 5

ASSOC IN SURGERY

Jun. 8. 2016 11:35AM

From:

06/10/2016 16:56

#584 P.003/003

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

From:

06/17/2016 15:33

#834 P.002/002

Page: 1 / 1

Pano: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 06/16/2016

SUPPLEMENTAL ORDER

[msptorder/rpptord/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

48672471

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
SignatureElectronically 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/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 06/20/2016

[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

Refno: I1455456

Patient: KNIGHT, DANIEL

Location: 2222

Date: 07/08/2016

SUPPLEMENTAL ORDER

[msprorder/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 : I1455456

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

Clinician Name: AMANDA SOLES LPN

Date: 07/07/2016

Kate Cannon, RN

Physician
Signature

Date

7/29/16

48788062

00

Time: 10:02:05

Page: 1 of 2

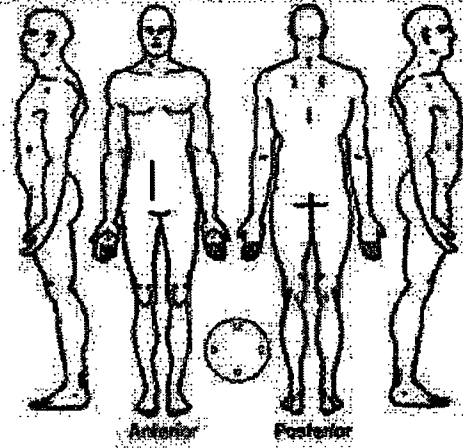
Time in: 09:00 Time Out: 11:00

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 05/30/2016 MR#: I1455458

Agentcode: FRED000245

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 coloration.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☒ Clean: ASEPTIC		Surgical	☒	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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 ABDOMIN

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 *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

0 = 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	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 INTERVENTIONSWound care done: ☒ Yes ☐ No

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

☒ Soiled dressing removedBy: ☐ 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 OUT 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

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Date: 05/30/2016 Patient: KNIGHT, DANIEL (I1455456) Agent: FREDERICK, KIMBERLY, RN (PR0000245)
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 ☐ AM ☐ PM 09:00 TIME OUT ☐ AM ☐ PM 11:00
Agency: Amedisys Home Health of Conway (2222)

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 RTV 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)

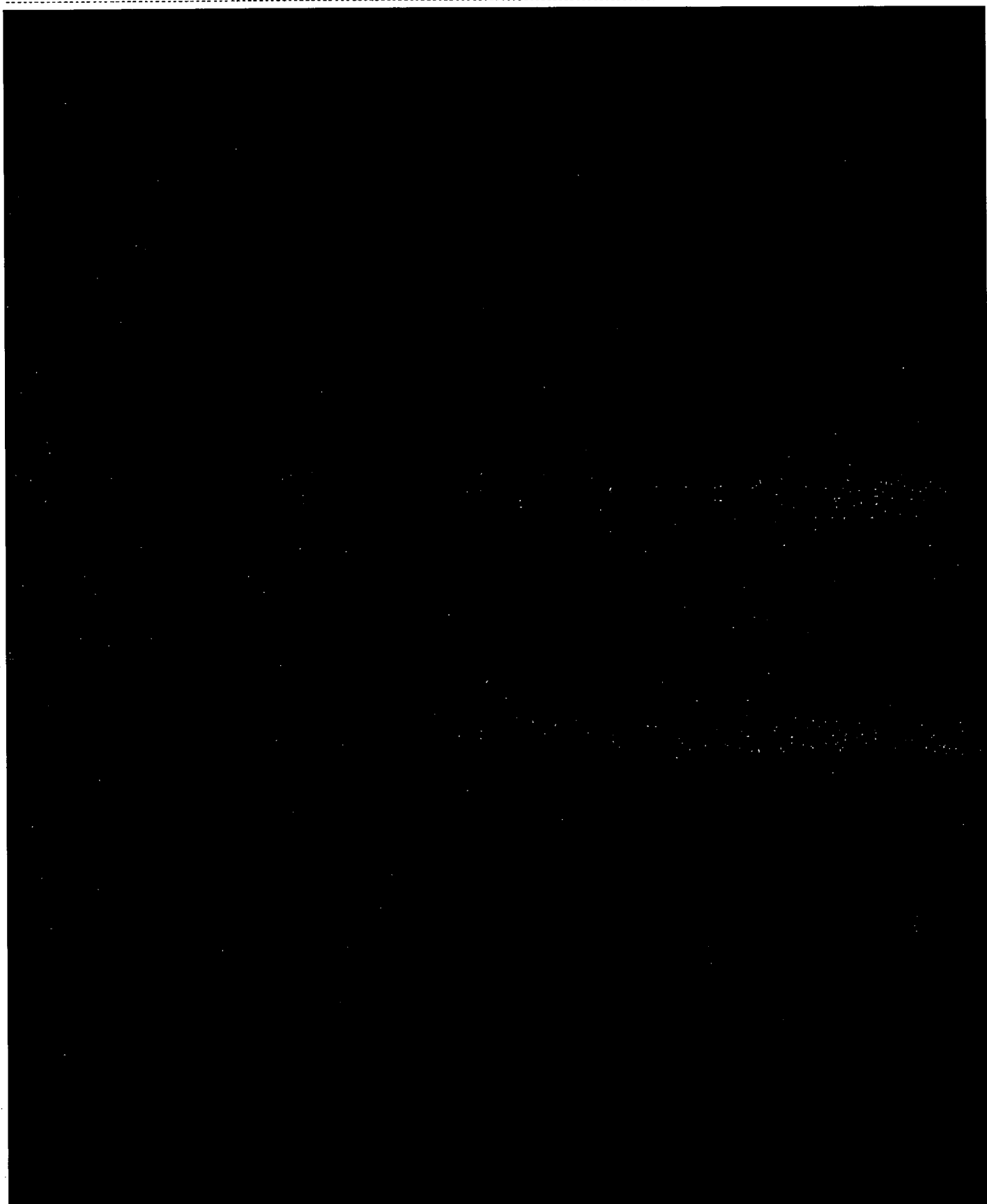
- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☒ 6 - White

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SOC/ROC ASSESSMENT

Patient: KNIGHT, DANIEL (11455456) Agent: FREDERICK, KIMBERLY, RN (FR0000245)



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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:

☒ 1 - RN ☐ 2 - PT ☐ 3 - SLP/ST ☐ 4 - OT

(M0890) Date Assessment Completed:

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

☐ Right

☐ Right

Prior Weight:

Previous Weight:

☐ Right

Sitting

☒ Left

102

/ 60

Standing

☐ Left

Lying

☐ Left

Temperature:

☐ Refused / Unable To Assess / Deferred

98.3

F

☐ ORAL

☐ AXILLARY

☐ RECTAL

☒ TYPHANIC

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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 Tool

Oasis Questions	Have Patient Demonstrate These Tasks PRIOR to Opening the OASIS Set	Clinician Education
M1200	Required Demonstration	
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	2. Ask the patient to sit down in a chair, then ask them to stand up by themselves.	'In order to be scored "0", must complete ALL transfers safely, effectively, and efficiently without any kind of human intervention.'
Transferring	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/out of chair, on/off toilet, and in/out of tub
M1860	3. Once standing, have the patient walk to the bathroom or at least 20 feet.	'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	(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)	'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	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 VAD 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").'
M1840 Toilet	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 SSC, 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 OASIS 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.

Number of Stage I Pressure Ulcers

MI308 Number of Unhealed Stage II or Higher Pressure Ulcers MI326 & MI324

Most Problematic Pressure Ulcer MI334

Stasis Ulcer Status MI342 Surgical Wound Status MI242 Pain

MI740 Behavior Problems

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 NPWP guidelines to determine wound status and staging. Infection, necrosis, lack of wound progress, all may indicate "non-healing" status. A stage 1 pressure ulcer is not healing.

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 pain could still interfere with activity or movement. Determining factors that aggravate pain may help identify pain that interferes. 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 (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?).

Be aware of functional patterns. 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 (NFI)
 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

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- ☐ 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, Z, Y, or Z codes or surgical codes):

Inpatient Facility Diagnosis

ICD-10-C M Code

- a. Peritonitis, unspecified
b. Perforation of intestine (nontrauma)
c.

K65.9
K63.1

- 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, Z, Y, or Z codes or surgical codes):

Changed Medical Regimen Diagnosis:

ICD-10-C M Code

- a. Peritonitis, unspecified
b. Perforation of intestine (nontrauma)
c.
d.
e.
f.

K65.9
K63.1

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

PRIOR HISTORY

- | | | | |
|--|--|--|--|
| ☐ Hypertension | ☐ Respiratory | ☐ Infection | ☐ Cancer (site): |
| ☐ CHF | ☐ Osteoporosis | ☐ Immunosuppressed | ☐ Surgeries: |
| ☐ Other Cardiac | ☐ Fractures | ☐ Open Wound | ☐ Other (specify): |
| ☐ Diabetes | ☐ Osteoarthritis | ☐ CVA | ☐ Mastectomy, date: |
| R / L | | | |
| ☐ Menopause | ☐ Falls | ☐ Hysterectomy, date: | |
| ☐ Chronic Vertigo | ☐ 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 EMERGENT CARE: ☒ No ☐ Yes Number of times:
Reason(s) / Date(s):

PREVIOUS THERAPY: ☒ No ☐ Yes Number of times:

Reason(s) / Date(s):
/ Outcomes

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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 ILEOSTOMY

(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 risks 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

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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	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☒ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 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)	☐ Y ☒ N ☐ N/A	Insects/Rodents	☐ Y ☒ N ☐ N/A
Improper bathroom accessibility	☐ Y ☒ N ☐ N/A	Residence poorly maintained	☐ Y ☒ N ☐ N/A
Uneven floor surfaces / entry	☐ Y ☒ N ☐ N/A	Ramp present	☐ Y ☐ N ☒ N/A
Unsafe placement of rugs/cords furniture, etc.	☐ Y ☒ N ☐ N/A	At risk for falls	☒ Y ☐ N ☐ N/A
Inadequate heating/cooling/electricity	☐ Y ☒ N ☐ N/A	Stairs inside home	☐ Y ☒ N ☐ N/A
Inadequate sanitation/plumbing	☐ Y ☒ N ☐ N/A	Cluttered soiled area	☐ Y ☒ N ☐ N/A
Inadequate refrigeration	☐ Y ☒ N ☐ N/A	Emergency planning/fire safety/equipment maintenance:	
Unsafe gas/electric appliances or outlets	☐ Y ☒ N ☐ N/A	Smoke detectors on all levels of home	☒ Y ☐ N ☐ N/A
Inadequate running water	☐ Y ☒ N ☐ N/A	More than one exit	☒ Y ☐ N ☐ N/A
Inadequate lighting	☐ Y ☒ N ☐ N/A	Plan for power failure	☒ Y ☐ N ☐ N/A
Unsafe storage of supplies/equipment	☐ Y ☒ N ☐ N/A	Oxygen in use - signs posted	☐ Y ☐ N ☒ N/A
Oxygen back-up:	☐ Available	Handles smoking materials safely	☐ Y ☐ N ☒ N/A
	☐ Knows how to use	Lack of fire safety devices	☐ Y ☒ N ☐ N/A
	☐ Electrical/fire safety	Fire extinguishers	☒ Y ☐ N ☐ N/A

