Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Acute PAIN and alteration in comfort level related to Dementia. Most current RAI PAIN score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage pain each day through to the next review. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with Saud/SDM about pain management, goals of treatment, plan of care and treatment options. Revision on: 09/03/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse Registered Practical Nurse RN	
• STRONG PARTICIPATION in Activities ISE Score: 2/6 Revision on: 08/31/2025 Revision by: Laura Morris (Restorative Care Aide)	• Saud will be supported to maintain participation in activities 5-10 times per month by the next review date. Revision on: 05/29/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 12/02/2025	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; friendly/1: 1 visits, arts & crafts, discussion groups, exercise, games, Montessori, music programs, outdoor activities, reading, reminiscing, socials on main floor, bingo, happy hour, spiritual programs etc. Revision on: 05/29/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as watching/listening to TV, reading independently, adult coloring, listening to music, etc. Revision on: 05/29/2025 Revision by: Laura Morris (Restorative Care Aide) • ASSISTANCE: Provide assistance/encouragement to get him to scheduled activities - Accompany off home area, Walk with, Guide to, Cue Direction, Reminders, etc. Revision on: 05/29/2025 Revision by: Laura Morris (Restorative Care Aide) • HELPFUL HINTS: Identify Helpful Hints to ease communication while providing care/interactions for Saud can often be found laying in bed but will happily get up to attend programs whenever he is invited. He is not really sleeping just resting or bored.	ACT	

Allergies	No Known Allergies	**D.O.B.**	12/15/1959	**Physician**	Albert Patrick Ng
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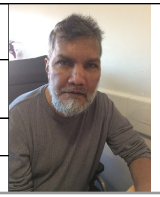
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Abdullah, Saud (922131005258)	**Admission Date**	07/26/2019	**Location**	4 419 C



Last Care Plan Review Completed:	**09/02/2025**

Care Plan Report

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• STRONG PARTICIPATION in Activities ISE Score: 2/6 Revision on: 08/31/2025 Revision by: Laura Morris (Restorative Care Aide)		Revision on: 01/03/2023 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide) • ONE to ONE: Provide him with individual visits for conversation, reading, reminiscing, iPad games (connect the dots, loves Connect 4), etc. Revision on: 01/03/2023 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide)	ACT	
• URINARY continence- continent Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Saud will receive support to (use toilet) and promote urinary continence each shift through to the next review. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 07/19/2022 Revision by: Maryola Perion (RN) • URINARY Continence level is Continent. Report change to level as noted. Revision on: 12/06/2024 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Saud uses a PUM on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA	
• Potential for Expressive Behaviour of RESISTANCE to care need (medication, bath/shower, to eat) related to Dementia, Schizophrenia Revision on: 12/06/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 03/02/2025 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with (Saud)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 03/13/2024 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Saud for indications to change in or for escalating expressive behaviour risk. Revision on: 03/13/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusal to bathe, refusing medication, to eat, etc.) as expressions of behaviour include (confusion, misunderstanding care needs, poor judgement etc.) Revision on: 09/03/2024	BSO - Internal Social Worker	

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Resident	Abdullah, Saud (922131005258)	**Admission Date**	07/26/2019	**Location**	4 419 C
Last Care Plan Review Completed:	**09/02/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Saud is declining to (bathe, take medications, to eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 09/03/2024 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 12/06/2024 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• HALLUCINATION: Saud came to the Registered staff and said the voices are telling me to take laxatives. The resident has been re-directed and was monitored. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Expressed Wishes and Beliefs related to Saud's Medical Treatment and End of Life Care Revision on: 06/11/2024 Revision by: Ramil Santillan (Quality Improvement Coordinator)	• To support and honor Saud's expressed wishes and beliefs through to the End of Life. Revision on: 06/11/2024 Revision by: Ramil Santillan (Quality Improvement Coordinator) Target Date: 12/02/2025	• CPR: Saud wishes express NO CPR, however TRANSFER to hospital decision will be made at the time. Revision on: 06/11/2024 Revision by: Ramil Santillan (Quality Improvement Coordinator)	All	
		• SPIRITUAL/RELIGIOUS needs: Contact Windsor Islamic Association (Northwood) in case he passed away, to perform final rites for him. He practices fasting during Ramadan. Revision on: 06/11/2024 Revision by: Ramil Santillan (Quality Improvement Coordinator)	All	
• Increased risk for FALLS related to: Dementia, Consuming Psychotropic medication, Pacing, history of falls, unsteady gait. Revision on: 01/26/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with Saud/SDM in decision making in fall prevention Plan of Care. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within reach of Saud, check that it is in working order and remind/encourage to use it. Saud may not remember how to use it. Revision on: 11/16/2022 Revision by: Haley Cadarian (Quality Lead)	PCA	D/E/N
		• ENVIRONMENT: reduce clutter to reduce fall risk for Saud. Revision on: 08/31/2023 Revision by: Alyssa Egan (Staff Development Coordinator)	PCA	

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Resident	Abdullah, Saud (922131005258)	**Admission Date**	07/26/2019	**Location**	4 419 C
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		• FOOTWEAR: Ensure resident wears appropriate footwear. Revision on: 08/15/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• SUPPLEMENT: Vitamin D supplement as per MD order to maintain bone density to prevent injuries.	Registered Staff	
• BOWEL Continence - Saud is continent and has self recognition of urge to defecate. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	• Saud to remain continent of bowels through next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• BOWEL Continence level is CONTINENT. Report change to level as noted. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	PCA	
		• SELF TOILETING: Saud toilets self. Each shift ask if he had BOWEL MOVEMENT and if there has been any changes to continence level. Report changes to Registered Staff. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience alteration in MOOD as exhibited by (Hx of repetitive physical movement, sad, pained, worried facial expression) related to Cognitive decline, Dementia, Schizophrenia, Bipolar Affective Disorder, Hx of Auditory and Visual hallucination. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	• Saud will be supported to maintain mood stability as evidenced by DRS score at a range of 0-2 by the review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with Saud/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 01/26/2021 Revision by: Maryola Perion (RN)		
		• HEALTH EDUCATION: Provide education and support to Saud/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 01/26/2021 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
		• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Saud for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 09/25/2020 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 09/25/2020 Revision by: Maryola Perion (RN)		
• Potential for CONSTIPATION related to	• To minimize the potential for	• COMMUNICATION: Involve/collaborate with Saud/SDM for decision making		

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Last Care Plan Review Completed:	**09/02/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
decreased mobility. Revision on: 01/28/2021 Revision by: Maryola Perion (RN)	episodes/ complications of constipation through to the next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025 • Saud will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	regarding constipation management. Revision on: 01/28/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • NUTRITION increased fibre intervention in place. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Diet Registered Staff Registered Staff	
• Risk for/Impaired SKIN INTEGRITY related to Incontinence, Impaired Mobility, Shear/Friction Revision on: 01/28/2021 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted. • HEALTH EDUCATION: Engage resident/SDM in health education regarding prevention of skin impairment and management. Revision on: 08/02/2024 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgment, etc.) related to Diagnosis of Dementia, Impaired decision making, Schizophrenia, Bipolar Affective Disorder. Revision on: 01/28/2021 Revision by: Maryola Perion (RN)	• Saud will be supported to maintain cognitive function through the review date. Current CPS is 3/6. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with Saud/SDM in decision making of Cognitive Loss for Dementia. Revision on: 01/28/2021 Revision by: Maryola Perion (RN) • ORIENTATION: Gently reorient to (person, place, time) as needed when Saud is feeling lost or in confused state. Revision on: 09/24/2020 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	12/15/1959	**Physician**	Albert Patrick Ng
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• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 09/25/2020 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with Saud/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 09/25/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 09/25/2020 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed. Revision on: 09/25/2020 Revision by: Maryola Perion (RN)	Registered Staff	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, etc.) related to Dementia. Revision on: 09/25/2020 Revision by: Maryola Perion (RN)	• Saud will be supported to maintain current communication abilities to (express self, comprehend information, etc.) each day through to the review date Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025 • Saud will be able to make basic needs known each day through to the review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with Saud/SDM for decision making about strategies needed to support effective communication. Revision on: 09/25/2020 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Saud's primary language is Arabic. He is able to speak/understand English. Revision on: 09/25/2020 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc. Revision on: 09/25/2020 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: Saud needs intermittent cueing or demonstrative instruction in tasks and activities. Revision on: 09/25/2020 Revision by: Maryola Perion (RN)	ACT	
• SPIRITUAL BELIEFS: Saud is of the Muslim Faith.	• To provide Saud spiritual support as interested through to	• SPIRITUAL PROGRAMS: Encourage him to attend spiritual programs of his choice, Imam visits, spiritual discussion, etc.		

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Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 05/04/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	the next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	Revision on: 05/29/2025 Revision by: Laura Morris (Restorative Care Aide)		
• Altered ability to complete Activities of Daily Living (ADLs) related to: Dementia, Schizophrenia, Bipolar Affective Disorder. Revision on: 08/15/2019 Revision by: Maryola Perion (Registered Nurse)	• Saud will feel supported in coping with changing functional abilities due to disease diagnosis through the review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025 • Saud will maintain current self sufficiency in ADL abilities in all ADL's through the review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• BATHING: Saud prefers (shower) on (Mondays and Fridays on Day shift). Saud participates by (providing a wash cloth and cues). One staff (limited) assistance for bathing. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: Saud is able to turn and reposition while in bed Independently. Revision on: 08/02/2021 Revision by: Maryola Perion (RN) • DRESSING: Saud is able to dress himself independently. May require reminders. He may require Limited assistance from one staff at times when fatigued. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • EATING: Saud is able to drink his fluids and eat his food independently. May require encouragement. Staff to cut up his food into small pieces when needed. Eats in the main floor dining room. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • LOCOMOTION: Saud is able to walk Independently on and off unit. Revision on: 03/13/2024 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: Saud is able to wash/dry his face and hands, comb his hair, brush his teeth with staff cueing and reminders. He requires one staff to shave him. Revision on: 05/29/2025	PCA PCA PCA PCA PCA	

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• Altered ability to complete Activities of Daily Living (ADLs) related to: Dementia, Schizophrenia, Bipolar Affective Disorder. Revision on: 08/15/2019 Revision by: Maryola Perion (Registered Nurse)		Revision by: Danielle Loreto (RAI Coordinator) • HAND HYGIENE: Saud is able to independently complete task of Hand Hygiene each day once cued to do to by 1 team member Revision on: 09/14/2021 Revision by: Haley Cadarian (Quality Lead) • TOILET USE: Saud is able to transfer on/off the toilet, adjusts clothes and cleanses himself. Saud will ask for assistance as needed for peri care, pull up change at times after toileting needs. Revision on: 06/13/2024 Revision by: Maryola Perion (RN) • TRANSFERRING: Saud is able to transfer himself independently from a sit to stand position. Revision on: 10/15/2023 Revision by: Maryola Perion (RN) • ORAL CARE: Saud is independent. May require cues and reminders with set up when fatigued. Has upper and lower denture. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • SHAVING - Saud to be shaved on his bath/shower days and as needed. Revision on: 09/20/2023 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA PCA	D
• Sleep Patterns. Revision on: 08/15/2019 Revision by: Maryola Perion (Registered Nurse)	• To promote adequate rest/sleep for Saud based on identified sleep patterns/preferences each night through to the next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025	• REST PATTERN: Preferred bedtime: Around 19:00 & usual wake time: Between 6:00-7:00 Revision on: 01/28/2021 Revision by: Maryola Perion (RN) • SLEEPWEAR: Saud prefers to wear his own clothes or PJs. Revision on: 01/28/2021 Revision by: Maryola Perion (RN)	PCA PCA	
• Nutrition Risk Level (diet details)	• Saud will be adequately nourished aeb consuming >75% at meals and snacks through to	• NUTRITION RISK: Saud is moderate risk level Revision on: 01/26/2021 Revision by: Anna Slack (Registered Dietitian)	Dietitian (RD) Dietary Manager	

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	next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025 • Will weigh within GWR/IBW/Realistic weight range of 70-75kg through to next review date. Revision on: 09/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/02/2025 • Saud will be adequately hydrated aeb drinking at least 1335ml per day based on 75% of total fluid requirement of 1780 ml @ 25 ml/kg, 71.2 kg through to next review date. Revision on: 09/03/2024 Revision by: Rachelle Ly (Dietitian (RD)) Target Date: 12/02/2025 • Will meet estimated nutritional requirements of 1780-2136kcal @ 25-30 kcal/kg, 71 g protein @ 1.0g/kg through to next review date. Revision on: 09/03/2024 Revision by: Rachelle Ly (Dietitian (RD)) Target Date: 12/02/2025	• DIET ORDER: Saud will receive regular diet, regular texture Revision on: 02/17/2021 Revision by: Anna Slack (Registered Dietitian)	Diet Food Services Aide PCA	
		• FLUID CONSISTENCY: Saud drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/14/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: Encourage Saud to drink a minimum 1335ml daily. Revision on: 09/03/2024 Revision by: Rachelle Ly (Dietitian (RD))	PCA	
		• EXTRA FLUIDS: Offer a minimum of 125ml water tid outside of meals and snacks daily. Revision on: 01/26/2021 Revision by: Anna Slack (Registered Dietitian)	Dietary aide PCA	
		• DINING INSTRUCTIONS: Do not serve pork. Serve double portion protein at dinner on Monday/Thursday (fasting days). Save plate covered, dated, in the fridge for him to eat at night. Revision on: 09/11/2025 Revision by: Holly Laasanen (Dietitian (RD))	Registered Practical Nurse	
		• Staff provide meal/snack on night shift Monday/Thursday per resident's request (fasting during the day) Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D/E

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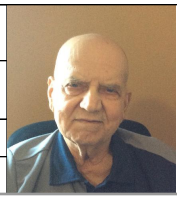
Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Talib is experiencing episode of INFECTION suspected UTI related to increased confusion October 28th 2025. Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To have infection adequately managed and treated without further complications by the next 14 days Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/12/2025	• COMMUNICATION: Involve/collaborate with (Talib/SDM) with decision making for infection treatment plan and update accordingly. Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • HEALTH EDUCATION: Engage with resident/SDM to enhance their knowledge of infection control practices Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • MONITORING: Utilize holistic perspective of monitoring resident for (signs/symptoms, hydration status, overall health condition, process of healing, secondary infections) until stable. Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Alteration in skin integrity related to Open Lesion # 19 on the Face/Left Cheek . Revision on: 10/16/2025 Revision by: Jane Del Rosario (RPN)	• To promote intact skin integrity through healing of Open Lesion # 19 on Face/Left Cheek until the next review date. Revision on: 10/16/2025 Revision by: Jane Del Rosario (RPN) Target Date: 12/03/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Open Lesion # 19 on Face/Left Cheek until for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/16/2025 Revision by: Jane Del Rosario (RPN) • TX: Administer treatment as per MD/NP order. Revision on: 10/17/2025 Revision by: Maryola Perion (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/16/2025 Revision by: Jane Del Rosario (RPN)	Registered Practical Nurse RN Registered Practical Nurse Registered Practical Nurse	
• Potential for Acute PAIN and alteration in comfort level related to CHF, History of fall with fracture, HTN, Chronic Kidney Disease, Fracture to right Tibial buckle fracture without step deformity, Ingrown great left toe discomfort, neck pain to left	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI	• COMMUNICATION: Involve/collaborate with (Talib)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain	RN Registered	

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng	
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C	
Last Care Plan Review Completed:	09/03/2025					

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side. Most Current RAI Pain Score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	Coordinator) Target Date: 12/03/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 12/03/2025	optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. He takes his medication whole. Revision on: 12/13/2023 Revision by: Elsie Calumpang (RN)	Practical Nurse Registered Practical Nurse RN	
• Alteration in skin integrity related to #18 - Open Lesion Left Foot, 1st Digit (Hallux) Revision on: 09/12/2025 Revision by: Gurjit Kaur (RN)	• To promote intact skin integrity through healing of open lesion within the target date. Revision on: 09/27/2025 Revision by: Maryola Perion (RN) Target Date: 12/03/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with changes to health status and alteration or complications affecting skin integrity. Revision on: 09/12/2025 Revision by: Gurjit Kaur (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 09/12/2025 Revision by: Gurjit Kaur (RN)	Registered Practical Nurse RN	
• STRONG PARTICIPATION in Activities. ISE Score: 6/6 Revision on: 08/14/2025 Revision by: Laura Morris (Restorative Care Aide)	• To support Talib's Psycho-Social well being through to the next review. Talib will be encouraged to participate in, 20-25x group, and/or 1:1 activities per month through the next review date. Revision on: 08/14/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 12/03/2025	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; friendly/1: 1 visits, trivia, men's club, happy Hour, special events, etc. Revision on: 08/14/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as watching/listening to TV, listening to music/radio, visiting with residents/team members, etc. Revision on: 12/25/2023 Revision by: Mitchell Atkinson (Recreation Aide) • ONE to ONE: Provide him with individual visits for conversation, reading, reminiscing, music, humour, etc. Revision on: 12/25/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SOCIAL INTERACTION: Promote the opportunity for Talib to make friendships and sit with friends during activities. Revision on: 12/25/2023		

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Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C

Last Care Plan Review Completed:	**09/03/2025**

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• STRONG PARTICIPATION in Activities. ISE Score: 6/6 Revision on: 08/14/2025 Revision by: Laura Morris (Restorative Care Aide)		Revision by: Mitchell Atkinson (Recreation Aide)		
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, antidepressant and immunosuppressant meds) Revision on: 02/26/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/collaborate with Talib/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 12/21/2023 Revision by: Jenny Liu (RAI Coord Back-up) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • PREFERENCE: Staff to Hazardous-Handle Properly for these two meds: Tacrolimus and Mycophenolic acid. Revision on: 12/21/2023 Revision by: Jenny Liu (RAI Coord Back-up) • PHARMACY MEDICATION REVIEW: Request Pharmacy Medication Review when clinically appropriate. Revision on: 12/21/2023 Revision by: Jenny Liu (RAI Coord Back-up)		
• Risk for Impaired SKIN INTEGRITY related to current wound, history of right hip fracture with ORIF, right lateral foot pressure injury, swelling on right knee (5/20/24), Incontinence and the use of	• To protect and maintain skin integrity each day through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator)	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted. • HEALTH EDUCATION: Engage resident/SDM in health education regarding	PCA Registered Staff	

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incontinent product. Revision on: 11/28/2024 Revision by: Maryola Perion (RN)	Target Date: 12/03/2025	prevention of skin impairment and management. Revision on: 05/20/2024 Revision by: Maryola Perion (RN)		
		• HAZZARDOUS MEDICATION RISK: Talib has potential to experience skin irritation (redness, burning, itchiness, etc.), report observed symptoms to Registered Staff immediately as noted. Team mem Revision on: 08/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Increased risk for FALLS related to history of falls with fractured right hip, unsteady gait. Hx of tibial plateau fracture, dizziness, impaired mobility and balance. Revision on: 11/28/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/collaborate with (Talib)/SDM in decision making in fall prevention Plan of Care. Revision on: 05/23/2024 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within Talib's reach, check that it is in working order and remind/encourage to use it. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE AIDS: Place urinal within easy reach of resident. Empty urinal every shift and when needed. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 08/31/2024 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position to lower risk for injury. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure Talib wears appropriate footwear with transferring and ambulating Revision on: 08/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• HIP PROTECTORS: Talib wears hip protectors at all times during day and evening shift to safeguard against injury. Report immediately to Registered Staff if not wearing.Please donot use at night shift according to family requested.	PCA	D/E/N

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to history of falls with fractured right hip, unsteady gait. Hx of tibial plateau fracture, dizziness, impaired mobility and balance. Revision on: 11/28/2024 Revision by: Maryola Perion (RN)		Revision on: 01/06/2025 Revision by: Prabhjot Maan (ADOC) • FLOOR MAT to left side of bed to lower risk of injury. Revision on: 03/21/2025 Revision by: Prabhjot Maan (ADOC) • ALARMS: Bed and chair alarm in place . Res has both bed pad and clip arm. Check placement and working order while resident on the bed. Staff to respond promptly to resident when alarm sounding. Revision on: 07/19/2024 Revision by: Katie Savo (RAI Coordinator) • PURPOSEFUL ROUNDING: Conduct purposeful rounding twice a shift to assess residents needs; for pain, positioning, peri-needs or possessions for safety. Revision on: 04/24/2024 Revision by: Prabhjot Maan (ADOC)	PCA PCA PCA Registered Practical Nurse RN	D/E/N
• Sleep Patterns. Revision on: 11/12/2024 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for Talib based on identified sleep patterns/preferences each night through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• REST PATTERN: Talib wakes up between 0500-0600hrs and resides around 200-2200hrs. Naps at no particular time during the day. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Nutrition: Swallowing difficulty risk for choking and aspiration Revision on: 11/08/2024 Revision by: Danielle Loreto (RAI Coordinator)	• To maintain safe swallowing through to next review date Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• Provide diet/texture interventions as per Nutrition Risk Level • Resident to eat slowly. Food to be swallowed before offering the next helping. Monitor for tolerance to texture. Refer to RD as needed. Revision on: 11/08/2024		

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	• To obtain or maintain adequate intake to meet estimated nutritional requirements through to next review date Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025 • To prevent or reduce choking episodes as medically feasible through to next review date Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	Revision by: Danielle Loreto (RAI Coordinator)		
• Individualized Fall Prevention and Injury Reduction Plan	• To decrease the number of falls for throughout this review period. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• Encourage and remind resident to ask for assistance.		
• URINARY Mixed INCONTINENCE related to altered mobility Revision on: 09/06/2024 Revision by: Maryola Perion (RN)	• Talib will receive support to use toilet, commode, urinal and promote urinary continence each shift through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/collaborate with Talib and SDM's for decision making about toileting options or incontinence management Revision on: 12/19/2023 Revision by: Chelsea Campbell-Wright (ADOC) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 12/22/2023 Revision by: Jenny Liu (RAI Coord Back-up) • URINARY Continence level is FREQUENTLY Incontinent. Report change to level as noted. Revision on: 09/06/2024	PCA	

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• URINARY Mixed INCONTINENCE related to altered mobility Revision on: 09/06/2024 Revision by: Maryola Perion (RN)	• Talib will have urinary incontinence managed every shift through to the next review period. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Talib uses a Blue Brief on Days and Evening shifts. Orange Brief for the Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • ADAPTIVE EQUIPMENT/AID: Resident uses urinal, ensure it is within reach at all times. Empty urinal as needed. Revision on: 09/06/2024 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential for bruising, bleeding, clotting or other complications related to use of (ANTICOAGULANT & antiplatelet) medication. Revision on: 08/31/2024 Revision by: Maryola Perion (RN)	• To monitor for bleeding and minimize complications related to use of anticoagulant and antiplatelet through the review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/collaborate with (Talib)/SDM in decision making and health teaching of Anti-coagulation medication use. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using Anticoagulant therapy for changes to health status and complications causing bleeding or clotting issues. Revision on: 12/21/2023 Revision by: Jenny Liu (RAI Coord Back-up) • BLEEDING ALERT: Notify nurse immediately if Talib is bleeding (noted blood in urine/stool, bleeding nose/gums, unexplained bruising, etc.). Revision on: 12/21/2023 Revision by: Jenny Liu (RAI Coord Back-up) • MEDICATION: Administer medications as per MD Order. Report abnormal or unexplained bleeding, unexplained or excessive bruising, etc. to MD as noted.	PCA Registered Staff	
• Potential for Expressive Behaviour RESISTANCE to care need related to Inability to COPE, decline in health status Revision on: 08/31/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator)	• COMMUNICATION: Involve/collaborate with (Talib)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to treatment, assessment, etc.) as expressions of behaviour include (misunderstanding care needs, poor judgement, etc.)	BSO - Internal Social Worker	

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	Target Date: 12/03/2025	Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Talib is declining to (treatments, assessment, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 08/31/2024 Revision by: Maryola Perion (RN)		
• Potential for BOWEL INCONTINENCE related to impaired mobility and balance, recent fracture and no weight bearing. Revision on: 05/23/2024 Revision by: Maryola Perion (RN)	• Talib will have bowel incontinence managed every shift through to the next review period. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function.	Registered Staff	
		• BOWEL Continence level is Frequently Incontinence. Report changes to level as noted. Staff to use bedpan for bowel movement. Revision on: 05/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 05/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Talib uses a Blue Brief on Days and Evening shifts. Orange Brief for the Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Altered ability to complete Activities of Daily Living (ADLs) related to history of right hip fracture with ORIF surgery, CHF, CAD, Aortic Stenosis, Atrial Fibrillation, HTN, CHronic Kidney disease, Fracture to right Tibial buckle fracture without step deformity. Revision on: 05/22/2024 Revision by: Katie Savo	• Talib will have ALL ADL care needs met each day through the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• BATHING: Talib prefers (shower) on (Mondays and Thursdays on Evening shift). Talib participates by (providing a wash cloth and washing the upper part of the body). 1 team member extensive assistance for bathing. Care level varies on fatigue and strength may require 2 person Maximal. Nail care to be provided on shower/bath day. Revision on: 08/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY: Talib is able to grab onto the bed rails to help turn and reposition in bed with weight bearing assistance from team members. Two 1/4 bed rails to be used as a PASD for turning and repositioning when in bed. Revision on: 05/31/2024 Revision by: Katie Savo (RAI Coordinator)	PCA	

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		• DRESSING: Extensive Assist- Talib requires weight bearing assistance from one team member to dress his upper body but requires two staff members to dress his lower body. Care level varies on fatigue and strength may require 2 person Maximal. Revision on: 08/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• EATING: Talib is able to eat independently with supervision and encouragement from the team. Eat in the First floor dining room. Revision on: 05/26/2025 Revision by: Jenny Liu (RAI Coordinator)	PCA	
		• LOCOMOTION: Talib is using a wheelchair with one team member to propel his wheelchair on the unit. Talib walks PT/PA with 2 person side to side assist with walker with w/c follow up behind Revision on: 09/17/2024 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Maximal Assist: Talib is able to wash his hands, face with staff to set up but requires extensive assistance from the team to provide peri-care. Care level varies on fatigue and strength may require 2 person Maximal. Revision on: 08/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• HAND HYGIENE: 1 staff to provide LIMITED assistance to use soap/water, apply sanitizer, rub hands together, dry hands for hand hygiene. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• TOILET USE: Talib requires two staff assistance to transfer him to and from wheelchair to the toilet, one staff to assist with adjusting his clothes and changing his incontinent product and to provide peri care. If unable to go to the toilet, he will be toileted in bed with a bed pan. Urinal is at the bedside and within reach, staff to assist Talib with the use of urinal when needed. Revision on: 09/13/2024 Revision by: Maryola Perion (RN)	PCA	

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• Altered ability to complete Activities of Daily Living (ADLs) related to history of right hip fracture with ORIF surgery, CHF, CAD, Aortic Stenosis, Atrial Fibrillation, HTN, CHronic Kidney disease, Fracture to right Tibial buckle fracture without step deformity. Revision on: 05/22/2024 Revision by: Katie Savo		• TRANSFERRING: Talib requires two staff side by side to transfer him to and from bed to wheelchair. Revision on: 09/06/2024 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Talib has his own teeth. He is able to brush his own teeth with set up by the team. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• SHAVING- Talib requires the team to assist with shaving him on his shower days. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	D
• Pain related to tissue injury due to fall	• Optimal pain control and management of adverse effects. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• Rescreen for the presence of new or worsening pain once per shift during comfort rounds and also after a significant change in health status and before, during and after a potentially painful procedure or intervention.		
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (bed mobility, turning and repositioning). Revision on: 03/19/2024 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Talib will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living (bed mobility) each day through to the next review date.	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails. Revision on: 12/22/2023 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate bed mobility.		

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C

Last Care Plan Review Completed:	**09/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	Revision on: 12/22/2023 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with bed mobility, turning and repositioning. Monitor every shift. Revision on: 12/22/2023 Revision by: Suzanne Azar (RN)	PCA	D/E/N
• Potential for CONSTIPATION related to decreased mobility, etc. Revision on: 01/29/2024 Revision by: Maryola Perion (RN)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025 • Talib will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/collaborate with (Talib/SDM) for decision making regarding constipation management. Revision on: 01/29/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	
• SPIRITUAL BELIEFS: Talib is of the Muslim Faith. Revision on: 01/22/2024 Revision by: Mitchell Atkinson (Recreation Aide)	• To provide Talib spiritual support as interested through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• SPIRITUAL PROGRAMS: Encourage him to attend spiritual programs of his choice including Muslim spiritual programs, etc. Revision on: 01/22/2024 Revision by: Mitchell Atkinson (Recreation Aide)		
• Transfers/Transfer Training Revision on: 12/14/2023 Revision by: Shina Wadhwa (PT -	• Reduced assistance needed for transfers from 2 assist to 1	• 1:1 assist transfer training, cue to push from rails/bed to stand up, Include pre-gait exs like marching, heel raise and weight shifts; 3-5 reps, 2-3 x a week Revision on: 07/30/2025	PT - Physiotherapist	

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C
Last Care Plan Review Completed:	**09/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Physiotherapist)	assist in next 3 months; Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	Revision by: Shina Wadhwa (Physical Therapist)	PTA	
• Ambulation/Gait Training Revision on: 12/14/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Increased walking endurance from 100ft to 200ft in next 3 months; Revision on: 02/20/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/03/2025	• Gait training 1 Assist with RW, small laps, Slowly increase distance, cue for foot clearance while walking, smaller laps 2-3/week as tolerated. Revision on: 07/30/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Strength Revision on: 12/14/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Increased ROM for knee extension from -10 degrees to neutral position in next 3 months Improved Strength for B/L LE strength from 3+/5 to 4/5 in next 3 months Revision on: 07/30/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/03/2025	• AROM exs for B/L UE and LE, 10 reps, 1-2 sets, or as best tolerated, 4-5 x a week; Revision on: 11/28/2024 Revision by: Shina Wadhwa (Physical Therapist) • Strengthening exercises using 1-2 lbs. Weights for B/L UE and LT LE 1set, 10rps., 4-5/week as tolerated, Revision on: 09/16/2024 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA PT - Physiotherapist PTA	
• Altered VISION related to wears glasses for vision correction, Cataracts. Revision on: 12/13/2023 Revision by: Elsie Calumpang (RN)	• Talib supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• EYEGLASSES: Talib wears eyeglasses. Assist to clean eyeglasses as needed and store on night table when sleeping. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Talib has Chronic Kidney Disease (CKD). Revision on: 12/13/2023	• To treat and minimize complications associated with	• MONITORING: Utilize holistic perspective of continuous monitoring of Talib with CKD for changes to health status and alteration or complications affecting renal		

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C
Last Care Plan Review Completed:	**09/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Katie Wolters-Savo (RAI Coordinator)	Chronic Renal Failure through to next review date Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	function. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • LABWORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES (NIDDM) Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/ collaborate with (Talib)/SDM in decision making of diabetes care management. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Talib for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication ORAL ANTIHYPERGLYCEMIC medication for DIABETES as per MD order. Monitor effectiveness and for side effects. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential to experience alteration in CARDIAC FUNCTION related to; history of Chronic Heart Failure (CHF), Aortic Stenosis, HTN. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To treat and minimize signs/symptoms or complications associated with history of Chronic Heart Failure (CHF), Aortic Stenosis, HTN through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/collaborate with (Talib)/SDM in decision making of Cardiac Care Management for history of Chronic Heart Failure (CHF), Aortic Stenosis, HTN. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Talib with history of Chronic Heart Failure (CHF), Aortic Stenosis, HTN for changes to health status and alteration or complications affecting cardiac function. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication for history of Chronic Heart Failure (CHF), Aortic Stenosis, HTN as per MD Order and monitor for side effects.	Registered Practical	

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C
Last Care Plan Review Completed:	**09/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • RESCUE MEDICATIONS: Administer NITRO-Patch for chest pain as per MD Order. Revision on: 08/24/2024 Revision by: Jenny Liu (RAI Coord Back-up) • OXYGEN: Administer Oxygen as per MD order. Revision on: 08/31/2024 Revision by: Maryola Perion (RN)	Nurse RN Registered Practical Nurse RN Registered Practical Nurse RN	
• Potential to experience alteration in ENDOCRINE FUNCTION related to HYPOTHYROIDISM- On Levothyroxine Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To treat and/or minimize signs/symptoms of HYPOTHYROIDISM through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• COMMUNICATION: Involve/ collaborate with (Talib)/SDM in decision making of thyroid care management. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Talib with HYPOTHYROIDISM for changes to health status and alteration or complications affecting endocrine function. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication for HYPOTHYROIDISM as per MD order. Monitor effectiveness and for side effects. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • LAB WORK: Monitor lab and diagnostic results for and report results to MD as needed. Follow up as indicated. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Nutrition Risk Level	• Talib will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• Honor religious rituals related to diet/eating: Do not serve pork. Revision on: 08/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) • NUTRITION RISK: Talib is moderate risk level. Revision on: 11/26/2024 Revision by: Lexi Dakin (Dietitian (RD)) • DIET ORDER: Talib will receive Regular diet, Regular texture - see dining instructions	Dietitian (RD) PCA	

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C
Last Care Plan Review Completed:	**09/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	• Will weigh within GWR/IBW/Realistic weight range of 70-80 kg/BMI 25-29 through to next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025 • Talib will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 1925 ml/day (25 ml/kg using 77 kg weight) through to next review date. Revision on: 08/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/03/2025	Revision on: 09/26/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FLUID CONSISTENCY: Talib drinks REGULAR/THIN Level 0 Fluids. Revision on: 12/13/2023 Revision by: Anna Slack (Registered Dietitian) • FLUID TARGET: Encourage Talib to drink a minimum of 1540 ml/day Revision on: 08/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DINING INSTRUCTIONS: - No pork - Encourage softer options - Cut food into small pieces Revision on: 09/26/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA PCA Registered Practical Nurse	
• Expressed Wishes and Beliefs related to Talib's Medical Treatment and End of Life Care Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To support and honor Talib's expressed wishes and beliefs through to the End of Life. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• CPR: Talib wishes to have CPR and TRANSFER to hospital. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential to experience alteration in MOOD as exhibited by history of low mood related to Depression. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Talib will be supported to maintain mood stability as evidenced by DRS score at a range of 0-2 by the review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator)	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Talib for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • RESIDENT STRENGTHS: Build on Talib's effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities.		

Allergies	Penicillin, Benzodiazepines	**D.O.B.**	07/01/1944	**Physician**	Albert Patrick Ng
Diagnosis	Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery(I25.10), Aortic (valve) stenosis(I35.0...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Al-Roubaiai, Talib (922131005546)	**Admission Date**	12/13/2023	**Location**	4 424 C
Last Care Plan Review Completed:	**09/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 12/03/2025	Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Altered COMMUNICATION as exhibited by limitations to comprehension related to language barrier. Revision on: 12/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Talib will be supported to make basic needs known each day through to the review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/03/2025	• PRIMARY LANGUAGE: Talib's primary language is Arabic. He understands English and is able to speak in English Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • INTERPRETER Required: Staff members that speak Arabic. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.. Revision on: 08/31/2024 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: Talib needs (intermittent) cueing or demonstrative instruction in tasks and activities. Revision on: 08/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Diagnosis

Type 2 diabetes mellitus without (mention of) complications(E11.9), Congestive heart failure(I50.0), Atherosclerotic heart disease of native coronary artery (I25.10), Aortic (valve) stenosis(I35.0), Atrial fibrillation, unspecified(I48.90), Benign hypertension(I10.0), Chronic kidney disease, unspecified(N18.9), Anxiety disorder, unspecified(F41.9), Unspecified fracture of neck of femur, closed(S72.090), Unspecified viral hepatitis without hepatic coma(B19.9), Personal history of COVID-19(U07.5), Fracture of upper (proximal) end of tibia with or without fibula, closed(S82.100), Sepsis, unspecified(A41.9), Embolism and thrombosis of other specified veins(I82.8)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to SKIN TEAR to #9 - Skin Tear on the upper lip. Revision on: 10/26/2025 Revision by: Ravinder Kaur (Registered Nurse)	• To promote optimal healing of SKIN TEAR within (specify date of expected healing or end of treatment date *** and remember to also alter the goal until the next review date. Revision on: 10/26/2025 Revision by: Ravinder Kaur (Registered Nurse) Target Date: 01/06/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with SKIN TEAR to #9 - Skin Tear on upper lip for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/26/2025 Revision by: Ravinder Kaur (Registered Nurse) • TREATMENT PLAN: Administer treatment for SKIN TEAR #9 - Skin Tear as per MD Order. Revision on: 10/26/2025 Revision by: Ravinder Kaur (Registered Nurse) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 10/26/2025 Revision by: Ravinder Kaur (Registered Nurse)		
• Potential for PAIN and alteration in comfort level related to (dependence), Impaired mobility. Most Current RAI Pain Score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	• Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • NON VERBAL CUES of PAIN for Lynn includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 10/06/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse PCA Registered Practical Nurse RN	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Low Motivation, Cognitive Limitation, Rest/Sleep Patterns	• Team members will support Lynn in decreasing social isolation by participating in activities of personal choice for 20-25 times per month by the next review date.	• STRUCTURED ACTIVITIES: Invite her to programs of personal interest; baking, bingo, concerts, cards, movies, parties, tea social, music programs, doll/pet therapies, etc.). Revision on: 09/21/2025 Revision by: Kameron Stewart (Recreation Aide) • ONE to ONE: Provide her with individual visits for hand massages, bedside activity,		

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng	
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C	
Last Care Plan Review Completed:	**10/06/2025**					

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 09/21/2025 Revision by: Kameron Stewart (Recreation Aide) Target Date: 01/06/2026	reading, pet/doll therapies, sensory activities, etc.) Revision on: 09/21/2025 Revision by: Kameron Stewart (Recreation Aide)		
• Risk for Impaired SKIN INTEGRITY related to edema to bilateral feet, Incontinence, Impaired mobility, Swelling to back of right hand, redness to left thigh medial. Revision on: 08/26/2025 Revision by: Shabnam Mustary (RPN)	• To protect and maintain skin integrity each day through to the next review. Target Date: 01/06/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• EQUIPMENT: Lynn requires (Heel posey's on both legs) to offload pressure. Revision on: 06/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• POSITIONING: Turn, reposition every 2 hours when in bed/wheelchair to offload pressure. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	Q2h
• Increased risk for FALLS related to Limitation of cognitive function/altered judgement (Frontal lobe Dementia), impaired mobility. Revision on: 07/08/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Target Date: 01/06/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making in fall prevention Plan of Care. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 01/15/2025 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment: reduce clutter etc. to reduce fall risk for Lynn. Revision on: 01/15/2025 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers. Revision on: 01/15/2025 Revision by: Maryola Perion (RN)	PCA	
		• SUPPLEMENT: Administer supplement as per MD order to maintain bone density		

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to Limitation of cognitive function/altered judgement (Frontal lobe Dementia), impaired mobility. Revision on: 07/08/2025 Revision by: Maryola Perion (RN)		to prevent injuries. Revision on: 10/06/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in MOOD as exhibited by sheets tightly tucked around her head and neck while she was in bed, NSGAR score of 5, Crying related to Frontal Lobe Dementia Revision on: 05/19/2025 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 07/08/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• COMMUNICATION: Involve/collaborate with SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 05/19/2025 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Lynn for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 05/19/2025 Revision by: Maryola Perion (RN) • SUICIDAL IDEATIONS: Report to Registered Staff IMMEDIATELY if Lynn is trying to harm self. (sheets tightly tucked around her head and neck while she was in bed) Revision on: 05/19/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in RESPIRATORY FUNCTION related to: Asthma Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Asthma each day through to next review date. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Asthma for changes to health status and alteration or complications affecting respiratory function. Revision on: 04/18/2025 Revision by: Maryola Perion (RN) • POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing.	Registered Staff PCA	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/06/2026			
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, no speech) related to Expressive Aphasia, frontal lobe Dementia, Apraxia. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	• Lynn is unable to express self and will be supported to have needs interpreted each day through the next review. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/06/2026	• PRIMARY LANGUAGE: Lynn primary language is English. She is (specify able or unable to understand) English. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) • SUPPORTIVE TECHNIQUES: (Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases). Resident cannot speak and this can cause frustration. Approach conversations slowly. Pay attention to sounds and gestures are her form of communication. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential to experience alteration in CARDIAC FUNCTION related to: Hyperlipidaemia Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Hyperlipidaemia through to the next review date. Revision on: 04/18/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• COMMUNICATION: Involve/collaborate with (SDM in decision making of Cardiac Care Management for Hyperlipidaemia. Revision on: 04/18/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hyperlipidaemia for changes to health status and alteration or complications affecting cardiac function. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Limitation, Frontal Lobe Dementia, Apraxia, Dysphasia and Aphasia. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	• Lynn will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026 • Lynn will have ALL ADL care	• BATHING: Lynn prefers (tub bath) on (Wednesdays and Sundays on Evening shift). Two staff (Total) assistance for bathing. Sit to stand lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/08/2025 Revision by: Maryola Perion (RN) • BED MOBILITY: Lynn requires two staff Total assistance to turn and reposition her when in bed. Revision on: 07/08/2025 Revision by: Maryola Perion (RN) • DRESSING: Lynn requires Total assistance with two team members to dress her	PCA PCA PCA	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	needs met each day through the next review date. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/06/2026	from head to toe. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)		
		• EATING: Lynn is dependent on 1 team member to feed her. Feed resident slowly, check for swallowing before offering the next bite or sip. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• LOCOMOTION: Lynn is using a wheelchair as her mode of locomotion and requires one staff total assistance to propel her on and off the unit. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Lynn is not able to assist with her personal hygiene. She requires total assistance from two team members. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide (TOTAL) assistance to (use soap/water, apply sanitizer, rub hands together, dry hands, etc.) for hand hygiene. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TOILET USE: If Lynn is not toilted, she is provided with check and change of the brief in bed with 2 team members total assistance. 2 team members with Sara lift if using the toilet. Resident is not be left unattended on the toilet Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Lynn is able to bear weight. 2 staff to provide lift via the Sara lift: Sit to Stand lift. Revision on: 01/16/2025 Revision by: Lara Ismail (RN)	PCA	
		• ORAL CARE: Lynn has (Own teeth- 2 implants on her right side.) and is dependent on the team for her oral care. Do not take out partial implants. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	PCA	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, etc.) Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Norvasc, ACE Inhibitors. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	• Lynn will be protected from exposure to allergen each day through next review date. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about ALLERGY to Norvasc, ACE Inhibitors. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • ALLERGY ALERT: Lynn has ALLERGY to Norvasc, ACE Inhibitors. Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • MD/PHARMACY ALERT: Notify the MD and Pharmacy of Lynn's Allergy to Norvasc, ACE Inhibitors and minimize risk for exposure to allergen. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to use of diuretic, episodes of LBMs. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)	• COMMUNICATION: Involve/collaborate with SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration.		

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/06/2026	Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • PROMOTE FLUIDS: Promote Lynn to consume fluids; amount as per Nutrition Care Plan. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)		
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (during care). Revision on: 01/23/2025 Revision by: Suzanne Azar (RN)	• Lynn will be effectively supported with use of (two 1/4 bed rails) to optimize Activity of Daily Living (care) each day through to the next review date. Revision on: 01/23/2025 Revision by: Suzanne Azar (RN) Target Date: 01/06/2026	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails Revision on: 01/23/2025 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate ADL (during care). Revision on: 01/23/2025 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with (bed mobility, during care). Monitor every shift. Revision on: 01/23/2025 Revision by: Suzanne Azar (RN)	PCA	D/E/N
• ROM Exs Revision on: 01/14/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increased ROM for B/L shoulder from AA110 to 120 degrees in next 3 months; Revision on: 10/01/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/06/2026	• AAROM exs for B/L UE and LE, as best tolerated, within pain limits,10 reps, 1-2 sets, 2-3 x a week; Passive stretching for B/L Hams and Calf with 15-20 sec hold, 3-5 reps, 2-3 x a week; Revision on: 01/14/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Expressed Wishes and Beliefs related to Lynn Medical Treatment and End of Life Care Revision on: 01/14/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To support and honor Lynn's expressed wishes and beliefs through to the End of Life. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• CPR: Lynn's preference- DO NOT ATTEMPT CPR: Transfer to hospital decision will be made as needed - see PoET Individualized Summary for details Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• COGNITIVE LOSS; alteration in thought	• Lynn is severely impaired in	• COMMUNICATION: Involve/collaborate with SDM in decision making of Cognitive		

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
processes (memory loss, difficulty concentrating, altered judgement) related to progression of Frontal lobe Dementia Revision on: 01/14/2025 Revision by: Shina Wadhwa (Physical Therapist)	cognition and will have needs interpreted and met each day through to the review date. CPS score is 6. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	Loss for Frontal Lobe Dementia. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	PCA	
• Potential for Expressive Behaviour of (resistive to care, smearing and ingesting own feces) nature related to Frontal lobe dementia Revision on: 01/14/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To promote safety for Lynn and/or others during each episode of (physical during care) through to the next review date. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/06/2026 • To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 04/18/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• COMMUNICATION: Involve/collaborate with SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Lynn for indications to change in or for escalating expressive behaviour risk. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • TRIGGERS leading to PHYSICAL (Hitting, Punching, Slapping, Biting, Kicking) as expression of behaviour include (Frustration, confusion, invasion of personal space, personal care) Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) • PHYSICAL Behaviour: If Lynn is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (resistive to change clothing, bathe, eat, medication) as expression of behaviour include (confusion, misunderstanding care needs, poor judgement) Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) • RESISTANCE to Care Need: If Lynn is declining to (bathe, change clothes, take	BSO - Internal Social Worker	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C

Last Care Plan Review Completed:	**10/06/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of (resistive to care, smearing and ingesting own feces) nature related to Frontal lobe dementia Revision on: 01/14/2025 Revision by: Shina Wadhwa (Physical Therapist)		medications, eat.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to SOCIALLY Inappropriate (smearing feces, ingesting feces) as expression of behaviour include (confusion, decreased insight, poor judgement, limitation in communication.) Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) • SOCIALLY Inappropriate Behaviour: If Lynn is noted to ingesting, smearing feces) clean area using appropriate PPE. Report episode to Registered Staff. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Potential for BOWEL INCONTINENCE related to dementia Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Lynn will have bowel incontinence managed every shift through to the next review period. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Total Incontinence. Report changes to level as noted. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Lynn uses Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• Sleep Patterns; Potential for alteration in sleep patterns related to frontal lobe dementia Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote adequate rest/sleep for Lynn based on identified sleep patterns/preferences each night through to the next review date.	• REST PATTERN: Preferred bedtime 1930-2000, usual wake time prior to breakfast and daytime naps often after lunch. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/06/2026			
• URINARY (Mixed) INCONTINENCE related to Dementia Diagnosis Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Lynn will have urinary incontinence managed every shift through to the next review period. Revision on: 04/18/2025 Revision by: Maryola Perion (RN) Target Date: 01/06/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 01/24/2025 Revision by: Maryola Perion (RN)		
		• URINARY Continence level is TOTAL Incontinence. Report change to level as noted. Revision on: 04/18/2025 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Lynn uses Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA	
• Nutrition Risk Level	• Lynn will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 01/20/2025 Revision by: Debora Choi (Dietitian (RD)) Target Date: 01/06/2026	• Labelled Item Breakfast: apple sauce daily (for LBM) Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D
		• Labelled Item Dinner: apple sauce daily (for LBM) Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	E
	• Will weigh within realistic GWR: 65-70 kg through to next review date. Revision on: 04/17/2025 Revision by: Holly Laasanen (Dietitian (RD))	• Labelled Item Lunch: Greek yogurt daily Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D
		• NUTRITION RISK: Lynn is moderate risk level.	Dietitian (RD)	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C

Last Care Plan Review Completed:	**10/06/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level	Target Date: 01/06/2026 • Lynn will be adequately hydrated aeb drinking at least 87% of total fluid requirement: 1725 ml/day (25 ml/kg using 69 kg weight) through to next review date. Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/06/2026	Revision on: 09/24/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIET ORDER: Lynn will receive regular diet, pureed texture Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FLUID CONSISTENCY: Lynn drinks REGULAR/THIN Level 0 Fluids. Revision on: 01/10/2025 Revision by: Ronnie Fung (FSM - Food Services Manager) • FLUID TARGET: Encourage Lynn to drink a minimum of 1500 ml per day. Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD)) • EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily. • DINING INSTRUCTIONS: Provide lactose-free milk to drink (for LBM) Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD)) • MEDPASS SUPPLEMENTS: - 237 ml Boost Fruit Beverage once daily with medpass Revision on: 09/24/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA PCA PCA Dietary aide PCA Registered Practical Nurse	

Allergies	Norvasc, ACE Inhibitors	**D.O.B.**	02/02/1945	**Physician**	Albert Patrick Ng
Diagnosis	Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of f...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Arrand, Lynn (922131005610)	**Admission Date**	01/10/2025	**Location**	4 421 C
Last Care Plan Review Completed:	**10/06/2025**				

Diagnosis

Frontal lobe dementia(G31.02), Dysphasia and aphasia(R47.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Hyperlipidaemia, unspecified(E78.5), Unspecified fracture of neck of femur, closed(S72.090), Obesity, unspecified(E66.9), Apraxia(R48.2)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Sleep Patterns r/t insomnia Revision on: 10/16/2025 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for Branka based on identified sleep patterns/preferences each night through to the next review date. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/10/2026	• REST PATTERN: Preferred bedtime (0000), usual wake time (0800). Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	PCA	
		• MONITOR: Monitor Branka sleeping patterns. Document when awake or asleep. Revision on: 05/22/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	Q1H
• Expressed Wishes and Beliefs related to Branka Medical Treatment and End of Life Care Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To support and honor Branka's expressed wishes and beliefs through to the End of Life. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• Attempt CPR: transfer to hospital decisions to be made as needed - see PoET Individualized Summary for details Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Limitation, Fracture left hip, Limited Mobility Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Branka will have ALL ADL care needs met each day through the next review date. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/10/2026	• BATHING: Branks prefers (shower) on (Tuesdays and Fridays on Day shift). Branks participates by (providing a wash cloth and cues). Two staff (EXTENSIVE) assistance for bathing. Sit to stand lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY: Branka is Independent but may require one to two staff assistance to turn and reposition her in bed at times. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Branka is able to assist in lifting her arms and legs with cueing from staff. One staff to provide Extensive assistance for dressing UPPER & LOWER body. She may require two staff maximal assistance at times. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Branka is Independent with set up from staff. Eats on the main floor for meals. (Cut food into small pieces). Branka will at times stay in bed and eat in her room and may require supervision and	PCA	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed:	**10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		set up from staff and to ensure proper positioning when eating. Encouragement is required as she may refuse to eat. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)		
		• LOCOMOTION: Branka requires the use of a wheelchair and she is able to propel herself on and off the unit. She may require one staff to bring her down for meals or activities. Branka will try to walk using her wheelchair as a walker or will try to walk by herself in the room by holding on to the appliances. She is encouraged to use the call bell and to ask for assistance as needed. Revision on: 04/23/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Branka is able assist with combing her hair, washing her face and hands with cueing from staff. One to two staff maximal assistance with peri care. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide (LIMITED) assistance to (Specify; use soap/water, apply sanitizer, rub hands together, dry hands, etc.) for hand hygiene. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TOILET USE: Branka requires the use of a sit to stand lift to transfer her to and from wheelchair to toilet with two staff to assist with transfer. One staff to assist with peri care and brief change. Branka also uses a bed pan. Staff to ask Branka if she wants to be toileted or to use the bed pan. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Branka requires maximal assistance with the use of a sit to stand lift with two staff assistance. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFER LIFT/SLING: Sit to stand lift and Yellow SIZE of sling needed for transfer. Revision on: 01/21/2025		

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed:	**10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Limitation, Fracture left hip, Limited Mobility Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)		Revision by: Maryola Perion (RN) • ORAL CARE: Branka has (own teeth) and is able to (brush her teeth with set up assistance) from 1 team member Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Potential for (persistent) PAIN and alteration in comfort level related to recent left hip fracture prior to move in, Stroke, pain to swelling left buttock. Most Current RAI Pain Score is 0. Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Target Date: 01/10/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• COMMUNICATION: Involve/collaborate with (Branka)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • NON VERBAL CUES of PAIN for Branka includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	RN Registered Practical Nurse PCA Registered Practical Nurse	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
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Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed: **10/10/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for (persistent) PAIN and alteration in comfort level related to recent left hip fracture prior to move in, Stroke, pain to swelling left buttock. Most Current RAI Pain Score is 0. Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)		Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	RN	
• Increased risk for FALLS related to history of falls, unsteady gait and balance, Use of antipsychotic and antidepressant medication, self transferring, toileting and attempts to ambulate without assistance. Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Target Date: 01/10/2026	• COMMUNICATION: Involve/collaborate with Branka & Son Zika (POA) in decision making in fall prevention Plan of Care. Revision on: 01/29/2025 Revision by: Katherine Arca (RPN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 01/21/2025 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment: reduce clutter, etc. to reduce fall risk for Branka Revision on: 01/21/2025 Revision by: Maryola Perion (RN)	PCA	
		• BED: Bed at lowest position to lower risk for injury. Revision on: 01/29/2025 Revision by: Katherine Arca (RPN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers, ambulation. Revision on: 01/21/2025 Revision by: Maryola Perion (RN)	PCA	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
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Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed: **10/10/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to history of falls, unsteady gait and balance, Use of antipsychotic and antidepressant medication, self transferring, toileting and attempts to ambulate without assistance. Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)		• SPECIAL CONSIDERATION to PREVENT FALLS: Resident will self transfer, toilet self and attempt to ambulate. Team to monitor for risk taking, team to escort, redirect and assist to call for assistance and reminder her of the importance to do so. Revision on: 09/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • SUPPLEMENT: Administer supplement/medication as per MD order to maintain bone density to prevent injuries. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	PCA	
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty making decisions) related to stroke Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Branka will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• ORIENTATION: Gently reorient to (person, place, time) as needed when Branka is feeling lost or in confused state. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • CUE TASKS: Break tasks into manageable subtasks, Branka can comprehend and follow Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Altered COMMUNICATION as exhibited by limitations to (primary language is serbian, minimal hearing loss when in loud areas.) Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Branka will be supported to maintain current communication abilities to (simple English words, gestures or with translator) each day through to the review date. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI	• PRIMARY LANGUAGE: (Branka) primary language is (Serbian). They are able to understand some English. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) • INTERPRETER Required: when resident is not able to express needs.Translator app works when communicating with resident as well Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A
Last Care Plan Review Completed:	**10/10/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Coordinator) Target Date: 01/10/2026	• SUPPORTIVE TECHNIQUES: (Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.). Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Altered VISION related to need for reading glasses Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Branka supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/10/2026	• EYEGLASSES: Branka wears reading eyeglasses. Assist to clean eyeglasses as needed and store (on night table) when not in use Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• READING: Branka uses (large print material) to aid with reading. Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (turning and repositioning). Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Branka will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living (turning and repositioning) each day through to the next review date. Revision on: 02/08/2025 Revision by: Suzanne Azar (RN) Target Date: 01/10/2026	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails. Revision on: 02/08/2025 Revision by: Suzanne Azar (RN)		
		• MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate bed mobility. Revision on: 02/08/2025 Revision by: Suzanne Azar (RN)		
		• BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with bed mobility. Monitor every shift. Revision on: 09/30/2025 Revision by: Tola Omolade (ADOC)	PCA	D/E/N
• Risk for Impaired SKIN INTEGRITY related to Impaired Mobility, Cytotoxic medications, Incontinence, left foot/ankle is swollen Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To protect and maintain skin integrity each day through to the next review. Target Date: 01/10/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• CYTOTOXIC MEDICATION RISK: Branka has potential to experience skin irritation (redness, burning, itchiness, etc.), report observed symptoms to Registered Staff immediately as noted. Revision on: 06/23/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A
Last Care Plan Review Completed:	**10/10/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in CARDIAC FUNCTION related to: PATENT FORAMEN OVALE, Hypertension, Dyslipidemia. Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with PATENT FORAMEN OVALE, Hypertension, Dyslipidemia through to the next review date. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with PATENT FORAMEN OVALE, Hypertension, dyslipidemia for changes to health status and alteration or complications affecting cardiac function. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication as per MD Order and monitor for side effects. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES Type 2. Revision on: 10/08/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Target Date: 01/10/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status.	Registered Staff	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest and Rest/Sleep Patterns, ISE score: 4/6 Revision on: 10/02/2025 Revision by: Laura Morris (Restorative Care Aide)	• Team members will support Branka in decreasing social isolation by participating in activities of personal choice for 5-10 times per month by the next review date. Revision on: 02/20/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/10/2026 • To support Branka's Psycho-Social well being through to the next review. Revision on: 02/20/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/10/2026	• STRUCTURED ACTIVITIES: Invite Branka to programs of personal interest; music programs, exercise, spiritual programs, movies, games. Revision on: 04/15/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage Branka to engage in self-directed activities such as watching TV in own room, conversing with peers. Revision on: 02/20/2025 Revision by: Laura Morris (Restorative Care Aide) • ONE to ONE: Provide Branka with individual visits for conversation, listening to music, reminiscing, etc. Revision on: 02/20/2025 Revision by: Laura Morris (Restorative Care Aide)		

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed: **10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest and Rest/Sleep Patterns, ISE score: 4/6 Revision on: 10/02/2025 Revision by: Laura Morris (Restorative Care Aide)				
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications) Revision on: 06/23/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• COMMUNICATION: Involve/collaborate with (Branka)/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Potential for CONSTIPATION related to (decreased mobility, refusing stool softener, etc.) Revision on: 05/01/2025 Revision by: Maryola Perion (RN)	• Branka will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026 • To minimize the potential for	• COMMUNICATION: Involve/collaborate with (Branka/SDM) for decision making regarding constipation management. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care	Registered Staff Registered	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A
Last Care Plan Review Completed:	**10/10/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	episodes/ complications of constipation through to the next review date. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	Plan. • BOWEL PROTOCOL: In place as per MD order	Staff Registered Staff	
• Potential for altered hematologic symptoms or complications related to diagnosis of Essential thrombocytosis. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with Essential thrombocytosis each day through to the next review date. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Essential thrombocytosis for complications or changes to health status. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for Essential thrombocytosis as per MD Order. Monitor effectiveness and for side effects. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)		
• Potential for Expressive Behaviour of RESISTANCE to care needs, Physical (swatting, hitting), Disruptive Behavioural Symptoms/Socially Inappropriate (spitting her medication, resident urinated in the waste basket located in her room), wandering (going to other resident's room), yelling and spitting to the son related to Inability to COPE Revision on: 04/04/2025 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be less than 3. Revision on: 10/10/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• COMMUNICATION: Involve/collaborate with (Branka)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 01/24/2025 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Branka for indications to change in or for escalating expressive behaviour risk. Revision on: 09/30/2025 Revision by: Ranjita Yadav (RPN) • TRIGGERS leading to PHYSICAL (swatting Registered staff's hand when refusing medication, hits another resident arm with fist, etc.) as expressions of behaviour include (confusion, etc.) Revision on: 03/29/2025 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: If Branka is attempting to swat or strikeout, she will hit others unprovoked and with care. She has been noted to stick her foot out to attempt to trip; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance. Revision on: 03/28/2025	BSO - Internal Social Worker PCA Registered Practical Nurse	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Focus	Goal	Interventions	Position	Freq/Resolved
		Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to VERBAL (yelling, etc.) as expression of behaviour include (loss of control, frustration, limitation in self expression, misunderstanding care intention, etc.) Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Branka is heard yelling, swearing or calling others names; calmly remind to lower her voice and that chosen words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing medication, transfer, bath/shower, to eat, etc.) as expressions of behaviour include (misunderstanding care needs, poor judgement, fearfulness, etc.) Revision on: 10/10/2025 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Branka is declining to (refusing medication, transfer, bath/shower, to eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 10/10/2025 Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If Branka is noted to (yelling and calling out to use the washroom after she was toileted, spitting her medication, spitting on the floor rummaging through other residents drawers, spitting to her son) gently redirect her that she just went. Ask if she needs anything. Assess for unmet needs. May need interpretation. Use PPE when cleaning up spit. Revision on: 03/28/2025 Revision by: Danielle Loreto (RAI Coordinator) • SOCIALLY Inappropriate Behaviour: If Branka is noted (resident urinated in the waste basket located in her room, etc.) clean area using appropriate PPE. Report episode to Registered Staff. Revision on: 04/04/2025 Revision by: Maryola Perion (RN) • WANDERING: Permit Branka to safely roam in common area. Redirect away from	PCA	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A
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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of RESISTANCE to care needs, Physical (swatting, hitting), Disruptive Behavioural Symptoms/Socially Inappropriate (spitting her medication, resident urinated in the waste basket located in her room), wandering (going to other resident's room), yelling and spitting to the son related to Inability to COPE Revision on: 04/04/2025 Revision by: Maryola Perion (RN)		exit doors, elevator or other resident rooms as needed. Revision on: 03/06/2025 Revision by: Maryola Perion (RN) • ONE to ONE Care: Apr 23, 2025 (Evening shift). See Registered Staff for updates. Now 1:1 only for evening shifts. Revision on: 09/30/2025 Revision by: Ranjita Yadav (RPN) • BSO RECOMMENDATIONS: (specify intervention in easy to follow instruction) Verbal: Yelling, calling others names Triggers: Misunderstanding care needs, poor judgement, fearfulness Socially Inappropriate: Yelling out, calling out to use the washroom after she was toileted. The resident can be forgetful and accusatory of tasks not being done that have been completed. Resistance to care: Refusing medication, eating, transfers Triggers: misunderstanding care needs, poor judgement, fearfulness Recommendations: Verbal: Calmly ask the resident to lower her voice check for unmet needs. Resistance to Care: Reapproach in 10-15 minutes. Report to registered staff. Build rapport. Start a conversation and involve the son to encourage his mother to have a shower. Approach with choices to allow resident to make decisions (Ex."Would you like a shower now before breakfast or after?") Reassure the resident team member will assist with the transfer and she can wash her own body. Offer to fill the tub for her and once transferred in the tub, staff may need to turn back and give the resident some privacy as she shared she doesn't like to be washed by others. During personal care, encourage independence as much as possible. Ask the resident to take off/on her own clothes/towels.Encourage resident to pull down shirts once over her head or pull up her pants. Once in the tub, team member can hand cloth encouraging independence and team member can step back and give reassurance that the resident has privacy. The resident likes to drain the tub after and hand shower head as she will rinse off. Socially Inappropriate: Gently redirect her that she just used the washroom. Ask if she needs anything. Assess for unmet needs. Monitor for signs of pain and infection. The resident enjoys visits with her son, talking about her family, life in Serbia and watching TV.		

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
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Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed:	**10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of RESISTANCE to care needs, Physical (swatting, hitting), Disruptive Behavioural Symptoms/Socially Inappropriate (spitting her medication, resident urinated in the waste basket located in her room), wandering (going to other resident's room), yelling and spitting to the son related to Inability to COPE Revision on: 04/04/2025 Revision by: Maryola Perion (RN)		Revision on: 10/08/2025 Revision by: Leslie Meloche (Recreation Aide)		
• Potential for bruising, bleeding, clotting or other complications related to use of ANTICOAGULANT medication. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	• To monitor for bleeding and minimize complications related to use of anticoagulant through the review date. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• COMMUNICATION: Involve/collaborate with (Branka)/SDM in decision making and health teaching of Anti-coagulation medication use. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using Anticoagulant therapy for changes to health status and complications causing bleeding or clotting issues. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed: **10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		• BLEEDING ALERT: Notify nurse immediately if Branka is bleeding (noted blood in urine/stool, bleeding nose/gums, unexplained bruising, etc.). Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	PCA	
		• MEDICATION: Administer medications as per MD Order. Report abnormal or unexplained bleeding, unexplained or excessive bruising, etc. to MD as noted.	Registered Staff	
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: Stroke, SEIZURE Disorder Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/ symptoms or complications associated with Stroke, SEIZURE Disorder through to the next review date. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• COMMUNICATION: Involve/ collaborate with (Branka)/ SDM in decision making of neurological care management for Stroke, SEIZURE Disorder. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	PCA	
		• MEDICATION: Administer medication for Stroke, SEIZURE Disorder as per MD order. Monitor effectiveness and for side effects. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Stroke, SEIZURE Disorder for changes to health status and alteration or complications affecting neurological function. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)		
		• SEIZURE Disorder: If seizure activity occurs alert registered staff immediately; place on side, protect from injury, maintain open airway.	PCA Registered Staff All	
		• SEIZURE Disorder: Branka has potential for seizure activity, injury related to seizure disorder. Inform MD as it occurs. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in MOOD as exhibited by repetitive verbalizations, persistent anger with self or others, repetitive health complaints, sad, pained, worried facial expressions related to Loss of Independence, Stroke Revision on: 02/05/2025	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)	• COMMUNICATION: Involve/collaborate with (Branka)/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)		
		• HEALTH EDUCATION: Provide education and support to (Branka)/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed.	RN Registered Practical	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed:	**10/10/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	Target Date: 01/10/2026	Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Branka for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Branka's effort to maintain control. Encourage her to express self, state preferences and make safe choices for care and activities. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 02/05/2025 Revision by: Maryola Perion (RN)	Nurse	
		• 1 to 1 MONITORING/CARE: Branka is receiving 1:1 care for support of mental wellbeing to monitor safety and for episodes of self harm. Initiated on: Apr 23, 2025 (Evening shift). See Registered Staff for updates. Now 1:1 only for evening and night shifts. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	PCA	
• Nutrition Risk Level	• Branka will be adequately nourished through to next review date. Revision on: 02/03/2025 Revision by: Holly Laasanen Target Date: 01/10/2026 • Will weigh within realistic GWR of 49-59 kg through to next review date. Revision on: 02/03/2025 Revision by: Holly Laasanen Target Date: 01/10/2026	• Labelled Item Lunch: Magic Cup daily to promote weight stability Revision on: 07/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D
		• LABELLED SNACK HS: ice cream cup per resident's preference Revision on: 06/19/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	E
		• LABELLED SNACK PM: wafer cookies per resident's preference Revision on: 07/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed: **10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	• Branka will be adequately hydrated aeb drinking at least 75% of total fluid requirement 1000 ml/day (20-25 ml/kg) through to next review date. Revision on: 07/14/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 01/10/2026	• NUTRITION RISK: Branka is at moderate nutritional risk. Revision on: 10/01/2025 Revision by: Brittany Hyde (Registered Dietitian)	Dietitian (RD)	
		• DIET ORDER: Branka will receive regular diet, regular texture. Special instructions: cut food into small pieces, encourage alternating bites of food with sips of fluids. Revision on: 07/15/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• FLUID CONSISTENCY: Branka drinks REGULAR/THIN level 0 fluids. Revision on: 02/03/2025 Revision by: Holly Laasanen	PCA	
		• FLUID TARGET: Encourage Branka to drink a minimum of 1000 ml per day. Revision on: 07/14/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA	
		• EXTRA FLUIDS: offer a minimum of 250 ml high moisture food or fluid outside of meals and snacks daily. Revision on: 02/03/2025 Revision by: Holly Laasanen	PCA	
		• FOOD PREFERENCES: Branka enjoys eating lunch meats, fried chicken, cabbage rolls, and hamburgers. Revision on: 07/15/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• MEDPASS SUPPLEMENTS: 237ml Boost fruit beverage at breakfast (History of refusing Resource 2.0) Revision on: 10/01/2025 Revision by: Brittany Hyde (Registered Dietitian)		
		• HIGH FIBRE: prune juice at breakfast M-W-F Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D/E
		• LABELLED SNACK: gingerale at AM snack daily to promote hydration per resident's preference Revision on: 02/27/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D/E
• Potential for BOWEL INCONTINENCE	• Branka will have bowel	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for	Registered	

Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A

Last Care Plan Review Completed: **10/10/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
related to altered mobility Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	incontinence managed every shift through to the next review period. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026 • Branka will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Infrequently Incontinent. Report change to level as noted. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Branka uses a White Brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Staff PCA PCA PCA	
• URINARY Mixed INCONTINENCE related to altered mobility Revision on: 01/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Branka will have urinary incontinence managed every shift through to the next review period. Revision on: 01/25/2025 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/10/2026 • Branka will receive support to use toilet and promote urinary continence each shift through to the next review. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/10/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 01/21/2025 Revision by: Maryola Perion (RN) • URINARY Continence level is Frequently Incontinent. Report change to level as noted. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Branka uses a White Brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	 PCA PCA	

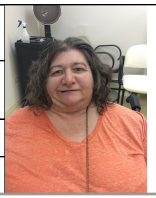
Allergies	No Known Allergies	**D.O.B.**	07/12/1946	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, n...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Bacvanski, Branka (922131005611)	**Admission Date**	01/21/2025	**Location**	4 422 A
Last Care Plan Review Completed:	**10/10/2025**				

Diagnosis

Benign hypertension(I10.0), Cachexia(R64), Thrombocytopenia, unspecified(D69.6), Atrial septal defect(Q21.1), Other specified diabetes mellitus without (mention of) complication(E13.9), Stroke, not specified as haemorrhage or infarction(I64), Unspecified fracture of neck of femur, closed(S72.090), Lipoprotein deficiency(E78.6), Seizure disorder, so described(R56.80), Paranoid personality disorder(F60.0)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Resident prefers to have the closet door removed to accommodate personal comfort and ease of access to belongings.	• Resident's room environment will reflect their preferences while maintaining safety, and dignity. Revision on: 10/21/2025 Revision by: Tola Omolade (ADOC) Target Date: 01/26/2026	• Review and monitor resident satisfaction with the environmental change during routine care conferences and daily interaction.	Registered Practical Nurse Social Worker	
• Potential for Persistent PAIN and alteration in comfort level related to Stroke with left side weakness, leg pain, sinus pain, headache. Most Current RAI Pain Score is 0/3. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Natalie/SDM about pain management, goals of treatment, plan of care, prognosis and treatment options. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	RN Registered Practical Nurse Registered Practical Nurse RN	
• Natalee DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 3/6 Revision on: 05/10/2025 Revision by: Laura Morris (Restorative Care Aide)	• Natalee participates in Independent/Self-Directed activities monthly through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as listening to music (pop, 98.7), watching TV (Ghost Whisperer, CSI, NCIS Los Angeles), using computer/cell phone, reading (crime, mystery, world events), visiting with residents/team members, family/friend visits, family/friends phone call, etc. Revision on: 11/27/2024 Revision by: Maryola Perion (RN) • FRIENDLY VISIT: Provide her one to one visits as tolerated. Touch Base to maintain contact and to converse about topics of interest, identify up-coming special events, etc. Revision on: 05/02/2020 Revision by: Shayna Lee Wonsch (Activation Manager) • INVITATION: Offer friendly invites to structured programs scheduled in the home.	ACT ACT	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng	
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A	

Last Care Plan Review Completed:	**08/22/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Natalee DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 3/6 Revision on: 05/10/2025 Revision by: Laura Morris (Restorative Care Aide)		Natalee enjoys exercise, manicures & hand massages, etc. Revision on: 03/19/2023 Revision by: Judy Woods (Activation aide)		
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, antidepressant) Revision on: 02/26/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote Natalee understanding of treatment regime and possible side effects of medication taken through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026 • To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Natalee/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Potential for Expressive Behaviour of VERBAL abusive and SOCIALLY Inappropriate, resisting care, refusing her hair to be brush, refusing to change wet	• To decrease the episodic frequency of Expressive behavior by the next review date. ABS score will be less	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Natalee for indications to change in or for escalating expressive behaviour risk. Revision on: 06/16/2023 Revision by: Maryola Perion (RN)	Registered Staff	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
pants related to loss of independence. Revision on: 11/27/2024 Revision by: Maryola Perion (RN)	than 2. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• TRIGGERS leading to VERBAL (yelling, accusing team and residents of hurting her screaming, calling names) as expression of behaviour include (loss of control, frustration, limitation in self expression, pain, misunderstanding care intention, etc.) Revision on: 03/17/2025 Revision by: Danielle Loreto (RAI Coordinator) • VERBAL Behaviour: If Natalee is heard yelling, swearing or calling others names, accusing the team and other residents of hurting her, calling the team members names; calmly remind to lower his/her voice and that chosen words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Revision on: 03/17/2025 Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to REFUSAL OF Care Needs of (refusing to change clothing (wet pants), refusal to eat snacks, refusing to have her hair brushed, etc.) as expressions of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 02/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • REFUSES CARE: If Natalee is refusing to (refusing to change clothing (wet pants), refusal to eat snacks, refusing to have her hair brushed, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 02/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • SOCIALLY Inappropriate Behaviour: If Natalie is Inappropriately talking about staff members, try to redirect and if She has any concerns, to Inform Registered staff on the floor. Revision on: 03/15/2025 Revision by: Maryola Perion (RN) • ENVIRONMENT:Natalie is most calm with door closed, quiet area, small groups. Revision on: 03/15/2023 Revision by: Leslie Meloche (Activities/Rec Therapy) • MEDICATION: Administer medication for therapeutic treatment as per MD Order. Monitor effectiveness and for side effects. Revision on: 01/13/2022 Revision by: Maryola Perion (RN) • SPECIAL CONSIDERATIONS:The resident is high intensity for preferred	Registered Practical Nurse RN	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of VERBAL abusive and SOCIALLY Inappropriate, resisting care, refusing her hair to be brush, refusing to change wet pants related to loss of independence. Revision on: 11/27/2024 Revision by: Maryola Perion (RN)		accommodation. Revision on: 09/14/2024 Revision by: Ranjita Yadav (RPN) • BSO RECOMMENDATIONS: ASSESS/MONITOR: Natalee is followed by Internal BSO. Verbal: Yelling, swearing, calling others names, accusatory of staff. Triggers: Loss of control, frustration, pain, limitation of self expression, misunderstanding care intention, loss of independence. Use stop and go approach. Re-approach when she is calm/ready.Staff to provide reassurance, comfort, validate her feelings and actively listen to her concerns when exhibiting responsive behaviours (try to resolve her concerns). Report to registered staff.Inform/explain to Natalee what you are going to do prior to care. Two staff are in the room when personal care is provided (Accusatory towards the staff of hurting her during care)Natalie enjoys watching tv in her room or in the lounge on her floor. Staff to ensure residents are placed at a safe distance when Natalee is sitting in common areas such as the dining room. Natalee enjoys listening to music (classical), watching tv and reading.Natalee is more comfortable and calm when her door is closed or in a quiet area and participating in small group programs. Monitor for signs of pain and infection, document and report all expressions to the nurse. BSO recommends resident to remain in a private room due to her arguing with her roommates. Revision on: 10/13/2025 Revision by: Leslie Meloche (Recreation Aide)		
• Potential to experience alteration in MOOD as exhibited by repetitive questions and verbalizations, anger with self/others and unpleasant in the AM, repetitive anxious complaints, sad, pained, worried facial expression related to Loss of Independence, CVA Revision on: 11/27/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Negative mood symptoms by the next review date. DRS score will be less than 1. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Natalee/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • HEALTH EDUCATION: Provide education and support to Natalee/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Natalee for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life.	RN Registered Practical Nurse	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 04/24/2021 Revision by: Jenny Liu (RAI Coord Back-up) • RESIDENT STRENGTHS: Build on Natalee effort to maintain control. Encourage her to express self, state preferences and make safe choices for care and activities. Revision on: 04/24/2021 Revision by: Jenny Liu (RAI Coord Back-up) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 04/24/2021 Revision by: Jenny Liu (RAI Coord Back-up)		
• Altered VISION related to the use of glasses Revision on: 11/27/2024 Revision by: Maryola Perion (RN)	• Natalee supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• EYEGLASSES: Natalee wears eyeglasses. Assist to clean eyeglasses as needed. Revision on: 11/27/2024 Revision by: Maryola Perion (RN)	PCA	
• Risk for/Impaired Skin Integrity r/t: Incontinence, Impaired Mobility, Use of an incontinent product, Stroke with Left side weakness, edema to left lower leg. Revision on: 08/02/2024 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted. • EQUIPMENT: Natalee requires Roho cushion to offload pressure. Revision on: 02/12/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • POSITIONING: Turn, reposition at least every 2 hours when in bed as per Natalee's preference to offload pressure. Remind and assist Natalee as needed to reposition while in her wheelchair. Revision on: 05/21/2024 Revision by: Katie Savo	PCA PCA PCA	 Q2h
• Increased risk for FALLS related to: Impaired mobility, Seizure Activity, Stroke with Left side weakness, Anti-depressant medication, history of falls.	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period.	• COMMUNICATION: Involve/collaborate with Natalee/SDM in decision making in fall prevention Plan of Care. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)		

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 01/26/2024 Revision by: Maryola Perion (RN)	Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• CALL BELL: Place call bell within resident's reach (RIGHT side if needed), check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment:(high/low bed, wheelchair) Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA All	
		• ENVIRONMENT: Secure environment: reduce clutter to reduce fall risk for Natalee Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position to lower risk for injury. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• SUPPLEMENT: Vitamin D supplement as per MD order to maintain bone density to prevent injuries.	Registered Staff	
• Potential to experience side effects or complications related to use of BOTOX as treatment as Focal Spasticity Management for left arm and left calf. Revision on: 10/19/2023 Revision by: Maryola Perion (RN)	• To monitor effectiveness (change in movement & spasticity level) and for side effects of medication used through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Natalee)/SDM in decision making and health teaching about Focal Spasticity Management and appropriate medication use. Revision on: 10/19/2023 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident having BOTOX injection for changes to health status and for side effects (ie.; malaise, redness/swelling at injection site, etc.).	RN Registered Practical Nurse	
• Natalee is enrolled in NEURO-GYM program for 6-7 days a week and has the potential to show improvement to transferring related to personal motivation	• Natalee will participate in NEURO-GYM program 6-7 days a week to promote improved function of transferring through	• COMMUNICATION: Involve/collaborate with Natalie about performance in NEURO-GYM as part of Nursing Restorative Program including goals, options, and plan of care as needed. Revision on: 03/13/2023 Revision by: Haley Barisic (Quality Lead)		

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A

Last Care Plan Review Completed: 08/22/2025

Focus	Goal	Interventions	Position	Freq/Resolved
to participate in exercise program, ability to follow directions and functional ability to safely perform exercises. When willing to participate Revision on: 09/13/2023 Revision by: Alyssa Egan (Staff Development Coordinator)	to next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Natalie when partaking in NEURO-GYM as park of Nursing Restorative Program. Revision on: 03/13/2023 Revision by: Haley Barisic (Quality Lead)		
		• NEURO-GYM: Natalee attends NEURO-GYM STEPPER using 2 bands for 15 minutes 6-7 days a week or as tolerated. Revision on: 06/16/2023 Revision by: Haley Barisic (Quality Lead)	Restorative Care Aide	DEqshiftNprn
		• WHEELCHAIR EXERCISE: Neurogym for 15 mins or as tolerated by the resident 6-7 days/ week Revision on: 03/13/2023 Revision by: Haley Barisic (Quality Lead)	Restorative Care Aide	
• Natalie is enrolled in PASSIVE RANGE OF MOTION nursing restorative program and has the potential to show improvement to left arm function related to personal motivation to participate in exercise program, ability to follow directions and functional ability to safely perform exercises. Revision on: 08/09/2023 Revision by: Alyssa Egan (Staff Development Coordinator)	• SHORT TERM GOAL: To improve Natalie's movement in left arm using PROM strength to be able to complete minimum of 15 minutes each day through the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• PROM EXERCISE JOINT: Provide cueing and demonstration of (abduction, adduction, extension, flexion, etc.) to Natalie for (Left shoulder, elbow, wrist, etc.) using (Heat, moisturizer, etc.). Complete daily for minimum of 15 minutes. Revision on: 09/13/2023 Revision by: Alyssa Egan (Staff Development Coordinator)	Restorative Care Aide	
		• TIME SPENT: Enter amount of time in MINUTES that Natalie performed PROM exercises. Revision on: 02/23/2024 Revision by: Katie Wolters-Savo (RAI Coordinator)	Restorative Care Aide	DEqshiftNprn
• Use of PASD (2 1/4 bed rails) to assist resident with Activity of Daily Living (turning & repositioning, care). Revision on: 07/28/2022 Revision by: Suzanne Azar (RN)	• Natalee will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living & bed mobility each day through to the next review date.	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails. Revision on: 07/28/2022 Revision by: Suzanne Azar (RN)		
		• MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate bed mobility and care.		