Comments::

Documentation of Skilled Intervention/Instruction/Management Problems:

SAFETY MEASURES

Safety Measures:

- | | | |
|--|--|---|
| ☐ 1 - Anticoagulant precautions | ☐ 8 - Direct patient supervision / Safety in ADL's | ☒ 14 - Bathroom Safety |
| ☐ 2 - Oxygen safety measures | ☒ 9 - Keep pathways clear | ☒ 15 - Fire Safety |
| ☐ 3 - Seizure precautions | ☐ 10 - Support during transfer and ambulation | ☐ 16 - Immunosuppression precautions |
| ☐ 4 - Fall prevention safety measures | ☒ 11 - Standard precautions / Infection control | ☒ 17 - Medication Safety |
| ☐ 5 - Aspiration precautions | ☐ 12 - Ambulate with assistive devices (wheelchair, walker, cane) | |
| ☐ 6 - Keep siderails up | ☐ 13 - Assistance with ADL's | ☒ 18 - Slow position change |
| ☐ 7 - HOB elevated | ☐ 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, newspaper.
- ☐ 1 - Partially impaired: cannot see medication labels or newspaper, 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.

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☐ 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,

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- 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: ABDOMIN 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
☐ Immobility
☒ Other:
DRESSING CHANGE

- ☒ Localized
☐ Radiates

Pain Relieved By:

Non Pharmacological Interventions:

- ☒ Diversion ☐ Heat ☐ Ice ☐ Massage
☒ Repositioning ☒ Rest/Relaxation ☐ Other:

Pharmacological Interventions:

- ☒ Medication: OXYCODONE THIS AM

Pain Medication Last Given:

Pain relieved according to patient goal:

Duration of Relief: VARIES ☒ Yes ☐ No ☐ 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:

(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:

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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

INTERGUMENTARY SYSTEM

☐ No problem ☒ See wound addendum ☐ New Wound

☐ Skin breakdown Location:

Highlight all applicable skin assessment:

Skin Color: <Pale> / Jaundice / Redness

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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:

BRADEN SCALE

RISK FACTOR BRADEN SCALE - For Predicting Pressure Sore Risk
 * Fill out per organizational policy [] Deferred HIGH RISK: score < 12 MODERATE RISK: score 13 - 14 LOW RISK: score 15 - 18 SCORE

SENSORY PERCEPTION	1. COMPLETELY LIMITED	2. VERY LIMITED	3. SLIGHTLY LIMITED	4. NO IMPAIRMENT
Ability to respond meaningfully	Unresponsive (does not mean,	Responds only to painful	Responds to verbal commands,	Responds to verbal
to pressure-related discomfort	flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation.	stimuli. Cannot communicate or restlessness	but cannot always communicate discomfort or the need to be turned.	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 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.	

1

MOISTURE	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.

1

ACTIVITY	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.

1

MOBILITY	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.

1

NUTRITION	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 OR	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

1

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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.

FRICTION & 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.

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 re ulcers and healed Stage II pressure ulcers)

or designated as Unstageable? (Excludes Stage I pressure

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)

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 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

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 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) 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 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:

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☐ Palpitations ☐ Fatigues Easily Chest pain relieved by:
LVEF assessment: Date 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 ☒ Right lower: Clear
☐ Cough: Dry / Acute / Chronic ☐ Unable to cough up secretions
☐ Productive: Thick / Thin / Frothy Sputum Color Amount
Oxygen:
O2 @ 28 lpm per ☐ N/A
O2 saturation 98 % ☐ YES ☐ NO
Does this patient have a trach?
Who manages? ☐ Self ☐ RN ☐ Cg/family
☐ Other:
☒ Dyspnea: ☐ Rest ☒ Exertion ☐ Ambulation Rest ☐ 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

Diets ☐ Low sodium diet ☐ 3 MEALS DAILY 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:

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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

Eats fewer than 2 meals per day

Eats few fruits, vegetables or milk products

Has 3 or more drinks of beer, liquor or wine almost everyday

Has tooth or mouth problems that make it hard to eat

Does not always have enough money to buy the food needed

Eats alone most of the time

Takes 3 or more different prescribed or over-the-counter drugs a day

Without wanting to, has lost or gained 10 pounds in the last 6 months

Not always physically able to shop, cook and / or feed self

☐ No Problem

TOTAL

☒ 2
☐ 3
☐ 2
☐ 2
☐ 2
☐ 4
☐ 1
☐ 1
☐ 2
☒ 2

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

Abdominal 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:

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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 anuria 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?

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- ☐ 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):
- ☐ Lesions
- ☐ Masses
- ☐ Inflammation
- ☐ Surgical Alteration
- ☐ Prostate Problem: BPH / TURP Date:
- ☐ Self-testicular exam Frequency:
- ☐ Blister
- ☐ Cyst
- ☐ Breast self-exam Frequency:
- ☐ Discharge: R / L
- ☐ 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

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☐ 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 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

(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 - 10 days	11 - 14 days	Unable to respond
a) Little interest or pleasure in doing things	☒ 0	☐ 1	☐ 2	☐ 3	☐ NA
b) Feeling down, depressed, or hopeless?	☒ 0	☐ 1	☐ 2	☐ 3	☐ 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.

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(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 ☐ Poor conditioning ☐ Muscle wasting ☐ Decreased muscle tone

☐ Limited ROM

Location:

☐ Skin Numbness / Tingling

☒ Decreased mobility LIMITED ☒ Decreased endurance WEAKNESS

☐ 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:

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FUNCTIONAL LIMITATIONS

(Locator #18A)

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

☒ 6 - Endurance

ACTIVITIES PERMITTED

- | | | | |
|---|---|--|------------------------------------|
| ☐ 1 - Complete bedrest | ☐ 5 - Exercises prescribed | ☐ 9 - Cane | ☐ D - Other |
| ☐ 2 - Bedrest/BRP | ☐ 6 - Partial weight bearing | ☐ A - Wheelchair | |
| ☒ 3 - Up as tolerated | ☐ 7 - Independent at home | ☐ B - Walker | |
| ☐ 4 - Transfer bed/chair | ☐ 8 - Crutches | ☐ 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

g zippers, buttons, and snaps:

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

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

Ability to Dress Lower Body

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

- ☐ 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 reheated delivered meals safely:
☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheated 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 Help	Dependent
a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)	☒ 0	☐ 1	☐ 2
b. Ambulation	☒ 0	☐ 1	☐ 2
c. Transfer	☒ 0	☐ 1	☐ 2
d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)	☒ 0	☐ 1	☐ 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 ☒ 0 ☐ 1

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

Inability to make it to the bathroom or commode in timely manner

Includes frequency, urgency, and/or nocturia. ☒ 0 ☐ 1
 Visual impairment ☒ 0 ☐ 1

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 ☐ 0 ☒ 1

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 ☐ 0 ☒ 1

May include but not limited to, poor illumination, equipment tripping, 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) ☒ 0 ☐ 1

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.

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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
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(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.

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- ☐ 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	☒ 0	☐ 1	☐ 2	☐ NA
b. Injectable medications	☐ 0	☐ 1	☐ 2	☒ 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.)

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

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(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.

Column 3: (OPTIONAL) There is no requirement that HHAs 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,

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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, Z 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	V, W, X, Y, Z codes NOT allowed	V, W, X, Y, Z codes NOT allowed
b. <u>Encounter for attention to ileostom</u>	<u>Z43.2</u>	b.	b.
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				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				Patient has no diabetes or is on insulin therapy. No foot care needed.
c. Falls prevention interventions	[] 0	[X] 1	[] NA	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	[] 0	[X] 1	[] NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2)

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has some symptoms of depression but does

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

- Intervention(s) to monitor and mitigate pain
- e. ☐ 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 has been requested from 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 22 HOURS, IF NOT WORKING FOR 2 HOURS, REMOVE AND APPLY NET TO DRY DRESSING. NET WITH NORMAL SALINE, SQUEEZE EXCESS OUT FLUFF IN WOUND AND COVER WITH 4x4 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

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[] 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 (must answer PT and INR or PTT for results).
Reported to Dr.
[] 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 If 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	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Early warning S/S to report	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Medications (list meds taught)	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Pain	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Therapy: IV / Parenteral / O2	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Treatments (Resp, etc)	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Equipment Use/Management	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Diet / Fluid management	[X] Patient	[X] Caregiver	[X] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Activity Guidelines	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
ADL's / Self-care tasks	[X] Patient	[X] Caregiver	[X] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Safety Factors	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Lifestyle adjustments/Coping	[X] Patient	[X] Caregiver	[X] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Community Resources	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration
Other (Specify)	[] Patient	[] Caregiver	[] Verbalized	[] Questionable	[] Compliant	[] Return Demonstration

WRITTEN INSTRUCTIONS/MATERIALS PROVIDED

[X] Medication regimen/administration
[X] Pain levels
[X] Treatment options
[X] Disease progression
[X] Agency phone number/after hours number

[X] Universal precautions/handwashing
[X] Basic home safety
[X] Rights and responsibilities
[X] HIPAA privacy
[X] State hotline number

[X] Advance directives
[X] DNR/DNI
[X] Confidentiality
[X] Emergency planning in the event if service is disrupted.