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Last Care Plan Review Completed:	**08/22/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	Revision on: 07/28/2022 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with bed mobility. Monitor every shift Revision on: 11/16/2022 Revision by: Maryola Perion (RN)	PCA	D/E/N
• Potential to experience alteration in RESPIRATORY FUNCTION related to: Asthma Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with asthma each day through to next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Natalee/SDM in decision making of Respiratory Management for asthma Revision on: 10/16/2021 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with asthma for changes to health status and alteration or complications affecting respiratory function. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	Registered Staff	
		• POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing.	Registered Staff PCA	
		• OXYGEN: Administer Oxygen as per MD order. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)		
		• Administer medications as ordered and monitor for side effects, effectiveness. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	Registered Staff	
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder	• To treat and minimize signs/ symptoms or complications associated with CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/ collaborate with Natalee/ SDM in decision making of neurological care management for CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	PCA	
		• LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder as per MD order. Monitor effectiveness and for side		

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A

Last Care Plan Review Completed:	**08/22/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		effects. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder for changes to health status and alteration or complications affecting neurological function. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • SEIZURE Disorder: If seizure activity occurs alert registered staff immediately; place on side, protect from injury, maintain open airway. • SEIZURE Disorder: Natalee has potential for seizure activity, injury related to seizure disorder. Inform MD as it occurs. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	PCA Registered Staff All	
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Codeine, Iodine, Pantoloc, Reglan, Environmental, IVP dye. Revision on: 01/22/2021 Revision by: Jenny Liu (RAI Coord Back-up)	• Natalee will be protected from exposure to allergen each day through next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Natalee/SDM in decision making and health teaching about ALLERGY to Codeine, Iodine, Pantoloc, Reglan, Environmental, IVP dye Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications mortality. Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • ALLERGY ALERT: Natalee has ALLERGY to Codeine, Iodine, Pantoloc, Reglan, Environmental, IVP dye. Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 10/16/2021 Revision by: Maryola Perion (RN) • MD/PHARMACY ALERT: Notify the MD and Pharmacy of Natalee's Allergy to Codeine, Iodine, Pantoloc, Reglan, Environmental, IVP dye and minimize risk for exposure to allergen. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)		

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Codeine, Iodine, Pantoloc, Reglan, Environmental, IVP dye. Revision on: 01/22/2021 Revision by: Jenny Liu (RAI Coord Back-up)		• RESCUE MEDICATION: Administer EPINEPHRINE as per MD/NP Order. Monitor effectiveness and immediately notify MD/NP of use.	Registered Staff	
• Expressed Wishes and Beliefs related to Natalee's Medical Treatment and End of Life Care Revision on: 12/04/2020 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To support and honor Natalee's expressed wishes and beliefs through to the End of Life. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• CPR: Natalee wishes to have CPR and TRANSFER to hospital. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	All	
• SPIRITUAL BELIEFS: Natalee is of the United Faith. Revision on: 05/02/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide Natalee spiritual support as interested through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• PERSONAL CHOICE: Respect Natalee's right to decline participation in Spiritual Programs. Does not partake in faith programs at this time. Revision on: 07/30/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and/or minimize discomfort/ complications associated with GERD through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI	• COMMUNICATION: Involve/collaborate with Natalee/SDM in decision making for GERD Management. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status.	Registered Staff Registered Staff	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Last Care Plan Review Completed:	**08/22/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Coordinator) Target Date: 01/26/2026	Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals.	PCA Registered Staff	
		• MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	Registered Staff	
• Potential to experience alteration in CARDIAC FUNCTION related to: Hypertension. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and minimize signs/symptoms or complications associated with Hypertension through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Natalee/SDM in decision making of Cardiac Care Management for Hypertension. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• MEDICATION: Administer medication for Hypertension as per MD Order and monitor for side effects. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Practical Nurse RN	
• Sleep Patterns. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To promote adequate rest/sleep for Natalee based on identified sleep patterns/preferences each night through to the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• REST PATTERN: Preferred bedtime: 20:00-21:00, usual wake time: After 7:00 Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• SLEEPWEAR: Natalee prefers to wear night gown. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
• BOWEL Continence - Natalee is continent and has self recognition of urge to defecate. Revision on: 11/08/2019	• Natalee to remain continent of bowels through next review date Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI	• BOWEL Continence level is CONTINENT. Report change to level as noted.	PCA	
		• TOILETING: Natalee require staff assistance to toilet or bed pan for bowel	PCA	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
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Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (Registered Nurse)	Coordinator) Target Date: 01/26/2026	movements. Staff to document her BOWEL MOVEMENT and if there has been any changes to continence level. Report changes to Registered Staff. Revision on: 02/26/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• URINARY (Functional) INCONTINENCE related to: altered mobility, Use of Muscle Relaxant medication. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• Natalee will receive support to (use toilet, bed pan) and promote urinary continence each shift through to the next review. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)		
		• URINARY Continence level is (OCCASIONALLY Incontinent). Report change to level as noted. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• INCONTINENCE PRODUCT: Natalee uses a PUXXL on Days and Evening shifts. She wears a Beige brief on Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• ADAPTIVE EQUIPMENT/AID: Natalee uses bedpan at night. Revision on: 11/12/2021 Revision by: Maryola Perion (RN)	PCA	
• Altered ability to complete Activities of Daily Living (ADLs) related to: Impaired mobility, Seizure disorder, Asthma, Stroke with Left side weakness. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• Natalee will feel supported in coping with changing functional abilities due to disease diagnosis through the review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026 • Natalee will have ALL ADL care needs met each day through the next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI	• BATHING: Natalee prefers (shower) on (Tuesdays and Fridays on Evening shift). Two staff (TOTAL) assistance for bathing. Maxi lift for transfer with two staff to assist. Encourage Natalee to have her hair brushed/combed. Provide health teachings and inform Registered staff. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY: Natalee requires Maximal assistance with two staff to turn and reposition while in bed d/t CVA. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Natalee is able to to help with her R+ side with dressing, but hemiplegia on the left side. When dressing the upper part of her body, Natalie would like her left arm placed in her top, then over her head and then her right arm inserted. Extensive assistance provide with 2 team member to dress upper and lower body.	PCA	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
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	Coordinator) Target Date: 01/26/2026	Apply hand posey on left hand during day and off during night. Leg brace to be left on until after transferred to bed. Once in bed then remove. Revision on: 06/03/2024 Revision by: Katie Savo (RAI Coordinator)		
		• EATING: Natalee ia able to eat Independently using her Rt. hand. Eats on the main floor dining room. Revision on: 10/16/2021 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Natalee has an electric wheelchair and able to independently operate it on her own on and off unit. Revision on: 03/21/2023 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Natalee is able to help with washing her hands, face and comb her hair, but she has hemiplegia on the left side. Maximal assistance required to complete her peri care and brief change from two staff. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide REMINDER assistance to apply sanitizer or use wipes for hand hygiene. Revision on: 01/23/2022 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Natalee requires Maximal assistance with two staff using sit to stand lift(SARA Lift) to transfer her from wheelchair to the toilet. As per Natalee's request, she wants to lift her all the way up for toileting. Toilet Natalee whenever she ask. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Natalee requires a MAXI lift with two team members assistance to transfer her to bed to wheelchair. From Wheelchair to bed Natalee is to be transferred By Maxi Lift . Arm trough to left arm of wheelchair. Team to assist with placing arm and securing per PT's instruction. Revision on: 05/28/2024 Revision by: Katie Savo	PCA	
		• TRANSFER LIFT/SLING: Blue sling for maxi lift (transferring to and from bed to		

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
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Last Care Plan Review Completed:	**08/22/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: Impaired mobility, Seizure disorder, Asthma, Stroke with Left side weakness. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)		wheelchair). Green sling for sara lift (toileting). Revision on: 10/25/2023 Revision by: Maryola Perion (RN)		
		• ORAL CARE: Natalee is able to brush her own teeth when set up. She has her own teeth not missing any. Revision on: 09/29/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• FOOT CARE: PSW to complete toenail care every bath/shower days and as needed. Report long toe nails or other abnormalities as noted. Revision on: 03/07/2024 Revision by: Maryola Perion (RN)	PCA	
		• Ensure that there are two staff present at all times when providing care with the Natalee. Reminder: Staff to be careful when giving care especially to her Left side per Natalee. Revision on: 05/15/2025 Revision by: Maryola Perion (RN)	PCA	
		• SPECIFIC RESIDENT Request: Resident has request to have wheelchair only cleaned with Soap and Water. Please do not use any cleaner on her wheelchair. PERSONAL BELONGINGS such as deodorant, etc. Kindly put it back where they belong or where the staff got it. Revision on: 05/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• ADAPTIVE EQUIPMENT/ASSISTIVE DEVICE: Left hand posey to be put on during the day and removed in the evening. Splint to be put on a night and removed in the AM Revision on: 07/11/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Strength Revision on: 10/24/2019 Revision by: Milap Patel (Physiotherapist)	• Natalee to increase strength of Rt.UE≤ joints from 3+/5 to 4/5 Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator)	• Strength exe of Rt UE and LE with 2-3 lb. of wt.,10 reps of 1-2 sets, 2-3/week as tolerated. Revision on: 02/20/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A

Last Care Plan Review Completed:	**08/22/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Strength Revision on: 10/24/2019 Revision by: Milap Patel (Physiotherapist)	Target Date: 01/26/2026			
• Passive ROM. Revision on: 10/24/2019 Revision by: Milap Patel (Physiotherapist)	• In next 3 months Natalee to maintain ROM at Lt UE and LE Revision on: 02/20/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/26/2026	• PROM exs for Lt UE & LE, 10 reps of 1-2 sets,3x as tolerated Lt Hand stretching for finger flex as able,5 reps, hold 30 sec, 2-3/week as tolerated. Revision on: 02/20/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Nutrition Risk Level (diet details)	• Natalee will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 12/12/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026 • Will weigh within realistic GWR 102-112 kg through to next review date. Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/26/2026 • Natalee will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 2700 ml/day (25 ml/kg using 108 kg weight) through to next review date.	• Labelled Item Breakfast: Greek yogurt daily Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD)) • NUTRITION RISK: Natalee is moderate risk level. Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DIET ORDER: Natalee will receive regular diet, regular texture. Revision on: 12/10/2020 Revision by: Anna Slack • FLUID CONSISTENCY: Natalee drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/14/2021 Revision by: Olivia Kuhlmann (Dietetic Intern) • FLUID TARGET: Encourage Natalee to drink a minimum of 2160 ml/day. Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD)) • EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily. • FOOD PREFERENCES: Natalee enjoys eating fresh fruit e.g., bananas, apple slices, and melon. Dislikes fruit cocktail and fruit from frozen. Revision on: 07/29/2025	PCA Registered Practical Nurse RN Dietitian (RD) Diet Food Services Aide PCA Diet PCA PCA Dietary aide PCA PCA	D

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)	Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/26/2026	Revision by: Holly Laasanen (Dietitian (RD)) • WEIGHT MANAGEMENT: Encourage fruit for dessert, encourage vegetables if resident requests seconds at meals, and encourage water as beverage of choice. Revision on: 07/29/2025 Revision by: Holly Laasanen (Dietitian (RD)) • LABELLED SNACK: Natalee receives yogurt in place of the standard nourishment at HS daily Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA PCA	 E

Diagnosis Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Hemiplegia of unspecified type of unspecified [unilateral] side(G81.99), Seizure disorder, so described(R56.80)

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragra...See last page for a complete listing of the Resident's allergies	**D.O.B.**	02/27/1963	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Stroke, not specified as haemorrhage or infarction(I64), Gastro-oesophageal reflux disease without oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cadarette, Natalee (92213100608)	**Admission Date**	10/14/2019	**Location**	4 412 A
Last Care Plan Review Completed:	**08/22/2025**				

Allergies	Codeine, Iodine, Pantoloc, Reglan, Contrast Dye, Fragrance, Environmental

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• William is experiencing episode of INFECTION wound. Onset date Oct 28, 2025 Revision on: 10/28/2025 Revision by: Janina Lucero (RN)	• To have infection adequately managed and treated without further complications by November 4, 2025. Revision on: 10/28/2025 Revision by: Janina Lucero (RN) Target Date: 11/04/2025	• MONITORING: Utilize holistic perspective of monitoring resident for signs/symptoms, hydration status, overall health condition, process of healing, secondary infections, exacerbation of their chronic condition until stable. Revision on: 10/28/2025 Revision by: Janina Lucero (RN)		
• Alteration in skin integrity related to MASD TO COCCYX. Revision on: 10/25/2025 Revision by: Katherine Arca (RPN)	• To promote intact skin integrity through healing of MASD TO COCCYX. Revision on: 10/25/2025 Revision by: Katherine Arca (RPN) Target Date: 01/24/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MASD TO COCCYX. for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/25/2025 Revision by: Katherine Arca (RPN) • COMMUNICATION: Involve/collaborate with (resident name)/SDM in decision making for treatment of skin issues. Revision on: 10/25/2025 Revision by: Katherine Arca (RPN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/25/2025 Revision by: Katherine Arca (RPN)	Registered Practical Nurse RN	
• Alteration in skin integrity with risk for infection or complications related to SKIN TEAR to #16 - Skin Tear - Right Knee Revision on: 09/23/2025 Revision by: Janina Lucero (RN)	• To promote optimal healing of SKIN TEAR within the next review date. Revision on: 09/23/2025 Revision by: Janina Lucero (RN) Target Date: 01/24/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with SKIN TEAR to #16 - Skin Tear - Right Knee for changes to health status and alteration or complications affecting skin integrity. Revision on: 09/23/2025 Revision by: Janina Lucero (RN) • TREATMENT PLAN: Administer treatment for SKIN TEAR to #16 - Skin Tear - Right Knee as per MD Order. Revision on: 09/23/2025 Revision by: Janina Lucero (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 09/23/2025		

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng	
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension (I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A	

Last Care Plan Review Completed: **10/24/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to SKIN TEAR to #16 - Skin Tear - Right Knee Revision on: 09/23/2025 Revision by: Janina Lucero (RN)		Revision by: Janina Lucero (RN)		
• William has Hep C Revision on: 07/08/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To have infection adequately managed and treated without further complications by next review date Revision on: 07/08/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/24/2026	• MONITORING: Perform risk assessment which each contact for care HEP C-universal precautions. Revision on: 07/08/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential for Persistent PAIN and alteration in comfort level related to 2nd degree burns. Most Current MDS Pain Score is 0. Revision on: 02/01/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Target Date: 01/24/2026 • Promote MDS Pain Score of 0 through to the next review. Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • REST: accommodate resident rest and relaxation preference (breaks between activities, remaining in bed, etc.). Revision on: 11/04/2024 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically	RN Registered Practical Nurse Registered Practical Nurse	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Persistent PAIN and alteration in comfort level related to 2nd degree burns. Most Current MDS Pain Score is 0. Revision on: 02/01/2025 Revision by: Maryola Perion (RN)		needed. Revision on: 02/01/2025 Revision by: Maryola Perion (RN)	RN	
• Altered VISION related to Use of eyeglasses for reading. Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• William (Bill) supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM for decision making pertaining to change in visual status as needed. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • EYEGLASSES: William (Bill) wears eyeglasses. Assist to clean eyeglasses as needed and put it on top of the bed side table when sleeping. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	PCA	
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, altered judgement, etc.) related to progression of Cardiovascular Accident (CVA) Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• William (Bill) will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• ORIENTATION: Gently reorient to (person, place, time) as needed when William (Bill) is feeling lost or in confused state. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	PCA	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, slurred speech, mumbled	• William (Bill) will be supported to maintain current communication abilities to	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM for decision making about strategies needed to support effective communication. Revision on: 11/13/2024		

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
speech, etc.) related to CVA with Right sided weakness, hearing problem. Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	(express self, comprehend information, etc.) each day through to the review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: William (Bill) primary language is English. He is able to speak/understand English. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: William (Bill) needs intermittent cueing or demonstrative instruction in tasks and activities. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
• Potential for Expressive Behaviour of RESISTANCE to care need related to Inability to COPE, Pain r/t burns. Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 10/24/2025 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of William (Bill) for indications to change in or for escalating expressive behaviour risk. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of refusal to eat, refusing to get up, etc. as expressions of behaviour include (misunderstanding care needs, poor judgement, pain, etc.) Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If William (Bill) is refusal to eat, refusing to get up, etc., re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	BSO - Internal Social Worker	
• Use of PASD (Bed rails two 1/4) to assist resident with Activity of Daily Living and bed mobility. Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• William (Bill) will be effectively supported with use of Two 1/4 bed rails to optimize Activity of Daily Living (turning and repositioning) each day through to the next review date. Revision on: 01/15/2025 Revision by: Maryola Perion (RN)	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of Two 1/4 bedrails to be used when in bed to aid in turning and repositioning. Revision on: 01/15/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use of Two 1/4 bedrails to be used when in bed to aid in turning and		

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/24/2026	repositioning. Revision on: 01/15/2025 Revision by: Maryola Perion (RN)		
		• BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist William (Bill) with (turning and repositioning). Monitor every shift. Revision on: 01/15/2025 Revision by: Maryola Perion (RN)	PCA	D/E/N
• Potential to experience alteration in RESPIRATORY FUNCTION related to Chronic Obstructive Pulmonary Disorder (COPD) Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with (COPD) each day through to next review date. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM in decision making of Respiratory Management for COPD. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with (COPD) for changes to health status and alteration or complications affecting respiratory function. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)		
		• POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	PCA	
		• OXYGEN: Administer Oxygen as per MD order. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication (inhalers) for COPD as per MD order and monitor for side effects. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
• Risk for Impaired SKIN INTEGRITY related to Impaired Mobility, burns, Incontinence, Use of incontinent product. Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To protect and maintain skin integrity each day through to the next review. Target Date: 01/24/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS. Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with OSTEOARTHRITIS through to the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/ collaborate with (William (Bill))/SDM in decision making of musculoskeletal care management. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of OSTEOARTHRITIS as per MD order. Monitor effectiveness and for side effects. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of OSTEOARTHRITIS for discomfort/ complications or changes to health status. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT for OSTEOARTHRITIS prescribed and in place; refer to Pain Care Plan. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
• (Bill) is experiencing colonization with Antibiotic Resistant Organism (MRSA) as of confirmed date: (October 3rd 2024 left hip burn site). Revision on: 01/29/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To lower risk of infection and prevent transmission of identified Antibiotic Resistant Organism through to the next review. Target Date: 01/24/2026	• PPE PRECAUTIONS: Precaution identified as (CONTACT) for (MRSA) and requires use of the following PPEs (Gloves, Gown) when (providing direct care, handling soiled clothes and linens, disposing of incontinent product). Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential for altered skin healing, infection or complications related to second degree burn to LEFT THIGH FRONT, LEFT CALF, RIGHT THIGH FRONT, secondary to Trauma Revision on: 01/07/2025 Revision by: Janina Lucero (RN)	• To minimize risk of second degree burn to Left calf LEFT THIGH REAR and FRONT, LEFT CALF, RIGHT THIGH FRONT infection each day until fully healed. Revision on: 01/07/2025 Revision by: Janina Lucero (RN) Target Date: 01/24/2026	• TREATMENT PLAN: Administer treatment for second degree burn to Left calf (rear and lateral), left thigh (front and rear), right thigh and upper right arm as per MD Order. Revision on: 11/01/2024 Revision by: Mary Kagayutan (RPN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with second degree burn LEFT THIGH REAR and FRONT, LEFT CALF, RIGHT THIGH FRONT,for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 01/07/2025		

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	• To promote optimal healing of second degree burn to LEFT THIGH REAR and FRONT, LEFT CALF, RIGHT THIGH FRONT,within the next review date. Revision on: 01/07/2025 Revision by: Janina Lucero (RN) Target Date: 01/24/2026	Revision by: Janina Lucero (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator)		
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest. ISE score: 2/6 Revision on: 12/17/2024 Revision by: Laura Morris (Restorative Care Aide)	• To support William's Psycho-Social well being through to the next review. Revision on: 12/17/2024 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/24/2026	• SELF-DIRECTED ACTIVITIES: Encourage William to engage in self-directed activities such as watching TV in own room, playing cards, chess, conversing with peers, etc. Revision on: 07/17/2025 Revision by: Laura Morris (Restorative Care Aide) • ONE to ONE: Provide William with individual visits for conversation,reading, reminiscing, etc. Revision on: 12/17/2024 Revision by: Laura Morris (Restorative Care Aide)		
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for altered genitourinary function or complications related to diagnosis of BENIGN PROSTATIC HYPERTROPHY (BPH). Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with BPH through to next review date. Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM in decision making for BPH care management. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Benign Prostatic Hypertrophy for changes to health status and alteration or complications affecting urinary function. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication as per MD order and monitor for side effects and effectiveness. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to Use of Diuretic medication. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William)Bill))/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • PROMOTE FLUIDS: Promote William (Bill) to consume fluids; amount as per Nutrition Care Plan. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA) with Right sided hemiplegia. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	• To treat and minimize signs/ symptoms or complications associated with CEREBROVASCULAR ACCIDENT (CVA) through to the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/ collaborate with (William (Bill))/ SDM in decision making of neurological care management for CEREBROVASCULAR ACCIDENT (CVA). Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with (CVA) for changes to health status and alteration or complications affecting neurological function. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA) with Right sided hemiplegia. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		• Observe SWALLOWING: Inform Registered staff of changes or any signs of difficulty in swallowing (coughing during eating, drooling, etc.).	PCA Registered Staff	
• Potential to experience alteration in MOOD as exhibited by sad, pained, worried facial expressions, insomnia/unusual sleep pattern related to Loss of Independence, Burns, Pain. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 02/01/2025 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of William (Bill) for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on William (Bill) effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • SLEEP/REST: Promote adequate sleep and rest to stability of William (Bill) mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)		
• Increased risk for FALLS related to Impaired Mobility, Limitation of cognitive	• To promote safety, minimize risk for falls and/or fall related	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM in decision making in fall prevention Plan of Care. Revision on: 11/13/2024		

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
function/altered judgement), CVA with Rt. sided weakness, history of falls. Revision on: 11/13/2024 Revision by: Maryola Perion (RN)	injury each day through to the next review period. Target Date: 01/24/2026	Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach (left side), check that it is in working order and remind/encourage to use it. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • ENVIRONMENT: Secure environment (reduce clutter) to reduce fall risk for (Bill) Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) • BED: (use high/low bed) to lower risk for injury. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) • SUPPLEMENT: Administer supplement/medication as per MD order to maintain bone density to prevent injuries. Revision on: 02/01/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA	D/E/N
• Nutrition Risk Level	• William will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 11/13/2024 Revision by: Lexi Dakin (Dietitian (RD)) Target Date: 01/24/2026 • Will weigh within realistic weight range of 85-95 kg through to next review date. Revision on: 10/17/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/24/2026	• NUTRITION RISK: William is moderate risk level. Revision on: 04/30/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIET ORDER: William will receive regular diet, regular texture (resident is aware of choking risks, wishes to receive regular) Revision on: 12/02/2024 Revision by: Lexi Dakin (Dietitian (RD)) • THICKENED FLUIDS: William drinks thickened fluids at Mildly Thick (MT2) consistency. Revision on: 02/20/2025 Revision by: Ronnie Fung (FSM - Food Services Manager) • FLUID TARGET: Encourage William to drink a minimum of 1908 ml/day Revision on: 10/17/2025 Revision by: Holly Laasanen (Dietitian (RD)) • ADAPTIVE AIDS: William requires rimmed plate and weighted utensils Revision on: 08/28/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD) PCA PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level	• William will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 2385 ml/day (25 ml/kg using 95.4 kg weight) through to next review date. Revision on: 10/17/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/24/2026	• MEDPASS SUPPLEMENTS: To support burn healing: Resource 2.0 60 ml TID Protein powder 1 scoop BID - add to 200 ml mildly thick beverage of choice or hot cereal at breakfast or mashed potatoes at dinner Revision on: 08/28/2025 Revision by: Holly Laasanen (Dietitian (RD))		
• Altered ability to complete Activities of Daily Living (ADLs) related to Activity Intolerance, Limited Mobility, CVA, Burns from house fire Revision on: 11/08/2024 Revision by: Shina Wadhwa (Physical Therapist)	• William (Bill) will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026 • William (Bill) will have ALL ADL care needs met each day through the next review date. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• BATHING: William prefers (shower/bed bath) on (Thursdays and Sundays on Evening shift). William participates by (providing a wash cloth and washing the upper part of the body). Two staff (MAXIMAL) assistance for bathing. Maxi Lift for transfer with two staff assists. Nail care to be provided on shower/bath day. Revision on: 10/24/2025 Revision by: Maryola Perion (RN)	PCA	
		• BED MOBILITY: William (Bill) is able to (can minimally assist to shift weight). (2) staff to provide (EXTENSIVE) assistance for bed mobility. PASD- Two 1/4 bedrails to be used when in bed to aid in turning and repositioning. Revision on: 02/01/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: William (Bill) is able to (minimally participate) (Two) staff to provide (MAXIMAL) assistance for dressing UPPER & LOWER body Revision on: 05/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: William (Bill) requires supervision and set up from staff. Eats in the Petunia Lane dining room. If William (Bill) is eating in bed, staff to ensure proper positioning for William (Bill) while eating. Revision on: 02/01/2025 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: (Bill) requires 1 staff to provide (TOTAL) assistance for locomotion	PCA	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Activity Intolerance, Limited Mobility, CVA, Burns from house fire Revision on: 11/08/2024 Revision by: Shina Wadhwa (Physical Therapist)		(in wheelchair on and/or off unit). Revision on: 10/24/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: (Bill) is able to (minimally participate). One to two staff to provide (Maximal) assistance for hygiene needs and peri care. Revision on: 05/02/2025 Revision by: Maryola Perion (RN) • HAND HYGIENE: 1 staff to provide (EXTENSIVE) assistance to (use soap/water, apply sanitizer, rub hands together, dry hands) for hand hygiene. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) • TOILET USE: (Bill) is able to (aid in movement and participate in toileting/check and change of brief). (2) staff to provide (Maximal) assistance for toileting. Revision on: 05/02/2025 Revision by: Maryola Perion (RN) • TRANSFERRING: William (Bill) requires the use of a Maxi lift to transfer him to and from bed to wheelchair with two staff assistance. Revision on: 05/02/2025 Revision by: Maryola Perion (RN) • TRANSFER LIFT/SLING: Maxi Lift and Medium SIZE of sling needed for transfer. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • ORAL CARE: (Bill) has (DENTURES,full upper and lower.) 1 staff to provide (TOTAL) assistance for oral care. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA PCA PCA PCA PCA	
• Expressed Wishes and Beliefs related to Bill's Medical Treatment and End of Life Care Revision on: 11/08/2024 Revision by: Shina Wadhwa (Physical Therapist)	• To support and honor Bill's expressed wishes and beliefs through to the End of Life. Revision on: 11/01/2024 Revision by: Elsie Calumpang (RN) Target Date: 01/24/2026	• CPR: DO NOT ATTEMPT CPR: Transfer to hospital decision will be made as needed - see PoET Individualized Summary for details Revision on: 10/24/2025 Revision by: Maryola Perion (RN)		
• Strengthening Rxs	• Increase B/L elbow extension	• B/L UE strengthening exs with 1-2lbs;10 reps;2-3 x a week;	PT -	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 11/08/2024 Revision by: Shina Wadhwa (Physical Therapist)	from -10 degrees to neutral in next 3 months Revision on: 02/14/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/24/2026	Gentle stretch at elbow extension: 3-5 reps:2-3 x a week: Revision on: 11/08/2024 Revision by: Shina Wadhwa (Physical Therapist)	Physiotherapist PTA	
• ROM exs Revision on: 11/08/2024 Revision by: Shina Wadhwa (Physical Therapist)	• Increase ROM of RT knee from -30 to -20 degrees in next 3 months Revision on: 10/21/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/24/2026	• PROM exs for B/L LE within pain limits with passive gentle stretch, as best tolerated,10 reps, 2-3 x a week Revision on: 10/21/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential for CONSTIPATION related to (decreased mobility) Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator)	• (William) will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/24/2026 • To minimize the potential for episodes and complications of constipation through to the next review date. Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/24/2026	• COMMUNICATION: Involve/collaborate with (William (Bill)/SDM) for decision making regarding constipation management. Revision on: 11/13/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	
• Potential for BOWEL INCONTINENCE related to (Mixed incontinence) Revision on: 11/06/2024	• William (Bill) will have bowel incontinence managed every shift through to the next review	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function.	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Danielle Loreto (RAI Coordinator)	period. Revision on: 02/05/2025 Revision by: Maryola Perion (RN) Target Date: 01/24/2026	• BOWEL Continence level is (Total Incontinence). Report change to level as noted. Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency.	PCA	
		• INCONTINENCE PRODUCT: William uses a Blue brief on Days and Evening shifts. Orange Brief on Night shift. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Sleep Patterns; Potential for alteration in sleep patterns related to awake all or most of the night). Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	• To promote adequate rest/sleep for (Bill) based on identified sleep patterns/preferences each night through to the next review date. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/24/2026	• PREFERENCE: (Bill) wakes during the night and enjoys (watching TV) Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• REST PATTERN: Preferred bedtime (2200), usual wake time (0800) and daytime naps (specify). Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Nutrition: Chewing difficulty related to CVA Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	• To maintain safe chewing through to next review date Target Date: 01/24/2026	• Provide diet/texture interventions as per Nutrition Risk Level		
	• To obtain or maintain adequate intake to meet estimated nutritional requirements through to next review date Target Date: 01/24/2026			
	• To prevent any episodes of choking through to next review date Target Date: 01/24/2026			

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition: Swallowing difficulty related to CVA Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	• To maintain safe swallowing through to next review date Target Date: 01/24/2026 • To obtain or maintain adequate intake to meet estimated nutritional requirements through to next review date Target Date: 01/24/2026	• Provide diet/texture interventions as per Nutrition Risk Level		
• URINARY (mixed, functional) INCONTINENCE related to altered mobility Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator)	• (Bill) will have urinary incontinence managed every shift through to the next review period. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/24/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) • URINARY Continence level is (total incontinent). Report change to level as noted. Revision on: 11/01/2024 Revision by: Danielle Loreto (RAI Coordinator) • INCONTINENCE PRODUCT: William uses a Blue brief on Days and Evening shifts. Orange Brief on Night shift. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	06/25/1957	**Physician**	Albert Patrick Ng
Diagnosis	Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cameron, William (922131005595)	**Admission Date**	11/01/2024	**Location**	4 407 A
Last Care Plan Review Completed:	**10/24/2025**				

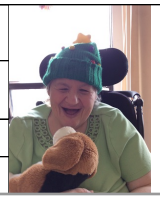
Diagnosis

Encephalopathy in diseases classified elsewhere(G94.3), Extrapyramidal and movement disorder, unspecified(G25.9), Acute hepatitis C(B17.1), Benign hypertension(I10.0), Polyneuropathy, unspecified(G62.9), Drug abuse counselling and surveillance(Z71.5), Primary generalized (osteo)arthrosis(M15.0), Chronic obstructive pulmonary disease, unspecified(J44.9), Resistance to methicillin(U82.1), Stroke, not specified as haemorrhage or infarction(I64), Burn of unspecified body region, unspecified degree(T30.0), Hyperplasia of prostate(N40), Post-traumatic wound infection, not elsewhere classified(T79.3)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity related to MASD to abdominal folds Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote intact skin integrity through healing of MASD to abdominal folds Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/29/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with rash to abdominal folds for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	Registered Practical Nurse RN	
		• COMMUNICATION: Involve/collaborate with Rina Cassin in decision making for treatment of skin issues. Revision on: 10/21/2025 Revision by: Katherine Arca (RPN)		
		• MEDICATION: Administer medication for RASH as per MD Order. Monitor effectiveness and for side effects. Revision on: 10/21/2025 Revision by: Katherine Arca (RPN)	Registered Practical Nurse RN	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/21/2025 Revision by: Katherine Arca (RPN)		
• Viviana is experiencing episode of RESPIRATORY INFECTION (LRTI) Onset date: 10/8/2025 Revision on: 10/08/2025 Revision by: Katherine Arca (RPN)	• To effectively treat and manage RESPIRATORY INFECTION without further complications by 10/8/2025. Revision on: 10/08/2025 Revision by: Katherine Arca (RPN) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with Rina C with decision making for RESPIRATORY INFECTION treatment plan and update accordingly. Revision on: 10/08/2025 Revision by: Katherine Arca (RPN)		
		• HEALTH EDUCATION: Engage with resident/SDM to enhance their knowledge of infection control practices (Specify; hand hygiene, visitation, PPEs, isolation, transmission, etc.). Revision on: 10/08/2025 Revision by: Katherine Arca (RPN)		
		• MEDICATIONS: Administer medication/oxygen for Respiratory infection as per MD/NP order. Revision on: 10/08/2025 Revision by: Katherine Arca (RPN)		
		• MONITORING: Utilize holistic perspective of monitoring resident with RESPIRATORY INFECTION for (Specify; signs/symptoms, hydration status, overall health condition, process of healing, secondary infections, exacerbation of their chronic condition such as Diabetes/COPD, etc.) until stable.		

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A



Last Care Plan Review Completed:	**08/29/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Viviana is experiencing episode of RESPIRATORY INFECTION (LRTI) Onset date: 10/8/2025 Revision on: 10/08/2025 Revision by: Katherine Arca (RPN)		Revision on: 10/08/2025 Revision by: Katherine Arca (RPN) • PPE PRECAUTIONS: Precaution identified as CONTACT & DROPLET for RESPIRATORY INFECTION and requires use of the following PPE: GOWN, MASK, GLOVES & FACESHIELD for direct care, handling soiled clothes and linens, disposing of incontinent product, etc. Revision on: 10/08/2025 Revision by: Katherine Arca (RPN) • VITAL SIGNS: Monitor VITAL SIGNS Revision on: 10/08/2025 Revision by: Katherine Arca (RPN)		
• Alteration in skin integrity related to RASH/ query injury from bite to Right Inner Forearm Revision on: 10/02/2025 Revision by: Haley Barisic (Quality Improvement Coordinator)	• To promote intact skin integrity through healing of RASH Revision on: 10/01/2025 Revision by: Rana Maghnieh (RPN) Target Date: 11/29/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with RASH for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/01/2025 Revision by: Rana Maghnieh (RPN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD Revision on: 10/01/2025 Revision by: Rana Maghnieh (RPN)	Registered Practical Nurse RN	
• Potential for Acute PAIN and alteration in comfort level related to Osteoarthritis, Impaired mobility. Most Current RAI Pain Score is 0. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025 • Promote RAI Pain Score of 0 through to the next review.	• COMMUNICATION: Involve/collaborate with SDM about pain management, goals of treatment, plan of care, prognosis and treatment options. Revision on: 10/19/2019 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • NON VERBAL CUES of PAIN for Viviana includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed.	Registered Staff RN Registered Practical Nurse PCA	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 11/29/2025	Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	Registered Practical Nurse RN	
• STRONG PARTICIPATION in Activities. ISE 6/6 Revision on: 08/21/2025 Revision by: Laura Morris (Restorative Care Aide)	• Viviana will be supported to maintain participation in activities 20-35 times per month by the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• STRUCTURED ACTIVITIES: Invite her to programs of personal interest; friendly/1:1 visits, electronic pet therapy, arts & crafts, comedy corner, exercise groups, games - Bingo, Montessori, music groups, outdoor patio programs, outings, main floor socials, special events, spiritual, TV/movies (comedy), etc. Revision on: 12/15/2024 Revision by: Judy Woods (Activation aide) • SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities (with set-up) such as visiting with family/friends, visiting with residents/team members, watching/listening to TV, doll therapy, etc. Revision on: 07/13/2020 Revision by: Shayna Lee Wonsch (Activation Manager) • ASSISTANCE: Provide assistance/encouragement to get her to scheduled activities - Porter, reminders, cueing, etc. Revision on: 12/29/2021 Revision by: Mitchell Atkinson (Recreation Aide) • SENSORY STIMULATION: Provide her with Sensory Stimulation for Hand Massage, Snoezelen Therapy, Reading Aloud, Sensory Pictures/Videos, Electronic Pet Visits, Doll Therapy, etc. Revision on: 07/13/2020 Revision by: Shayna Lee Wonsch (Activation Manager) • FAMILY INVOLVEMENT: High involvement. Revision on: 12/29/2021 Revision by: Mitchell Atkinson (Recreation Aide)	ACT ACT ACT ACT	
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBRAL PALSY	• To treat and minimize signs/ symptoms or complications associated with CEREBRAL PALSY through to the next review date. Revision on: 05/29/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with CEREBRAL PALSY for changes to health status and alteration or complications affecting neurological function. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBRAL PALSY	Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/29/2025			
• Potential for Expressive Behaviour of PHYSICAL, SOCIALLY Inappropriate/Disruptive behavioral symptoms, resisting care, yelling, hitting staff and the table (3/10/25) related to Developmental delay, Cognitive impairment. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	• To promote safety for Viviana and/or others during each episode of Expressive Behaviour through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025 • To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be less than 2. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 03/24/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to PHYSICAL (Hitting (staff and table), Punching, Slapping, Biting, Kicking, grabbing, etc.) as expression of behaviour include confusion, etc. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: If Viviana is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance. Revision on: 03/24/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to eat, refusing medication, etc.) as expression of behaviour include (confusion, misunderstanding care needs, poor judgement, fearfulness, etc.) Revision on: 06/23/2023 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Viviana is refusing to (change clothes, take medications, eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 06/23/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate (making loud noises, spitting, etc.) as expression of behaviour include (confusion, decreased insight, poor judgement, limitation in communication, etc.) Revision on: 09/20/2023	BSO - Internal BSO - External Social Worker	

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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of PHYSICAL, SOCIALLY Inappropriate/Disruptive behavioral symptoms, resisting care, yelling, hitting staff and the table (3/10/25) related to Developmental delay, Cognitive impairment. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If Viviana is noted to (make loud disruptive noises in dining room/program, etc.) gently redirect her to focus on task at hand or escort to quieter area. Revision on: 03/24/2023 Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If Viviana is noted to (spitting, etc.) clean area using appropriate PPE. Report episode to Registered Staff. Revision on: 09/20/2023 Revision by: Maryola Perion (RN) • BSO RECOMMENDATIONS: (specify intervention in easy to follow instruction) The resident is being followed by Internal BSO for hitting, spitting and grabbing during care. Recommendations: Give Vivian something soft to hold onto during care (fidget cuff, teddy bear) if she is striking out. 2 staff for care. One to distract, one to complete care. Explain each task to be completed prior to care. Try to get Vivian to make eye contact, making sure she understands tasks to be done. If Vivian is striking out while changing her brief while in bed, try to change brief while she is on the sara lift, keeping her hands busy holding onto the bars. BSO SSW has given Vivian a fidget cuff that she likes to hold onto. Revision on: 10/13/2025 Revision by: Leslie Meloche (Recreation Aide)	PCA	
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, unpleasant mood in the morning, sad, pained, worried facial expression, crying, repetitive verbalization and movements related to Developmental delay, Cognitive Impairment. Revision on: 03/02/2025 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 01/26/2020 Revision by: Maryola Perion (Registered Nurse) • HEALTH EDUCATION: Provide education and support to Viviana/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 01/26/2020 Revision by: Maryola Perion (Registered Nurse) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Viviana for indications to change in MOOD including labile mood or increase of symptoms	Registered Staff RN Registered Practical Nurse Registered Staff	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed:	**08/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		that negatively impact residents quality of life. Revision on: 01/26/2020 Revision by: Maryola Perion (Registered Nurse)		
		• DISTRACTION ACTIVITIES: Viviana can be calmed doing activities of interest including (Specify; listening to music, doing puzzles, watching movies, etc.) Revision on: 01/26/2020 Revision by: Maryola Perion (Registered Nurse)	ACT All	
		• FAMILY SUPPORT: Viviana enjoys visits from her mother and private duty staff on the main floor after lunch daily. Revision on: 06/23/2023 Revision by: Maryola Perion (RN)		
• Risk for/Impaired SKIN INTEGRITY related to Friction, Incontinence, Impaired mobility, use of incontinent product, superficial mass to L-side of neck. Bilateral ankle swelling. Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator)	• To protect and maintain skin integrity each day through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• EQUIPMENT: Viviana requires Roho cushion to offload pressure. Revision on: 02/12/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• POSITIONING: Turn, reposition at least every 2 hours when in bed/wheelchair to offload pressure. Revision on: 07/09/2021 Revision by: Maryola Perion (RN)	PCA	Q2h
• Use of PASD Two 1/4 bed rails to assist resident with Activity of Daily Living (bed mobility). Tilt wheelchair for repositioning and comfort. Revision on: 03/12/2024 Revision by: Maryola Perion (RN)	• Viviana will be effectively supported with use of two 1/4 bed rails and tilt wheelchair to optimize Activity of Daily Living (turning and repositioning) each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of bed rails and tilt wheelchair. Revision on: 03/12/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate (bed mobility) and tilt wheelchair for repositioning and comfort. Revision on: 03/12/2024 Revision by: Maryola Perion (RN)		
		• BED RAIL (TWO PARTIAL): (1/4 Rails) in USE as a PASD to assist resident with (bed mobility). Monitor every shift. Revision on: 11/26/2022 Revision by: Shelby McCarthy (Registered Practical Nurse)	PCA	D/E/N

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Focus	Goal	Interventions	Position	Freq/Resolved
		• TILTED CHAIR in USE as a PASD to support resident for repositioning and comfort. Monitor every shift. Revision on: 03/12/2024 Revision by: Maryola Perion (RN)	PCA	D/E/N
• Increased risk for FALLS related to Hx of fall, Impaired Cognitive, Impaired Mobility. Revision on: 01/26/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM in decision making in fall prevention Plan of Care. Revision on: 04/09/2021 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: high/low bed, wheelchair. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position to lower risk for injury. Revision on: 10/19/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	PCA	
		• FLOOR MAT: Position floor mat on floor both side of bed to lower risk of injury. Revision on: 10/19/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to developmental disorder, cerebral palsy, Osteoarthritis, GERD. Revision on: 12/19/2023 Revision by: Maryola Perion (RN)	• Viviana will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 12/25/2024	• BATHING: Viviana prefers (shower) on (Tuesdays and Fridays on Day shift). Two staff (MAXIMAL) assistance for bathing. Requires the use of a Sit to stand lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	

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Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• BED MOBILITY: Viviana requires 2 team member maximal assistance for movement when in bed. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• DRESSING: 2 team members maximal assistance with dressing of her upper and lower body. She can assist with guiding her arms and head when dressing upper body and guiding her legs and shifting weight for lower body. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• EATING: Viviana is encouraged to eat independently by staff with cueing and supervision. She requires one staff to assist her to finish her food or her drink. Eats in the 4th floor dining room. Revision on: 12/13/2024 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Viviana require Total assistance from one staff to propel her on and off unit. Uses wheelchair as her main mode of locomotion. Revision on: 10/20/2018 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• PERSONAL HYGIENE: Viviana requires two staff maximal assistance with her personal hygiene. She can aid in washing her face but requires the team to complete the resident if the tasks. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• HAND HYGIENE: 1 staff to provide TOTAL assistance to apply sanitizer or use wipes for hand hygiene. Revision on: 01/23/2022 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Viviana requires Maximal assistance from two staff using a Sit to stand lift. Viviana is not to be left unattended while on the Toilet. Staff member MUST be with her while she is on the toilet. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
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• Altered ability to complete Activities of Daily Living (ADLs) related to developmental disorder, cerebral palsy, Osteoarthritis, GERD. Revision on: 12/19/2023 Revision by: Maryola Perion (RN)		• TRANSFERRING: Viviana requires two staff using a Sit to stand lift to transfer her to and from bed to wheelchair. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFER LIFT/SLING: Sit to stand lift and Yellow Sling Revision on: 06/13/2024 Revision by: Maryola Perion (RN)		
		• ORAL CARE: Viviana requires one staff to provide oral hygiene. All teeth missing. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: Registered staff to complete during shower days. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	PCA	
		• Specific family request: Please ensure that Viviana is not left in her room during the day, unless she is in bed for a nap. Viviana enjoys being around other people and watching tv. Revision on: 08/06/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
• Potential for altered hematologic symptoms or complications related to diagnosis of Vit B12 ANEMIA Revision on: 03/24/2023 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with ANEMIA each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM in decision making of hematologic care management for Anemia. Revision on: 03/24/2023 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with ANEMIA for complications or changes to health status.	Registered Staff	
		• LAB WORK: Monitor blood lab work and report results to MD as needed. Follow up as indicated.	Registered Staff	
		• MEDICATION: Administer medication for ANEMIA as per MD Order. Monitor effectiveness and for side effects.	Registered Staff	

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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for CONSTIPATION related to decreased mobility Revision on: 02/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Viviana will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM for decision making regarding constipation management. Revision on: 03/02/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Viviana for constipation management and changes to health status and symptoms/ complications of constipation. Revision on: 02/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • FLUIDS: Encourage Viviana to meet daily beverage minimums. See Nutrition Care Plan. Revision on: 02/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• NUTRITION increased fibre intervention in place. See Nutrition Care Plan.	Diet Registered Staff	
		• BOWEL PROTOCOL: In place as per MD order	Registered Staff	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, etc.) related to developmental delay, Rarely or Never Understood, Sometimes Understands, Impaired hearing. Revision on: 04/09/2021 Revision by: Maryola Perion (RN)	• Viviana is unable to express self and will be supported to have needs interpreted each day through the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM for decision making about strategies needed to support effective communication. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Viviana's primary language is English. She is able to understand English. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: (Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.). Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • INSTRUCTION GUIDANCE: Viviana needs (intermittent to constant) cueing or demonstrative instruction in tasks and activities. Revision on: 05/29/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Expressed Wishes and Beliefs related to	• To support and honor Viviana's	• CPR:Viviana wishes DO NOT ATTEMPT CPR: Transfer to hospital decision will be	All	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
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Focus	Goal	Interventions	Position	Freq/Resolved
Viviana's Medical Treatment and End of Life Care Revision on: 04/09/2021 Revision by: Maryola Perion (RN)	expressed wishes and beliefs through to the End of Life. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	made as needed. Revision on: 06/02/2025 Revision by: Maryola Perion (RN)		
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM in decision making for GERD Management. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals. • MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	PCA Registered Staff Registered Staff	
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, etc.) Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 01/26/2020 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using poly-pharmacy for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 01/26/2020 Revision by: Maryola Perion (Registered Nurse) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff Registered Staff Registered Staff	
• Potential for muscular dysfunction,	• To treat and minimize	• COMMUNICATION: Involve/ collaborate with SDM in decision making of		

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
contractures and bone deformity related to Osteoarthritis. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	signs/symptoms or complications associated with Osteoarthritis through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	musculoskeletal care management. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of Osteoarthritis as per MD order. Monitor effectiveness and for side effects. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of osteoarthritis for discomfort/ complications or changes to health status. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT for osteoarthritis prescribed and in place; refer to Pain Care Plan. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in ENDOCRINE FUNCTION related to HYPOTHYROIDISM	• To treat and/or minimize signs/symptoms of HYPOTHYROIDISM through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/ collaborate with SDM in decision making of thyroid care management. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with HYPOTHYROIDISM for changes to health status and alteration or complications affecting endocrine function. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for HYPOTHYROIDISM as per MD order. Monitor effectiveness and for side effects. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY to	• Viviana will be protected from exposure to allergen each day	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about ALLERGY to Cefzil, Sulfa ABO		

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Cefzil, Sulfa Antibiotics Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	through next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications mortality. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • ALLERGY ALERT: Viviana has ALLERGY to Cefzil, Sulfa ABO. Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • MD/PHARMACY ALERT: Notify the MD and Pharmacy of Viviana's Allergy and minimize risk for exposure to allergen. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • RESCUE MEDICATION: Administer EPINEPHRINE as per MD/NP Order. Monitor effectiveness and immediately notify MD/NP of use.	Registered Staff	
• Potential for BOWEL INCONTINENCE related to Impaired Mobility. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	• Viviana will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is continent. Report change to level as noted. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Viviana wears Blue brief on Days, Evenings and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• URINARY (Functional) INCONTINENCE related to Impaired Mobility. Revision on: 01/08/2021	• Viviana will have urinary incontinence managed every shift through to the next review	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 01/08/2021		

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	period. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	Revision by: Maryola Perion (RN) • URINARY Continence level is TOTAL Incontinent. Report change to level as noted. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Viviana wears Blue brief on Days, Evenings and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA PCA PCA	
• Altered VISION related to: Highly Impaired - object identification in question, but eyes appear to follow objects, Developmental Delay. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	• Viviana will be able to function safely in her environment through next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM for decision making pertaining to change in visual status as needed. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)		
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to Developmental disorder, poor decision making. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	• Viviana will cope with progressive cognitive decline and be supported to maintain safety each day through the review date. Current CPS score is 5. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• COMMUNICATION: Involve/collaborate with SDM in decision making of Cognitive Loss. Revision on: 01/08/2021 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 01/08/2021 Revision by: Maryola Perion (RN)	 PCA	
• SPIRITUAL BELIEFS: Viviana is of the Roman Catholic Faith. Revision on: 07/13/2020 Revision by: Shayna Lee Wonsch (Activation	• To provide Viviana spiritual support as interested through to the next review date. Revision on: 12/25/2024	• PERSONAL CHOICE: Respect Viviana's right to decline participation in spiritual programs. Attempt to actively engage if she decides to attend. Revision on: 07/13/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Manager)	Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025			
• Sleep Patterns. Revision on: 07/21/2018 Revision by: Katherine Arca (Registered Practical Nurse)	• To meet Viviana personal preferences for sleep patterns through the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• REST PATTERN: Preferred bedtime: Between 19:00 - 20:00, usual wake time: Between 6:30-7:00 Revision on: 04/09/2021 Revision by: Maryola Perion (RN)	PCA	
		• Preferred night attire: Johnny Shirt. Revision on: 07/21/2018 Revision by: Katherine Arca (Registered Practical Nurse)	PCA	
• Nutrition Risk Level (diet details)	• Viviana will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 11/29/2025	• Labelled Item Breakfast: Applesauce daily Revision on: 08/21/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D
		• Labelled Item Lunch: receives ice cream to promote hydration. Revision on: 05/07/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA Registered Practical Nurse RN	D
	• Will weigh within realistic GWR 90-95 kg through to next review date. Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 11/29/2025	• NUTRITION RISK: Viviana is moderate risk level. Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD)	
		• DIET ORDER: Viviana will receive regular diet, pureed texture. Do not serve milk products itself: cheese, milk to drink, pudding,ice cream, yogurt, orange juice per resident's mother's request Revision on: 02/24/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA	
	• Viviana will be adequately hydrated aeb drinking at least 75% of total fluid requirement: 1860 ml/day (20 ml/kg using 93 kg weight) through to next review date.	• FLUID CONSISTENCY: Viviana drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/15/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: Encourage Viviana to drink a minimum of 1395 ml/day Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)	Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 11/29/2025	• EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily.	Dietary aide PCA	
		• DINING INSTRUCTIONS: Add 1 package of peanut butter and jam each to her hot cereal AND puree bread- mix well to ensure no clumps do not serve spinach, green peas, green beans Revision on: 05/18/2023 Revision by: Anna Slack (Registered Dietitian)	Diet Food Services Aide Registered Practical Nurse	
		• ADAPTIVE AIDS: Viviana requires rimmed plate and sippy cup Revision on: 08/21/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• HIGH FIBRE: Prune juice at breakfast daily Revision on: 08/21/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	PRN
		• LABELLED SNACK: Jello at AM/PM snacks Revision on: 08/21/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	

Allergies	Cefzil, Sulfa Antibiotics	**D.O.B.**	04/13/1964	**Physician**	Albert Patrick Ng
Diagnosis	Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Cassin, Viviana (922131005040)	**Admission Date**	07/03/2018	**Location**	4 421 A
Last Care Plan Review Completed:	**08/29/2025**				

Diagnosis

Cerebral palsy, unspecified(G80.9), Developmental disorder of speech and language, unspecified(F80.9), Hypothyroidism, unspecified(E03.9), Primary generalized (osteo)arthrosis(M15.0), Fracture of ankle NOS, closed(S82.890), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Vitamin B12 deficiency anaemia, unspecified(D51.9), Benign lipomatous neoplasm of other sites(D17.7)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Persistent PAIN and alteration in comfort level related to OA, generalized pain, obesity, lower back pain, neck pain Lt. side, impaired mobility, Right knee, pedal edema on the R. Most Current RAI Pain Score is 0. Revision on: 10/22/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025 • Promote RAI Pain Score of 0 through to the next review. Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with Isabel/SDM) about pain management, goals of treatment, plan of care, prognosis and treatment options. Revision on: 12/09/2020 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control.	RN Registered Practical Nurse	
		• NON VERBAL CUES of PAIN for Isabel includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	PCA	
		• MEDICATION: Administer analgesic and/or topical medication for knee as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 08/04/2021 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Alteration in skin integrity related to RASH (MASD) to right thigh. Revision on: 09/10/2025 Revision by: Suzanne Azar (RN)	• To promote intact skin integrity through healing of RASH by the target date. Revision on: 10/16/2025 Revision by: Maryola Perion (RN) Target Date: 12/04/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MASD for changes to health status and alteration or complications affecting skin integrity. Revision on: 09/10/2025 Revision by: Suzanne Azar (RN)	Registered Practical Nurse RN	
		• COMMUNICATION: Involve/collaborate with (Isabel)/SDM in decision making for treatment of skin issues. Revision on: 10/16/2025 Revision by: Maryola Perion (RN)		
		• TOPICAL TX: Apply topical treatment to the right thigh as MD Order. Revision on: 09/10/2025 Revision by: Suzanne Azar (RN)	Registered Practical Nurse	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound	Registered Practical Nurse	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C

Last Care Plan Review Completed: 09/04/2025

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity related to RASH (MASD) to right thigh. Revision on: 09/10/2025 Revision by: Suzanne Azar (RN)		Care Lead and MD as needed. Revision on: 10/16/2025 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to: COPD, Obesity, Hypertension, Impaired Mobility, decline in cognitive status. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	• Isabel will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• BATHING: Isabel prefers (shower/tub bath) on (Thursdays and Sundays on Evening shift). Isabel participates by (providing a wash cloth and cues). One staff (MAXIMAL) assistance for bathing. Requires the use of a Maxi lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY: Isabel requires maximal assistance from team members to turn, move and reposition in bed. 2 persons care at all times due to being paranoid and accusing staff. Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Isabel is able to (lift her arm and legs with staff's cueing) Two staff to provide MAXIMAL assistance for dressing UPPER & LOWER body. 2 persons care at all times due to being paranoid and accusing staff. Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Isabel is able to eat independently with supervision and set up. She may require one staff oversight, cueing when needed. Hx of trying to eat napkins. Eats in the main dining room - 1st floor. Revision on: 10/28/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• LOCOMOTION: Wheelchair as mode of locomotion and requires one staff Total assistance to porter her on and off the unit.	PCA	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: COPD, Obesity, Hypertension, Impaired Mobility, decline in cognitive status. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)		Revision on: 06/13/2024 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: Isabel is able to brush her hair, wash/dry her face, hands with staff's oversight, cueing, reminders and encouragement. She requires maximal assistance from two staff to change her brief and to provide peri care. 2 persons care at all times due to being paranoid and accusing staff. Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide limited assistance to use sanitizer or wipes for hand hygiene. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Isabel requires two staff maximal assistance with checking and changing her incontinence product while in bed, she is able to assist by turning to her side with staff cueing and instructions. MAXI lift to transfer her back to bed. 2 persons care at all times due to being paranoid and accusing staff. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Isabel requires a total mechanical lift with two team members for transferring. Black/Blue comfort sling to be used during transfers. Revision on: 07/24/2024 Revision by: Katherine Arca (RPN)	PCA	
		• TRANSFER LIFT/SLING: Maxi lift and Black/Blue comfort sling. Revision on: 07/25/2024 Revision by: Maryola Perion (RN)		
		• ORAL CARE: Isabel has her Lower denture. Staff to assist with oral hygiene, cleaning and storing her lower denture. Missing Upper denture at this time. Revision on: 09/09/2024 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: Registered staff to complete during shower days. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	PCA	
• Potential for gastric discomfort/complications related to	• To treat and/or minimize complications associated with	• HEALTH TEACHING: Engage with (Isabel/SDM) to enhance his/her comprehension of treatment, possible complications, disease trajectory, etc.	RN Registered	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
episodes of nausea/Vomiting Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	nausea/Vomiting through to target date Revision on: 06/06/2025 Revision by: Maryola Perion (RN) Target Date: 12/04/2025	associated with nausea/VOMITING. Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	Practical Nurse	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of NAUSEA/VOMITING or changes to health status.	Registered Staff	
		• MEDICATION: Administer medication for NAUSEA/VOMITING as per MD order. Monitor effectiveness and for side effects.	Registered Staff	
• Potential to experience alteration in MOOD as exhibited by repetitive questions & verbalizations, thinks something terrible will happen to her, repetitive heath/non-health complaints and sad worried facial expression, anxious, feels sad and wanted to die (suicidal thoughts - 9/29/23), I want to commit suicide (4/11/25)(2025-05-15) related to: Depression, Bipolar Disorder, Anxiety Disorder. Revision on: 05/16/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with Isabel/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)		
		• HEALTH EDUCATION: Provide education and support to (Isabel)/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 01/02/2023 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
		• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Isabel for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)		
		• RESIDENT STRENGTHS: Build on Isabel's effort to maintain control. Encourage him/her to express self, state preferences and make safe choices for care and activities. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)		
		• SUICIDAL IDEATIONS: Report to Registered Staff IMMEDIATELY if Isabel expresses thoughts to harm to self. Revision on: 09/30/2023		

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C

Last Care Plan Review Completed: **09/04/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by repetitive questions & verbalizations, thinks something terrible will happen to her, repetitive heath/non-health complaints and sad worried facial expression, anxious, feels sad and wanted to die (suicidal thoughts - 9/29/23), I want to commit suicide (4/11/25)(2025-05-15) related to: Depression, Bipolar Disorder, Anxiety Disorder. Revision on: 05/16/2025 Revision by: Danielle Loreto (RAI Coordinator)		Revision by: Maryola Perion (RN)		
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (turning and repositioning). Revision on: 03/19/2025 Revision by: Suzanne Azar (RN)	• Isabel will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living (turning and repositioning) each day through to the next review date. Revision on: 03/19/2025 Revision by: Suzanne Azar (RN) Target Date: 12/04/2025	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails. Revision on: 03/19/2025 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate turning and repositioning. Revision on: 03/19/2025 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with bed mobility. Monitor every shift. Revision on: 03/19/2025 Revision by: Suzanne Azar (RN)	PCA	D/E/N
• Increased risk for FALLS related to: Impaired mobility, unsteady gait, use of	• To promote safety, minimize risk for falls and/or fall related	• COMMUNICATION: Involve/collaborate with Isabel/SDM in decision making in fall prevention Plan of Care.		

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
psychotropic medications, History of falls. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	injury each day through to the next review period. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 10/04/2022 Revision by: Jenny Liu (RAI Coord Back-up) • BED: place bed in lowest position to lower risk for injury. Revision on: 10/21/2022 Revision by: Kenya Mosely (RPN) • FLOOR MAT: Position on floor both side of bed to lower risk of injury. Revision on: 03/21/2025 Revision by: Prabhjot Maan (ADOC) • SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA	D/E/N
• Altered VISION related to the use of eyeglasses. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	• Isabel supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 03/06/2025 Revision by: Maryola Perion (RN) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with (Isabel)/SDM for decision making pertaining to change in visual status as needed. Revision on: 03/06/2025 Revision by: Maryola Perion (RN) • EYEGLASSES: Isabel wears eyeglasses. Assist to clean eyeglasses as needed and store on night table or in night table drawer when sleeping. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	PCA	
• Isabel has acute Renal Failure Revision on: 12/13/2024 Revision by: Maryola Perion (RN)	• To treat and minimize complications associated with Acute Renal Failure through to next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Acute Renal Failure for changes to health status and alteration or complications affecting renal function. Revision on: 12/13/2024 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Isabel has acute Renal Failure Revision on: 12/13/2024 Revision by: Maryola Perion (RN)				
• Risk for/Impaired SKIN INTEGRITY related to: Obesity, Incontinence, use of an incontinent products, Impaired mobility. Revision on: 12/13/2024 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted. • EQUIPMENT: Isabell requires air mattress and ROHO to offload pressure. Revision on: 04/24/2023 Revision by: Janina Lucero (RN)	PCA PCA	
• Potential to experience alteration in RESPIRATORY FUNCTION related to: Chronic Obstructive Pulmonary Disorder (COPD). Revision on: 11/28/2024 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Chronic Obstructive Pulmonary Disorder (COPD) each day through to next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with Isabel/SDM in decision making of Respiratory Management for Chronic Obstructive Pulmonary Disorder (COPD). Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Chronic Obstructive Pulmonary Disorder (COPD) for changes to health status and alteration or complications affecting respiratory function. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing. • OXYGEN: Administer Oxygen as per MD order. Revision on: 11/23/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for Chronic Obstructive Pulmonary Disorder (COPD) as per MD order and monitor for side effects. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)	Registered Staff PCA	
• Nutrition: Risk for choking related to	• To maintain safe swallowing	• Provide diet/texture interventions as per Nutrition Risk Level		

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C

Last Care Plan Review Completed: **09/04/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
coughing noted during intake Revision on: 11/25/2024 Revision by: Danielle Loreto (RAI Coordinator)	through to next review date Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025 • To obtain or maintain adequate intake to meet estimated nutritional requirements through to next review date Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• Monitor tolerance to diet. Monitor for coughing, pocking difficulty swallowing at meals and report to the nurse for follow up if noted Revision on: 11/25/2024 Revision by: Danielle Loreto (RAI Coordinator)		
• ROM Exs Revision on: 09/16/2024 Revision by: Shina Wadhwa (Physical Therapist)	• Increase AA-PROM B/L Knee extension from -10 to WFL in 3 months Revision on: 09/03/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/04/2025	• AA-PROM for B/L LE, as best tolerated, 1-2 sets of 10 reps, 2-3 x a week; Stretching of B/L Hams and calf for 10-20sec, 3-5 reps, 2-3 x a week Revision on: 06/04/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential for Expressive Behaviour of (RESISTANCE to care need and hx of very territorial to her roommate, she didn't allow her to make any noise or watch her TV, refused to eat related to Depression, Bipolar Disorder, Anxiety Disorder. Revision on: 06/13/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 06/06/2025 Revision by: Maryola Perion (RN) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with Isabel/SDM about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Isabel for indications to change in or for escalating expressive behaviour risk. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusal to bathe/shower, eat, etc.) as expression of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 06/13/2024	BSO - Internal BSO - External Social Worker	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C

Last Care Plan Review Completed: 09/04/2025

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Isabel is refusing to (bathe/shower, eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 06/13/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 09/21/2023 Revision by: Maryola Perion (RN) • SPECIAL CONSIDERATIONS: Isabel has been known to become angry and displeased with staff when encouraging her to participate in her own physical care. Isabel is very sensitive to loud noises (ie fire drill). Revision on: 06/27/2023 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Balance. Revision on: 12/14/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Isabel to improve wt.bearing ability to prevent pressure on the buttocks in 3 months. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• Isabel to perform sit-stand exercises +2A,1set,5rps.,hold up 45 sec to 1 mint.3/wk as tolerated, per rehab treatment. Revision on: 06/16/2023 Revision by: Keyur Patel (Resident Physiotherapist)	PT - Physiotherapist PTA	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to disinterest, low motivation. ISE Score: 3/6 Revision on: 12/26/2022 Revision by: Mitchell Atkinson (Recreation Aide)	• Team members will support Isabel in decreasing social isolation by participating in activities of personal choice 10-15 times per month by the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• STRUCTURED ACTIVITIES: Invite her to programs of personal interest; friendly/1:1 visits, discussion groups, games (trivia), manicures and hand massages, music (country, 70s & 80s), outdoor patio programs, Happy Hour, special events, spiritual, etc. Revision on: 05/28/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as visiting with residents/team members, watching/listening to TV, listening to music, etc. Revision on: 05/28/2025 Revision by: Laura Morris (Restorative Care Aide) • ASSISTANCE: Provide assistance/encouragement to get her to scheduled activities - Reminders, etc.	ACT	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 06/27/2022 Revision by: Mitchell Atkinson (Recreation Aide) • HELPFUL HINTS: She enjoys talking about her son Jerry. Revision on: 06/17/2025 Revision by: Laura Morris (Restorative Care Aide) • ONE to ONE: Provide her with individual visits for conversation, reminiscing, spiritual support, music, humour, etc. Revision on: 12/18/2023 Revision by: Mitchell Atkinson (Recreation Aide)		
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, minimum difficulty of hearing) related to Cognitive impairment. Revision on: 07/03/2022 Revision by: Jenny Liu (RAI Coord Back-up)	• Isabel will be supported to maintain current communication abilities to (express self, comprehend information, etc.) each day through to the review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025 • Isabel will be able to make basic needs known each day through to the review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with (Isabel)/SDM for decision making about strategies needed to support effective communication. Revision on: 12/13/2023 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Isabel's primary language is English. She is able to speak/understand English. Revision on: 05/02/2021 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: Isabel needs intermittent cueing or demonstrative instruction in tasks and activities. Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	ACT	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 05/02/2021 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up)	• COMMUNICATION: Involve/collaborate with Isabel/SDM in decision making for GERD Management. Revision on: 05/02/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 05/02/2021		

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C

Last Care Plan Review Completed:	**09/04/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 12/04/2025	Revision by: Maryola Perion (RN) • POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals. • MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	PCA Registered Staff Registered Staff	
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS	• To treat and minimize signs/symptoms or complications associated with OSTEOARTHRITIS through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• COMMUNICATION: Involve/ collaborate with Isabel/SDM in decision making of musculoskeletal care management. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of OSTEOARTHRITIS as per MD order. Monitor effectiveness and for side effects. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of OSTEOARTHRITIS for discomfort/ complications or changes to health status. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT for OSTEOARTHRITIS prescribed and in place; refer to Pain Care Plan. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with Isabel/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-anxiety, anti-depressant medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and	Registered	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience complications and side effects impacting quality of life related to use of multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		as needed.	Staff	
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to Cognitive decline. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• Isabel will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• ORIENTATION: Gently reorient to person, place, time as needed when Isabel is feeling lost or in confused state. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • PERSONAL ITEMS: Keep (eyeglasses, family pictures, etc.) in a consistent place. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	 PCA PCA	
• SPIRITUAL BELIEFS: Isabel is of the Presbyterian Faith. Revision on: 06/25/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide Isabel spiritual support as interested through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• SPIRITUAL PROGRAMS: Encourage her to attend spiritual programs of her choice including church service, spiritual music, etc. Revision on: 08/12/2020 Revision by: Shayna Lee Wonsch (Activation Manager) • SELF-DIRECTED SPIRITUAL Activities: Isabel engages in praying, reading bible, spiritual music, etc. Revision on: 07/07/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT ACT	
• Expressed Wishes and Beliefs related to Isabel's Medical Treatment and End of Life Care Revision on: 06/10/2020 Revision by: Shayna Lee Wonsch (Activation	• To support and honor Isabel's expressed wishes and beliefs through to the End of Life. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord	• CPR: Isabel wishes express NO CPR and NO TRANSFER to hospital Revision on: 04/11/2022 Revision by: Kenya Mosely (RPN) • FUNERAL Arrangements: Anderson Funeral Home, 895 Ouellette Ave. (519) 254-3223	 Social Worker ST	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C

Last Care Plan Review Completed: **09/04/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
Manager)	Back-up) Target Date: 12/04/2025	Revision on: 09/04/2025 Revision by: Maryola Perion (RN)		
• Strength Revision on: 06/09/2020 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• Isabel to increase strength of B/L UE from 3+/5 to 4/5 in 3 months. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• Strength exe. with use of 1-2lbs. wt.cuff, 1set, 10rps for B/L UE,2-3/wk as tolerated. Revision on: 09/16/2024 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential to experience alteration in CARDIAC FUNCTION related to: Hypertension Revision on: 05/11/2020 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Hypertension through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• COMMUNICATION: Involve/collaborate with Isabel/SDM in decision making of Cardiac Care Management for Hypertension. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for Hypertension as per MD Order and monitor for side effects. Revision on: 08/02/2021 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Sleep Patterns. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for Isabel based on identified sleep patterns/preferences each night through to the next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• REST PATTERN: Preferred bedtime: around 20:00, usual wake time: 1000. Resident prefers not to be woken up, and wants to wake up on her own. Expressed difficulty sleeping after talking to son on the phone. Revision on: 03/23/2023 Revision by: Maryola Perion (RN) • SLEEPWEAR: Isabel prefers to wear own Pyjamas Revision on: 05/11/2020 Revision by: Maryola Perion (RN)	PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Sleep Patterns. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)				
• Potential for BOWEL INCONTINENCE related to impaired mobility. Revision on: 05/11/2020 Revision by: Maryola Perion (RN)	• Isabel will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Totally Incontinent. Report change to level as noted. Revision on: 10/04/2022 Revision by: Jenny Liu (RAI Coord Back-up) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Isabel uses a Blue Brief for Days, Evenings and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• URINARY (Functional) INCONTINENCE related to: Impaired Mobility, Obesity Revision on: 05/11/2020 Revision by: Maryola Perion (RN)	• Isabel will receive support to use toilet and promote urinary continence each shift through to the next review. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 05/11/2020 Revision by: Maryola Perion (RN) • URINARY Continence level is Totally Incontinent. Report change to level as noted. Revision on: 07/03/2022 Revision by: Jenny Liu (RAI Coord Back-up) • INCONTINENCE PRODUCT: Isabel uses a Blue Brief for Days, Evenings and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)	• Isabel will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 12/25/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 12/04/2025	• NUTRITION RISK: Isabel is moderate risk level. Revision on: 08/26/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD)	
		• DIET ORDER: Isabel will receive regular diet, puree texture Revision on: 09/29/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA	
		• THICKENED FLUIDS: Isabel drinks fluids at mildly thick level 2 (nectar-like) consistency Revision on: 08/26/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
	• Will weigh within Realistic weight range of 90-95kg through to next review date. Revision on: 03/03/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 12/04/2025	• FLUID TARGET: Encourage Isabel to drink a minimum of 1400 ml/day Revision on: 10/22/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA	
		• EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily.	Dietary aide PCA	
	• Isabel will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 20 ml/kg through to next review date. Revision on: 10/22/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 12/04/2025	• DINING INSTRUCTIONS: Small teaspoons only, encourage small bites and sips of fluids between bites Encourage whole grain bread (pureed) Encourage oatmeal at breakfast Revision on: 08/26/2025 Revision by: Holly Laasanen (Dietitian (RD))	Registered Practical Nurse	
		• FOOD ALLERGY/INTOLERANCE: Isabel has intolerance to lactose in milk only. Reaction: GI upset. Provide Lactaid milk (thickened). Revision on: 08/26/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Restorative Care Aide	
		• HIGH CALORIE/PROTEIN AM SNACK: applesauce Revision on: 12/09/2024 Revision by: Lexi Dakin (Dietitian (RD))	PCA	D
		• HIGH CALORIE/PROTEIN PM SNACK: applesauce Revision on: 12/09/2024 Revision by: Lexi Dakin (Dietitian (RD))	PCA	E
		• LABELLED SNACK: 355 ml thickened gingerale at AM snack daily Revision on: 08/26/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D/E