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☐ 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

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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: CNC 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: OTXCODONE 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

Time: 10:03:22

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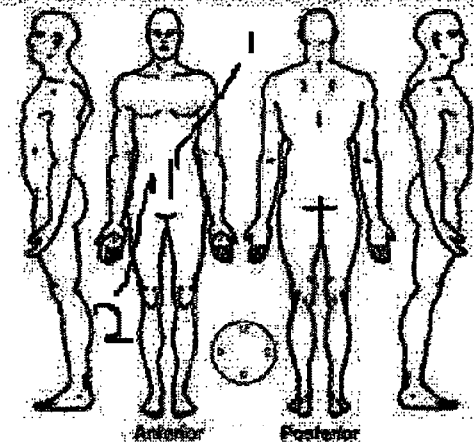
Time in: 15:45 Time Out: 17:15

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.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☒ Clean: ASEPTIC		Surgical	☒	☒	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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: 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/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: 06/01/2016 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 INTERVENTIONSWound 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 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 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 OUT 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 INTERVENTIONSWound 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 careEducation: ☐ 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
Date: 06/01/2016
Time in: 15:45 Time Out: 17:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN0000889)

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 06/01/2016

TIME IN

[] AM [] PM

Start of Care Date:

05/30/2016

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 MED 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:

Page: 2 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

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 signs 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: / 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:

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN000089)

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
[] Right / [] Right
Prior Weight: Previous Weight:

Sitting [X] Left 102 / 72 Standing [] Left / Lying [] Left /

Temperature: [] Refused / Unable To Assess / Deferred
98.6 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred

[] Apical [] Brachial [X] <Regular> / Irregular [X] Radial 86 [] Carotid [X] Rest [] Activity

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

Gastrointestinal

Nutritional Status

Appetite [X] 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 [X] Regular diet [] Other:
[] 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

[X] 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)

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN000089)

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: 06/01/2016 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 Site:

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 ☐ 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

Page: 5 SKILLED NURSE VISIT NOTE
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☐ 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 ☒ 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
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:

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN000089)

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: BX / AX / UE Left: BX / AX / 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

Page: 7 SKILLED NURSE VISIT NOTE
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Time in: 15:45 Time Out: 17:15

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 C
AREGIVER 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
AFTER 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 FO
DS EATEN DAILY. TO HELP SEE WHICH FOODS CAN EAT WITH OUT PROBLEMS. NEED EAT SLOWLY, CHEW FOOD THOROUGHLY, AVOID GUM, SMOKING OR DRINKING THROUGH STRAW. TRY YOGURT OR BUTTE
RMILK 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 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 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	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Medications (list meds taught)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Pain	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Therapy: IV / Parenteral / OZ	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

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SKILLED NURSE VISIT NOTE

Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN000089)

Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: CUNNINGHAM, PATRICIA, LPN (CUN000089)

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

Time: 10:03:58

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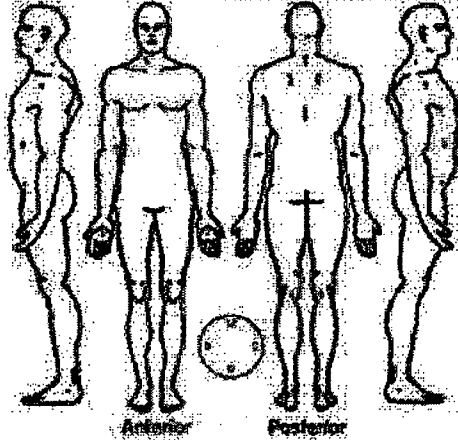
Time in: 14:00 Time Out: 14:51

WOUND ADDENDUM

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

Agentcode: RUC000018

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.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☒ Clean: ASEPTIC		Surgical	☒	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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 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/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: 06/03/2016 MR#: I1455456

Agentcode: 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 = 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	T = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

WOUND INTERVENTIONSWound 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: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE 06/03/2016

TIME IN

☐ AM ☐ PM

Start of Care Date:

14:00

TIME OUT

05/30/2016

☐ AM ☐ PM

14:51

TYPE OF VISIT: ☒ Skilled <Planned> / PRN / Infusion / <Wound care> ☐ Skilled & Supervisory

☐ Supervisory Only

☐ Other

Reason for visit: WOUND CARE, 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

☐ 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:

Page: 2 SKILLED NURSE VISIT NOTE
Date: 06/03/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)
Time in: 14:00 Time Out: 14:51

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

☐ 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: PERCOCET
WELLB 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
/ 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:

Specs transported to

Laboratory via CSHA protocol.

☐ Universal precautions / infection control maintained

INTRODUCTORY SYSTEM

☐ No problem ☒ See wound addendum ☐ New Wound
☐ Skin breakdown Location:
Highlight all applicable skin assessment:

Page: 3 SKILLED NURSE VISIT NOTE
Date: 06/03/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)
Time In: 14:00 Time Out: 14:51

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

Blood Pressure: [] Refused / Unable To Assess / Deferred Prior Weight:
[X] Right 100 / 67 [] Right / Previous Weight:
[] Right /

Sitting [] Left / Standing [] Left / Lying [] Left /

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

Pulse: [] Refused / Unable To Assess / Deferred

[X] Apical 94 [] Brachial [X] <Regular> / Irregular [] Radial [] Carotid [X] Rest [] Activity

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

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

Documentation of Skilled Intervention / Instruction / Management problems:

Gastrointestinal

Nutritional Status

Appetite [] Good [X] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals 2-3 MEALS PER DAY
Diets [] Low sodium diet [] Calorie ADA diet [] Bland diet [X] Protein diet [] High carbohydrate diet

[] Low carbohydrate diet [] Mechanical diet [] Soft diet [] Regular diet [X] Other: LOW RESIDUAL
[] 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

[X] 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: 4
Date: 06/03/2016
Time in: 14:00 Time Out: 14:51
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000010)

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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/03/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)
Time in: 14:00 Time Out: 14:51

☐ 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 @ lpm 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 Munkness / 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

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Date: 06/03/2016
Time in: 14:00 Time Out: 14:51
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)

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, generalized weakness Medical necessity: wound care, education SN into see patient. Patient A+Gx3, 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
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	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Medications (list meds taught)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Pain	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Therapy: IV / Parenteral / O2	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

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Date: 06/03/2016
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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000419)

Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ 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	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
	<u>BOOST FOR NUTRITION AND HEALING, PREVENT WEIGHT LOSS</u>					
Activity Guidelines	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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:

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Date: 06/03/2016
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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000018)

☒ 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

Time: 10:04:39

Page: 1 of 2

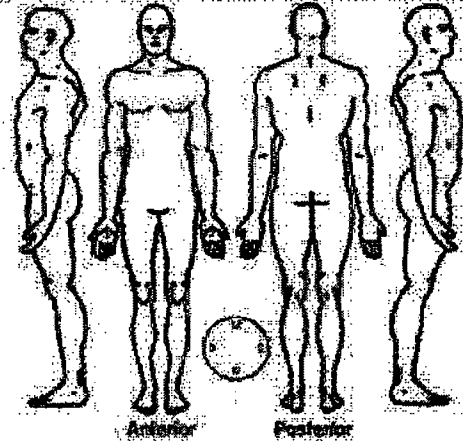
Time in: 10:15 Time Out: 11:00

WOUND ADDENDUM

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

Agentcode: ATND000009

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 coloration.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☐ Clean:		Surgical	☐	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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/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: 06/06/2016 MR#: I1455456

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 3.2x0.2 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: 06/06/2016

Time: 10:05:06

Page: 1 of 2

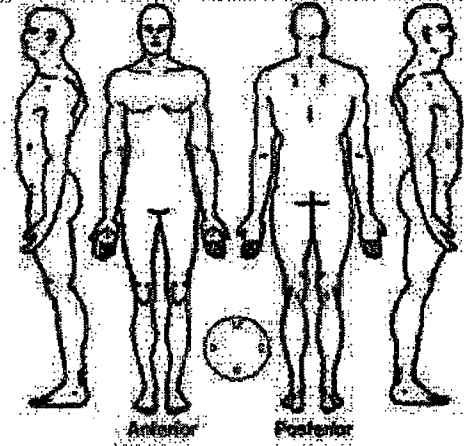
Time in: 11:10 Time Out: 11:45

WOUND ADDENDUM

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

Agentcode: RU0000018

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



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☒ Clean: ASEPTIC		Surgical	☒	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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: 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: 06/08/2016 MR#: I1455456

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 INTERVENTIONSWound 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 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 soiled 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

Time: 10:06:36

Page: 1 of 2

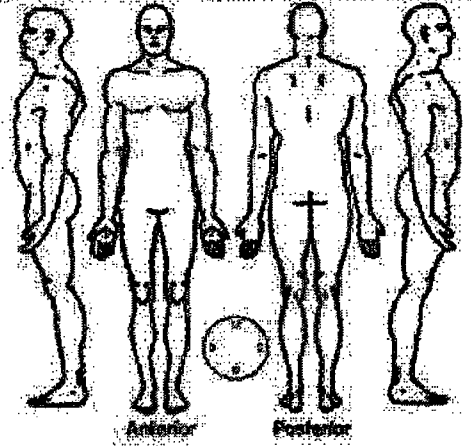
Time in: 09:00 Time Out: 10:00

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 volume.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☐ Clean:		Surgical	☐	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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)					
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/Cdcr					

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 = Crust	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 INTERVENTIONSWound 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/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 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: 06/08/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)
Time in: 11:10 Time Out: 11:45

NURSING VISIT NOTE

Agency: Amadys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 06/08/2016

TIME IN

☐ AM ☐ PM

Start of Care Date:

05/30/2016

TIME OUT

☐ AM ☐ PM

11:45

TYPE OF VISIT: ☒ Skilled Planned / <PRN> / Infusion / <Wound care> ☐ Skilled & Supervisory

☐ Supervisory Only

☐ Other

Reason for visit: PRE 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:

Page: 2
Date: 06/08/2016
Time in: 11:10 Time Out: 11:45
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)

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

☐ Localized
☐ Radiates

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:

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

☐ 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:

Lab's 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:

Page: 3
Date: 06/08/2016
Time in: 11:10 Time Out: 11:45
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

Blood Pressure: [] Refused / Unable To Assess / Deferred Prior Weight: [] Reported
[] Right [] Left Previous Weight: [] Right [] Left

Sitting [X] Left 102 / 60 Standing [] Left [] Right Lying [] Left [] Right

Temperature: [] Refused / Unable To Assess / Deferred
98.2 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred

[X] Apical 102 [] Brachial [X] <Regular> / Irregular [] Radial [] Carotid [X] Rest [] Activity

Blood Sugar: [] Refused / Unable To Assess / Deferred 0 [] ac [] pc
Respirations: 16 [] Refused / Unable To Assess / Deferred [X] <Regular> / Irregular [] Cheyne-Stokes [] Death rattle [] Apnea periods sec.
Documentation of Skilled intervention / instruction / management problems:

Gastrointestinal

Nutritional Status

Appetite [] Good [X] 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 [X] 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

[X] 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: 4 SKILLED NURSE VISIT NOTE
Date: 06/08/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)
Time in: 11:10 Time Out: 11:45

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 ☐ 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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/09/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000019)
Time in: 11:10 Time Out: 11:45

☐ 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 ☒ Right lower: Clear

☐ 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
☐ 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):
Amount ml Frequency Returns
Patient tolerated procedure well ☐ YES ☐ NO