Allergies	No Known Allergies	**D.O.B.**	04/20/1943	**Physician**	Albert Patrick Ng
Diagnosis	Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40)...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Dee, Isabel (922131005370)	**Admission Date**	04/22/2020	**Location**	4 414 C
Last Care Plan Review Completed:	**09/04/2025**				

Diagnosis

Depressive episode, unspecified(F32.9), Benign hypertension(I10.0), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Personal history of alcohol abuse(Z86.40), Obesity, unspecified(E66.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Primary generalized (osteo)arthrosis(M15.0), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Injury of kidney NOS without open wound into cavity(S37.090), Acute renal failure, unspecified(N17.9)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Persistent PAIN and alteration in comfort level related to OA, pain on right knee due to previous fracture, Scoliosis, pain to right shoulder post fall 1/29/23 (mild subluxation of joint). Pain to Rt and Lt Iliac crest, Hx of anterior sub coracoid dislocation of Dislocated right shoulder/ FRACTURE of Right Shoulder/Clavicle Most Current LTCF score 0 Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with James/SDM about pain management, goals of treatment, plan of care and treatment options. Revision on: 01/17/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	RN Registered Practical Nurse Registered Practical Nurse RN	
• James DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 5/6 Revision on: 06/26/2025 Revision by: Laura Morris (Restorative Care Aide)	• James participates in Independent/Self-Directed activities monthly through to the next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as reading (books and magazines), music (soft rock), watching TV (Beverly Hillbillies), smoking on the patio, visiting with residents/team members, etc. Revision on: 05/28/2020 Revision by: Shayna Lee Wonsch (Activation Manager) • FRIENDLY VISIT: Provide him one to one visits as tolerated. Touch Base to maintain contact and to; converse about topics of interest, identify upcoming special events, reminisce, etc. Revision on: 08/16/2022 Revision by: Shayna Lee Wonsch • INVITATION: Offer friendly invite to structured programs scheduled in the home. James enjoys the tuck shop, special events, Happy Hour & outdoor patio programs. Revision on: 08/07/2023 Revision by: Mitchell Atkinson (Recreation Aide)	ACT ACT	
• Risk for/Impaired Skin Integrity r/t: Fragile skin, impaired mobility, medium lump to right side of his groin Incontinence, Use of incontinent product.	• To protect and maintain skin integrity each day through to the next review. Target Date: 01/17/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng	
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C	

Last Care Plan Review Completed: **10/17/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 04/28/2025 Revision by: Danielle Loreto (RAI Coordinator)		• POSITIONING: Turn, reposition at least every 2 hours when in bed/wheelchair to offload pressure. Revision on: 11/28/2023 Revision by: Ramil Santillan (Quality Improvement Coordinator)	PCA	Q2h
• Increased risk for FALLS related to OA, use of antipsychotic medication, impaired mobility and balance, history of falls, unsteady gait, anterior subcoracoid dislocation, poor seated posture, slides in chair. Revision on: 04/11/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with James/SDM in decision making in fall prevention Plan of Care. If James is noted to be reaching over outside to pick up cigarette butts off the ground, provide education on infection control and redirect as he is at risk for tipping his chair. Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use Call bell when he need help.. Revision on: 12/06/2023 Revision by: Kuljeet Kaur (RN)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: high/low bed, wheelchair. Assist with positioning in chair when he is accepting of it. Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• ENVIRONMENT: Secure environment (reduce clutter, etc.) to reduce fall risk for James. Revision on: 05/10/2023 Revision by: Maryola Perion (RN)	PCA	
		• BED: Place bed in lowest position to lower risk for injury. Revision on: 12/06/2023 Revision by: Kuljeet Kaur (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	PCA	
		• FLOOR MAT: Position floor mat on floor next to right side of bed to lower risk of injury.	PCA	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to OA, use of antipsychotic medication, impaired mobility and balance, history of falls, unsteady gait, anterior subcoracoid dislocation, poor seated posture, slides in chair. Revision on: 04/11/2025 Revision by: Danielle Loreto (RAI Coordinator)		Revision on: 09/08/2023 Revision by: Maryola Perion (RN) • SUPPLEMENT: Vitamin D supplement as per MD order to maintain bone density to prevent injuries. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)		
• Use of PASD tilt 15 degrees to assist resident with Activity of Daily Living for positioning, Pommel cushion in use. Revision on: 08/22/2024 Revision by: Maryola Perion (RN)	• James will be effectively supported with use of tilt wheelchair to optimize Activity of Daily Living (positioning) each day through to the next review date. Revision on: 10/19/2023 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• HEALTH EDUCATION: Engage with SDM Alan to enhance their knowledge of possible benefits and challenges associated with Use of Tilt chair for positoning. Revision on: 10/18/2023 Revision by: Chelsea Campbell-Wright (ADOC) • MONITORING: Utilize holistic perspective of monitoring James for continued benefit to tilt wheelchair as to support appropriate positioning in wheelchair. Revision on: 10/19/2023 Revision by: Maryola Perion (RN) • TILTED CHAIR in USE as a PASD to support resident with positioning. Monitor every shift. Revision on: 10/18/2023 Revision by: Chelsea Campbell-Wright (ADOC) • POMMEL CUSHION in USE as a PASD to support resident for positioning, etc.). Monitor every shift. Revision on: 08/22/2024 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA	 D/E/N D/E/N

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by repetitive verbalization, persistent anger with self or others, repetitive health and non health complaints, unpleasant mood in the morning, sad, pained, worried facial expressions, insomnia/change in usual sleep pattern, repetitive physical movement related to Schizophrenia, anterior subcoracoid dislocation. Revision on: 11/08/2023 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with James/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 12/30/2020 Revision by: Clarisa Amir (RPN) • HEALTH EDUCATION: Provide education and support to James/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 12/30/2020 Revision by: Clarisa Amir (RPN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of James for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 08/31/2021 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on James effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 05/28/2021 Revision by: Maryola Perion (RN) • SLEEP/REST: Promote adequate sleep and rest to stability of James mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 05/10/2023 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 05/10/2023 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
• Altered COMMUNICATION as exhibited by limitations to self expression, comprehension, etc.) related to Cognitive decline. Revision on: 11/08/2023 Revision by: Maryola Perion (RN)	• James will be supported to maintain current communication abilities to comprehend information each day through to the review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• PRIMARY LANGUAGE: James primary language is English. He is able to speak/understand English. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: James needs intermittent cueing or demonstrative		

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	• James will be able to make basic needs known each day through to the review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	instruction in tasks and activities. Revision on: 07/30/2024 Revision by: Maryola Perion (RN)		
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, altered judgement, etc.) related to progression of memory loss, impaired decision making, Schizophrenia. Revision on: 11/08/2023 Revision by: Maryola Perion (RN)	• James will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• ORIENTATION: Gently reorient to person, place, time as needed when James is feeling lost or in confused state. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routines and activities. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	PCA	
• Potential for Expressive Behaviour of RESISTANCE to care need & to eat during meal times, SEXUAL (exposing private part), Verbally and physically expressive regarding outbreak protocols, Inappropriately disposing of soiled briefs related Schizophrenia Revision on: 02/10/2023 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with James/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 08/03/2021 Revision by: Leslie Meloche (Activities/Rec Therapy) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of James for indications to change in or for escalating expressive behaviour risk. Revision on: 08/03/2021 Revision by: Leslie Meloche (Activities/Rec Therapy) • TRIGGERS leading to PHYSICAL (Hitting others) as expressions of behaviour include (anger, frustration, confusion, etc.) Revision on: 03/28/2025 Revision by: Danielle Loreto (RAI Coordinator) • PHYSICAL Behaviour: If James is attempting to strikeout; move back from his reach. Calmly indicate that care will continue when he is calm/ready. Seek Registered Staff assistance.	BSO - Internal BSO - External Social Worker	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 04/01/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • TRIGGERS leading to VERBAL (yelling, swearing, calling names, etc.) as expression of behaviour include (frustration, limitation in self expression, pain, misunderstanding care intention, etc.) Revision on: 03/11/2024 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If James is heard yelling, swearing or calling others names; calmly remind to lower his voice and that chosen words are not appropriate. Attempt to resolve his concern. Report episode to Registered Staff. Revision on: 04/01/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • TRIGGERS leading to RESISTANCE to Care Needs of refusal to bathe, refusal to eat, etc. as expression of behaviour include (cause: misunderstanding care needs, poor judgment). Revision on: 05/08/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If James is refusing to bathe/shower, refusing to eat; re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 08/03/2021 Revision by: Leslie Meloche (Activities/Rec Therapy) • SEXUAL Behaviour: If James is noted to (exposing his private part) calmly assist him back to the privacy of his room. Revision on: 08/03/2021 Revision by: Leslie Meloche (Activities/Rec Therapy) • MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 02/16/2022 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Altered ability to complete Activities of Daily Living (ADLs) related to Schizophrenia, OA, Scoliosis, mild subluxation of joint to right shoulder Revision on: 02/07/2023 Revision by: Katie Wolters-Savo (RAI	• James will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 08/11/2023	• BATHING: James prefers (shower/tub bath) on (Wednesdays and Saturdays on Day shift). James participates by (providing a wash cloth and cues). Two staff (MAXIMAL) assistance for bathing. Requires the use of a Maxi lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025	PCA	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Coordinator)	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: James requires 1 team member extensive assistance assistance to turn and reposition him while in bed. 2 person maximal if fatigued and/or cannot participate Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator) • DRESSING: James requires 1 team member extensive assist with removing/putting on his top, removing/putting on his pants, brief change. One staff member to put on his socks and shoes. 2 person maximal if fatigued and/or cannot participate Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator) • EATING: James requires one staff extensive assistance to feed him at all meals and snacks. He is able to assist with drinking his fluids. Eats in the unit dining room - Petunia Lane. Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator) • LOCOMOTION: Uses a wheelchair with a pommel as a primary mode of locomotion. Able to propel himself independently on and off unit. May require one staff assistance at times to push him on the unit or inside the home coming from the patio. He slides in his chair when feet propelling. Offer to reposition him. He may decline the offer. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: James requires one team member to assist with washing his face and brushing his teeth as well as shaving him. He requires two team members to assist in providing peri-care. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • HAND HYGIENE: 1 staff to provide limited to total assistance to apply sanitizer or	PCA PCA PCA PCA PCA	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Schizophrenia, OA, Scoliosis, mild subluxation of joint to right shoulder Revision on: 02/07/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		use wipes for hand hygiene. Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• TOILET USE: James requires two team members maximal to total assist with checking and changing his incontinence product while in bed. Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: James is a MAXI LIFT with Yellow sling for all transfers with two staff assistance. James will try to self transfer. Staff to provide reminders and health teaching to call for assistance. Revision on: 09/08/2023 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFER LIFT/SLING: Maxi lift and Yellow sling Revision on: 02/07/2024 Revision by: Maryola Perion (RN)		
		• ORAL CARE: James needs total assistance from one team with oral care. Some teeth are missing. Some are carious. Revision on: 05/08/2024 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: PSW to complete toenail care every after bath/shower and as needed. Report long toe nails or other abnormalities as noted. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	PCA	
		• SHAVING - Staff to shave James on his bath/shower days and as needed. Revision on: 09/08/2023 Revision by: Maryola Perion (RN)	PCA	D
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS. Revision on: 11/28/2021 Revision by: Maryola Perion (RN)	• To treat and minimize complications associated with OSTEOPOROSIS through to the next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve/ collaborate with James/SDM in decision making of osteoporosis care management. Revision on: 11/28/2021 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for osteoporosis management. Monitor effectiveness and for side effects.	Registered Staff	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for	Registered	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS. Revision on: 11/28/2021 Revision by: Maryola Perion (RN)		management of osteoporosis for discomfort/ complications or changes to health status.	Staff	
• James has potential to experience a safety hazard/burn injury related to personal SMOKING habits. (cigarette/cannabis) Revision on: 05/28/2021 Revision by: Maryola Perion (RN)	• James will be safe when choosing to smoke through to the next review Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve James/SDM in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) and identify the designated area/s where smoking is permitted. Revision on: 01/24/2021 Revision by: Maryola Perion (RN)	Social Worker	
		• SMOKING CONTRACT: James has agreed to follow safe smoking rules and accepts the consequences of breaking those agreed upon rules by signing the smoking contract. Revision on: 02/25/2021 Revision by: Maryola Perion (RN)	Social Worker Administrator	
• Potential for CONSTIPATION related to (daily use of medication with binding effect, decreased mobility, etc.) Revision on: 05/25/2021 Revision by: Maryola Perion (RN)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with James/SDM for decision making regarding constipation management. Revision on: 05/25/2021 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation.	Registered Staff	
	• James will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan.	Registered Staff	
		• NUTRITION increased fibre intervention in place. See Nutrition Care Plan.	Diet Registered Staff	
		• BOWEL PROTOCOL: In place as per MD order	Registered Staff	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for CONSTIPATION related to (daily use of medication with binding effect, decreased mobility, etc.) Revision on: 05/25/2021 Revision by: Maryola Perion (RN)				
• Expressed Wishes and Beliefs related to James' End of Life Care Revision on: 05/25/2021 Revision by: Maryola Perion (RN)	• To support and honor James expressed wishes and beliefs through to the End of Life. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• CPR: James wishes express NO CPR and NO TRANSFER to hospital. Revision on: 09/21/2019 Revision by: Maryola Perion (Registered Nurse) • FUNERAL Arrangements: Victoria Greenlawn Funeral Home and Cemetery- 1525 Highway #3 Windsor, ON. N0R 1L0 (519) 969-3939 Revision on: 07/30/2024 Revision by: Maryola Perion (RN)	All Social Worker ST	
• URINARY (Functionad) INCONTINENCE related to Impaired Mobility Revision on: 02/25/2021 Revision by: Maryola Perion (RN)	• James will have urinary incontinence managed every shift through to the next review period. Revision on: 07/30/2024 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 02/25/2021 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: James uses a White brief for Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Assess for need to check and change every 2 hours and as needed. Revision on: 07/03/2025 Revision by: Danielle Loreto (RAI Coordinator)	 PCA PCA	
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY to Haldol	• James will be protected from exposure to allergen each day through next review date.	• MONITORING: Utilize holistic perspective of continuous monitoring of James with allergy for changes to health status and complications mortality. Revision on: 06/23/2020		

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 02/25/2021 Revision by: Maryola Perion (RN)	Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	Revision by: Maryola Perion (RN) • Staff to remain aware of allergen (Haldol) and prevent contact with. Revision on: 02/25/2021 Revision by: Maryola Perion (RN) • ALLERGY ALERT: James has ALLERGY to Haldol. Prevent contact with and report if noted to experience symptoms (Specify; rash, hives, swelling, difficulty breathing, etc.). Revision on: 02/25/2021 Revision by: Maryola Perion (RN) • RESCUE MEDICATION: Administer EPINEPHRINE as per MD/NP Order. Monitor effectiveness and immediately notify MD/NP of use.	Registered Staff	
• Potential for BOWEL INCONTINENCE related to impaired mobility. Revision on: 02/25/2021 Revision by: Maryola Perion (RN)	• James will have bowel incontinence managed every shift through to the next review period. Revision on: 07/30/2024 Revision by: Maryola Perion (RN) Target Date: 01/17/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is totally incontinent. Report change to level as noted. Revision on: 09/07/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: James uses a White brief for Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• Potential for muscular dysfunction, contractures and bone deformity related to Osteoarthritis. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Osteoarthritis through to the next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve/ collaborate with James/SDM in decision making of musculoskeletal care management. Revision on: 05/28/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of osteoarthritis as per MD order. Monitor effectiveness and for side effects. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for		

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		management of osteoarthritis for discomfort/ complications or changes to health status. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT prescribed and in place; refer to Pain Care Plan. Revision on: 05/28/2021 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with James/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 06/23/2020 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)		
• Altered VISION related to: See large print. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	• James will be able to function safely in his environment through next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• COMMUNICATION: Involve/collaborate with (James)/SDM for decision making pertaining to change in visual status as needed. Revision on: 05/10/2023 Revision by: Maryola Perion (RN) • READING: James uses large print material to aid with reading. Revision on: 06/23/2020 Revision by: Maryola Perion (RN)	PCA	
• SPIRITUAL BELIEFS: James is of the Roman Catholic Faith. Revision on: 11/22/2019 Revision by: Megan Pipe (Restorative Care Aide)	• To provide James spiritual support as interested through to the next review date Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• PERSONAL CHOICE: Respect James' right to decline participation in Spiritual Programs. Revision on: 05/28/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• SPIRITUAL BELIEFS: James is of the Roman Catholic Faith. Revision on: 11/22/2019 Revision by: Megan Pipe (Restorative Care Aide)				
• Sleep Patterns. Revision on: 04/06/2019 Revision by: Maryola Perion (Registered Nurse)	• To promote adequate rest/sleep for James based on identified sleep patterns/preferences each night through to the next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• REST PATTERN: Preferred bed time: Between 20:00-21:00 and usual wake time: Between 6:00-7:00 Revision on: 02/23/2021 Revision by: Maryola Perion (RN)	PCA	
		• SLEEPWEAR: James prefers to wear his own clothes. Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	PCA	
• Nutrition Risk Level (diet details)	• James will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 08/11/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/17/2026	• NUTRITION RISK: James is high risk level. Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD)	
		• DIET ORDER: James will receive regular diet, regular texture. Revision on: 11/24/2020 Revision by: Anna Slack	Diet Food Services Aide PCA	
	• Will weigh within Realistic weight range of 40-50kg/BMI15-19.5 through to next review date. Revision on: 01/13/2025 Revision by: Debora Choi (Dietitian (RD)) Target Date: 01/17/2026	• FLUID CONSISTENCY: James drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/15/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: Encourage James to drink a minimum of 1334 ml per day Revision on: 09/23/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• DINING INSTRUCTIONS: Serve/encourage double portion protein/main entree at meals. Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))	Diet Food Services Aide Personal Support Workers	

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)	• James will be adequately hydrated aeb drinking 100% of total fluid requirement: 1334 ml/day (35 ml/kg using 38.1 kg weight) through to next review date. Revision on: 09/23/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/17/2026		Registered Practical Nurse	
		• HIGH CALORIE/PROTEIN AM SNACK: soft cookie or muffin with peanut butter daily Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D
		• HIGH CALORIE/PROTEIN PM SNACK: ice cream cup daily Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D
		• HIGH CALORIE/PROTEIN HS SNACK: crackers and cheese or assorted sandwich (alternating) daily Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	E
		• MEDPASS SUPPLEMENTS: Boost Fruit Beverage with breakfast daily 120 ml Resource 2.0 QID with medpass 1 scoop Beneprotein BID with medpass Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))		
		• HIGH FIBRE: 125 ml prune juice at breakfast M-W-F Revision on: 08/05/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D

Allergies	Haldol	**D.O.B.**	04/29/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicul...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Desrosiers, James (922131005098)	**Admission Date**	03/04/2019	**Location**	4 418 C
Last Care Plan Review Completed:	**10/17/2025**				

Diagnosis Schizophrenia, unspecified(F20.9), Other forms of scoliosis, unspecified site(M41.89), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Dislocation of sternoclavicular joint, closed(S43.200), Constipation(K59.0)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to Diabetic foot ulcer to Diabetic foot ulcer Right Foot, 2nd Digit (Second Toe) Revision on: 10/29/2025 Revision by: Maryola Perion (RN)	• To promote optimal healing of Diabetic foot ulcer within the next review date Revision on: 05/09/2025 Revision by: Janina Lucero (RN) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Diabetic foot ulcer to #11 - Diabetic foot ulcer Right Foot, 2nd Digit (Second Toe) for changes to health status and alteration or complications affecting skin integrity. Revision on: 05/09/2025 Revision by: Janina Lucero (RN) • TREATMENT PLAN: Administer treatment for Diabetic foot ulcer to #11 - Diabetic foot ulcer - Right Foot, 2nd Digit (Second Toe) as per MD Order. Revision on: 05/09/2025 Revision by: Janina Lucero (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 03/26/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Alteration in skin integrity related to RASH Right lower back . Revision on: 10/25/2025 Revision by: Ravinder Kaur (Registered Nurse)	• To promote intact skin integrity through healing of RASH by next review date. Revision on: 10/25/2025 Revision by: Ravinder Kaur (Registered Nurse) Target Date: 11/30/2025	• MONITORING: Utilize the holistic perspective of continuous monitoring of resident with Rash on Right lower back for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/25/2025 Revision by: Ravinder Kaur (Registered Nurse) • COMMUNICATION: Involve/collaborate with Gaston for treatment of skin issues. Revision on: 10/25/2025 Revision by: Ravinder Kaur (Registered Nurse) • MEDICATION: Administer medication for RASH as per MD Order. Monitor effectiveness and for side effects. Revision on: 10/26/2025 Revision by: Maryola Perion (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 10/25/2025 Revision by: Ravinder Kaur (Registered Nurse)	Registered Practical Nurse RN Registered Practical Nurse RN	
• Alteration in skin integrity with risk for infection or complications related to abrasion to the right chest. Revision on: 10/05/2025	• To promote optimal healing of Abrasion within next weekly assessment. Revision on: 10/05/2025	• TREATMENT PLAN Abrasion on the right chest Management: cleanse with normal saline, pat skin dry, apply marathon or small optifoam q 3 days and prn. Revision on: 10/05/2025 Revision by: Idylle Labrado (RPN)		

Allergies	No Known Allergies	**D.O.B.**	10/12/1941	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Other specified diabetes mellitus without (mention of) complication(E13.9), Gastrointestinal haemorrhage, unspecified(K92.2), Other specifie...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Duran, Gaston (92213100471)	**Admission Date**	07/12/2021	**Location**	4 418 A

Last Care Plan Review Completed:	**08/03/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Idylle Labrado (RPN)	Revision by: Idylle Labrado (RPN) Target Date: 01/18/2026	• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 10/05/2025 Revision by: Idylle Labrado (RPN)		
• Potential for Acute PAIN and alteration in comfort level related to DM and HTN, Impaired Mobility.. Most Current RAI Pain Score is (0). Revision on: 08/03/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 08/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • NON VERBAL CUES of PAIN for Gaston includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 08/03/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 12/15/2022 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse PCA Registered Practical Nurse RN	
• STRONG PARTICIPATION in Activities. ISE score: 5/6 Revision on: 07/22/2025 Revision by: Laura Morris (Restorative Care Aide)	• Gaston will be supported to maintain participation in activities 10-20 times per month by the next review date. Revision on: 07/22/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/18/2026	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; Friendly/1: 1 visits, exercise programs, dice games, Montessori - sequencing, music programs, happy hour, karaoke, reading circle, sensory -Snoezelen therapy, spiritual programs, TV/movies (soccer), etc. Revision on: 07/22/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as watching/listening to TV, listening to music, visiting with residents/team members, doll therapy, etc. Revision on: 05/02/2022 Revision by: Mitchell Atkinson (Recreation Aide) • ASSISTANCE: Provide assistance/encouragement to get him to scheduled activities - Accompany off home area, Revision on: 10/08/2022 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide)	 ACT ACT	

Allergies	No Known Allergies	**D.O.B.**	10/12/1941	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Other specified diabetes mellitus without (mention of) complication(E13.9), Gastrointestinal haemorrhage, unspecified(K92.2), Other specifie...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Duran, Gaston (92213100471)	**Admission Date**	07/12/2021	**Location**	4 418 A

Last Care Plan Review Completed: 08/03/2025

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• STRONG PARTICIPATION in Activities. ISE score: 5/6 Revision on: 07/22/2025 Revision by: Laura Morris (Restorative Care Aide)		• HELPFUL HINTS: Identify Helpful Hints to ease communication while providing care/interactions for Gaston, Gaston loves spanish music in particular spanish guitar, the three stooges and funny slapstick programs. Revision on: 10/09/2022 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide)	ACT	
		• ONE to ONE: Provide him with individual visits for conversation, reading, reminiscing, music, doll therapy, music, etc. Revision on: 10/08/2022 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide)	ACT	
• Potential for bowel Incontinence r/t Dementia. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	• Gaston will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026 • Gaston will have bowel incontinence managed every shift through to the next review period. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function.	Registered Staff	
		• BOWEL Continence level is Frequently Incontinent. Report change to level as noted. Continence Level is incontinent. Revision on: 08/03/2025 Revision by: Maryola Perion (RN)	PCA	
		• BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	PCA	
		• INCONTINENCE PRODUCT: Gaston uses a Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Risk for/Impaired Skin Integrity r/t: Diabetes Mellitus, Fragile skin, Incontinence and use of incontinent product, Impaired mobility. Revision on: 11/23/2024	• To protect and maintain skin integrity each day through to the next review. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• EQUIPMENT: Gaston requires Roho cushion to offload pressure.	PCA	

Allergies	No Known Allergies	**D.O.B.**	10/12/1941	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Other specified diabetes mellitus without (mention of) complication(E13.9), Gastrointestinal haemorrhage, unspecified(K92.2), Other specifie...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Duran, Gaston (92213100471)	**Admission Date**	07/12/2021	**Location**	4 418 A
Last Care Plan Review Completed:	**08/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	(RAI Coordinator) Target Date: 01/18/2026	Revision on: 02/12/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • POSITIONING: Turn, reposition at least every 2 hours when in bed/wheelchair as per Gaston's preference to offload pressure. Revision on: 05/06/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	Q2h
• Increased risk for FALLS related to HTN, Diabetes Mellitus, Hx of falls, Impaired mobility and balance, Dementia. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 12/15/2022 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position to lower risk for injury. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear (non-slip) for transfers. Revision on: 08/03/2025 Revision by: Maryola Perion (RN)	PCA	
		• HIP PROTECTORS: Gaston wears hip protector to safeguard against injury. Report to Registered Staff if not wearing. Revision on: 12/12/2024 Revision by: Katherine Arca (RPN)	PCA	D/E/N
		• SPECIAL CONSIDERATION to PREVENT FALLS: Resident participates in the Optimal Mobility Program. AAROM bilateral upper and lower extremity exercises 5-10 reps, Sitting balance- maintain position upright 10s+ increase each time, bilateral H/S stretch 30s 3 reps bilateral, with PT- 3-5x week, participates with group exs classes- 3x week Revision on: 08/26/2025 Revision by: Courtney Cipparone (PT - Physiotherapist)	PCA	
		• FLOOR MAT: on floor next to left side of bed to lower risk of injury. Revision on: 03/21/2025 Revision by: Prabhjot Maan (ADOC)	PCA	
		• ALARMS: Requires Chair alarm. Check placement and working order,also to use when in bed.	PCA	D/E/N

Allergies	No Known Allergies	**D.O.B.**	10/12/1941	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Other specified diabetes mellitus without (mention of) complication(E13.9), Gastrointestinal haemorrhage, unspecified(K92.2), Other specifie...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Duran, Gaston (92213100471)	**Admission Date**	07/12/2021	**Location**	4 418 A
Last Care Plan Review Completed:	**08/03/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to HTN, Diabetes Mellitus, Hx of falls, Impaired mobility and balance, Dementia. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)		Revision on: 11/19/2024 Revision by: Meggan Gignac (RPN) • SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 08/03/2025 Revision by: Maryola Perion (RN)		
• Potential for Expressive Behaviour of RESISTANCE to care, meals and snacks related to Dementia. Revision on: 12/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To decrease the episodic frequency of resistive to care by next review date. ABS score will be maintained to 0. Revision on: 11/23/2024 Revision by: Maryola Perion (RN) Target Date: 01/18/2026	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of (resident name) for indications to change in or for escalating expressive behaviour risk. • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to bathe, refusal to eat, refusing medication, etc.) as expression of behaviour include (confusion, misunderstanding care needs, poor judgement, etc.) Revision on: 12/15/2022 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Gaston is refusing to (bathe, change clothes, take medications, eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 12/15/2022 Revision by: Maryola Perion (RN)	Registered Staff	
• Activities of Daily Living, self care r/t Dementia, HTN,Diabetes Mellitus and Pacemaker. Revision on: 07/01/2023 Revision by: Karamjeet Hayer (RN)	• Gaston will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date.	• BATHING: Gaston prefers (shower) on (Wednesdays and Saturdays on Evening shift). Two staff (TOTAL) assistance for bathing. Requires the use of a Sit to stand lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025	PCA	

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	Revision on: 11/23/2024 Revision by: Maryola Perion (RN) Target Date: 01/18/2026	Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: Extensive Assist. Gaston requires weight bearing assist from one to two team members to turn and reposition in bed. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Gaston requires two staff to provide MAXIMAL assistance for dressing UPPER & LOWER body. Revision on: 05/09/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Gaston will feed himself with guidance from the team. Monitor as he plays with his food and redirect when needed. One staff assistance as needed. Eats on Petunia Lane dining room. Revision on: 05/09/2025 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Total Assist. Gaston does require a wheelchair and is dependent of the team to push him on and off the unit. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Gaston require extensive assistance from one or two staff. Gaston requires one to two team members to assist with providing pericare. One team member to assist with providing oral care, brushing hair and washing face. Revision on: 12/07/2020 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• TOILET USE: Gaston requires extensive assistance with the use of Sara lift with two team member assists for transferring onto and off of the toilet, adjust his clothing and incontinent products change. The team assists with checking and changing Gaston's incontinent product while in bed if incontinent. Revision on: 08/03/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Gaston requires two staff to transfer him to and from bed to wheelchair with the use of a sit to stand lift. Revision on: 10/29/2025 Revision by: Maryola Perion (RN)	PCA	

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Care Plan Report

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• Activities of Daily Living, self care r/t Dementia, HTN,Diabetes Mellitus and Pacemaker. Revision on: 07/01/2023 Revision by: Karamjeet Hayer (RN)		• TRANSFER LIFT/SLING: Sit to stand lift and a medium (yellow) sling Revision on: 11/23/2024 Revision by: Maryola Perion (RN)		
		• ORAL CARE: Gaston has some teeth missing. He requires one staff to provide oral hygiene. Revision on: 02/16/2025 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: Foot Care Nurse to complete toenail care every 6-8 weeks. Report long toe nails or other abnormalities as noted. Revision on: 10/02/2021 Revision by: Maryola Perion (RN)	PCA	
		• SHAVING - Gaston requires assistance with shaving on his shower days and as needed. Revision on: 02/16/2025 Revision by: Maryola Perion (RN)	PCA	D
• Potential to experience alteration in CARDIAC FUNCTION related to; Hypertension, 3rd degree heart block Revision on: 06/14/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To treat and minimize signs/symptoms or complications associated with Diagnosis through to the next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 12/15/2022 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for Hypertension as per MD Order and monitor for side effects. Revision on: 12/15/2022 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• OXYGEN: Administer Oxygen as per MD order. Revision on: 12/18/2019 Revision by: Qiufeng Liu (Registered Practical Nurse)	Registered Practical Nurse RN	
		• BP MONITORING: Monitor BLOOD PRESSURE as ordered. Notify MD of abnormalities as needed.	Registered Staff	

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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in CARDIAC FUNCTION related to; Hypertension, 3rd degree heart block Revision on: 06/14/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		Revision on: 12/18/2019 Revision by: Qiufeng Liu (Registered Practical Nurse) • PACEMAKER Insitu: Gaston has pacemaker 6/30/23. Follow up appointments as required. Revision on: 07/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential for CONSTIPATION related to decreased mobility. Revision on: 11/18/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To minimize the potential for episodes and complications of constipation through to the next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of Gaston for constipation management and changes to health status and symptoms/ complications of constipation. Revision on: 11/18/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan.	Registered Staff	
		• NUTRITION increased fibre intervention in place. See Nutrition Care Plan.	Diet Registered Staff	
		• BOWEL PROTOCOL: In place as per MD order	Registered Staff	
• Potential to experience alteration in MOOD as exhibited by repetitive physical movements, unpleasant in the AM, insomnia, anger with self/others and repetitive verbalizations) related to Dementia. Revision on: 12/07/2020 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To decrease episodic frequency of history of repetitive physical movements, unpleasant in the AM, insomnia, anger with self/others and repetitive verbalizations by next review date. DRS score will be less than (0). Revision on: 09/18/2023	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Gaston for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up)		
		• RESIDENT STRENGTHS: Build on Gaston effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up)		

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Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• SLEEP/REST: Promote adequate sleep and rest to stability of Gaston's mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 02/16/2025 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of current meds. Revision on: 09/25/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident using current meds for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 09/25/2020 Revision by: Qiufeng Liu (RPN/RAI back up) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension.) related to Dementia and Language barrier. Revision on: 09/25/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	• Gaston will continue to freely express self and adequately comprehend information each day through to the next review period. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026 • Gaston will be able to make basic needs known each day through to the review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• PRIMARY LANGUAGE: Gaston primary language is Spanish. He is able to speak/understand English. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up)		
• Expressed Wishes and Beliefs related to Gaston End of Life Care Revision on: 09/25/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	• To support and honor Gaston expressed wishes and beliefs through to the End of Life. Revision on: 09/18/2023	• CPR: Gaston wishes express NO CPR and NO TRANSFER to hospital. Revision on: 02/16/2025 Revision by: Maryola Perion (RN)		

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Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026			
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgment.) related to r/t Dementia. Revision on: 05/29/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• Gaston will maintain current cognitive abilities through the review date. Current CPS is 5/6. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• PERSONAL ROUTINE:Provide consistency in care routines and activities. Revision on: 03/29/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	PCA	
• Potential to experience FOOT/FEET complications related to Diabetes. Revision on: 03/29/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	• To maintain adequate Foot/Feet/Toenail care and minimize episodes of inflammation, infection or complications through to the next review date. Revision on: 05/01/2024 Revision by: Chelsea Campbell-Wright (ADOC) Target Date: 01/18/2026	• TREATMENT PLAN: Gaston requires fingernail and toenail care by registered staff on shower days or PRN. Revision on: 05/01/2024 Revision by: Chelsea Campbell-Wright (ADOC) • PREFERENCE: Gaston likes to have footcare on his baths by registered staff. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	Footcare Nurse - Internal	
• SPIRITUAL BELIEFS: Gaston is of the Roman Catholic Faith. Revision on: 11/29/2019 Revision by: Hannelore Steinke-Nelson (Activation aide)	• To provide Gaston spiritual support as interested through to the next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• SPIRITUAL PROGRAMS: Encourage him to attend spiritual programs of his choice including spiritual celebrations, spiritual music, prayer circles, etc. Revision on: 05/29/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Urinary Incontinence r/t Dementia. Revision on: 06/29/2016 Revision by: Qiufeng Liu (Registered Practical	• Gaston will receive the appropriate support (take to toilet) to manage incontinence	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 03/31/2020		

Allergies	No Known Allergies	**D.O.B.**	10/12/1941	**Physician**	Albert Patrick Ng
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Nurse)	through the review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	Revision by: Qiufeng Liu (RPN/RAI back up) • URINARY Continence level is Incontinence. Report change to level as noted. Revision on: 12/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • INCONTINENCE PRODUCT: Gaston uses a Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed. Revision on: 11/23/2024 Revision by: Maryola Perion (RN)	PCA PCA PCA	
• Sleep Patterns. Revision on: 04/01/2016 Revision by: Qiufeng Liu (Registered Practical Nurse)	• To promote adequate rest/sleep for Gaston based on identified sleep patterns/preferences each night through to the next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• REST PATTERN: Preferred bedtime whenever he is tired, usual wake time 06.30. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up) • SLEEPWEAR: Gaston prefers to wear own pajama Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up)	PCA PCA	
• Potential for hyper/hypoglycemia, other complications related to Diabetes Mellitus.	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. Revision on: 03/31/2020 Revision by: Qiufeng Liu (RPN/RAI back up)		
• Nutrition Risk Level (diet details)	• Gaston will be adequately nourished aeb consuming >75% at meals and snacks through to	• NUTRITION RISK: Gaston is moderate risk level. Revision on: 05/06/2025 Revision by: Ronnie Fung (FSM - Food Services Manager)	Dietitian (RD)	

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Focus	Goal	Interventions	Position	Freq/Resolved
	next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026 • Will weigh within Realistic weight range of 65-70kg kg through to next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026 • Gaston will be adequately hydrated aeb drinking at least 1277ml per day based on 75% of total fluid requirement of 25-30ml @ 30-35 ml/kg, 68kg through to next review date. Revision on: 03/14/2024 Revision by: Anna Slack (Registered Dietitian) Target Date: 01/18/2026 • Will meet estimated nutritional requirements of 1700-2040 kcal @ 25-30 kcal/kg, 68g protein @ 1.0g/kg through to next review date. Revision on: 09/18/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/18/2026	• DIET ORDER: Gaston will receive regular diet, minced texture Revision on: 11/26/2020 Revision by: Anna Slack • FLUID CONSISTENCY: Gaston drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/15/2021 Revision by: Olivia Kuhlmann (Dietetic Intern) • FLUID TARGET: Encourage Gaston to drink a minimum 1277mL/D. Likes to drink assorted juice, water and milk Revision on: 03/14/2024 Revision by: Anna Slack (Registered Dietitian) • EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily. • PORTION SIZE: Gaston prefers large portion of protein/entree at all meals. Revision on: 02/12/2024 Revision by: Anna Slack (Registered Dietitian) • ADAPTIVE AIDS: Gaston requires a rimmed/lip plate at meals Revision on: 07/05/2022 Revision by: Anna Slack (Registered Dietitian) • HIGH FIBRE: 1 tbsp fruit rite spread at breakfast daily Revision on: 12/13/2022 Revision by: Anna Slack (Registered Dietitian) • LABELLED SNACK: pudding AM and jello PM snack pass daily Revision on: 01/26/2024 Revision by: Anna Slack (Registered Dietitian)	Diet Food Services Aide PCA Diet PCA PCA Dietary aide PCA PCA Diet PCA Diet PCA PCA	 D D/E