☐ Other (specify)

Documentation of Skilled intervention / instruction / management problems:

Page: 6 SKILLED NURSE VISIT NOTE
Date: 06/09/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)
Time in: 11:10 Time Out: 11:45

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 R / L
☐ 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

Page: 7
Date: 06/08/2016
Time in: 11:10 Time Out: 11:45
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)

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: per visit for colostomy care and wound care SN into see patient. Patient A+Ox3, 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.
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	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Medications (list meds taught)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Pain	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Therapy: IV / Parenteral / O2	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Treatments (Resp, etc)	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

Page: 8 SKILLED NURSE VISIT NOTE
Date: 06/08/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000018)
Time in: 11:18 Time Out: 11:45

	WET TO DRY DRESSING CHANGE, COLOSTOMY BAG CHANGE					
	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐	☐	☐	☐	☐	☐
Diet / Fluid management	☐	☐	☐	☐	☐	☐
Activity Guidelines	☐	☐	☐	☐	☐	☐
ADL's / Self-care tasks	☐	☐	☐	☐	☐	☐
Safety Factors	☐	☐	☐	☐	☐	☐
Lifestyle adjustments/Coping	☐	☐	☐	☐	☐	☐
Community Resources	☐	☐	☐	☐	☐	☐
Other (Specify)	☐	☐	☐	☐	☐	☐

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:

Page: 9 SKILLED NURSE VISIT NOTE
Date: 06/08/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)
Time in: 11:10 Time Out: 11:45

☒ <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 ☐ RN ☐ 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: 06/08/2016 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)

DATE 06/08/2016

TIME IN

[] AM [] PM

Start of Care Date:

05/30/2016

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:

[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:

Page: 2
Date: 06/08/2016
Time in: 09:00 Time Out: 16:00
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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: ORFODONE 9AM

Pain Medication Last Given:

Pain relieved according to patient goal:

Duration of Relief: VARIES ☒ Yes ☐ No ☐ 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: / 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:

Labels 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:

Page: 3
Date: 06/08/2016
Time in: 09:00 Time Out: 10:00
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

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

Sitting [] Left / Standing [] Left / Lying [] Left /

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

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

Blood Sugar: [] Refused / Unable To Assess / Deferred 0 [] ac [] pc
Respirations: [] Refused / Unable To Assess / Deferred
16 [X] <Regular> / Irregular [] Cheyne-Stokes [] Death rattle [] Apnea periods sec.
Documentation of skilled intervention / instruction / management problems:

974

Gastrointestinal

Nutritional Status

Appetite [X] Good [] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals
Diets [] Low sodium diet [] THREE TIMES PLUS SNACKS
[] Low carbohydrate diet [] Mechanical diet [] Soft diet [X] Regular diet [] Other:
[] Increase fluids [] Restrict fluids ant. 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

[X] 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)

Page: 4 SKILLED NURSE VISIT NOTE
Date: 06/08/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:00 Time Out: 10:00

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 06/08/2016 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 % Date

Pace-maker: Date Type

☒ No Edema

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

☐ Upper Extremities Right / Left

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/06/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:00 Time Out: 10:00

☐ 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

☒ Right middle: Clear

☒ Right lower: Clear

☒ Left lower: Clear

☒ Posterior:

☒ Right upper: Clear

☒ Right middle: Clear

☒ Right lower: Clear

☒ Left upper: Clear

☒ Left 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:

Page: 6 SKILLED NURSE VISIT NOTE
Date: 06/08/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000009)
Time in: 09:00 Time Out: 10:00

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 / 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

Page: 7 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

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

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

TEACHING/TRAINING

SUBJECT INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE

Disease processes	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Medications (list meds taught)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Pain	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Therapy: IV / Parenteral / O2	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

Page: 8
Date: 06/08/2016
Time in: 09:00 Time Out: 10:00
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000009)

Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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 SKILLED NURSE VISIT NOTE
Date: 06/08/2016 Patient: KNIGHT, DANIEL (11455455) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:00 Time Out: 10:00

☒ 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

Time: 10:07:22

Page: 1 of 2

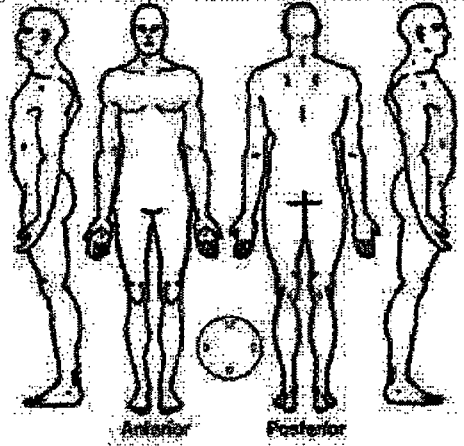
Time in: 09:00 Time Out: 09:30

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 columns.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☐ Clean:		Surgical	☐	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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)	12.0 *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#: I1455456

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 = 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	I = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

WOUND INTERVENTIONSWound care done: ☐ Yes ☒ No

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

☒ Soiled dressing removedBy: ☐ Patient ☐ Caregiver ☐ Family ☒ RN/PT☒ Wound cleaned with (specify):

WC

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

MOIST WET/DRY DRESSING

☐ 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. 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.

Record on Appeal 1449

Signature: KIMBERLY ATWELL, LPN

Date: 06/10/2016

Page: 1 SKILLED NURSE VISIT NOTE
Date: 06/10/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTN000009)
Time in: 09:00 Time Out: 09:30

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 06/10/2016

TIME IN

[] AM

[] PM

Start of Care Date:

05/30/2016

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:

[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:

Page: 2 SKILLED NURSE VISIT NOTE
Date: 06/10/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000009)
Time in: 09:00 Time Out: 09:30

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:

Lab's 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:

Page: 3
Date: 06/10/2016
Time in: 09:00 Time Out: 09:30
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

Blood Pressure: [] Refused / Unable To Assess / Deferred Prior Weight:
[X] Right 128 / 78 [] Right Previous Weight:
Sitting Standing Lying

Temperature: [] Refused / Unable To Assess / Deferred
Pulse: [] Refused / Unable To Assess / Deferred [X] Radial 98 [] Carotid [X] Rest [] Activity

[] Apical [] Brachial [X] <Regular> / Irregular [X] Radial 98 [] Carotid [X] Rest [] Activity
Blood Sugar: [] Refused / Unable To Assess / Deferred 0 [] ac [] pc
Respirations: [] Refused / Unable To Assess / Deferred 16 [X] <Regular> / Irregular [] Cheyne-Stokes [] Death rattle [] Apnea periods sec.

Documentation of Skilled intervention / instruction / management problems:

984

Gastrointestinal

Nutritional Status

Appetite [X] Good [] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals

Diet: [] Low sodium diet [] Bland diet [] Protein diet [] High carbohydrate diet

[] Low carbohydrate diet [] Mechanical diet [] Soft diet [X] Regular diet [] Other:
[] 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

[X] 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)

Page: 4 SKILLED NURSE VISIT NOTE
Date: 06/10/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:00 Time Out: 09:30

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 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

Page: 5
Date: 06/10/2016
Time in: 09:00 Time Out: 09:30
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

☐ 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:

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/10/2016 Patient: KNIGHT, DANIEL (114554561) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)
Time in: 09:00 Time Out: 09:30

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

Page: 7 SKILLED NURSE VISIT NOTE
Date: 06/10/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)
Time in: 09:00 Time Out: 09:30

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 S/S 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 we/c/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	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Medications (list meds taught)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Pain	☒ Patient NO PAIN NOTED	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Therapy: IV / Parenteral / O2	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

Page: 8 SKILLED NURSE VISIT NOTE
Date: 06/10/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:00 Time Out: 09:30

Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> ☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

HOMESOUND 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 ☐ 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:

Page: 9
Date: 06/10/2016
Time in: 09:00 Time Out: 09:30
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (I1455456) 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

☒ 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

Time: 10:07:49

Page: 1 of 2

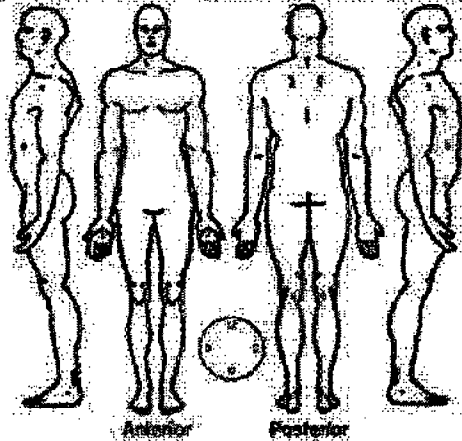
Time in: 09:40 Time Out: 10:15

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 estimates.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☐ Clean:		Surgical	☐	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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: 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 INTERVENTIONSWound 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 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.

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 (ATW000009)
Time in: 09:40 Time Out: 10:15

NURSING VISIT NOTE

Agency: Anedisy'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: ☒ Skilled ☐ Planned ☐ PRN ☐ Infusion ☐ Wound care ☐ Skilled & Supervisory ☐ Supervisory Only
☐ Other
Reason for visit: SN VISIT AND 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:

Page: 2
Date: 06/13/2016
Time in: 09:40 Time Out: 10:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

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
☐ Immobility
☐ Other:

☐ Localized
☐ Radiates

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:

Page: 3
Date: 06/13/2016
Time in: 09:40 Time Out: 10:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11459456) Agent: ATWELL, KIMBERLY, LPN (RTW000909)
Time in: 09:40 Time Out: 10:15

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

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

Sitting [] Left / Standing [] Left / Lying [] Left /

Temperature: [] Refused / Unable To Assess / Deferred
98.0 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred

[] Apical [] Brachial [X] <Regular> / Irregular [X] Radial 90 [] Carotid [X] Rest [] Activity

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

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

Documentation of Skilled intervention / instruction / management problems:

938

Gastrointestinal

Nutritional Status

Appetite [X] Good [] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals

Diet [] Low sodium diet [] THREE MEALS PLUS SNACKS Calorie ADA diet [] Bland diet [] Protein diet [] High carbohydrate diet

[] Low carbohydrate diet [] Mechanical diet [] Soft diet [X] 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

[X] 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: 4 SKILLED NURSE VISIT NOTE
Date: 06/13/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:40 Time Out: 10:15

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 06/13/2016 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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/13/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 09:40 Time Out: 10:15

☐ 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

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

Infused 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:

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Date: 06/13/2016
Time in: 09:40 Time Out: 10:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW0000091)

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: SX / AX / UE Left: SX / AX / 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

Page: 7 SKILLED NURSE VISIT NOTE
Date: 06/13/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LFN (ATW000009)
Time in: 09:40 Time Out: 10:15

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/B 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. Kimms 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

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE
Disease processes	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Early warning S/S to report	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
NO S/S OF INFECTION	
Medications (list meds taught)	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Pain	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Therapy: IV / Parenteral / O2	☒ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Treatments (Resp, etc)	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

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Date: 06/11/2016
Time in: 09:40 Time Out: 10:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
	AS TOLERATED					
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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: 06/13/2016
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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

☒ 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

Time: 10:06:15

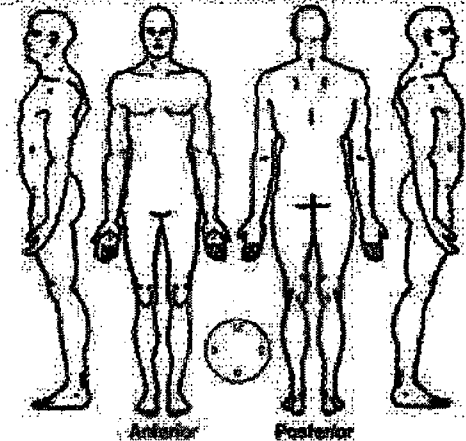
Page: 1 of 2

Time in: 10:45 Time Out: 11:50

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).



LOCATION:	#1	#2	#3	#4
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 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	E				
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 INTERVENTIONSWound 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

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Date: 06/15/2016
Time in: 10:45 Time Out: 11:50

SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

NURSING VISIT NOTE

Agency: **Amedisys Home Health of Conway (2222)**

Patient: **KNIGHT, DANIEL (11455456)**

DATE: **06/15/2016**

TIME IN

[] AM

[] PM

Start of Care Date:

05/30/2016

10:45

TIME OUT

[] AM

[] PM

11:50

TYPE OF VISIT: [X] Skilled <Planned> / PRN / Infusion / Wound care [] Skilled & Supervisory

[] Supervisory Only

[] Other

Reason for visit: **SN 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:

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (114554556) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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 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: OTYCODONE 10AM

Pain Medication Last Given:

Pain relieved according to patient goal:

Duration of Relief: VARIES ☒ Yes ☐ No ☐ 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: / 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:

Lab's transported to

☐ Universal precautions / infection control maintained

laboratory via OSHA protocol.

INTEGUMENTARY SYSTEM

☒ No problem

☐ Skin breakdown Location: ☐ See wound addendum ☐ New Wound

Highlight all applicable skin assessment:

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Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

Blood Pressure: [] Refused / Unable To Assess / Deferred
[X] Right 102 / 68 [] Right /
Prior Weight:
Previous Weight:

Sitting [] Left / Standing [] Left / Lying [] Left /

Temperature: [] Refused / Unable To Assess / Deferred
98.6 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred

[] Apical [] Brachial [X] <Regular> / Irregular [X] Radial 60 [] Carotid [X] Rest [] Activity

Blood Sugar: [] Refused / Unable To Assess / Deferred 0 [] ac [] pc
Respirations: [] Refused / Unable To Assess / Deferred
16 [X] <Regular> / Irregular [] Cheyne-Stokes [] Death rattle [] Apnea periods sec.
Documentation of Skilled intervention / instruction / management problems:

97%

Gastrointestinal

Nutritional Status

Appetite [X] Good [] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals
Diets [] Low sodium diet [] Bland diet [] Protein diet [] High carbohydrate diet
[] Low carbohydrate diet [] Mechanical diet [] Soft diet [X] 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

[X] 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)

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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 06/15/2016 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

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

☐ 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
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)
☐ 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:

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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: 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

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SKILLED NURSE VISIT NOTE

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 wouldn't 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 ☐ 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 (must answer PT and INR or PTT for results).
- Reported to Dr.
- ☐ 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

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE
Disease processes	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Early warning S/S to report	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
S/S OF INFECTION	
Medications (list meds taught)	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Pain	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
PAIN IN THE INCISION	
Therapy: IV / Parenteral / O2	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

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Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> ☒ Patient ☐ Caregiver <u>NEEDS ASSISTANCE WITH ADL'S</u>		☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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 ☐ 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

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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 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 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)

DATE 06/17/2016

TIME IN

[] AM [] PM

Start of Care Date:

05/30/2016

11:00

TIME OUT

[] AM [] PM

12:00

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:

[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:

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Date: 06/17/2016
Time in: 11:00 Time Out: 12:00
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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: 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

☐ 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:

Lab's transported to

laboratory via CSHA protocol.

☐ Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

☒ No problem

☐ Skin breakdown ☐ See wound addendum

Location:

☐ New Wound

Highlight all applicable skin assessment:

Page: 3 SKILLED NURSE VISIT NOTE
Date: 06/17/2016 Patient: KNIGHT, DANIEL (114554561) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 11:00 Time Out: 12:00

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

Blood Pressure: [] Refused / Unable To Assess / Deferred Prior Weight:
[X] Right 100 / 60 [] Right / Previous Weight:
[] Left /

Sitting [] Left / Standing [] Left / Lying [] Left /

Temperature: [] Refused / Unable To Assess / Deferred
98.5 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred

[] Apical [] Brachial [X] <Regular> / Irregular [X] Radial 97 [] Carotid [X] Rest [] Activity

Blood Sugar: [] Refused / Unable To Assess / Deferred 0 [] ac [] pc
Respirations: [] Refused / Unable To Assess / Deferred
16 [X] <Regular> / Irregular [] Cheyne-Stokes [] Death rattle [] Apnea periods sec.
Documentation of skilled intervention / instruction / management problems:

97%

Gastrointestinal

Nutritional Status

Appetite [X] 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 [X] 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

[X] 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/Wite care: (specify)

Page: 4 SKILLED NURSE VISIT NOTE
Date: 06/17/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 11:00 Time Out: 12:00

Performed by: ☐ Self ☐ Nurse ☐ Caregiver ☐ Other

Flush Protocol: (amt./specify)

Interventions/Instructions/Comments:

Who manages?

Documentation of Skilled intervention / instruction / management problems:

Abdomen / S.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 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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/17/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LBN (ATW000009)
Time in: 11:00 Time Out: 12:00

☐ 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

☐ 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

☐ 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:

Page: 6
Date: 06/17/2016
Time in: 11:00 Time Out: 12:00
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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 Munkness / 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

Page: 7 SKILLED NURSE VISIT NOTE
Date: 06/17/2016 Patient: KNIGHT, DANIEL (11459456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 11:00 Time Out: 12:00

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 ☐ 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	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Medications (list meds taught)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Pain	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Therapy: IV / Parenteral / O3	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration

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 Date: 06/17/2016
 Time in: 11:00 Time Out: 12:00

SKILLED NURSE VISIT NOTE

Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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:

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Date: 06/17/2016
Time in: 11:00 Time Out: 12:00
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455455) 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

☒ 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

Time: 10:06:52

Page: 1 of 2

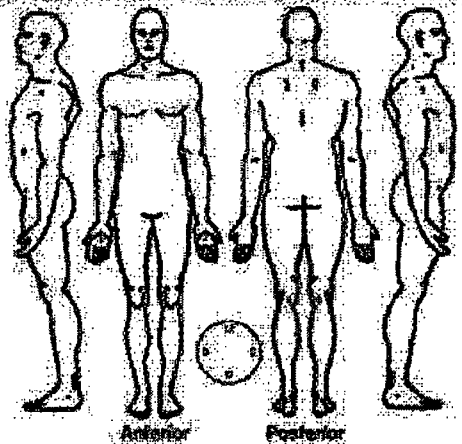
Time in: 10:30 Time Out: 11:45

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/20/2016 MR#: I1455458

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).



☐ NO WOUND	LOCATION:	#1	#2	#3	#4	
Technique used for wound care: ☐ Clean: ☐ Sterile ☐ 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 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	I = Tenderness	
	C = Copious		E = Edema	
			P = Pain	
			F = Fever	

WOUND INTERVENTIONSWound 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 CMC. 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: Anedisy's Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 06/20/2016

TIME IN

☐ AM

☐ PM

Start of Care Date:

05/30/2016

10:30

TIME OUT

☐ AM

☐ PM

11:45

TYPE OF VISIT: ☒ 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:

Page: 2 SKILLED NURSE VISIT NOTE
Date: 06/20/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time In: 10:30 Time Out: 11:45

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 signs 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: OXICODONE 9AM

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 / Pains / 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 CSHA protocol.

☐ Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

☒ No problem

☐ See wound addendum

☐ New Wound

☐ Skin breakdown

Location:

Highlight all applicable skin assessment:

Page: 3
Date: 06/20/2016
Time In: 10:30 Time Out: 11:45
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

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" [X] Reported [] Actual Weight: [] Refused / Unable To Assess / Deferred [] Reported [] Actual

Blood Pressure: [] Refused / Unable To Assess / Deferred
[X] Right 106 / 62 [] Right /
Prior Weight: Previous Weight:

Sitting [] Left / Standing [] Left / Lying [] Left /

Temperature: [] Refused / Unable To Assess / Deferred
99.3 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred

[] Apical [] Brachial [X] <Regular> / Irregular [X] Radial 88 [] Carotid [X] Rest [] Activity

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

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

Documentation of Skilled Intervention / Instruction / Management problems:

978

Gastrointestinal

Nutritional Status

Appetite: [X] Good [] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals

Diets: [] Low sodium diet [] Bland diet [] Protein diet [] High carbohydrate diet

[] Low carbohydrate diet [] Mechanical diet [] Soft diet [X] 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

[X] 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: 4 SKILLED NURSE VISIT NOTE
Date: 06/20/2016 Patient: KNIGHT, DANIEL (11455455) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:30 Time Out: 11:45

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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/20/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000009)
Time in: 10:30 Time Out: 11:45

☐ 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

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

☐ Skill / Foley catheter care / Change French

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 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:

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 / 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

Page: 7
Date: 06/20/2016
Time in: 10:30 Time Out: 11:45
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

SKILLED NURSE VISIT NOTE

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/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 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 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 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

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE
Disease processes	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Early warning S/S to report	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
NO S/S OF INFECTION	
Medications (list meds taught)	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Pain	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Therapy: IV / Parenteral / O2	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Page: 8 SKILLED NURSE VISIT NOTE
Date: 06/20/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:30 Time Out: 11:45

Treatments (Resp, etc)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> ☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
	<u>NEEDS ASSISTANCE WITH ADLs</u>					
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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

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Date: 06/20/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:30 Time Out: 11:45