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Diagnosis Unspecified dementia(F03), Benign hypertension(I10.0), Other specified diabetes mellitus without (mention of) complication(E13.9), Gastrointestinal haemorrhage, unspecified(K92.2), Other specified heart block(I45.5), Presence of cardiac pacemaker(Z95.00)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for (Persistent) PAIN and alteration in comfort level related to Lung Ca, Stroke, Osteoporosis, Hx of fracture. Most Current RAI Pain Score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Bruce about pain management, goals of treatment, plan of care and treatment options. Revision on: 06/11/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse Registered Practical Nurse RN	
• Bruce DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 6/6 Revision on: 06/17/2025 Revision by: Laura Morris (Restorative Care Aide)	• Bruce participates in Independent/Self-Directed activities each month through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as smoking on the patio, reading independently, watching/listening to TV(sports {Golf, Hockey, Yankees, Bears}, news) computer use, visiting with residents/team members, social media, etc. Revision on: 06/09/2021 Revision by: Shayna Lee Wonsch • FRIENDLY VISIT: Provide him one to one visits as tolerated. Touch Base to maintain contact and to converse about topics of interest (sports, politics, current events), identify up-coming special events, etc. Revision on: 05/18/2021 Revision by: Shayna Lee Wonsch • INVITATION: Offer invitations to structured programs scheduled in the home. Bruce enjoys discussion - current events, community walks, outings, Resident Council & Food Committee, Happy Hour, special events, tuck shop, Pen Pals, games (cribbage), etc. Revision on: 09/11/2025 Revision by: Laura Morris (Restorative Care Aide)	ACT ACT	
• URINARY (Mixed) INCONTINENCE related to having episodes of incontinence at night time, does not want to be	• Bruce will have urinary incontinence managed on night shift through to the next review	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 04/23/2025		

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng	
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A	

Last Care Plan Review Completed:	**09/12/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
disturbed. Revision on: 04/23/2025 Revision by: Maryola Perion (RN)	period. Revision on: 04/23/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	Revision by: Maryola Perion (RN) • URINARY Continence level is (USUALLY continent). Report changes to level as noted. Revision on: 04/23/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: During night the time, Bruce is having episodes of incontinence and will be a White brief only at night. Urinal to be changed (label with name & date) every day shift starting on the 20th and ending on the 20th every month *Located in the clean utility room* Revision on: 06/12/2025 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential for CONSTIPATION related to decreased mobility, etc. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	• Bruce will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025 • To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with (Bruce/SDM) for decision making regarding constipation management. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, antidepressant use etc.) Revision on: 12/19/2024	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo	• COMMUNICATION: Involve/collaborate with Bruce/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident		

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A
Last Care Plan Review Completed:	**09/12/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Danielle Loreto (RAI Coordinator)	(RAI Coordinator) Target Date: 12/12/2025	using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		
• Increased risk for FALLS related to: Stroke, Epilepsy, History of falls, Vertigo. Revision on: 01/26/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Bruce in decision making in fall prevention Plan of Care. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: high/low bed, electric wheelchair, walker. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • BED: place bed in lowest position to lower risk for injury. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • FOOTWEAR: Ensure resident wears appropriate footwear for transfers, ambulation. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 06/11/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA	D/E/N
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA), Epilepsy. Revision on: 07/12/2023	• To treat and minimize signs/ symptoms or complications associated with CEREBROVASCULAR ACCIDENT (CVA), Epilepsy	• COMMUNICATION: Involve/ collaborate with Bruce in decision making of neurological care management for CEREBROVASCULAR ACCIDENT (CVA), Epilepsy. Revision on: 07/12/2023 Revision by: Maryola Perion (RN)	PCA	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A

Last Care Plan Review Completed:	**09/12/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• MEDICATION: Administer medication for Epilepsy as per MD order. Monitor effectiveness and for side effects. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with CEREBROVASCULAR ACCIDENT (CVA), Epilepsy for changes to health status and alteration or complications affecting neurological function. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		
• COGNITIVE LOSS; alteration in thought processes (memory loss, poor judgement, etc.) related to Cardiovascular Accident (CVA) Revision on: 01/16/2023 Revision by: Maryola Perion (RN)	• Bruce will be supported to maintain cognitive function through the review date. Current CPS is 1. Revision on: 06/11/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	• PERSONAL ROUTINE: Provide consistency in care routine and activities Revision on: 01/16/2023 Revision by: Maryola Perion (RN) • PERSONAL ITEMS: Keep personal items in a consistent place. Revision on: 01/16/2023 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential for Expressive Behaviour of RESISTANCE to care need (history of refusing bath/shower), verbal abuse towards other residents. Revision on: 01/13/2023 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by next review date. ABS score will be maintained to 0. Revision on: 04/10/2024 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Bruce about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 05/14/2021 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Bruce for indications to change in or for escalating expressive behaviour risk. Revision on: 05/14/2021 Revision by: Maryola Perion (RN) • TRIGGERS leading to VERBAL (yelling, screaming, calling names, etc.) as expression of behaviour include (loss of control, frustration, misunderstanding care intention, etc.) Revision on: 01/13/2023 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Bruce is heard yelling, swearing or calling others names;	BSO - Internal BSO - External Social Worker	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A

Last Care Plan Review Completed:	**09/12/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of RESISTANCE to care need (history of refusing bath/shower), verbal abuse towards other residents. Revision on: 01/13/2023 Revision by: Maryola Perion (RN)		calmly remind to lower his voice and that chosen words are not appropriate. Attempt to resolve his concern. Report episode to Registered Staff. Revision on: 01/13/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusal to bathe/shower) as expression of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 05/14/2021 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Bruce is refusing to bathe, re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 05/14/2021 Revision by: Maryola Perion (RN)		
• Bruce has potential to experience a safety hazard/burn injury related to personal SMOKING habits. Revision on: 05/14/2021 Revision by: Maryola Perion (RN)	• Bruce will be safe when choosing to smoke through to the next review Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve Bruce/SDM in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) and identify the designated area/s where smoking is permitted. Revision on: 01/24/2021 Revision by: Maryola Perion (RN) • SMOKING CONTRACT: Bruce has agreed to follow safe smoking rules and accepts the consequences of breaking those agreed upon rules by signing the smoking contract. Revision on: 01/24/2021 Revision by: Maryola Perion (RN)	Social Worker Social Worker Administrator	
• Potential to experience alteration in RESPIRATORY FUNCTION related to Chronic Obstructive Pulmonary Disorder (COPD) Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with COPD each day through to next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Bruce in decision making of Respiratory Management for COPD. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with COPD for changes to health status and alteration or complications affecting respiratory function. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to	PCA	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A
Last Care Plan Review Completed:	**09/12/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		improve breathing. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • OXYGEN: Administer Oxygen as per MD order. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication (inhalers, etc.) for COPD as per MD order and monitor for side effects. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• To treat and minimize complications associated with OSTEOPOROSIS through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/ collaborate with Bruce in decision making of osteoporosis care management. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • EXERCISE: To help maintain bone mass, encourage weight bearing and/or exercise as tolerated/ therapeutically suggested. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for osteoporosis management. Monitor effectiveness and for side effects. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of osteoporosis for discomfort/ complications or changes to health status. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	PCA ACT	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with (resident name)/SDM in decision making for GERD Management. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A

Last Care Plan Review Completed: **09/12/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		• POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	PCA	
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • COMMUNICATION: Involve/ collaborate with Bruce/SDM in decision making of diabetes care management. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • LAB WORK: Monitor lab and diagnostic results for (fasting blood glucose and/or HbA1c) and report results to MD as needed. Follow up as indicated. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		
• BOWEL Continence - Bruce is continent and has self recognition of urge to defecate. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• Bruce to remain continent of bowels through next review date Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• BOWEL Continence level is CONTINENT. Report change to level as noted. • Bruce to report to staff when BM occurs to be documented/monitored. Report abnormalaties to Nurse/MD. Revision on: 08/15/2019 Revision by: Joe Albano (RAI Coordinator)	PCA PCA	
• Altered ability to complete Activities of Daily Living (ADLs) related to Lung Ca, COPD, Diabetes Mellitus, Stroke, Epilepsy Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• Bruce will feel supported in coping with changing functional abilities due to disease diagnosis through the review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• BATHING: Bruce prefers (shower) on (Thursdays and Sundays on Day shift). Bruce is able to do his own shower. One staff (SUPERVISION, oversight and to help set up his clothes, towels, etc.) assistance for bathing. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: Bruce is able to turn and reposition self independently. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • DRESSING: Bruce is able to change his clothing independently with no help or	PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A
Last Care Plan Review Completed:	**09/12/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	• Bruce will have ALL ADL care tasks met each day through the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	oversight from staff. Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		
		• EATING: Bruce is able to eat independently with no help or oversight from staff. Eats in the main dining room - 1st floor. Revision on: 07/12/2023 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Bruce is using an electric wheelchair as mode of locomotion. Able to drive it safely on and off unit. Bruce walks in his room Independently and uses a walker when walking in his room and with PT/PTA. Revision on: 06/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Bruce is able to do his own personal hygiene independently with no help or oversight from staff. May require assistance from one staff member on night shift for incontinent product change and peri care. Revision on: 06/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide REMINDER assistance to apply sanitizer or use wipes for hand hygiene. Revision on: 01/23/2022 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Bruce is able to go to the toilet by himself, transfers on/off the toilet, adjusts clothes, cleanses independently without any help or oversight from staff. May require assistance from one staff member on night shift for incontinent product change and peri care. Revision on: 06/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Bruce is able to transfer from a sit to stand position independently Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Bruce is Independent. Has dentures. Revision on: 08/15/2019	PCA	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A

Last Care Plan Review Completed:	**09/12/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Lung Ca, COPD, Diabetes Mellitus, Stroke, Epilepsy Revision on: 02/16/2021 Revision by: Maryola Perion (RN)		Revision by: Joe Albano (RAI Coordinator) • SHAVING - Bruce has his own electric razor and he does his own shaving. Revision on: 10/11/2023 Revision by: Maryola Perion (RN)	PCA	D
• Potential for altered hematologic symptoms or complications related to diagnosis of Iron deficiency ANEMIA Revision on: 08/17/2020 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with ANEMIA each day through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Bruce in decision making of hematologic care management for Anemia. Revision on: 08/17/2020 Revision by: Maryola Perion (RN) • HEALTH TEACHING: Engage with Bruce to enhance his comprehension of treatment, possible complications, disease trajectory, etc. associated with anemia. Revision on: 08/17/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with ANEMIA for complications or changes to health status. • LAB WORK: Monitor blood lab work and report results to MD as needed. Follow up as indicated. • MEDICATION: Administer medication for ANEMIA as per MD Order. Monitor effectiveness and for side effects.	Registered Staff Registered Staff Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A

Last Care Plan Review Completed: **09/12/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• SPIRITUAL BELIEFS: Bruce is of the Protestant Faith. Revision on: 05/27/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide Bruce spiritual support as interested through to the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• PERSONAL CHOICE: Respect Bruce's right to decline participation in Spiritual Programs. Does not partake in faith programs at this time. Revision on: 05/27/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Expressed Wishes and Beliefs related to Bruce's Medical Treatment and End of Life Care Revision on: 05/25/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To support and honor Bruce's expressed wishes and beliefs through to the End of Life. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• CPR: Attempt CPR: transfer to hospital decisions to be made as needed - see PoET Individualized Summary for details. Revision on: 12/19/2024 Revision by: Danielle Loreto (RAI Coordinator) • FUNERAL Arrangements: Andersons Funeral Home- Cremation (519) 254- 3223 Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Social Worker ST	
• Strength Revision on: 10/01/2019 Revision by: Milap Patel (Physiotherapist)	• Bruce to maintain strength of B/L UE≤ at 4+/5 in 3 months. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• Bruce to perform strength ex using 1-3lbs.Weights B/L UE and LE, 1set,10rps.,3/wk as tolerated, per rehab treatment. Revision on: 07/07/2023 Revision by: Shina Wadhwa (Physiotherapist)	PT - Physiotherapist PTA	
• Balance. Revision on: 10/01/2019 Revision by: Milap Patel (Physiotherapist)	• Bruce to improve balance score from 22 to 23 in 3 months Revision on: 07/04/2024 Revision by: Shina Wadhwa (PT - Physiotherapist) Target Date: 12/12/2025	• Dynamic balance exercises in standing 1set,10rps.,2-3/wk as tolerated, per rehab treatment. Revision on: 10/11/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	PT - Physiotherapist PTA	
• Risk for/Impaired Skin Integrity r/t: Impaired mobility, Diabetes Mellitus, Stroke, Fragile skin.	• To protect and maintain skin integrity each day through to the next review.	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A
Last Care Plan Review Completed:	**09/12/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 09/02/2019 Revision by: Maryola Perion (Registered Nurse)	Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• EQUIPMENT: Bruce requires a air mattress to offload pressure. Revision on: 05/17/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Sleep Patterns. Revision on: 08/15/2019 Revision by: Joe Albano (RAI Coordinator)	• To meet Bruce's personal preferences for sleep patterns through the next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• REST PATTERN: Preferred bedtime: 22:00-23:00, usual wake time: Around 5:00 Revision on: 02/10/2021 Revision by: Maryola Perion (RN)	PCA	
		• Preferred night attire: Own Clothes Revision on: 02/10/2021 Revision by: Maryola Perion (RN)	PCA	
• Nutrition Risk Level (diet details) Revision on: 08/15/2019 Revision by: Joe Albano (RAI Coordinator)	• Bruce will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• NUTRITION RISK: Bruce is moderate risk level. Revision on: 10/17/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD)	
		• DIET ORDER: Bruce will receive regular diet, regular texture. Revision on: 12/09/2020 Revision by: Anna Slack	Diet Food Services Aide PCA	
	• Will weigh within Realistic weight range of >55-65 kg/BMI 18-20 through to next review date. Revision on: 01/15/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/12/2025	• FLUID CONSISTENCY: Bruce drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/15/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: 1500 ml/day fluid restriction: Breakfast - 400 ml (2 glasses) AM snack - 200 ml (1 glass) Lunch - 200 ml (1 glass) + soup PM snack - 200 ml (1 glass) Dinner - 200 ml (1 glass) HS snack - 200 ml (1 glass) Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
	• Bruce will be adequately hydrated and drinking 100% of fluid restriction: 1500 ml/day per	• DINING INSTRUCTIONS: Encourage low sodium. Do not add table salt to food. NO/limit hotdogs, bacon, sausages, ham, processed food.	Diet Food Services	

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Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A

Last Care Plan Review Completed: **09/12/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details) Revision on: 08/15/2019 Revision by: Joe Albano (RAI Coordinator)	MD's order. Revision on: 10/18/2025 Revision by: Suzanne Azar (RN) Target Date: 12/12/2025	Revision on: 06/29/2023 Revision by: Anna Slack (Registered Dietitian)	Aide Personal Support Workers Registered Practical Nurse	
		• HIGH CALORIE/PROTEIN IN MEALS: Offer 1 boiled egg at breakfast meal daily Revision on: 07/02/2024 Revision by: Sasha Sonny (Dietitian (RD))	PCA	
		• MEDPASS SUPPLEMENTS: 60mL Resource 2.0 BID Revision on: 09/03/2025 Revision by: Brittany Hyde (Registered Dietitian)	Diet	

Diagnosis

Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other specified(W02.08), Osteoporosis, unspecified(M81.9), Other specified diabetes mellitus without (mention of) complication(E13.9), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Stroke, not specified as haemorrhage or infarction(I64), Benign paroxysmal vertigo(H81.1), Diverticular disease of intestine, part unspecified, with perforation and abscess(K57.8), Iron deficiency anaemia, unspecified (D50.9)

Allergies	No Known Allergies	**D.O.B.**	09/02/1947	**Physician**	Albert Patrick Ng
Diagnosis	Malignant neoplasm bronchus or lung, unspecified, unspecified side(C34.99), Epilepsy, unspecified, intractable(G40.91), Chronic obstructive pulmonary disease, unspecified(J44.9), Fall other speci...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Garrie, Bruce (922131004026)	**Admission Date**	08/15/2019	**Location**	4 405 A
Last Care Plan Review Completed:	**09/12/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• STRONG PARTICIPATION in Activities. ISE Score: 2/6 Revision on: 10/29/2025 Revision by: Laura Morris (Restorative Care Aide)	• Sharon will be supported to maintain participation in activities 5-10 times per month by the next review date. Revision on: 11/12/2024 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/29/2026	• STRUCTURED ACTIVITIES: Invite her to programs of personal interest; friendly/1:1 visits, manicures & hand massages, Montessori, music groups, patio programs, reading groups, sensory groups, special events, spiritual programs, TV/movies, etc. Revision on: 05/08/2025 Revision by: Laura Morris (Restorative Care Aide)		
		• SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as watching/listening to TV, listening to music/radio, conversing with peers, doll therapy, etc. Revision on: 05/15/2023 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
		• ASSISTANCE: Provide assistance/encouragement to get her to scheduled activities - Porter to and from programs. Revision on: 05/08/2025 Revision by: Laura Morris (Restorative Care Aide)		
		• ONE to ONE: Provide her with individual visits for conversation, reading, reminiscing, music, etc. Revision on: 12/13/2021 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to decreased fluid consumption (not meeting the fluid target), etc. Revision on: 10/26/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 10/26/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 10/26/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration.	Registered Staff	
		• PROMOTE FLUIDS: Promote Sharon to consume fluids; amount as per Nutrition Care Plan. Revision on: 10/26/2025 Revision by: Maryola Perion (RN)		
• Potential for Acute PAIN and alteration in comfort level related to the aging process, Hx of right hip fracture. Most Current RAI Pain Score is 0/3 Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with (SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain	RN Registered	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A

Last Care Plan Review Completed:	**10/29/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	• Promote RAI Pain Score of 0 through to the next review. Revision on: 08/02/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	optimal resident satisfaction for pain control.	Practical Nurse	
		• NON VERBAL CUES of PAIN for Sharon includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 11/26/2022 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Risk for Impaired SKIN INTEGRITY related to incontinence, Alzheimer's Disease, Fragile skin, Impaired Mobility, Hx of ulcers. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• POSITIONING: Turn, reposition at least every 2 hours or when in bed/wheelchair to offload pressure. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	Q2h
• Increased risk for FALLS related to history falls, Alzheimer's Disease & Hx of Right hip fracture, impaired mobility and balance. Revision on: 02/11/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making in fall prevention Plan of Care. Revision on: 09/04/2021 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within Sharon's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Haley Cadarian (Quality Lead)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair. Revision on: 02/16/2024 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position, use high/low bed to lower risk for injury. Revision on: 09/04/2021	PCA	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to history falls, Alzheimer's Disease & Hx of Right hip fracture, impaired mobility and balance. Revision on: 02/11/2025 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN) • SUPPLEMENT: Administer supplement/medication as per MD order to maintain bone density to prevent injuries. Revision on: 02/11/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in MOOD as exhibited by repetitive verbalization, persistent anger with self or others, unpleasant mood in the morning, repetitive physical movements related to Loss of Independence, Inability to cope with change, Alzheimer's disease. Revision on: 08/16/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 05/09/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 11/26/2022 Revision by: Maryola Perion (RN) • HEALTH EDUCATION: Provide education and support to (Sharon)/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 11/26/2022 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Sharon for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 11/26/2022 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 11/26/2022 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
• Potential for Expressive Behaviour of Physically expressive towards the team (grabbing team members, Pinching the team, attempting to bite the team), Verbally	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be	• COMMUNICATION: Involve/collaborate with SDM about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 11/26/2022	BSO - Internal BSO - External Social Worker	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
expressive towards the team (cursing towards the team), Socially inappropriate spitting out medication at staff, calling out out of nowhere related to Alzheimer's Disease. Revision on: 08/10/2024 Revision by: Jenny Liu (RAI Coord Back-up)	maintained to 0. Revision on: 08/02/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	Revision by: Maryola Perion (RN) • TRIGGERS leading to PHYSICAL (Hitting, Punching, scratching, pinching, etc.) as expression of behaviour include (anger, confusion, invasion of personal space, Sundowning, etc.) Revision on: 05/19/2023 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: If Sharon is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance. Revision on: 09/13/2021 Revision by: Katie Wolters-Savo (RAI Coordinator) • TRIGGERS leading to VERBAL (yelling, screaming, calling names, calling out, etc.) as expression of behaviour include (frustration, limitation in self expression, pain, misunderstanding care intention, etc.) Revision on: 08/16/2024 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Sharon is heard yelling, swearing or calling others names, calling out; calmly remind to lower her voice and that chosen words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Revision on: 08/16/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to eat, etc.) as expression of behaviour include (confusion, misunderstanding care needs, poor judgement, etc.) Revision on: 11/26/2022 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Sharon is refusing to (change clothes, eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 11/26/2022 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate (spitting on floor, spitting her medication, etc.) as expressions of behaviour include (confusion, decreased insight, poor judgement, etc.) Revision on: 11/16/2023 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of Physically expressive towards the team (grabbing team members, Pinching the team, attempting to bite the team), Verbally expressive towards the team (cursing towards the team), Socially inappropriate spitting out medication at staff, calling out out of nowhere related to Alzheimer's Disease. Revision on: 08/10/2024 Revision by: Jenny Liu (RAI Coord Back-up)		• SOCIALLY Inappropriate Behaviour: If Sharon is noted to (make loud disruptive noises in the dining room/program/care (calling out), etc.) move to a quieter area, etc. Revision on: 08/16/2024 Revision by: Maryola Perion (RN)		
		• SOCIALLY Inappropriate Behaviour: If Sharon is noted to (spitting on floor, spitting her medication, etc.) clean area using appropriate PPE. Report episode to Registered Staff. Revision on: 11/16/2023 Revision by: Maryola Perion (RN)	PCA	
		• MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 11/26/2022 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• BSO RECOMMENDATIONS: (specify intervention in easy to follow instruction)The resident can have verbal and physical Expressions during care. Staff to use stop and go approach and explain what is being done prior to care and obtain consent, provide comfort and reassurance. The resident has a stuffed bear that can be given to her during care and have conversation about it. Use proper sling for mechanical lift to avoid discomfort. Offer food during the night if the resident is unable to sleep.The resident likes to listen to 70's music and enjoys socializing. External BSO Recommendations: A. Upon approach, make eye contact, smile and greet resident. Ask permission and softly touch the resident's hand, and explain what steps are going to take place. Wait a moment to allow muscles to relax. B. Suggest 2 team members provide personal care for both safety and distraction techniques. C. Suggest hand posey's to reduce risk for harm if resident grabs out. If not available, trial stuffed animal or small pillows. D. Do as much care as possible on one side before turning resident to the other side to reduce back and forth moving. E. The slower the team moves residents body parts the less resistance they may experience. F. Explain each step, use stop and go approach if resident becomes too reactive. Attempt to distract residents thought process by talking to her or playing soothing		

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of Physically expressive towards the team (grabbing team members, Pinching the team, attempting to bite the team), Verbally expressive towards the team (cursing towards the team), Socially inappropriate spitting out medication at staff, calling out out of nowhere related to Alzheimer's Disease. Revision on: 08/10/2024 Revision by: Jenny Liu (RAI Coord Back-up)		music. G. Warm and heat helps the muscles to relax, ensure peri cloth is warm. H. If completing all personal care in bed is too difficult, suggest PSWs complete peri-care and lower dressing first then attempt upper dressing and oral hygiene when seated in wheel chair. Revision on: 10/13/2025 Revision by: Leslie Meloche (Recreation Aide)		
• Altered COMMUNICATION as exhibited by limitations to comprehension related to Alzheimer's Disease, Difficulty hearing, unclear speech. Revision on: 02/16/2024 Revision by: Maryola Perion (RN)	• Sharon is unable to express self and will be supported to have needs interpreted each day through the next review. Revision on: 02/16/2024 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with SDM for decision making about strategies needed to support effective communication. Speaker to adjust tone and quality of voice so that it is adequate for Sharon to understand what is being communicated to her. Revision on: 05/09/2025 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Sharon's primary language is English. Revision on: 10/26/2025 Revision by: Maryola Perion (RN)		

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Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: Alzheimer's Disease. Revision on: 02/16/2024 Revision by: Maryola Perion (RN)	• Sharon will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 08/16/2024 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• BATHING: Sharon prefers (shower) on (Wednesdays and Sundays on Day shift). Two staff (TOTAL) assistance for bathing. Requires the use of a Maxi lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY: Sharon requires two team members total assistance to turn and reposition in bed. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Sharon requires two staff provide (TOTAL) assistance for dressing UPPER & LOWER body. Revision on: 05/09/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Sharon requires one staff Total assistance to feed her. She eats in the main floor dining room. Revision on: 05/09/2025 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Sharon requires a wheelchair as her primary mode of locomotion and requires one team member total assist with pushing her on the unit. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Sharon requires one team member with total assistance to wash/dry her face & hands, brush her teeth and comb her hair. Two team members to assist with providing peri care. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide total assistance to assist with wiping her hand with sanitized hand wipes for hand hygiene. Revision on: 08/18/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• TOILET USE: Sharon requires to be put back to bed with the use of a Maxi lift with two staff assistance. Staff to provide peri care and incontinence product change. Revision on: 07/26/2024	PCA	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: Alzheimer's Disease. Revision on: 02/16/2024 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN) • TRANSFERRING: Sharon requires a Maxi lift to transfer her to and from bed to wheelchair with two staff assistance. Black and yellow sling for comfort Revision on: 07/25/2024 Revision by: Katherine Arca (RPN) • TRANSFER LIFT/SLING:Maxi lift and Black/Yellow Comfort Sling to be used when using Maxi lift. Revision on: 08/16/2024 Revision by: Maryola Perion (RN) • ORAL CARE: Sharon has her own teeth remaining. She requires one team member to provide oral hygiene to Sharon. Revision on: 11/18/2024 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential for BOWEL INCONTINENCE related to right hip fracture, impaired mobility, Alzheimer's disease. Revision on: 11/16/2023 Revision by: Maryola Perion (RN)	• Sharon will have bowel incontinence managed every shift through to the next review period. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of Sharon for changes to health status, alteration of continence level or bowel function. Revision on: 09/20/2021 Revision by: Katie Wolters-Savo (RAI Coordinator) • BOWEL Continence level is Totally Incontinent. Report change to level as noted. Revision on: 02/16/2024 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor Sharon for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 09/20/2021 Revision by: Katie Wolters-Savo (RAI Coordinator) • INCONTINENCE PRODUCT: Sharon uses a Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	 PCA PCA PCA	
• Altered VISION related to Alzheimer's Disease, use of eyeglasses.	• Sharon will use glasses for vision correction daily through to	• EYEGLASSES: Sharon wears eyeglasses. Assist to clean eyeglasses as needed and store in the med room when sleeping. Sharon has a tendency of removing her	PCA	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 11/16/2023 Revision by: Maryola Perion (RN)	the next review date. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	glasses and putting them on the table. When she does this please remove them and put them in the med room for safety keeping. Revision on: 10/26/2025 Revision by: Maryola Perion (RN)		
• Sleep Patterns; Potential for alteration in sleep patterns related to insomnia Revision on: 12/14/2022 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for Sharon based on identified sleep patterns/preferences each night through to the next review date. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• REST PATTERN: Preferred bedtime: Between 1900-2000, usual wake time: Between 6:00-7:00 Revision on: 08/24/2022 Revision by: Maryola Perion (RN) • SLEEPWEAR: Sharon prefers to wear a Johnny shirt. Revision on: 08/24/2022 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential to experience complications and side effects impacting quality of life related to use of multipharmacy. Revision on: 11/30/2022 Revision by: Maryola Perion (RN)	• To promote Sharon's understanding of treatment regime and possible side effects of medication taken through to the next review. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 11/26/2022 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Sharon using polypharmacy for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 11/30/2022 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	 Registered Staff	
• COGNITIVE LOSS; alteration in thought processes: memory loss, difficulty concentrating, poor judgement, etc. related to Alzhiemer's Disease Revision on: 11/26/2022 Revision by: Maryola Perion (RN)	• Sharon is severely impaired in cognition and will have needs interpreted and met each day through to the review date. CPS score is 6. Revision on: 11/18/2024 Revision by: Maryola Perion (RN)	• COMMUNICATION: Involve/collaborate with SDM in decision making of Cognitive Loss for Alzheimer's Disease. Revision on: 05/09/2025 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine. Revision on: 02/16/2024 Revision by: Maryola Perion (RN)	 PCA	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/29/2026			
• Passive ROM/Stretching Revision on: 09/01/2022 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• To increase AA-PROM B/L Elbow from -25 to -10 in next 3 months; To increase AA-PROM for B/L shoulders from 90 to 110degrees in next 3 months; Revision on: 10/18/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/29/2026	• AA-PROM exs for B/L UE and LE, 10 reps, 1-2 sets within pain limits. Stretching exe. of B/L LE (hams.&Calf) and UE (elbow ext end range)1 set, 5 rps., hold up to 30 sec., 2-3/wk as tolerated. Revision on: 11/14/2024 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Use of PASD (1-1/4 bedrail to right side of bed and tilt wheelchair to assist resident with Activity of Daily Living providing comfort and repositioning as well as to aid in turning and repositioning in bed. Revision on: 05/13/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Sharon will be effectively supported with use of tilt wheelchair and one 1/4 bedrail to optimize Activity of Daily Living each day through to the next review date. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• MONITORING: Utilize holistic perspective of monitoring Sharon for continued benefit to use tilt wheelchair and one 1/4 bedrail as to support appropriate aid in turning and repositioning and tilt provided to aid in comfort and repositioning. Revision on: 05/13/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• BED RAIL (One PARTIAL): 1/4 in USE as a PASD to assist Sharon with bed mobility. Monitor every shift. Revision on: 11/16/2022 Revision by: Haley Cadarian (Quality Lead)	PCA	D/E/N
		• TILTED CHAIR in USE as a PASD to support Sharon with repositioning and providing comfort. Monitor every shift. Revision on: 11/16/2022 Revision by: Haley Cadarian (Quality Lead)	PCA	D/E/N
• Expressed Wishes and Beliefs related to Sharon's Medical Treatment and End of Life Care Revision on: 12/20/2021 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• To support and honor Sharon's expressed wishes and beliefs through to the End of Life. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• CPR: Sharon wishes express NO CPR, however TRANSFER to hospital decision will be made at the time. Revision on: 11/16/2023 Revision by: Maryola Perion (RN)		
		• FUNERAL Arrangements: Simple Choice Cremations on Dougall Avenue- 519-254-2585 Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	Social Worker ST	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for CONSTIPATION related to decreased mobility. Revision on: 11/09/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To minimize the potential for episodes/ complications of constipation through to the next review date Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with SDM for decision making regarding constipation management. Revision on: 11/26/2022 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation.	Registered Staff	
		• FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan.	Registered Staff	
		• NUTRITION increased fibre intervention in place. See Nutrition Care Plan.	Diet Registered Staff	
		• BOWEL PROTOCOL: In place as per MD order	Registered Staff	
• URINARY (mixed) INCONTINENCE related to frequent urinary incontinence. Per request from floor staff - continent product use-white in am, yellow evenings and nights Revision on: 10/05/2021 Revision by: Kelly June (ADOC)	• Sharon will have urinary incontinence managed every shift through to the next review period. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of Sharon for toileting needs, changes to health status and alteration of continence level. Revision on: 08/18/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• URINARY Continence level is Totally Incontinent. Report change to level as noted. Revision on: 02/16/2024 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Sharon uses a Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA	
• SPIRITUAL BELIEFS: Sharon is Non-religious. Revision on: 08/25/2021	• To provide Sharon spiritual support as interested through to the next review date.	• PERSONAL CHOICE: Respect Sharon's right to decline participation in Spiritual Program. Revision on: 08/25/2021	ACT	

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Mitchell Atkinson (Activities/Rec Therapy)	Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026	Revision by: Mitchell Atkinson (Activities/Rec Therapy)		
• Nutrition Risk Level	• Sharon will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 08/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/29/2026 • Will weigh within realistic GWR 55-60 kg through to next review date. Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/29/2026 • Sharon will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 1500 ml/day (26 ml/kg using 57.6 kg weight) through to next review date. Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/29/2026	• NUTRITION RISK: Sharon is HIGH nutrition risk level. Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DIET ORDER: Sharon will receive a regular diet, minced texture Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FLUID CONSISTENCY: Sharon drinks REGULAR/THIN Level 0 Fluids. Revision on: 08/30/2021 Revision by: Anna Slack (Registered Dietitian) • FLUID TARGET: Encourage Sharon to drink a minimum of 1200 ml/day Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) • EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily. Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) • MEDPASS SUPPLEMENTS: assist her to drink 237 ml bottle Boost Fruit Beverage once daily around PM snack time Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) • LABELLED SNACK AM: assist her to eat apple sauce (99 ml fluid) daily Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD) FSM PCA Diet PCA PCA PCA PCA	D/E

Allergies	No Known Allergies	**D.O.B.**	03/03/1945	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias](G47.0), Personal history of COVID-19(U07...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hammer, Sharon (922131005423)	**Admission Date**	08/18/2021	**Location**	4 408 A
Last Care Plan Review Completed:	**10/29/2025**				

Diagnosis

Alzheimer's disease, unspecified(G30.9), Unspecified fracture of neck of femur, closed(S72.090), Disorders of initiating and maintaining sleep [insomnias] (G47.0), Personal history of COVID-19(U07.5)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to: Hx of Fracture of calcaneus, Hx of falls, Unsteady gait, Impaired mobility and balance. Unspecified Dementia. Revision on: 10/24/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with Anei/SDM in decision making in fall prevention Plan of Care. Revision on: 02/28/2020 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 10/28/2025 Revision by: Tola Omolade (ADOC)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 07/22/2023 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment (reduce clutter) to reduce fall risk for Anei Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position to lower risk for injury. Revision on: 11/07/2022 Revision by: Josefina Arca (RPN)	PCA	
		• ACTIVITY: Engage Anei in meaningful activity to decrease boredom and or restlessness. Resident likes to: listen to music, watch TV, fold towels Revision on: 01/02/2024 Revision by: Chelsea Campbell-Wright (ADOC)		
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers Revision on: 12/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• FLOOR MAT: floor mat on floor/right side of bed to lower risk of injury. Revision on: 07/27/2023 Revision by: Lara Ismail (RN)	PCA	
		• ALARMS: Requires Bed/wheelchair alarm, padded alarm when in bed/wheelchair. Check placement and working order. Revision on: 07/27/2023 Revision by: Lara Ismail (RN)	PCA	D/E/N
		• SUPPLEMENT: Administer supplement/medication as per MD order to maintain bone density to prevent injuries. Revision on: 03/04/2025 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng	
Diagnosis	Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed (S92.000), Unspecified dementia(...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B	
Last Care Plan Review Completed:	**09/13/2025**					

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest, Low Motivation, Withdrawn. Revision on: 09/21/2025 Revision by: Kameron Stewart (Recreation Aide)	• Team members will support Anei in decreasing social isolation by participating in activities of personal choice for 15-20 times per month by the next review date. Revision on: 09/21/2025 Revision by: Kameron Stewart (Recreation Aide) Target Date: 12/13/2025 • To support Anei's Psycho-Social well being through to the next review. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• STRUCTURED ACTIVITIES: Invite her to programs of personal interest; Friendly/1: 1 visits, fun and games, sensory videos [animals, babies], spiritual (prayers, church), manicures and hand massage, music programs, special events, TV programs, etc. Revision on: 02/23/2025 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide) • SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as watching/listening to TV, visiting with residents/team members, doll therapy, folding laundry etc. Revision on: 09/13/2025 Revision by: Nick Carroll (Recreation Aide) • ASSISTANCE: Provide assistance/encouragement to get her to scheduled activities - porter her to main floor activities etc. Revision on: 02/23/2025 Revision by: Hannelore (Hannah) Steinke-Nelson (Recreation Aide) • ONE to ONE: Provide her with individual visits for conversation, reading, reminiscing, music, etc. Revision on: 08/11/2021 Revision by: Mitchell Atkinson (Activities/Rec Therapy)	Recreation Aide Recreation Aide ACT	
• Potential for Persistent PAIN and alteration in comfort level related to Hx Fracture of calcaneus, Left leg pain, Osteoarthritis, headache. Most Current RAI Pain Score is 1. Revision on: 06/21/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 06/21/2025 Revision by: Maryola Perion (RN) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with Anei/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 03/04/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 02/28/2020 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse Registered Practical Nurse RN	
• Potential for altered hematologic	• To treat and/or minimize	• MONITORING: Utilize holistic perspective of monitoring of resident with rectal		

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed(S92.000), Unspecified dementia(...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
symptoms or complications related to bleeding noted from rectum Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)	complications associated with bleeding each day through to the next review date. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/13/2025	bleeding for complications or changes to health status. Revision on: 01/10/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• URINARY (mixed) INCONTINENCE related to Impaired mobility, Dementia Diagnosis Revision on: 12/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	• Anei will receive support to use toilet and promote urinary continence each shift through to the next review. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 07/22/2023 Revision by: Maryola Perion (RN)		
		• URINARY Continence level is Frequently Incontinent. Report change to level as noted. Revision on: 06/21/2025 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Anei uses a White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• ROM Exs Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist)	• To maintain ROM/flexibility through B/L UE and LE. Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/13/2025	• A-AAROM exs for B/L UE and LE, within pain limits, 10 reps, as best tolerated. 1-2 sets, 2-3 x a week; Provide Stretching exs for B/L Hams & Calf 1set,5rps.,hold 30 sec, 2-3/week as tolerated. Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Risk for/Impaired SKIN INTEGRITY related to Impaired Mobility, Thin fragile Skin, Incontinence, use of incontinent product. Revision on: 08/02/2024 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• POSITIONING: Turn, reposition every 2 hours when in bed/wheelchair to offload pressure. Revision on: 12/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	Q2h

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed(S92.000), Unspecified dementia(...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, repetitive anxious complaints, unpleasant mood in the morning, sad, pained, worried facial expression, Insomnia/change in usual sleep pattern, repetitive physical movement related to Dementia, Depression. Revision on: 10/18/2023 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 09/20/2024 Revision by: Maryola Perion (RN) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with Anei/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 05/15/2021 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Anei for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 05/15/2021 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Anei's effort to maintain control. Encourage him/her to express self, state preferences and make safe choices for care and activities. Revision on: 05/15/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 05/15/2021 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to: Seizure Disorder, Hx of Fracture of Calcaneus, Dementia, OA, Osteoporosis.. Revision on: 10/18/2023 Revision by: Maryola Perion (RN)	• Anei will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• BATHING: Anei prefers (shower/tub bath) on Tuesday and Friday on day shift. Anei participates by (providing a washcloth and cues). One staff (EXTENSIVE) assistance for bathing. Two staff side to side for transfer. Nail care to be provided on shower/bath day. Revision on: 09/08/2025 Revision by: Shelby McCarthy (Registered Practical Nurse) • BED MOBILITY: Anei requires one to two staff assistance with turning and repositioning in bed. She is able to assist with the use of Two 1/4 bedrails as PASD. Revision on: 07/22/2023 Revision by: Maryola Perion (RN) • DRESSING: Anei is able to (assist minimally by lifting her arms and legs with staff to cure her). One to two staff to provide (EXTENSIVE to MAXIMAL) assistance for dressing UPPER & LOWER body. Revision on: 08/30/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed(S92.000), Unspecified dementia(...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		• EATING: Anei is able to eat Independently with staff cueing, encouragement and supervision and set up. She may require one staff to assist her as needed. She eats in the unit dining room, 5th floor. Revision on: 10/18/2023 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Anei is using a wheelchair for locomotion on the unit with one staff to assist in propelling her wheelchair on the unit. She will try to get out of the wheelchair and walk. She requires staff supervision. Revision on: 08/30/2023 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Anei requires two staff Maximal assistance to provide peri care and incontinent product change when soiled or wet. Revision on: 08/30/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide reminders, and as needed, increase level of assistance required to use soap/water, apply sanitizer, rub hands together, dry hands, etc for hand hygiene. Revision on: 09/15/2021 Revision by: Haley Cadarian (Quality Lead)	PCA	
		• TOILET USE: Anei requires two staff assistance to transfer her on/off the toilet and maximal assistance with adjusting her clothing, brief change and peri care and other toileting needs. Revision on: 08/30/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Extensive assistance. Anei requires two staff to transfer safely to and from bed to wheelchair. Anei will try to self transfer, encourage to her to ask for assistance. Revision on: 08/30/2025 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Anei has some teeth missing and needs 1 staff assistance. Revision on: 01/04/2024 Revision by: Elsie Calumpang (RN)	PCA	
		• FOOT CARE: Registered staff to complete footcare during shower days. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	PCA	

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed(S92.000), Unspecified dementia(...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of RESISTANCE to care (showers, drink fruit boost, eat, refuse medication/care), verbal and physical abuse (hitting, swatting, yelling) related to Dementia, Depression. Revision on: 08/07/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To decrease the episodic frequency of expressive behavior by the next review date. ABS score will be less than 1. Revision on: 08/30/2025 Revision by: Maryola Perion (RN) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with Anei/SDM about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 03/06/2020 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Anei for indications to change in or for escalating expressive behaviour risk. Revision on: 02/28/2020 Revision by: Maryola Perion (RN) • TRIGGERS leading to PHYSICAL (Hitting, swatting etc.) as expression of behaviour include (anger, frustration, confusion, etc.) Revision on: 04/20/2023 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: If Anei is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance. Revision on: 04/20/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to VERBAL (yelling, screaming, calling names, etc.) as expression of behaviour include (frustration, limitation in self expression, pain, misunderstanding care intention, etc.) Revision on: 04/20/2023 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Anei is heard yelling, swearing or calling others names; calmly remind her to lower her voice and that chosen words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Revision on: 04/20/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusal to bathe, drink fruit boost, refusing medications) as expression of behaviour include confusion, misunderstanding care needs, poor judgment. Revision on: 08/01/2022 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Anei is refusing to bathe, drink fruit boost, refusing medications, re-approach in 10-15 minutes. Report episode to Registered Staff.	BSO - Internal BSO - External Social Worker	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of RESISTANCE to care (showers, drink fruit boost, eat, refuse medication/care), verbal and physical abuse (hitting, swatting, yelling) related to Dementia, Depression. Revision on: 08/07/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		Revision on: 08/01/2022 Revision by: Maryola Perion (RN)		
• Potential for BOWEL INCONTINENCE related to impaired mobility Revision on: 07/22/2023 Revision by: Maryola Perion (RN)	• Anei will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Frequently Incontinent. Report change to level as noted. Revision on: 09/20/2024 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Anei uses a White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• Use of PASD (two 1/4 side rails) to assist resident with Activity of Daily Living (bed	• Anei will be effectively supported with use of two 1/4	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails.		