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

Time: 10:09:21

Page: 1 of 2

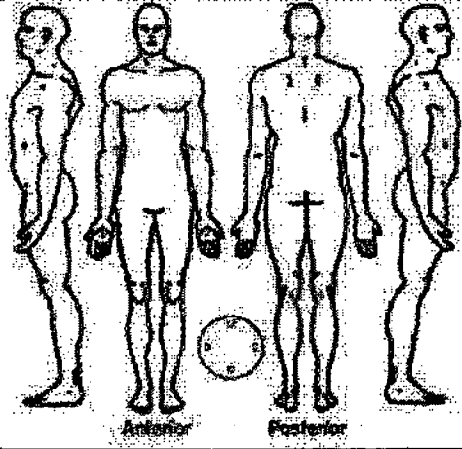
Time in: 10:00 Time Out: 10:45

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 on chart to include estimates.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☐ Clean:		Surgical	☐	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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 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	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: 08/23/2016 MR#: I1455456

Agentcode: 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	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 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 as a hernia around the stoma, when he went to the MD yesterday, Dr. Rinkus 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: 08/23/2016

Page: 1 SKILLED NURSE VISIT NOTE
Date: 06/23/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LFN (ATW000009)
Time in: 10:00 Time Out: 10:45

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE 06/23/2016

TIME IN

[] AM

[] PM

Start of Care Date:

05/30/2016

10:00

TIME OUT

[] AM

[] PM

10:45

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:

[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:

Page: 2
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)

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: / 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:

Page: 3 SKILLED NURSE VISIT NOTE
Date: 06/23/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:00 Time Out: 10:45

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 132 / 78 ☐ Right

Prior Weight:

Previous Weight:

Sitting ☐ Left Standing ☐ Left Lying ☐ Left

Temperature: ☐ Refused / Unable To Assess / Deferred

97.6

Pulse: ☐ Refused / Unable To Assess / Deferred
☐ Apical ☐ Brachial ☒ Radial 72 ☐ Carotid ☒ Rest ☐ Activity

Blood Sugar: ☐ Refused / Unable To Assess / Deferred 0

Respirations: ☐ Refused / Unable To Assess / Deferred 16

Documentation of Skilled intervention / instruction / management problems: ☒ Regular / Irregular ☐ Cheyne-Stokes ☐ Death rattle ☐ Apnea periods sec.

Gastrointestinal

Nutritional Status

Appetite ☒ Good ☐ Fair ☐ Poor ☐ NPO ☐ Anorexic

Eating Patterns / Frequency of Meals

Diet ☐ Low sodium 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) / 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)

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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 06/23/2016 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 ☐ 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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 06/23/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:00 Time Out: 10:45

☐ 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 @ 2 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

Patient tolerated procedure well ☐ YES ☐ NO

☐ Other (specify)

Documentation of skilled intervention / instruction / management problems:

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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 Location: ☐ Poor conditioning ☐ Muscle wasting ☐ Decreased muscle tone
☐ Limited ROM
☐ Skin Numbness / Tingling
☐ Decreased mobility ☐ Decreased endurance
☐ Prosthesis: RUE / RLE / LUE / LLE / Other
☐ Fracture (location)
☐ Shuffling / Wide-based gait ☒ Weakness GENERALIZED
☐ Amputation: Right: BX / AX / 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

Page: 7 SKILLED NURSE VISIT NOTE
Date: 06/23/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LFN (RTW000009)
Time in: 10:00 Time Out: 10:45

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. Rinkus 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 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 ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Early warning S/S to report ☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

NO S/S OF INFECTION

Medications (list meds taught) ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Pain ☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

NO PAIN NOTED

Therapy: IV / Parenteral / O2 ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Treatments (Resp, etc) ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Equipment Use/Management	☐	☐	☐	☐	☐	☐
Diet / Fluid management	☐	☐	☐	☐	☐	☐
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> ☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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.)

☐ ADR ☐ 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

Page: 9 SKILLED NURSE VISIT NOTE
Date: 06/23/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:00 Time Out: 10:45

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)

DATE: 06/27/2016

TIME IN

PM

PM

Start of Care Date:

05/30/2016

08:15

TIME OUT

PM

PM

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:

Page: 2 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

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
☐ 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: ORFICODONE 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

☐ 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 ☐ 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:

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SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)

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 / 74 ☐ Left ☐ Right ☐ Left
Prior Weight: ☐ Right ☐ Left
Previous Weight: ☐ Right ☐ Left

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: ☐ Refused / ☐ Unable To Assess / ☐ Deferred
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 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: 04 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

Performed by: ☐ Self ☐ Nurse ☐ Caregiver ☐ Other

Flush Protocol: (ast./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 ☐ Quad ☐ 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 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: 0.0 Date

Pacemaker: Date Type

☒ No Edema

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

☐ Upper Extremities ☐ Right / Left

Page: 5
Date: 06/27/2016
Time in: 08:15 Time Out: 08:55
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (RTW000009)

☐ 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:

Documentation of skilled intervention / instruction / management problems:

Documentation of skilled intervention / instruction / management problems:

1.1. Orders obtained

Page: 7
Date: 06/27/2016
Time in: 08:15 Time Out: 08:55
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000609)

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. He reported he now has a hernia around the stoma, when he went to the MD yesterday, Dr. Rinkus 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

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

Patient response

Specimen brought to

Lab. Results to be forwarded to Dr.

TEACHING/TRAINING

SUBJECT INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE

Disease processes ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Early warning S/S to report ☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

NO S/S OF INFECTION

Medications (list meds taught) ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Pain ☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Therapy: IV / Parenteral / O2 ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Treatments (Resp, etc) ☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

Page: 3.1. SKILLED NURSE VISIT NOTE
Date: 06/27/2016 Patient: KNIGHT, DANIEL (11459456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time In: 08:15 Time Out: 08:55

Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> ☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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.)

☐ 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 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 08:15 Time Out: 08:55

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

☐ Revised

COORDINATION OF CARE:

☐ Physician Physician name

☐ PT ☐ OT ☐ SLP ☐ SN ☒ 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

Time: 10:11:20

Page: 1 of 2

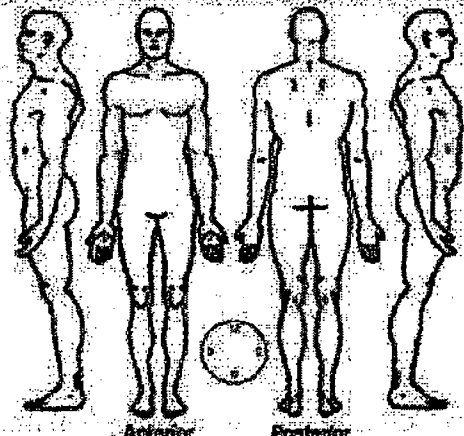
Time in: 10:00 Time Out: 10:45

WOUND ADDENDUM

Pt. Name: KNIGHT, DANIEL Visit Date: 06/30/2016 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 outcomes.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☐ Clean:		Surgical	☐	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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 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:	
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#: I1455456

Agentcode: 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 = 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):☒ Wound dressing applied (specify):

GAUZE, ABD 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 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.

Record on Appeal 1522

Signature: KIMBERLY ATWELL, LPN

Date: 08/30/2016

Page: 1 SKILLED NURSE VISIT NOTE
Date: 06/30/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time In: 10:00 Time Out: 10:45

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 06/30/2016

TIME IN

[] AM [] PM

Start of Care Date:

05/30/2016

10:00 TIME OUT

[] AM [] PM

10:45

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:

[X] Glasses

[] Blurred vision

[] Glaucoma

[] Cataract

[] Infectious

[] 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:

Page: 2 SKILLED NURSE VISIT NOTE
Date: 06/30/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:00 Time Out: 10:45

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

☐ 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 CSHA protocol.

☐ Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

☒ No problem

☐ See wound addendum

☐ New Wound

☐ Skin breakdown

Location:

Highlight all applicable skin assessment:

Page: 3 SKILLED NURSE VISIT NOTE
Date: 06/30/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time In: 10:00 Time Out: 10:45

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 118 / 68 ☐ Right / Previous Weight:

Sitting ☐ Left / Standing ☐ Left / Lying ☐ Left /

Temperature: ☐ Refused / Unable To Assess / Deferred
97.6 F ☒ ORAL ☐ AXILLARY ☐ 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: 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

Diet ☐ 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 ☐ 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/Wound care: (specify)

Page: 4 SKILLED NURSE VISIT NOTE
Date: 06/30/2016 Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW000009)
Time in: 10:00 Time Out: 10:45

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 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

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

Page: 72
Date: 06/30/2016
Time in: 10:00 Time Out: 10:45
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 NS 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

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE
Disease processes	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
early warning S/S to report	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Medications (list meds taught)	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Pain	☒ Patient ☐ Caregiver ☒ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration PAIN IN THE ABDOMEN
Therapy: IV / Parenteral / O2	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Treatments (Resp, etc)	☐ Patient ☐ Caregiver ☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

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Date: 06/30/2016
Time in: 10:00 Time Out: 10:45
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: ATWELL, KIMBERLY, LPN (ATW0000091)

Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	<u>AS TOLERATED</u> ☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
	<u>NEEDS ASSISTANCE WITH ADL'S</u>					
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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/ONR

☐ Confidentiality

☐ Emergency planning in the event if service is disrupted.

☐ Other

SUPERVISORY VISIT (Complete if applicable.)

☐ ADR ☐ 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

Page: 9
Date: 06/30/2016
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 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

[X] Not Yet Scheduled

Last physician visit

[X] 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

Time: 10:11:46

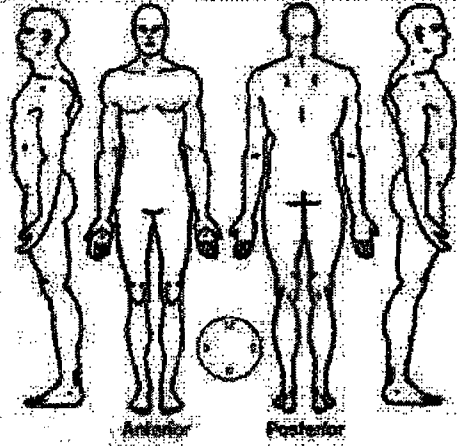
Page: 1 of 2

Time in: 11:06 Time Out: 11:36

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) on illustrations below. Proceed by completing appropriate information for each numbered site on chart to include estimates.