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
mobility and transfer). Revision on: 11/01/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	bed rails to optimize Activity of Daily Living (bed mobility and transfer) each day through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	Revision on: 08/05/2022 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate bed mobility. Revision on: 08/05/2022 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with ADLs (bed mobility, transfer in/out of bed). Monitor every shift. Revision on: 08/05/2022 Revision by: Suzanne Azar (RN)	PCA	D/E/N
• Potential for CONSTIPATION related to decreased mobility, etc. Revision on: 10/24/2022 Revision by: Maryola Perion (RN)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025 • Anei will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with (Anei/SDM) for decision making regarding constipation management. Revision on: 10/24/2022 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS	• To treat and minimize signs/symptoms or complications associated with OSTEOARTHRITIS through to the next review date. Revision on: 07/24/2023	• COMMUNICATION: Involve/ collaborate with Anei/SDM in decision making of musculoskeletal care management. Revision on: 08/16/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of OSTEOARTHRITIS as per MD order. Monitor effectiveness and for side effects.		

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	Revision on: 08/16/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of OSTEOARTHRITIS for discomfort/ complications or changes to health status. Revision on: 08/16/2021 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT for OSTEOARTHRITIS prescribed and in place; refer to Pain Care Plan. Revision on: 08/16/2021 Revision by: Maryola Perion (RN)		
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to impaired decision making, Dementia. Revision on: 08/16/2021 Revision by: Maryola Perion (RN)	• Anei will be supported to maintain cognitive function through the review date. Current CPS 4/6. Revision on: 06/21/2025 Revision by: Maryola Perion (RN) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with Anei/SDM in decision making of Cognitive Loss for Dementia. Revision on: 02/16/2021 Revision by: Maryola Perion (RN) • ORIENTATION: Gently reorient to person, place, time as needed when Anei is feeling lost or in confused state. Revision on: 02/28/2020 Revision by: Maryola Perion (RN)		
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS.	• To treat and minimize complications associated with OSTEOPOROSIS through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• COMMUNICATION: Involve/ collaborate with Anei/SDM in decision making of osteoporosis care management. Revision on: 05/15/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for osteoporosis management. Monitor effectiveness and for side effects. • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of osteoporosis for discomfort/ complications or changes to health status.	Registered Staff Registered Staff	
• Sleep Patterns;Potential for alteration in	• To promote adequate	• REST PATTERN: Preferred bedtime: Between 1900-2000, usual wake time:	PCA	

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
sleep patterns related to pain, hx of sleeping on the floor. Revision on: 04/19/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)	rest/sleep for Anei based on identified sleep patterns through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	Between 6:00-7:00. Revision on: 05/15/2021 Revision by: Maryola Perion (RN) • SLEEPWEAR: Anei prefers to wear own clothes. Revision on: 02/28/2020 Revision by: Maryola Perion (RN)	PCA	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, etc.) related to Cognitive decline Revision on: 02/16/2021 Revision by: Maryola Perion (RN)	• Anei will be supported to maintain current communication abilities to comprehend information each day through to the review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025 • Anei will be able to make basic needs known each day through to the review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• COMMUNICATION: Involve/collaborate with Anei/SDM for decision making about strategies needed to support effective communication. Revision on: 02/28/2020 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Anei's primary language is English. She is able to speak/understand English. Revision on: 02/28/2020 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: (Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.). Revision on: 12/18/2024 Revision by: Danielle Loreto (RAI Coordinator) • INSTRUCTION GUIDANCE: Anei needs intermittent cueing or demonstrative instruction in tasks and activities. Revision on: 04/20/2023 Revision by: Maryola Perion (RN)	ACT	
• Expressed Wishes and Beliefs related to Anei's Medical Treatment and End of Life Care Revision on: 05/27/2020 Revision by: Joe Albano (RAI Coordinator)	• To support and honor Anei's expressed wishes and beliefs through to the End of Life. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• DO NOT ATTEMPT CPR: Transfer to hospital, - see PoET Individualized Summary Revision on: 12/18/2024 Revision by: Danielle Loreto (RAI Coordinator) • FUNERAL Arrangements: Anderson Funeral Home, 895 Ouellette Ave. (519) 254-3223 Heather Soucie. Revision on: 09/15/2024 Revision by: Maryola Perion (RN)	Social Worker ST	

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: SEIZURE Disorder. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)	• To treat and minimize signs/ symptoms or complications associated with SEIZURE Disorder through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• COMMUNICATION: Involve/ collaborate with Anei/ SDM in decision making of neurological care management for SEIZURE Disorder Revision on: 03/06/2020 Revision by: Maryola Perion (RN)	PCA	
		• HEALTH EDUCATION: Engage with Anei/SDM to enhance his/her comprehension of treatment, possible complications, disease trajectory associated with SEIZURE Disorder. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		
		• LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for SEIZURE Disorder as per MD order. Monitor effectiveness and for side effects. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with SEIZURE Disorder for changes to health status and alteration or complications affecting neurological function. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		
		• SEIZURE Disorder: If seizure activity occurs alert registered staff immediately; place on side, protect from injury, maintain open airway.	PCA Registered Staff All	
		• SEIZURE Disorder: Anei has potential for seizure activity, injury related to seizure disorder. Inform MD as it occurs. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of multi-pharmacy, use of anti-depressant.	• To monitor effectiveness and for side effects of medication used each day through to the next review date.	• COMMUNICATION: Involve/collaborate with Anei/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 03/06/2020 Revision by: Maryola Perion (RN)	Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident using anti-depression medication, poly-pharmacy for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 03/06/2020 Revision by: Maryola Perion (RN)		
		• MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• SPIRITUAL BELIEFS: Anei is of the Catholic Faith. Revision on: 02/19/2020 Revision by: Hannelore Steinke-Nelson (Activation aide)	• To provide Anei spiritual support as interested through to the next review date. Revision on: 07/24/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/13/2025	• SPIRITUAL PROGRAMS: Encourage her to attend spiritual programs of her choice including church services (Parkwood, Catholic), spiritual music, bible study, spiritual discussion, etc. Revision on: 08/02/2022 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
		• SELF-DIRECTED SPIRITUAL Activities: Anei engages in praying. Revision on: 09/13/2025 Revision by: Nick Carroll (Recreation Aide)		
• Nutrition Risk Level (diet details)	• Anei will be adequately nourished aeb consuming >50% at meals and snacks through to next review date. Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/13/2025 • Will weigh within realistic GWR of 40-50 kg through to next review date. Revision on: 06/16/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/13/2025 • Anei will be adequately	• Honor religious rituals related to diet: do not serve meat or fish (she is lacto-ovo vegetarian) Revision on: 05/29/2025 Revision by: Holly Laasanen (Dietitian (RD))		
		• Labelled Item Dinner: Monday: 2 hard-boiled eggs Tuesday: cheddar cheese Wednesday: Greek yogurt Thursday: 2 hard-boiled eggs Friday: peanut butter and crackers Saturday: cottage cheese Sunday: Greek yogurt Revision on: 06/19/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	E
		• NUTRITION RISK: Anei is moderate risk level Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD)	

Allergies	No Known Allergies	**D.O.B.**	03/10/1945	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed(S92.000), Unspecified dementia(...See last page for a complete listing of the Resident's diagnoses				
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Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
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Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)	hydrated aeb drinking 100% of total fluid requirement: 1317 ml/day (30 ml/kg using 43.9 kg weight) through to next review date. Revision on: 06/16/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/13/2025	• DIET ORDER: Anei will receive lacto-ovo vegetarian diet, regular texture. Revision on: 06/19/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• FLUID CONSISTENCY: Anei drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/15/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: Encourage Anei to drink a minimum of 1317 ml/day. Revision on: 06/16/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily.	Dietary aide PCA	
		• DINING INSTRUCTIONS: - Reassure resident she doesn't have to pay for her food. - At lunch there are specific days where both protein choices are non-vegetarian. A substitute item is sent on those days. - At dinner, staff offer Anei the grain/starch choices and vegetable side choices available on our menu + a special-labelled lacto-ovo vegetarian protein item. Revision on: 10/30/2025 Revision by: Holly Laasanen (Dietitian (RD))	Registered Practical Nurse	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Hettiarachchilage, Anei (922131005342)	**Admission Date**	02/10/2020	**Location**	4 402 B
Last Care Plan Review Completed:	**09/13/2025**				

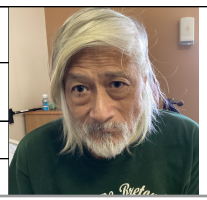
Diagnosis

Seizure disorder, so described(R56.80), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Fracture of calcaneus, closed(S92.000), Unspecified dementia(F03), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32.9), Osteoporosis, unspecified(M81.9)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for PAIN and alteration in comfort level related to history of falls and history of hip pain. Osteoarthritis. Bilateral feet- more in right foot and greater right toe Most Current RAI Pain Score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Target Date: 12/02/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with (Robert)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse Registered Practical Nurse RN	
• Potential for bruising, bleeding, clotting or other complications related to use of ANTIPLATELET medication. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	• To monitor for bleeding and minimize complications related to use of ANTIPLATELET medication through the review date. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with (Robert)/SDM in decision making and health teaching of ANTIPLATELET medication use. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using ANTIPLATELET therapy for changes to health status and complications causing bleeding or clotting issues. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • BLEEDING ALERT: Notify nurse immediately if Robert is bleeding (noted blood in urine/stool, bleeding nose/gums, unexplained bruising, etc.). Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medications as per MD Order. Report abnormal or unexplained bleeding, unexplained or excessive bruising, etc. to MD as noted.	PCA Registered Staff	
• Strengthening exs Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increased strength for B/L UE and LE from 3+/5 to 4/5 in next 3 months. Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Strengthening exs for B/L UE and LE; within pain limit; 10reps;1-2 sets with 1-2lbs: as best tolerated:1-3 x a week Passive stretching for B/L Knees, 20-30sec hold, 3-5 reps, 1-3 x a week; Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
Diagnosis	Primary generalized (osteo)arthrosis(M15.0), Cerebral infarction, unspecified(I63.9), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Depressive epis...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A



Last Care Plan Review Completed: 09/02/2025

Focus	Goal	Interventions	Position	Freq/Resolved
• Strengthening exs Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	Target Date: 12/02/2025			
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest and Rest/Sleep Patterns. ISE score: 2/6 Revision on: 02/19/2025 Revision by: Laura Morris (Restorative Care Aide)	• To support Robert's Psycho-Social well being through to the next review. Revision on: 02/19/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 12/02/2025	• STRUCTURED ACTIVITIES: Invite Robert to programs of personal interest; music programs, happy hour, pet therapy, trivia, movies and special events. Revision on: 02/19/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage Robert to engage in self-directed activities such as watching TV in own room and conversing with peers, etc. Revision on: 02/19/2025 Revision by: Laura Morris (Restorative Care Aide) • ONE to ONE: Provide Robert with individual visits for conversation. Revision on: 02/19/2025 Revision by: Laura Morris (Restorative Care Aide)		
• Gait Training Revision on: 01/17/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increased walking endurance from 100 to 200ft in next 3 months; Revision on: 02/20/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/02/2025	• 1:1 assist gait training with RW with w/c follow up, distance as best tolerated, small laps 2-3 x a week; Revision on: 07/30/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS. Revision on: 01/17/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with OSTEOARTHRITIS through to the next review date. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• COMMUNICATION: Involve/ collaborate with (Robert)/SDM in decision making of musculoskeletal care management. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of OSTEOARTHRITIS as per MD order. Monitor effectiveness and for side effects. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for		

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		management of OSTEOARTHRITIS for discomfort/ complications or changes to health status. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in CARDIAC FUNCTION related to: NSTEMI Revision on: 01/17/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with NSTEMI through to the next review date. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with (Robert)/SDM in decision making of Cardiac Care Management for NSTEMI. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with NSTEMI for changes to health status and alteration or complications affecting cardiac function. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for NSTEMI as per MD Order and monitor for side effects. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Risk for Impaired SKIN INTEGRITY related to Impaired mobility, use of incontinent product, swelling to right foot Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To protect and maintain skin integrity each day through to the next review. Target Date: 12/02/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Increased risk for FALLS related to ataxia and poor balance, History of falls, Impaired mobility and balance.. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Target Date: 12/02/2025	• COMMUNICATION: Involve/collaborate with (Robert)/SDM in decision making in fall prevention Plan of Care. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair, walker Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		• ENVIRONMENT: Secure environment: reduce clutter to reduce fall risk for Robert. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA	
		• BED: place bed in lowest position to lower risk for injury. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA	
		• SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)		
• URINARY (Mixed) INCONTINENCE related to altered mobility Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	• Robert will receive support to (use toilet, urinal) and promote urinary continence each shift through to the next review. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		
		• URINARY Continence level is Infrequently Incontinent. Report change to level as noted. Revision on: 05/26/2025 Revision by: Jenny Liu (RAI Coordinator)	PCA	
		• INCONTINENCE PRODUCT: Resident uses PUll up per prevail sheet Revision on: 05/27/2025 Revision by: Jenny Liu (RAI Coordinator)	PCA	
		• ADAPTIVE EQUIPMENT/AID: Resident uses urinal. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA	
• Alteration in thought processes (altered judgement, etc.) related to progression of mild cognitive impairment Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	• Robert will be supported to make independent choice and safe decisions each day through to the review date. Current CPS is 1. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• ORIENTATION: Gently reorient to person, place, time as needed when Robert is feeling lost or in confused state. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		
		• REMINDES FOR TASKS: Provide reminders and cues to Robert as needed to prompt him to make decisions or initiate tasks. Revision on: 02/24/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	• Robert will be supported to maintain cognitive function through the review date. Current CPS of 1. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025			
• Transfer training Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist)	• Reduce assistance needed for transfers from 1 assist to Sup assist in next 6 months; Revision on: 08/18/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/02/2025	• 1:1 assist with RW; Ensure pushing from armrest when getting up and hands back to armrest when sitting in the chair. 2-3 x a week; Revision on: 07/30/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Limitation, Limited Mobility, Depression, Ataxia. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	• Robert will be supported to maintain current self participation with the teams support in ADL care to ensure all ADL care needs are met each day through to the next review date. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025	• BATHING: Robert prefers (shower) on (Tuesdays and Saturdays on Evening shift). Robert participates by (move extremities, be given the washcloth and follow directions). One staff (EXTENSIVE) assistance for bathing and two staff side to side for transfer. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY:Robert is independent with his bed mobility. Care levels may vary depending on strength and fatigue. May require 1 to 2 team members with extensive assistance. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Supervision: Robert is able to dress himself up from head to toe. Staff to provide cues, or reminders to ensure he dressed properly and clothes changed. Revision on: 05/26/2025 Revision by: Jenny Liu (RAI Coordinator)	PCA	
		• EATING: Robert is independent with eating with set up assistance. Eats in the main dining room - 1st floor.	PCA	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • LOCOMOTION: Robert is using a wheelchair and is able to propel himself on a home area. Off home area he may require portering but is able to propel. He has a walker that he uses with PT. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Robert is able to wash his hands, face, comb his hair and provide peri-care. No assistance from the staff but requires set up. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide (LIMITED) assistance to (use soap/water, apply sanitizer, rub hands together and drying hands.) for hand hygiene. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TOILET USE: Robert requires guidance from the team member to help with transferring on/off the toilet; and to cleanse, and re-apply his incontinent product and adjust his clothes after. He will try to toilet self. Encourage to ask for assistance. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Robert is able to (aid in weight bearing). (2) staff to provide (extensive) assistance for transferring. Encourage Robert to ask for assistance, he self transfer. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Robert has (own teeth, some are missing and broken). 1 staff to provide (SUPERVISION and set up) assistance for oral care. Care level varies when fatigued and the team may have to complete the task. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: (PSW) to complete toenail care every (on bathing day and as needed). Report long toe nails or other abnormalities as noted.	PCA	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Limitation, Limited Mobility, Depression, Ataxia. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) • SHAVING - Staff to shave Robert on his shower days and when needed. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA	D
• Expressed Wishes and Beliefs related to Robert's Medical Treatment and End of Life Care Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	• To support and honor Robert's expressed wishes and beliefs through to the End of Life. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• CPR: Roberts wishes are DO NOT ATTEMPT CPR: Do not transfer to hospital, plan includes death at home - see PoET Individualized Summary Revision on: 02/24/2025 Revision by: Danielle Loreto (RAI Coordinator) • FUNERAL Arrangements: Simple Choice Cremations 3790 Dougall Ave 519-254-2585 Revision on: 05/20/2025 Revision by: Maryola Perion (RN)	Social Worker ST	
• Potential for Expressive Behaviour of (RESISTANCE to care need) nature related to: depression, low mood. Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0.	• COMMUNICATION: Involve/collaborate with (Robert)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	BSO - Internal Social Worker	

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Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
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Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 08/13/2025 Revision by: Maryola Perion (RN) Target Date: 12/02/2025 • Robert will be supported to adjust to his new environment to lower risk of triggering former (resisting care) behaviour episodes through to the next review. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of (resident name) for indications to change in or for escalating expressive behaviour risk. • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to bathe, refusal to eat, etc.) as expressions of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 11/29/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Robert is declining to (bathe, change clothes, take medications, eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. He has a history of not showering for long periods of time. Not brushing his teeth, changing his clothing, shaving. He needs encouragement and assistance to complete. May have to offer shower at times outside of schedule shower days to accommodate his refusals. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	Registered Staff	
• Altered COMMUNICATION as exhibited by limitations to (some difficulty expressing self) related to mild cognitive loss Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist)	• Robert will continue to freely express self and adequately comprehend information each day through to the next review period. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025	• PRIMARY LANGUAGE: Robert's primary language is English. He is able to speak and understand English. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: (Allow time to respond, repeat as needed). Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)		
• Altered VISION Revision on: 11/29/2024 Revision by: Shina Wadhwa (Physical Therapist)	• Robert supported to use eyeglasses for vision correction daily when needed through to	• EYEGLASSES: Robert wears eyeglasses for reading. Assist to clean eyeglasses as needed and store in night table drawer or on the table) when sleeping. Revision on: 11/18/2024	PCA	

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Focus	Goal	Interventions	Position	Freq/Resolved
	the next review date. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025	Revision by: Danielle Loreto (RAI Coordinator)		
• Nutrition Risk Level	• Robert will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 12/02/2024 Revision by: Lexi Dakin (Dietitian (RD)) Target Date: 12/02/2025 • Will weigh within GWR/IBW/Realistic weight range of 58-66kg (BMI 20-23) through to next review date. Revision on: 12/02/2024 Revision by: Lexi Dakin (Dietitian (RD)) Target Date: 12/02/2025 • Robert will be adequately hydrated aeb drinking at least 75% of total fluid requirement @25 ml/kg, 62.7kg through to next review date. Revision on: 12/02/2024 Revision by: Lexi Dakin (Dietitian (RD)) Target Date: 12/02/2025 • Will meet estimated nutritional requirements of 25-30kcal/kg,	• NUTRITION RISK: Robert is low risk level. Revision on: 08/06/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIET ORDER: Robert will receive regular diet, regular texture Revision on: 11/26/2024 Revision by: Ronnie Fung (FSM - Food Services Manager) • FLUID CONSISTENCY: Robert drinks REGULAR/THIN Level 0 Fluids. Revision on: 11/26/2024 Revision by: Ronnie Fung (FSM - Food Services Manager) • FLUID TARGET: Encourage Robert to drink a minimum of 1175mL/day per day Revision on: 12/02/2024 Revision by: Lexi Dakin (Dietitian (RD))	Dietitian (RD) PCA PCA PCA	

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Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
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Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level	1567-1881kcal/day, 1-1.2g/kg, 62.7-75.2gPRO/day through to next review date. Revision on: 12/02/2024 Revision by: Lexi Dakin (Dietitian (RD)) Target Date: 12/02/2025			
• Sleep Patterns; Potential for alteration in sleep patterns related to resident has complaints of not sleeping well. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	• To promote adequate rest/sleep for Roberts based on identified sleep patterns/preferences each night through to the next review date. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025	• PREFERENCE: Robert likes to have blankets on and at times will put them over his head to fall asleep. May have sleeplessness. Team to monitor sleep patterns and report to the nurse if resident is having trouble sleeping. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential to experience alteration in MOOD as exhibited by (refusing care, self care neglect, staying bed with blankets over his head) related to Depression Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	• Robert will be supported to maintain mood stability as evidenced by DRS score at a range of 0-2 by the review date. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025 • To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 11/29/2024 Revision by: Maryola Perion (RN) Target Date: 12/02/2025	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Robert for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) • RESIDENT STRENGTHS: Build on Robert effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) • SLEEP/REST: Promote adequate sleep and rest to stability of Robert mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by (refusing care, self care neglect, staying bed with blankets over his head) related to Depression Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)				
• BOWEL Continence - Robert is continent and has self recognition of urge to defecate. Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	• Robert to remain continent of bowels through next review date Revision on: 11/18/2024 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/02/2025	• BOWEL Continence level is CONTINENT. Report change to level as noted. • SELF TOILETING: Two Staff to toilet Robert for bowel movements. Staff to document accordingly. Report changes to bowel movements or continence level to Registered Staff as noted. Revision on: 11/29/2024 Revision by: Maryola Perion (RN)	PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
Diagnosis	Primary generalized (osteo)arthrosis(M15.0), Cerebral infarction, unspecified(I63.9), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Depressive epis...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

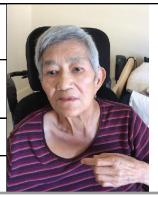
Diagnosis

Primary generalized (osteo)arthrosis(M15.0), Cerebral infarction, unspecified(I63.9), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Depressive episode, unspecified(F32.9), Ataxia, unspecified(R27.0), Other and unspecified abnormalities of heart beat(R00.8), Old myocardial infarction(I25.2), Disorders of initiating and maintaining sleep [insomnias](G47.0)

Allergies	No Known Allergies	**D.O.B.**	09/19/1950	**Physician**	Albert Patrick Ng
Diagnosis	Primary generalized (osteo)arthrosis(M15.0), Cerebral infarction, unspecified(I63.9), Other and unspecified symptoms and signs involving cognitive functions and awareness(R41.88), Depressive epis...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Jean, Robert (922131005598)	**Admission Date**	11/18/2024	**Location**	4 403 A
Last Care Plan Review Completed:	**09/02/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to Deep Tissue injury to bilateral heels secondary to Pressure Injury - Pressure - Deep Tissue Injury Right Heel Revision on: 10/29/2025 Revision by: Maryola Perion (RN)	• To minimize risk of #28 - Pressure - Deep Tissue Injury - Right Heel infection each day until fully healed. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) Target Date: 02/05/2026 • To promote optimal healing of #28 - Pressure - Deep Tissue Injury - Right Heel within the next review date. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) Target Date: 02/05/2026	• TREATMENT PLAN: Administer treatment for #28 - Pressure - Deep Tissue Injury - Right Heel as per MD Order. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Deep Tissue injury to bilateral heels for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)	Registered Staff	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)	Registered Staff	
		• EQUIPMENT: Sumiko requires offloading boots to offload pressure. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)	Registered Staff	
		• NUTRITIONAL SUPPLEMENT for Skin Healing in place; refer to Dietary Care Plan. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)	Dietitian (RD) Registered Staff	
• Alteration in skin integrity with risk for infection or complications related to - Pressure - Stage 2 - Left Medial Malleolus Revision on: 10/29/2025 Revision by: Maryola Perion (RN)	• To minimize risk of #27 - Pressure - Stage 2 - Left Medial Malleolus infection each day until fully healed. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) Target Date: 02/05/2026 • To promote optimal healing of #27 - Pressure - Stage 2 - Left Medial Malleolus within the next review date. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) Target Date: 02/05/2026	• TREATMENT PLAN: Administer treatment for #27 - Pressure - Stage 2 - Left Medial Malleolus as per MD Order. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with #27 - Pressure - Stage 2 - Left Medial Malleolus for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)		
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/14/2025 Revision by: Janina Lucero (RN)		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng	
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C	

Last Care Plan Review Completed:	**08/19/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to - Pressure - Stage 2 - Left Medial Malleolus Revision on: 10/29/2025 Revision by: Maryola Perion (RN)				
• Alteration in skin integrity with risk for infection or complications related to WOUND #29 - Pressure - Deep Tissue Injury - Right Medial Malleolus Revision on: 10/14/2025 Revision by: Janina Lucero (RN)	• To promote optimal healing of WOUND within the next review date. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) Target Date: 02/05/2026 • To minimize risk of DTI right medical Malleolus infection each day until fully healed. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) Target Date: 02/05/2026	• TREATMENT PLAN: Administer treatment for Stage (#29 - Pressure - Deep Tissue Injury - right medical malleolus as per MD Order. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Stage #29 - Pressure - Deep Tissue Injury - right medical malleolus for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 10/14/2025 Revision by: Janina Lucero (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 10/14/2025 Revision by: Janina Lucero (RN)	Registered Staff Registered Staff Registered Staff	
• Potential for Acute PAIN and alteration in comfort level related to Osteoarthritis, headache, soreness on her tongue	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through	• COMMUNICATION: Involve/collaborate with (Sumiko)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 05/22/2024		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
(2/23/25). Most Current RAI Pain Score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	to the next review. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 02/05/2026	Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	RN Registered Practical Nurse Registered Practical Nurse RN	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest, Low Motivation, Altered Mood. ISE Score: 6/6 Revision on: 08/02/2025 Revision by: Laura Morris (Restorative Care Aide)	• Team members will support "Mary" in decreasing social isolation by participating in activities of personal choice 10-20 times per month by the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• STRUCTURED ACTIVITIES: Invite Mary to programs of personal interest: Friendly/1:1 visits, colour relaxation, discussion group, exercise program, physical games, trivia, Montessori - sequencing, music appreciation, short stories, reminiscing, sensory - aromatherapy & YouTube videos, Happy Hour, hymn sing, church, TV - matinee movie, etc. Revision on: 05/10/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as watching/listening to TV, visiting with residents/team members, listening to music, family/friend visits, etc. Revision on: 05/10/2025 Revision by: Laura Morris (Restorative Care Aide) • ASSISTANCE: Provide assistance/encouragement to get Mary to scheduled activities: Porter, etc. Revision on: 12/27/2021 Revision by: Mitchell Atkinson (Recreation Aide) • ONE to ONE: Provide her with individual visits for; conversation, bedside activity, reading, reminiscing, etc. Revision on: 12/27/2021 Revision by: Mitchell Atkinson (Recreation Aide) • SENSORY STIMULATION: Provide her with Sensory Stimulation for; Snoezelen Therapy, Reading Aloud, Sensory Pictures/Videos, etc. Revision on: 12/27/2021	ACT ACT ACT	

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest, Low Motivation, Altered Mood. ISE Score: 6/6 Revision on: 08/02/2025 Revision by: Laura Morris (Restorative Care Aide)		Revision by: Mitchell Atkinson (Recreation Aide)		
• Increased risk for FALLS related to r/t Vascular Dementia, Osteoarthritis of the knee, Impaired mobility and balance and taking of Antipsychotic Medication. Revision on: 01/26/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making in fall prevention Plan of Care. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN)	PCA	
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair. Revision on: 06/30/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA All	
		• BED: Place bed in lowest position to lower risk for injury. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
• Potential for Expressive Behaviour of PHYSICAL, (slapping, hitting, grabbing, biting, pinching), RESISTANCE to care need, Socially Inappropriate / Disruptive Behavioural Symptoms, Bit a team	• To promote safety for Sumiko and/or others during each episode of Expressive Behaviour through to the next review date.	• Behavioral management plan- Staff is to let Sumiko sleep in until she is ready to wake up on her own time. (ex. After breakfast) As Sumiko is hard of hearing, staff is to communicate with her in a loud and clear voice. Staff is to ensure that Sumiko has given permission and understands the steps to be		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
members arm during care, scratching and pinching, Verbal (yelling and screaming at staff) related to Vascular Dementia, Depression. Revision on: 01/19/2024 Revision by: Maryola Perion (RN)	Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026 • To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be less than 2. Revision on: 10/29/2025 Revision by: Maryola Perion (RN) Target Date: 02/05/2026	taken prior to care. Give Mary time to express her needs and concerns, providing reassurance, comfort, understanding and validating her feelings. Prior to care put something soft in her hands such as a stuffed animal or towel. 2 staff at all times, one for care, one to distract her. Staff to use stop and go approach when providing care. Re-approach when calm. Report to nurse when the resident has expressions Set up the table away from other residents at mealtime due to her grabbing food off another resident's plate. Staff is to keep residents at a safe distance when Sumiko is sitting with them and to bring her back to her room when she is expressing responsive behaviors and to offer snacks and drinks. Playing country music, turning on her tv, watching funny animal videos, or giving the resident her stuffed toy or therapy doll can help to alleviate expressions. Revision on: 03/24/2025 Revision by: Leslie Meloche (Recreation Aide) • COMMUNICATION: Involve/collaborate with (Sumiko)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 11/24/2024 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Sumiko for indications to change in or for escalating expressive behaviour risk. Revision on: 01/23/2022 Revision by: Leslie Meloche (Activities/Rec Therapy) • TRIGGERS leading to PHYSICAL (slapping, hitting, grabbing, biting, pinching) as expression of behaviour include: allow for personal space. Avoid reaching over Sumiko as she may bite. Monitor for frustration, confusion, pain prior to providing care. Revision on: 02/21/2024 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: If Sumiko is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when he/she is calm/ready. Seek Registered Staff assistance. Revision on: 11/21/2023	BSO - Internal Social Worker	