☐ NO WOUND	LOCATION:	#1	#2	#3	#4
Technique used for wound care:	TYPE OF WOUND	Pressure Ulcer	☐	☐	☐
☒ Clean: ASEPTIC		Surgical	☒	☐	☐
☐ Sterile		Skin Tear	☐	☐	☐
☐ 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 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

Time: 10:11:47

Page: 2 of 2

Pt. Name: KNIGHT, DANIEL Visit Date: 07/05/2016 MR#: I1455456

Agent Code: RUC000010 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:

☒ Sciled 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 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

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 (RUC0900010)

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 07/05/2016

TIME IN

PM

PM

Start of Care Date:

05/30/2016

11:06

TIME OUT

PM

PM

11:36

TYPE OF VISIT: ☐ Skilled ☐ Planned ☐ PRN ☐ Infusion ☐ Wound care

☒ Skilled & Supervisory

☐ Supervisory Only

☐ Other

Reason for visit: SLP, RN 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:

Page: 2 SKILLED NURSE VISIT NOTE
Date: 07/09/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000018)
Time in: 11:06 Time Out: 11:36

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:

☐ Dull ache ☐ Appetite
☐ Throbbing ☐ Activity
☐ Pressure heaviness ☐ Sleep
☐ Burning ☐ Anget
☐ Shooting ☐ Moaning
☐ Sharp ☐ Crying

Frequency of pain:

☐ Occasional
☐ Always present
☐ Comes and goes
☐ Other:

Aggravating factors:

☐ Movement
☐ Ambulation
☐ Immobility
☐ Other:

☐ Localized ☐ Irritability
☐ Radiates ☐ 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: / 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:

Lab's 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:

Page: 3 SKILLED NURSE VISIT NOTE
Date: 07/05/2016 Patient: KNIGHT, DANIEL (11455455) Agent: RUCKMAN, NATALIE, RN (RUC000010)
Time in: 11:06 Time Out: 11:35

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 ☐ Left ☐ Right Previous Weight:
☐ Right

Sitting ☒ Left 97 / 68 Standing ☐ Left ☐ Right Lying ☐ Left

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 ☐ 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)

Page: 4 SKILLED NURSE VISIT NOTE
Date: 07/05/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000418)
Time in: 11:06 Time Out: 11:36

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

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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 07/05/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000410)
Time in: 11:06 Time Out: 11:35

☐ 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:

☐ Poley
☐ Suprapubic
☐ Intermittent
☐ Condon
☐ Other:

☐ Skilled catheter care

☐ Foley inserted (date) with

☐ Skill / Foley catheter care / Change French

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:

Page: 6 SKILLED NURSE VISIT NOTE
Date: 07/05/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000018)
Time in: 11:06 Time Out: 11:36

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 R / L
☐ 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: SX / AX / UE Left: SL / AL / 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

Page: 7
Date: 07/05/2016
Time in: 11:06 Time Out: 11:35
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000419)

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 A&Ox3, 766, 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

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

☐ Patient

☐ Caregiver

☐ Verbalized

☐ Questionable

☐ Compliant

☐ Return Demonstration

Early warning s/s to report

☐ Patient

☐ Caregiver

☐ Verbalized

☐ Questionable

☐ Compliant

☐ Return Demonstration

Medications (list meds taught)

☐ Patient

☐ Caregiver

☐ Verbalized

☐ Questionable

☐ Compliant

☐ Return Demonstration

Pain

☐ Patient

☐ Caregiver

☐ Verbalized

☐ Questionable

☐ Compliant

☐ Return Demonstration

Therapy: IV / Parenteral / O2

☐ Patient

☐ Caregiver

☐ Verbalized

☐ Questionable

☐ Compliant

☐ Return Demonstration

Treatments (Resp, etc)

☐ Patient

☐ Caregiver

☐ Verbalized

☐ Questionable

☐ Compliant

☐ Return Demonstration

Page: 8
Date: 07/05/2016
Time in: 11:06 Time Out: 11:36
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)

Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Diet / Fluid management	☒ Patient	☐ Caregiver	☒ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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
☐ Other:
☐ Balance issues
☐ Environmental Barriers
☐ Depression
☐ Agoraphobia
☐ Anxiety
☐ Schizophrenia
☐ Alzheimer's
☐ Mobility restrictions, Reason:
☐ State hotline number

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

Page: 9
Date: 07/05/2016
Time In: 11:06 Time Out: 11:35
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000010)

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 FTP Visit Medically necessary home health services ☐ SN ☐ PT ☐ GT
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 (801009079)
Time In: 10:40 Time Out: 11:15

NURSING VISIT NOTE

Agency: Amedisys Home Health of Conway (2222)

Patient: KNIGHT, DANIEL (11455456)

DATE: 07/07/2016

TIME IN

10:40

Start of Care Date:

05/30/2016

TIME OUT

11:15

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:

Page: 2
Date: 07/07/2016
Time in: 10:40 Time Out: 11:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: SOLES, AMANDA, LPN (SOLO00079)

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 CSHA protocol.

☐ Universal precautions / infection control maintained

INTEGUMENTARY SYSTEM

☐ No problem

☐ See wound addendum

☐ New Wound

☐ Skin breakdown

Location:

Highlight all applicable skin assessment:

Page: 3 SKILLED NURSE VISIT NOTE
Date: 07/07/2016 Patient: KNIGHT, DANIEL (11455455) Agent: SOLES, AMANDA, LPN (SOL000079)
Time in: 10:40 Time Out: 11:15

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" [X] Reported [] Actual Weight: [] Refused [] Unable To Assess [] Deferred [] Reported [] Actual

Blood Pressure: [] Refused [] Unable To Assess [] Deferred Prior Weight: [] Previous Weight: []

[] Right [] Right [] Right

Sitting [X] Left 108 / 70 Standing [] Left Lying [] Left

Temperature: [] Refused [] Unable To Assess [] Deferred

98.6 [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC

Pulse: [] Refused [] Unable To Assess [] Deferred

[X] Apical 80 [] Brachial [X] <Regular> / Irregular [] Radial [] Carotid [X] Rest [] Activity

Blood Sugar: [] Refused [] Unable To Assess [] Deferred 0 [] ac [] pc

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

Documentation of Skilled Intervention / Instruction / Management problems:

Gastrointestinal

Nutritional Status

Appetite [X] Good [] Fair [] Poor [] NPO [] Anorexic

Eating Patterns / Frequency of Meals: 3 MEALS PER DAY

Diet: [] Low sodium diet [] Calorie ADA diet [] Bland diet [] Protein diet [] High carbohydrate diet

[] Low carbohydrate diet [] Mechanical diet [] Soft diet [X] 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

[X] 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: 4 SKILLED NURSE VISIT NOTE
Date: 07/07/2016 Patient: KNIGHT, DANIEL (11455455) Agent: SOLES, AMANDA, LPN (801000079)
Time in: 10:40 Time Out: 11:15

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

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

Page: 5 SKILLED NURSE VISIT NOTE
Date: 07/07/2016 Patient: KNIGHT, DANIEL (11455455) Agent: SOLES, AMANDA, LPN (SOLES00079)
Time in: 10:40 Time Out: 11:15

☐ 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 ☒ Right lower: Clear

☐ Cough: Dry / Acute / Chronic ☐ Unable to cough up secretions

☐ Productive: Thick / Thin / Frothy Sputum Color Amount

Oxygen: ☐ 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 ☒ Yellow ☐ Straw ☐ Amber ☐ Brown ☐ Grey ☐ Blood-tinged

☐ Other: ☒ 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 ☐ French

☐ Suprapubic

☐ Intermittent

☐ Condom

☐ Other:

☐ Skilled catheter care ☐ with ☐ without difficulty

☐ Foley inserted (date)

☐ Skill / Foley catheter care / Change

Inflated balloon with ☐ ml ☐ without difficulty

Irrigation solution: Type (specify):

Amount ☐ ml Frequency

Patient tolerated procedure well ☐ YES ☐ NO

☐ Other (specify)

Documentation of Skilled intervention / instruction / management problems:

Page: 6
Date: 07/07/2016
Time in: 10:40 Time Out: 11:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: SOLES, RANDA, LPN (SOLO59079)

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
☐ Prosthesis: RUE / RLE / LUE / LLE / Other ☐ Decreased endurance
☐ 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

Page: 7 SKILLED NURSE VISIT NOTE
Date: 07/07/2016 Patient: KNIGHT, DANIEL (11455455) Agent: SOLES, AMANDA, LPN (SOL000079)
Time in: 10:40 Time Out: 11:15

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

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. 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

SUBJECT	Patient	Caregiver	Verbalized	Questionable	Compliant	Return Demonstration
Disease processes	☐	☐	☐	☐	☐	☐
Early warning S/S to report	☒	☐	☒	☐	☐	☐
<u>SEE ABOVE</u>						
Medications (list meds taught)	☐	☐	☐	☐	☐	☐
Pain	☐	☐	☐	☐	☐	☐
Therapy: IV / Parenteral / O2	☐	☐	☐	☐	☐	☐
Treatments (Resp, etc)	☐	☐	☐	☐	☐	☐
Equipment Use/Management	☐	☐	☐	☐	☐	☐

Page: 8
Date: 07/07/2016
Time in: 10:40 Time Out: 11:15
SKILLED NURSE VISIT NOTE
Patient: KNIGHT, DANIEL (11455456) Agent: SOLES, RANDA, LPN (SOL000079)

Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Activity Guidelines	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
ADL's / Self-care tasks	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Safety Factors	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Lifestyle adjustments/Coping	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Community Resources	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ Return Demonstration
Other (Specify)	☐ Patient	☐ Caregiver	☐ Verbalized	☐ Questionable	☐ Compliant	☐ 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 ☐ 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

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 (601000079)

☐ 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 07/08/2016 ☐ 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 (11455456) 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 [] CTA [X] LPN / LVN

STAFF: [] PRESENT [X] 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?

[X] 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: 11:45 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
Agency: Amadisys Home Health of Conway (2222)
TIME IN: 11:45
TIME OUT: 12:29

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: 11455456

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 CIRC DR CONWAY

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

(M0063) Medicare Number: (including suffix) ☒ NA - No Medicare

(M0064) Social Security Number: 408-45-6569 ☐ UK - Unknown or Not Available

☒ NA - No Medicaid

(M0065) Medicaid Number: (M0065) Birth Date: 09/26/1974

Patient HI Claim: ☒ 1 - Same as M0063 ☐ 2 - Same as M0065 ☐ 3 - Other:

(M0069) Gender:

☒ 1 - Male ☐ 2 - Female

(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)
- ☒ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify)
- ☐ UK - Unknown

(M0016) 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

Page: 2 SKILLED DISCHARGE OASIS
Date: 07/12/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000610)
Time in: 11:49 Time Out: 12:29

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:

☒ 1 - RN ☐ 2 - PT ☐ 3 - SLP/ST ☐ 4 - OT

(M0090) Date Assessment Completed:

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

VBP01 (Herpes Zoster Vaccine)

(VBP01) Did the patient report ever receiving the Herpes Zoster (Shingles) vaccine?

☒ No ☐ Yes

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VBP08, VBP09, VBP10 (Advance Care Plan)

(VBP08) Does the patient have an Advance Care Plan documented in the Home Health Medical Record?

☐ No

(VBP09) 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

(VBP10) Indicate information documented in the Advance Care Plan:

☒ 1) Medical Treatment Preferences

☐ 2) Mental Health/Behavioral Treatment Preferences

(VBP10-B) Indicate Mental Health/Behavioral Treatment Preferences:

☐ 3) Cultural/Social Preferences

☐ 4) Spiritual/Religious Preferences

(VBP10-C) Indicate Cultural/Social Preferences Type:

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VBP11, VBP12 (Surrogate Decision Maker)

(VBP11) Does the patient have a surrogate decision maker documented in the home health medical record?

☐ No

(VBP12) 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

(VBP11-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
☐ Right ☐ Left ☐ Right

Prior Weight:
Previous Weight:

Sitting

Standing

Lying

Page: 13 SKILLED DISCHARGE OASIS
Date: 07/12/2016 Patient: KNIGHT, DANIEL (114554561) Agent: RUCKMAN, NATALIE, RN (RUC0000418)
Time in: 11:49 Time Out: 12:29

[X] Left 94 / 75 [] Left / [] Left /
Temperature: [] Refused / Unable To Assess / Deferred
99.2 F [X] ORAL [] AXILLARY [] RECTAL [] TYMPANIC
Pulse: [] Refused / Unable To Assess / Deferred
[X] Apical 60 [] Brachial [X] <Regular> / Irregular [] Radial [] Carotid [X] Rest [] Activity
Blood Sugar: [] Refused / Unable To Assess / Deferred 0 [] ac [] pc
Respirations: [] Refused / Unable To Assess / Deferred
16 [X] <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]
[X] 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)
[X] 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:

- [X] 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:

- [] 1 - Offered and declined
[] 2 - Assessed and determined to have medical contraindication(s)
[X] 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
[] 4 - None of the above

CAREGIVER ASSISTANCE

- [X] 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

☐ 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:

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 QSHA 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

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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: 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

Page: 7 SKILLED DISCHARGE CASES
Date: 07/12/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC000018)
Time In: 11:49 Time Out: 12:29

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

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(M1334) STATUS OF MOST PROBLEMATIC STABIS ULCER

Status of Most Problematic Stablis 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 ☐ 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: 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: ☐ Thick / Thin / Frothy Sputum Color Amount

Page: 9 SKILLED DISCHARGE OASIS
Date: 07/12/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000418)
Time in: 11:49 Time Out: 12:29

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:

(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

Diet ☐ 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 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)

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Date: 07/12/2016
Time in: 11:49 Time Out: 12:29
SKILLED DISCHARGE OASIS
Patient: KNIGHT, DANIEL (114554561) Agent: RUCKMAN, NATALIE, RN (RUC0000019)

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

Eats fewer than 2 meals per day

Eats few fruits, vegetables or milk products

Has 3 or more drinks of beer, liquor or wine almost everyday

Has tooth or mouth problems that make it hard to eat

Does not always have enough money to buy the food needed

Eats alone most of the time

Takes 3 or more different prescribed or over-the-counter drugs a day

Without wanting to, has lost or gained 10 pounds in the last 6 months

Not always physically able to shop, cook and / or feed self

☒ 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 ☒ 4 quadrants

☐ Absent ☒ X ☐ Other

Last BM 07/12/2016 Usual Frequency

☐ Incontinence of Stool: Frequency

Abdominal 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:

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Date: 07/12/2016 Patient: KNIGHT, DANIEL (11455456) Agent: RUCKMAN, NATALIE, RN (RUC0000016)
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GENITOURINARY

☐ No Problem
Color: ☒ Yellow ☐ Straw ☐ Amber ☐ Brown ☐ Gray ☐ 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

☐ 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

☐ 1 - Yes

☐ NA - Patient on prophylactic treatment

☐ UX - Unknown (omit "UX" 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

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(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:

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Location

☐ Muscle Atrophy ☐ Poor conditioning ☐ Muscle wasting ☐ Decreased muscle tone
☐ Limited ROM Location:
☐ Skin Numbness / Tingling
☐ Decreased mobility ☐ Decreased endurance
☐ Prosthesis: RUE / RLE / LOE / 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:

(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

g zippers, buttons, and snaps:

safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managin

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

Ability to Dress Lower Body

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

☒ 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.

- [X] 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.

- [X] 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.

- [X] 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.

- [X] 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.

- [X] 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, puréed 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:

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- ☒ 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.

(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.

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- ☐ 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. Activities of Daily Living (ADL) assistance (for example, transfer/ambulation, bathing, dressing, toileting, eating/feeding)

☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

b. Instrumental ADL assistance (for example, meals, housekeeping, laundry, telephone, shopping, finances)

☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

c. Medication administration (for example, oral, inhaled or injectable)

☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

d. Medical procedures/ treatments (for example, changing wound dressing, home exercise programs)

☐ 1 ☐ 2 ☐ 3 ☐ 4

e. Management of Equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)

☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

f. Supervision and safety (for example, due to cognitive impairment)

☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

g. Advocacy or facilitation

of patient's participation in appropriate medical care (for example, transportation to or from appointments)

☒ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 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.
☐ UX - 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

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- 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
[] 0X - Reason unknown

(M2400) INTERVENTION SYNOPSIS

Box in each row.) At the time of or at any time since the previous OASIS assessment, were
Intervention Synopsis: (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			Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputees).
	[] 0	[] 1	[S] NA

b. Falls prevention interventions			Every standardized, validated multi-factor fall risk assessment conducted at or since the last OASIS assessment indicates the patient has no risk for falls.
	[] 0	[Z] 1	[] NA

c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment			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.
	[] 0	[S] 1	[] NA

d. Intervention(s) to monitor and mitigate pain			Every standardized, validated pain assessment conducted at or since the last OASIS assessment indicates the patient has no pain
	[] 0	[Z] 1	[] NA

e. Intervention(s) to prevent pressure ulcers			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.
	[] 0	[] 1	[S] NA

f. Pressure ulcer treatment based on principles of moist wound healing			Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.
	[] 0	[] 1	[Z] NA

(M2410) INPATIENT FACILITY ADMISSION

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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 [Unit "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.
HX - 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

Sn 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 Rimikus, 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 RIMIKUS

07/12/2016

[] FOT 485 Attached for Signature

☒ Discharge Date 07/12/2016

[] Transfer Date

[] Death Date

[] Copy sent

DISCIPLINES INV.

MET OUTCOMES

COMMENTS

☒ SN

MET

STABLE

HHA

PT

OT

SLE

MSM

Other

Other

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
al 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 psych
iatric symptoms: - None of the above behaviors demonstrated. (M1800) Grooming: - Grooming utensils must be placed within reach before able to complete groom
ing 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 t
o 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 b
ath. (M1840) Toilet Transferring: - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. (M1850) Transferrin
g: - Able to transfer with minimal human assistance or with use of an assistive device. (M1860) Ambulation/Locomotion: - Able to walk only with the supervisi
on or assistance of another person at all times. (M1870) Feeding or Eating: - Able to independently feed self.

Page: 18 SKILLED DISCHARGE CASES
Date: 07/12/2016 Patient: KNIGHT, DANIEL (11455455) Agent: RUCKMAN, NATALIE, RN (RUC0000018)
Time In: 11:49 Time Out: 12:29

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-GX3, 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.



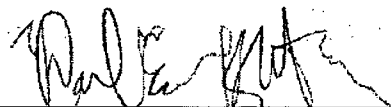
You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.
If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care.
If you get care from a different home health 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.
Ian Maguire, Esq.
Maguire Law Firm
1600 North Oak Street, Suite B
Myrtle Beach, SC 29577
eaves@maguirelawfirm.com
ian@maguirelawfirm.com

Joseph D. Thompson, III, Esq.
Hall Booth Smith, PC
40 Calhoun Street, Suite 550
Charleston, SC 29401
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 2nd.

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
Myrtle Beach, South Carolina 29577
Direct Dial: 843.663.1410
Office Fax: 843.361.7048
E-Mail: Eaves@MaguireLawFirm.com
Supervising Attorney: Ian D. Maguire, Esquire
Visit us on the web: 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; 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; 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

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

Date:

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 www.hallboothsmith.com

Please Note New Address and Phone Numbers

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**DEFENDANT'S
EXHIBIT**

STATE OF SOUTH CAROLINA)

COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
FOR THE 15TH JUDICIAL CIRCUIT
CASE NO.: 2016-CP-26-8032

DANIEL ERIC KNIGHT,)

Plaintiff,)

v.)

PHILLIP RAY CAUSEY,)

Defendant.)

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.

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.

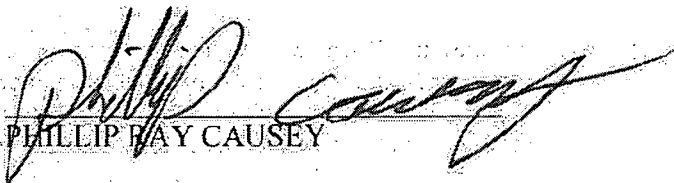
24) At the time of the hearing, I did not understand how or why a lawyer was holding the hearing, instead of a judge. It became more concerning when the lawyer excluded my father from the hearing without any explanation. While I still believed that I had the opportunity to dispute the accident, it became 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.

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.

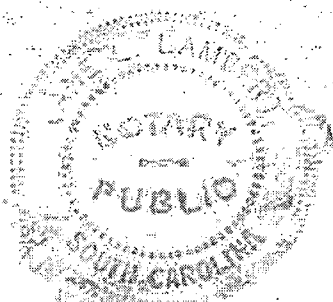
FURTHER AFFIANT SAYETH NOT!


PHILLIP RAY CAUSEY

Sworn to and subscribed before me
this 21st 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

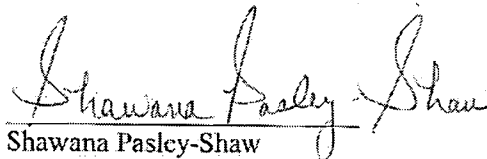
Docket No.: 16-CP-26-8032

**AFFIDAVIT OF
SHAWANA PASLEY-SHAW**

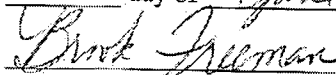
Shawana Pasley-Shaw, resident of Horry County, files this, her Affidavit, and states as follows:

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

28th day of June, 2017


Notary Public for South Carolina

My Commission Expires: 5/29/18