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of PHYSICAL, (slapping, hitting, grabbing, biting, pinching), RESISTANCE to care need, Socially Inappropriate / Disruptive Behavioural Symptoms, Bit a team members arm during care, scratching and pinching, Verbal (yelling and screaming at staff) related to Vascular Dementia, Depression. Revision on: 01/19/2024 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN) • TRIGGERS leading to VERBAL (yelling, screaming, etc.) as expression of behaviour include (loss of control, misunderstanding care intention, etc.) Revision on: 01/19/2024 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Sumiko is heard yelling, swearing or calling others names; calmly remind to lower her voice and that chosen words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Revision on: 01/19/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to bathe, refusal to eat, take medication, etc.) as expression of behaviour include (confusion, misunderstanding care needs, poor judgement, etc.) Revision on: 11/21/2023 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Sumiko is refusing to (bathe, change clothes, eat, take medication, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 11/21/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate (disruptive vocalizations, etc.) as expression of behaviour include confusion, decreased insight, poor judgement, etc. Revision on: 11/30/2022 Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If Sumiko is noted to make loud disruptive noises in dining room/program, etc. gently redirect her to focus on task at hand or escort to quieter area. Revision on: 11/30/2022 Revision by: Maryola Perion (RN) • Nurse to give medication prior to botox injection. Revision on: 11/21/2023 Revision by: Ranjita Yadav (RPN)		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience side effects or complications related to use of BOTOX as treatment as Focal Spasticity Management for Right hand and knee. Revision on: 11/28/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To monitor effectiveness (change in movement & spasticity level) and for side effects of medication used through to the next review date. Target Date: 02/05/2026	• COMMUNICATION: Involve/collaborate with (Sumiko)/SDM in decision making and health teaching about Focal Spasticity Management and appropriate medication use. Revision on: 10/19/2023 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident having BOTOX injection for changes to health status and for side effects (ie.; malaise, redness/swelling at injection site, etc.).	RN Registered Practical Nurse	
• Risk for/Impaired Skin Integrity r/t Fragile skin, DM and Vascular Dementia, Incontinence, Use of containment product, Impaired mobility. Revision on: 11/21/2023 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Target Date: 02/05/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• HEALTH EDUCATION: Engage resident/SDM in health education regarding prevention of skin impairment and management Revision on: 08/19/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• EQUIPMENT: Sumiko requires Roho cushion to offload pressure, posey to right hand (posey to be worn 24hrs) and air mattress to offload pressure. Revision on: 05/17/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• POSITIONING: Turn, reposition at least every 2 hours or more often when in bed/wheelchair to offload pressure. Revision on: 07/14/2025 Revision by: Chelsea Campbell-Wright (ADOC)	PCA	Q2h
• Potential for pain, discomfort related to Dx of Osteoarthritis. Revision on: 09/01/2023 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Osteoarthritis through to the next review date.. Revision on: 09/01/2023 Revision by: Maryola Perion (RN)	• COMMUNICATION: Involve/ collaborate with (Sumiko)/SDM in decision making of musculoskeletal care management. Revision on: 09/01/2023 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for management of Osteoarthritis as per MD order. Monitor effectiveness and for side effects. Revision on: 09/01/2023 Revision by: Maryola Perion (RN)		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 02/05/2026	• PAIN MANAGEMENT for Osteoarthritis prescribed and in place; refer to Pain Care Plan. Revision on: 09/01/2023 Revision by: Maryola Perion (RN)		
• Use of PASD two 1/4 bed rails to assist resident with Activity of Daily Living (bed mobility). Revision on: 03/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Sumiko will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living (bed mobility and care) each day through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails. Revision on: 12/12/2022 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use two 1/4 bed rails as to support appropriate bed mobility during care. Revision on: 12/12/2022 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with (bed mobility, care). Monitor every shift. Revision on: 12/12/2022 Revision by: Suzanne Azar (RN)	PCA	D/E/N
• Potential to experience alteration in MOOD as exhibited by repetitive questions and verbalizations, sad, worried facial expression, repetitive anxious complaints & physical movements and persistent anger with others, unpleasant mood in the morning related to Vascular Dementia, Depression. Revision on: 03/07/2023 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 05/15/2025 Revision by: Maryola Perion (RN) Target Date: 02/05/2026	• COMMUNICATION: Involve/collaborate with Sumiko/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 01/08/2021 Revision by: Katie Wolters-Savo (RAI Coordinator) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Sumiko for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 01/08/2021 Revision by: Katie Wolters-Savo (RAI Coordinator) • RESIDENT STRENGTHS: Build on Sumiko's effort to maintain control. Encourage her to express self, state preferences and make safe choices for care and activities. Revision on: 11/30/2022 Revision by: Maryola Perion (RN)	Registered Staff Registered Staff	
• URINARY (Mixed) INCONTINENCE related to altered mobility, Dementia Diagnosis, vaginal bleeding Revision on: 02/14/2023	• Sumiko will have urinary incontinence managed every shift through to the next review period.	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Katie Wolters-Savo (RAI Coordinator)	Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• URINARY Continence level is TOTAL Incontinent. Report change to level as noted. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Sumiko uses a White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
		• TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of multi-pharmacy, etc. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 06/05/2023 Revision by: Maryola Perion (RN)	Registered Staff	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)		
		• MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	Registered Staff	
• Potential to experience (rash, hives,	• Sumiko will be protected from	• COMMUNICATION: Involve/collaborate with SDM in decision making and health		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
anaphylaxis, etc.) related to ALLERGY of PCN, Pindolol, Celebrex, Cipro and Opioid Analgesics. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	exposure to allergen each day through next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	teaching about ALLERGY to PCN, Pindolol, Celebrex, Cipro and Opioid Analgesics. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications mortality. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		
		• ALLERGY ALERT: Sumiko has ALLERGY to PCN, Pindolol, Celebrex, Cipro and Opioid Analgesics. Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		
		• MD/PHARMACY ALERT: Notify the MD and Pharmacy of Sumiko's Allergy and minimize risk for exposure to allergen. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		
		• RESCUE MEDICATION: Administer EPINEPHRINE as per MD/NP Order. Monitor effectiveness and immediately notify MD/NP of use.	Registered Staff	
• Potential for BOWEL INCONTINENCE related to Dementia, Impaired mobility. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	• Sumiko will have bowel incontinence managed every shift through to the next review period. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function.	Registered Staff	
		• BOWEL Continence level is (Total Incontinence). Report change to level as noted. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
		• BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
		• INCONTINENCE PRODUCT: Sumiko uses a White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Altered COMMUNICATION as exhibited	• Sumiko will be supported to maintain current communication	• PRIMARY LANGUAGE: Sumiko primary language is English. Revision on: 03/25/2022		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
by limitations to (self expression, comprehension.) related to usually understands/understood, Dementia.. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	abilities to (express self, comprehend information, etc.) each day through to the review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026 • Sumiko will be able to make basic needs known each day through to the review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	Revision by: Jenny Liu (RAI Coord Back-up) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up) • INSTRUCTION GUIDANCE: Sumiko needs constant cueing or demonstrative instruction in tasks and activities. Revision on: 03/07/2023 Revision by: Maryola Perion (RN)	ACT	
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to Vascular Dementia. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	• Sumiko will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making of Cognitive Loss for Vascular Dementia. Revision on: 09/18/2022 Revision by: Maryola Perion (RN) • ORIENTATION: Gently reorient to person, place, time as needed when Sumiko is feeling lost or in confused state. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up) • PERSONAL ROUTINE: Provide consistency in care routine and activities Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	PCA	
• Altered ability to complete Activities of Daily Living (ADLs) related to DM, Vascular Dementia and Osteoarthritis. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	• Sumiko will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo	• BATHING: Sumiko prefers (shower) on (Mondays and Thursdays in Day shift). Sumiko participates by (providing a washcloth and cues). One staff (MAXIMAL) assistance for bathing. Requires Maxi lift for transfer with two staff to assist. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: Sumiko requires weight bearing assistance from two staff to turn	PCA PCA	

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	(RAI Coordinator) Target Date: 02/05/2026	and reposition her while in bed. Two 1/4 bedrails to be used when in bed to aid in turning and repositioning, Revision on: 09/01/2023 Revision by: Maryola Perion (RN)		
		• DRESSING: Sumiko is able to lift her arm legs minimally. Two staff to provide (MAXIMAL) assistance for dressing UPPER & LOWER body. Revision on: 05/15/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Sumiko is able to eat independently once set up by staff with cueing and reminders. She may require one staff to assist her with feeding at times. She eats in the 4th floor dining room. Revision on: 11/21/2023 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Sumiko is using a wheelchair with one staff total assistance to porter her on and off the unit. Revision on: 05/22/2024 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Sumiko requires one staff to comb her hair, washing/drying of face and hands, brushing her teeth. Two staff Maximal assistance to provide brief change and peri care related to incontinence. Revision on: 05/15/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide TOTAL assistance to use sanitizer wipes, rub hands together, dry hands for hand hygiene. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
		• TOILET USE: Total assistance from two staff-staff to change her in bed when soiled and to use Maxi lift for transfer. She is able to assist with turning. Revision on: 08/21/2024 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Total assistance- Sumiko require Maxi lift for transfer with two staff assistance. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
		• TRANSFER LIFT/SLING: Maxi Lift. black sling can be used .		

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to DM, Vascular Dementia and Osteoarthritis. Revision on: 09/18/2022 Revision by: Maryola Perion (RN)		Revision on: 01/30/2025 Revision by: Betsi Tony (RN) • ORAL CARE: Sumiko has her own teeth and requires one staff Total assist with oral care. Revision on: 05/15/2025 Revision by: Maryola Perion (RN) • FOOT CARE: PSW to complete toenail care every on her shower days. Report long toe nails or other abnormalities as noted. Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	PCA PCA	
• Potential for CONSTIPATION related to decreased mobility. Revision on: 02/03/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To minimize the potential for episodes and complications of constipation through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• COMMUNICATION: Involve/collaborate with SDM for decision making regarding constipation management. Revision on: 09/18/2022 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Sumiko's for constipation management and changes to health status and symptoms/ complications of constipation. Revision on: 02/03/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	 Registered Staff Registered Staff	
• Sleep Patterns.	• To promote adequate	• REST PATTERN: Preferred bedtime: Between 1900 - 2000, usual wake time:	PCA	

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 11/29/2021 Revision by: Jenny Liu (RAI Coord Back-up)	rest/sleep for Sumiko based on identified sleep patterns/preferences each night through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	around 06:30 Revision on: 09/18/2022 Revision by: Maryola Perion (RN) • SLEEPWEAR: Sumiko prefers to wear her own PJ Revision on: 09/18/2022 Revision by: Maryola Perion (RN)	PCA	
• Nutrition Risk Level (diet details) Revision on: 07/16/2020 Revision by: Anna Slack (Registered Dietitian)	• Sumiko to be comfortable and to provide comfort measures through to "end of life" Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026 • Sumiko will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026 • Will weigh within Realistic weight range of 58kg-66kg/BMI 22-25 through to next review date. h=162.5cm Revision on: 11/20/2024 Revision by: Lexi Dakin (Dietitian (RD)) Target Date: 02/05/2026	• NUTRITION RISK: Mary is moderate risk level. Revision on: 05/09/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIET ORDER: Mary will receive Regular diet, Regular texture Revision on: 08/20/2024 Revision by: Anika Dhalla (Dietitian (RD)) • FLUID CONSISTENCY: Mary drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/19/2021 Revision by: Olivia Kuhlmann (Dietetic Intern) • FLUID TARGET: Encourage Mary to drink a minimum 1232mL per day Revision on: 10/08/2024 Revision by: Rachelle Ly (Dietitian (RD)) • EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily. • ADAPTIVE AIDS: Mary requires rimmed/lip plate at meals and snacks. Revision on: 10/28/2020 Revision by: Anna Slack (Registered Dietitian) • FOOD ALLERGY/INTOLERANCE: lactose intolerance and reactions to this beverage is diarrhea. Provide Lactaid milk in place of regular milk Revision on: 12/23/2021 Revision by: Anna Slack (Registered Dietitian) • MEDPASS SUPPLEMENTS: 1. 120mL Resource 2.0 QID 1 scoop protein powder at breakfast daily mixed in 200ml beverage of her choice OR	Dietitian (RD) PCA Diet PCA PCA Dietary aide PCA Diet PCA Diet PCA Restorative Care Aide	

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details) Revision on: 07/16/2020 Revision by: Anna Slack (Registered Dietitian)	• Sumiko will be adequately hydrated aeb drinking at least 80% of total fluid requirement 1540mL @ 25mL/kg, 61.6kg through to next review date. Revision on: 10/08/2024 Revision by: Rachelle Ly (Dietitian (RD)) Target Date: 02/05/2026 • Will meet estimated nutritional requirements of 1974 kcal @ 30 kcal/kg, 79g protein @ 1.2g/kg through to next review date re: MASD, sacrum. Revision on: 08/20/2024 Revision by: Anika Dhalla (Dietitian (RD)) Target Date: 02/05/2026	mixed into hot cereal Revision on: 10/22/2025 Revision by: Brittany Hyde (Registered Dietitian) • LABELLED SNACK: Mary receives 1/2 peanut butter and jam sandwich PM Revision on: 11/20/2024 Revision by: Lexi Dakin (Dietitian (RD))	PCA	
• SPIRITUAL BELIEFS: "Mary" is not religious. Revision on: 07/15/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide "Mary" spiritual support as interested through to the next review date. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• PERSONAL CHOICE: Respect Mary's right to decline participation in Spiritual Programs. Please attempt to engage her in spiritual programs if she chooses to participate. Revision on: 11/27/2023 Revision by: Mitchell Atkinson (Recreation Aide)		
• Expressed Wishes and Beliefs related to Sumiko Medical Treatment and End of Life Care Revision on: 02/09/2020 Revision by: Qiufeng Liu (Registered Practical Nurse)	• To support and honor Sumiko expressed wishes and beliefs through to the End of Life. Revision on: 06/06/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 02/05/2026	• CPR: Sumiko wishes express NO CPR and NO TRANSFER to hospital. Revision on: 02/25/2020 Revision by: Qiufeng Liu (RPN) • FUNERAL Arrangements: Families First - Dougall Revision on: 05/20/2024 Revision by: Maryola Perion (RN)	Social Worker ST	

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C

Last Care Plan Review Completed: 08/19/2025

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved

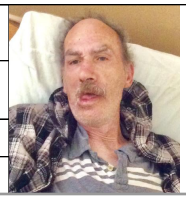
Diagnosis Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis (M15.0), Depressive episode, unspecified(F32.9), Constipation(K59.0)

Allergies Penicillin, Pindolol, Celebrex, Cipro, Morphine and Related

Allergies	Penicillin, Pindolol, Celebrex, Cipro, Morphine and Rel...See last page for a complete listing of the Resident's allergies	**D.O.B.**	03/06/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Vascular dementia, unspecified(F01.9), Primary generalized (osteo)arthrosis(M15.0), Depressive episode, unspecified(F32...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lefler, Sumiko (922131005209)	**Admission Date**	04/18/2019	**Location**	4 402 C
Last Care Plan Review Completed:	**08/19/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Acute PAIN and alteration in comfort level related to Generalized pain, foot pain, right ankle pain, Impaired mobility. Most Current RAI Pain Score is 0. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Target Date: 12/06/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/23/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	• COMMUNICATION: Involve/collaborate with Paul)/SDM) about pain management, goals of treatment, plan of care, prognosis and treatment options. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 06/30/2021 Revision by: Jenny Liu (RAI Coord Back-up)	RN Registered Practical Nurse Registered Practical Nurse RN	
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (self transfer and bed mobility). Revision on: 09/18/2025 Revision by: Suzanne Azar (RN)	• Paul will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living (self transfer and bed mobility) each day through to the next review date. Target Date: 12/06/2025	• BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with bed mobility, transfer in/out of bed. Monitor every shift.		
• Risk for/Impaired SKIN INTEGRITY related to Fragile Skin (ageing process), Incontinence episodes and using an Incontinent Product, impaired mobility. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Potential for Expressive Behaviour of resist care/eating/shower and socially inappropriate, exit seeking, stealing cigarettes from another resident, calling out and wandering the hallways, verbal related	• To promote safety for Paul and/or others through to the next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo	• Safety check every two hours for resident Revision on: 08/28/2025 Revision by: Tola Omolade (ADOC) • COMMUNICATION: Involve/collaborate with Paul)/SDM) about identified Risk of	PCA Registered Practical Nurse BSO - Internal BSO -	

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng	
Diagnosis	Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described(R56.80), Constipation(K59.0), Gastro-oeso...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A	

Last Care Plan Review Completed: 09/06/2025

Focus	Goal	Interventions	Position	Freq/Resolved
to Cognitive Impairment, Schizophrenia, Depression, Bipolar Affective Disorder. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	(RAI Coordinator) Target Date: 12/06/2025 • To decrease the episodic frequency of expressive behavior by the next review date. ABS score will be less than 5.. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 02/10/2022 Revision by: Leslie Meloche (Activities/Rec Therapy) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Paul for indications to change in or for escalating expressive behaviour risk. Revision on: 02/21/2024 Revision by: Jenny Liu (RAI Coord Back-up) • Paul will go into other residents drawers and try to steal others belongings. Stop Paul by monitoring his whereabouts, when seen going into others room, re-direct him. Find out from Paul the reason for his actions and find out from business office when he can get money for personal things. This may help decrease these behaviours. Revision on: 03/31/2021 Revision by: Leslie Meloche (Activities/Rec Therapy) • TRIGGERS leading to VERBAL (yelling, screaming, calling names, etc.) as expression of behaviour include (loss of control, frustration, etc.) Revision on: 01/12/2021 Revision by: Jenny Liu (RAI Coord Back-up) • VERBAL Behaviour: If Paul is heard yelling, swearing or calling others names; calmly remind to lower his voice and that chosen words are not appropriate. Attempt to resolve his concern. Report episode to Registered Staff. Revision on: 01/12/2021 Revision by: Jenny Liu (RAI Coord Back-up) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to bathe, refusal to eat, etc.) as expression of behaviour include (confusion, poor judgement) Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Paul is refusing to (bathe, change clothes and eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate (smoking in the facility or on berkshire properly; entering other resident's room without permission) as expression	External Social Worker PCA	

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described(R56.80), Constipation(K59.0), Gastro-oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A
Last Care Plan Review Completed:	**09/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of resist care/eating/shower and socially inappropriate, exit seeking, stealing cigarettes from another resident, calling out and wandering the hallways, verbal related to Cognitive Impairment, Schizophrenia, Depression, Bipolar Affective Disorder. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		of behaviour include (confusion, decreased insight, poor judgement, etc.) Revision on: 11/28/2023 Revision by: Jenny Liu (RAI Coord Back-up) • SOCIALLY Inappropriate Behaviour: Staff to re-direct him to smoke somewhere off the properly. continuous redirection and reminder to not go into other resident's room. Resident stated he understand and promised not to so it again. Revision on: 11/28/2023 Revision by: Jenny Liu (RAI Coord Back-up) • WANDERING: Permit Paul to safely roam in the common area. Revision on: 08/20/2025 Revision by: Chelsea Campbell-Wright (ADOC) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • If Paul is seen going to another resident's room, calmly redirect him to his own room and inform him that he is not allowed to go in another resident's room. Revision on: 05/11/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, slurred, mumbled speech) related to Cognitive impairment. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• Paul will be supported to maintain current communication abilities to (express self, comprehend information, etc.) each day through to the review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• PRIMARY LANGUAGE: Paul primary language is English. He is able to speak/understand English. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • INSTRUCTION GUIDANCE: Paul needs (intermittent) cueing or demonstrative instruction in tasks and activities. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described(R56.80), Constipation(K59.0), Gastro-oeso...See last page for a complete listing of the Resident's diagnoses				
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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, slurred, mumbled speech) related to Cognitive impairment. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• Paul will be able to make basic needs known on a daily basis through the review date Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025			
• Increased risk for FALLS related to History of Falls, Use of psychotropic medication, Cognitive Impairment, Schizophrenia and Epilepsy, Impaired balance and unsteady gait, self transferring. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• PURPOSEFUL ROUNDING: Conduct purposeful rounding every two hours to assess resident's needs; for pain, positioning, peri-needs or possessions for safety. Revision on: 08/06/2025 Revision by: Tola Omolade (ADOC)	PCA Registered Practical Nurse	
		• COMMUNICATION: Involve/collaborate with (Paul)/SDM in decision making in fall prevention Plan of Care. Revision on: 11/18/2024 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it Revision on: 11/16/2022 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment (reduce clutter, etc.) to reduce fall risk for Paul. Revision on: 11/18/2024 Revision by: Maryola Perion (RN)	PCA	
		• BED: Place bed in lowest position to lower risk for injury. Revision on: 08/28/2025 Revision by: Tola Omolade (ADOC)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear (non-slip footwear) for (transfers and ambulation). Revision on: 12/05/2020	PCA	

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Last Care Plan Review Completed: 09/06/2025

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to History of Falls, Use of psychotropic medication, Cognitive Impairment, Schizophrenia and Epilepsy, Impaired balance and unsteady gait, self transferring. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		Revision by: Jenny Liu (RAI Coord Back-up) • ALARM: Requires chair alarm at all times on resident's wheelchair. Check placement and working order. Staff respond when alarm is heard. Revision on: 08/28/2025 Revision by: Tola Omolade (ADOC) • SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 07/25/2025 Revision by: Maryola Perion (RN)	PCA	D/E/N
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to decreased fluid and oral intake. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of Paul with altered fluid intake for changes to health status and risk for dehydration. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • PROMOTE FLUIDS: Promote Paul to consume fluids; amount as per Nutrition Care Plan. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	Registered Staff All	
• Strength Training Revision on: 08/28/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Reduce assistance need for transfers from 2 assist to 1 assist in next 3 months Revision on: 08/28/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/06/2025	• Strengthening exs for B/L UE and LE with 1-2lbs, 10 reps, 2-3 x a week; 2 person side to side assist with walker or at the bar; Slowly increase standing endurance, 3-5 reps, 2-3 x a week; Revision on: 08/28/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A
Last Care Plan Review Completed:	**09/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Strength Training Revision on: 08/28/2025 Revision by: Shina Wadhwa (Physical Therapist)				
• Paul DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 5/6 Revision on: 07/17/2025 Revision by: Laura Morris (Restorative Care Aide)	• Paul will participate in 5-10x Independent/Self-Directed activities per month through to the next review date. Revision on: 08/31/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 12/06/2025	• SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as smoking on the patio, visiting with residents/team members, patio socializing/enjoying outdoors, community outings, helping others, etc. Revision on: 07/13/2020 Revision by: Shayna Lee Wonsch (Activation Manager) • FRIENDLY VISIT: Provide him one to one visits as tolerated. Touch Base to maintain contact and to converse about topics of interest, identify up-coming special events, etc. Revision on: 01/11/2020 Revision by: Mitchell Atkinson (Activities/Rec Therapy) • INVITATION: Offer friendly invite to structured programs scheduled in the home. Paul enjoys special events, evening trivia, etc. Revision on: 08/31/2025 Revision by: Laura Morris (Restorative Care Aide)	ACT ACT	
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, sad, pained, worried facial expression, suicidal ideation, crying, suicidal thoughts, calling out related to Schizophrenia, Depression, Bipolar Affective Disorder. Revision on: 06/07/2025 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 1. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	• COMMUNICATION: Involve/collaborate with (Paul)/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 02/10/2025 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Paul for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Monitor for interactions with resident L.R who causes resident to feel upset, sad and frustrated. Remind Paul to walk away and report if that resident is yelling or calling him names. Revision on: 06/02/2025 Revision by: Danielle Loreto (RAI Coordinator) • RESIDENT STRENGTHS: Build on Paul effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities.		

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A
Last Care Plan Review Completed:	**09/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • SLEEP/REST: Promote adequate sleep and rest to stability of Paul's mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 06/07/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • SUICIDAL IDEATIONS: Report to Registered Staff IMMEDIATELY if (Paul) expresses thoughts to harm to self. Triggers: If resident is being called names this is a trigger for him. He is scared that is he gets too upset he may have a seizure again. He is fearful of these. When he starts to talk about how his siblings treat him. He upset that by this. Co-resident D.R and L.R calling him names are yelling at him causes him to get upset and which triggers fear of having a seizure. When resident is speaking to the above, listen to him. Allow him to express how he is feeling. Do not rush him. Ask him if he has a plan to hurt himself. Gather information and report immediately to the charge nurse for follow up. Revision on: 06/06/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Paul has potential for safety hazard/ injuries related to unsafe SMOKING. Smoking privileges revoked May 5th 2025, for continued smoking in the room Revision on: 05/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Paul will be comply with smoking off property through to his next review date. Revision on: 05/05/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/06/2025	• COMMUNICATION: Involve Paul/SDM) in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) He has been spoken to and is aware as of May 5th 2025 that he is no longer safe to smoke on the property.	Social Worker	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Focus	Goal	Interventions	Position	Freq/Resolved
		He must hand in his lighter and cigarettes each time he returns from a smoke . He has been informed that the nurse will keep his cigarettes and lighter when he is not using them. Revision on: 05/05/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• CHECK: Paul is on observation to monitor for inappropriate smoking. Paul has a history of smoking (cigarettes & marijuana) in his room, the stairwell, main dining room and the basement. Provide room sweeps every shift for smoking materials. If noted please remove and report to charge nurse immediately. Revision on: 11/16/2022 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	D/E/N
		• STORAGE: Smoking materials to be removed from room. If resident is noted to have in possession and refuses to release them please and report to charge nurse. Revision on: 12/01/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)	Clerk	
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: EPILEPSY, Seizure Revision on: 05/02/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/ symptoms or complications associated with EPILEPSY, seizure through to the next review date. Revision on: 05/02/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	• COMMUNICATION: Involve/ collaborate with Paul/ SDM in decision making of neurological care management for EPILEPSY, Seizure. Revision on: 05/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• LAB WORK: Monitor lab and diagnostic results for (dilantin level, etc. and follow up instructions) and report results to MD as needed. Follow up as indicated. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)		
		• MEDICATION: Administer medication as per MD order. Monitor effectiveness and for side effects. Revision on: 05/02/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with EPILEPSY, Seizure for changes to health status and alteration or complications affecting neurological function. Revision on: 05/02/2025 Revision by: Maryola Perion (RN)		
		• SEIZURE Disorder: If seizure activity occurs alert registered staff immediately; place on side, protect from injury, maintain open airway.	PCA Registered	

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: EPILEPSY, Seizure Revision on: 05/02/2025 Revision by: Maryola Perion (RN)		• SEIZURE Disorder: Paul has potential for seizure activity, injury related to seizure disorder. Inform MD as it occurs. Revision on: 05/02/2025 Revision by: Maryola Perion (RN)	Staff All	
• Potential to experience complications and side effects impacting quality of life related to multi pharmacy. Revision on: 05/02/2025 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• COMMUNICATION: Involve/collaborate with Paul in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 06/17/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using medication for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 05/22/2024 Revision by: Jenny Liu (RAI Coord Back-up) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)		
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 02/10/2025 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Target Date: 12/06/2025	• COMMUNICATION: Involve/collaborate with (Paul)/SDM in decision making for GERD Management. Revision on: 02/10/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 02/10/2025 Revision by: Maryola Perion (RN)		

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed: **09/06/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		• POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals.	PCA Registered Staff	
		• MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	Registered Staff	
• Potential for BOWEL INCONTINENCE related to having an accident episode Revision on: 02/10/2025 Revision by: Maryola Perion (RN)	• Paul will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 02/10/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function.	Registered Staff	
		• BOWEL Continence level is Continent. Report change to level as noted. Revision on: 07/25/2025 Revision by: Maryola Perion (RN)	PCA	
		• BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency.	PCA	
		• INCONTINENCE PRODUCT: Paul uses a White Brief on Days, Evening and Nights shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• URINARY Incontinence Revision on: 09/27/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Paul will receive support and promote urinary continence each shift through to the next review. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)		
		• URINARY Continence level is frequently incontinent. Report change to level as noted. Revision on: 11/12/2022 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Paul uses a White Brief on Days, Evening and Nights shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Penicillin	• Paul will be protected from exposure to allergen each day through next review date.	• COMMUNICATION: Involve/collaborate with Paul/SDM in decision making and health teaching about ALLERGY to PCN. Revision on: 12/05/2020		

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed:	**09/06/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)	Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	Revision by: Jenny Liu (RAI Coord Back-up) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy of Penicillin for changes to health status and complications mortality. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • MD/PHARMACY ALERT: Notify the MD and Pharmacy of Paul Allergy to Penicillin and minimize risk for exposure to allergen. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • RESCUE MEDICATION: Administer EPINEPHRINE as per MD/NP Order. Monitor effectiveness and immediately notify MD/NP of use.	Registered Staff	
• COGNITIVE LOSS; alteration in thought processes (memory loss, poor judgment, etc.) related to Cognitive Impairment Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)	• Paul will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 12/06/2025	• ORIENTATION: Gently reorient to (person, place, time) as needed when Paul is feeling lost or in confused state. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Impairment, Schizophrenia and Epilepsy Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)	• Paul will be supported to maintain current self participation in ADL care and assisted to ensure all ADL care tasks are met each day through to the next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• BATHING: Paul prefers (shower) on (Wednesdays and Sundays on Day shift). Paul participates by (providing a wash cloth and washing the upper part of the body). One staff (EXTENSIVE) assistance for bathing. Two staff for Transfer. Nail care to be provided on shower/bath day. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • BED MOBILITY: Paul is able to turn and reposition himself Independently in bed but he may require one staff Limited assistance at times. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • DRESSING: Paul is able to guide his arms and legs through the clothes, but requires Extensive assistance from one staff member to dress his upper and lower body.	PCA PCA PCA	

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Last Care Plan Review Completed: **09/06/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		He would like to wear a sweater in the warmer months when he is cold. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
		• EATING: Paul eats in the main floor dining room and is able to feed himself with supervision and set up from a staff member. Remind and encourage Paul to go down for his meals and ensure that he stays to eat. Paul prefers to have his breakfast in the dining room before scheduled service start time. Revision on: 03/11/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• LOCOMOTION: Paul requires the use of a wheelchair as his mode of locomotion. He is able to propel it on and off the unit but may require one staff assistance at times. Paull will try to get up and walk by himself which puts him at risk due to weakness, impaired balance and/or unsteady gait. Staff to assist when needed and put him back safely in his wheelchair. Remind Paul to stay in his wheelchair and to ask for assistance as needed. Revision on: 09/23/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Paul requires one staff to check and provide peri-care as needed due to incontinence episodes and unable to clean himself properly. Paul is encouraged to ask for assistance as needed. Staff to shave him as needed. Revision on: 11/18/2024 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Paul is a 2 person assist to transfer on and off the toilet and to adjust his clothes. He may require 2 staff assistance at times to assist in changing his incontinent product and to provide peri care. Paul is encouraged to ask for assistance as needed. Revision on: 08/28/2025 Revision by: Idylle Labrado (RPN)	PCA	
		• TRANSFERRING: Paul is 2 person transfer Revision on: 08/28/2025 Revision by: Idylle Labrado (RPN)	PCA	

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described(R56.80), Constipation(K59.0), Gastro-oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A

Last Care Plan Review Completed:	**09/06/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Cognitive Impairment, Schizophrenia and Epilepsy Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)		• ORAL CARE: Paul is Independent with staff to set up -upper and lower dentures. One staff may be required to assist Paul in cleaning his dentures when Paul is weak. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: Personal Care Aides. Revision on: 12/18/2015 Revision by: Kenya Mosely (Registered Practical Nurse)	PCA Registered Staff	
		• SHAVING - Staff to ask Paul if he wanted to be shaved on his shower days and as needed. Revision on: 11/18/2024 Revision by: Maryola Perion (RN)	PCA	D
• Expressed Wishes and Beliefs related to Paul Medical Treatment and End of Life Care Revision on: 08/10/2020 Revision by: Joe Albano (RAI Coordinator)	• To support and honor Paul expressed wishes and beliefs through to the End of Life. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• CPR: Paul wishes to have CPR and TRANSFER to hospital. Revision on: 09/07/2022 Revision by: Jenny Liu (RAI Coord Back-up)		
• SPIRITUAL BELIEFS: Paul is of the Roman Catholic Faith. Revision on: 04/21/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide Paul spiritual support as interested through to the next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• PERSONAL CHOICE: Respect Paul's right to decline participation in Spiritual Programs. Revision on: 04/21/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Nutrition Risk Level (diet details)	• Paul will be adequately nourished aeb consuming >75%	• LABELLED SNACK PM: ice cream cup daily (115 ml fluid) Revision on: 08/22/2025	PCA Registered	D

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described(R56.80), Constipation(K59.0), Gastro-oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A
Last Care Plan Review Completed:	**09/06/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	at meals and snacks through to next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025 • Will weigh within Realistic weight range of 60-70kg through to next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025 • Paul will be adequately hydrated aeb drinking at least 95% of total fluid requirement: 1578 ml/day (25 ml/kg using 63.1 kg weight) through to next review date. Revision on: 04/17/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/06/2025	Revision by: Holly Laasanen (Dietitian (RD)) • NUTRITION RISK: Paul is moderate risk level. Revision on: 04/17/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DIET ORDER: Paul will receive regular diet, regular texture Revision on: 09/02/2022 Revision by: Anna Slack (Registered Dietitian) • FLUID CONSISTENCY: Paul drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/19/2021 Revision by: Olivia Kuhlmann (Dietetic Intern) • FLUID TARGET: Encourage Paul to drink a minimum 1500 ml/day. Revision on: 04/17/2025 Revision by: Holly Laasanen (Dietitian (RD)) • EXTRA FLUIDS: Offer a minimum of 300ml high moisture food or fluid outside of meals and snacks daily. Revision on: 05/10/2023 Revision by: Chelsea Campbell-Wright (IPAC LEAD) • HIGH CALORIE/PROTEIN IN MEALS: Try saving a plate for Paul (covered, in the fridge) for him to eat when he returns from LOA Revision on: 08/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	Practical Nurse RN Dietitian (RD) Diet Food Services Aide PCA Diet PCA PCA PCA PCA	 BLD
• SLEEP PATTERN Revision on: 12/18/2015 Revision by: Kenya Mosely (Registered Practical Nurse)	• To promote adequate rest/sleep for Paul based on identified sleep patterns/preferences each night through to the next review date. Revision on: 09/05/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/06/2025	• REST PATTERN: Paul prefers to get up right before breakfast and return back to bed at when he wants; he does take naps during the day. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up) • SLEEPWEAR: Staff to encourage and cue Paul to put on his Pajamas/Johnny Shirt at night because he will not change his clothing. Revision on: 12/05/2020 Revision by: Jenny Liu (RAI Coord Back-up)	PCA PCA	

Allergies	Penicillins	**D.O.B.**	02/06/1959	**Physician**	Albert Patrick Ng
Diagnosis	Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described(R56.80), Constipation(K59.0), Gastro-oeso...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Lesperance, Paul (922131002955)	**Admission Date**	11/16/2007	**Location**	4 425 A
Last Care Plan Review Completed:	**09/06/2025**				

Diagnosis Schizophrenia, unspecified(F20.9), Depressive episode, unspecified(F32.9), Bipolar affective disorder, unspecified(F31.9), Seizure disorder, so described (R56.80), Constipation(K59.0), Gastro-oesophageal reflux disease without oesophagitis(K21.9)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Need for PAIN and Symptom Management related to End of Life Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Ronald to be comfortable and have pain managed each day through to his/her end of life. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026 • To provide Ronald with End of Life symptom management each day through to the End of Life. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident in Palliative/End of Life phase for Pain/change to comfort level and symptoms of impending death Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • FATIGUE: Encourage Ronald to rest as needed. He indicates preference to (lay quietly with eyes closed, nap through day/night, etc.) Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • HYDRATION: Provide fluid orally as tolerated Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • DYSPNEA Management: Position head of bed elevated to 30-45 degrees as needed Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • OXYGEN: Provide Oxygen therapy as needed as MD/NP order. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer medications for (SOB, secretion management, pain, etc.) as per MD/NP order. Monitor effectiveness and seek re-assessment if clinically needed. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • POSITIONING: Turn and reposition Q2h and PRN. While repositioning monitor for moaning, facial grimacing, guarding, rigidity and obvious discomfort. If symptoms are noted; report to Registered Staff immediately after repositioning resident.	PCA	Q2h
• Decline in ADL function and increased dependency for ADL care related to the End of Life phase Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To ensure Ronald dignity and care needs are met each day through to the End of Life. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/26/2026	• BED MOBILITY - 1-2 staff TOTAL care to turn and re-position (Residents Name) every 2 hours and as needed. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator) • BATHING - 2 staff provide (TOTAL) care with provide bed daily as tolerated. May offer shower/tub bath if able.	PCA PCA	Q2h D

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A

Last Care Plan Review Completed:	**08/20/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• EATING - Meal service provided at bedside. 1 staff to feed resident snacks/meals/fluids as tolerated. Monitor swallowing and notify Nurse if difficulty noted. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• HYGIENE - 1-2 staff TOTAL care for hygiene care every shift + PRN. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• HAND HYGIENE: 1 staff to provide (TOTAL) assistance to (use soap/water, apply sanitizer, rub hands together, dry hands) for hand hygiene. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• ORAL HYGIENE: 1 staff to complete oral care every 2 hours and as needed. Resident may refuse. Respect choice. Reapproach when needed. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• EYE CARE: 1 staff to complete eye care every shift and as needed. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA Registered Practical Nurse RN	
		• DRESSING - 1-2 staff TOTAL care to dress Ronald from head to toe. Lt. foot drop and wears AFO (ankle foot orthosis). One staff to assist in removing and putting it on. Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TOILETING: 1-2 staff TOTAL care for check every 2 hours as needed and change as soiled). Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TRANSFER - (Resident Name) prefers to remain in bed. If transfer required/requested; 2 staff TOTAL care for transfer using Mechanical Lift (or Specify	PCA	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Decline in ADL function and increased dependency for ADL care related to the End of Life phase Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)		otherwise). • TRANSFER LIFT/SLING: (Specify TYPE of lift and SIZE of sling) needed for transfer. • LOCOMOTION (in/out of room): 1 staff to porter to/from destination as needed per resident preference Revision on: 10/30/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA All PCA	
• Alteration in skin integrity with risk for infection or complications related to Deep tissue injury to coccyx secondary to Pressure Injury Revision on: 10/24/2025 Revision by: Katherine Arca (RPN)	• To minimize risk ofDeep tissue injury to coccyx infection each day until fully healed. Revision on: 10/24/2025 Revision by: Katherine Arca (RPN) Target Date: 01/26/2026 • To promote optimal healing of Deep tissue injury to coccyx within (specify date of expected healing or end of treatment date or next review date *** and remember to also alter the goal target date to the same). Revision on: 10/24/2025	• TREATMENT PLAN: Administer treatment for Deep tissue injury to coccyx as per MD Order. Revision on: 10/24/2025 Revision by: Katherine Arca (RPN) • HEALTH EDUCATION: Engage with (Resident Name)/SDM to enhance his/her comprehension of suggested treatment and possible complications associated with Deep tissue injury to coccyx Revision on: 10/24/2025 Revision by: Katherine Arca (RPN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Stage Deep tissue injury to coccyx for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 10/24/2025 Revision by: Katherine Arca (RPN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN		

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to Deep tissue injury to coccyx secondary to Pressure Injury Revision on: 10/24/2025 Revision by: Katherine Arca (RPN)	Revision by: Katherine Arca (RPN) Target Date: 01/26/2026	using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/24/2025 Revision by: Katherine Arca (RPN)		
		• NUTRITIONAL SUPPLEMENT for Skin Healing in place; refer to Dietary Care Plan. Revision on: 10/24/2025 Revision by: Katherine Arca (RPN)	Dietitian (RD)	
• Potential to experience alteration in RESPIRATORY FUNCTION related to Shortness of breath, Low oxygen Saturation. Revision on: 10/15/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Shortness of breath, shortness of breath each day through to next review date. Revision on: 10/15/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM in decision making of Respiratory Management for SOB, Low Oxygen Saturation. Revision on: 10/15/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Shortness of breath, low oxygen saturation for changes to health status and alteration or complications affecting respiratory function. Revision on: 10/15/2025 Revision by: Maryola Perion (RN)	Registered Staff	
		• POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing. Revision on: 10/15/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA	
		• OXYGEN: Administer Oxygen as per MD order. Revision on: 10/15/2025 Revision by: Maryola Perion (RN)	Registered Staff	
		• MEDICATION: Administer medication (inhalers, etc.) for as per MD/NP order and monitor for side effects. Revision on: 10/15/2025 Revision by: Maryola Perion (RN)	Registered Staff	
• Alteration in skin integrity with risk for infection or complications related to	• To promote optimal healing of SKIN TEAR within the target	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with SKIN TEAR for changes to health status and alteration or complications affecting		

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
#92 - Skin Tear - Total Flap Loss Right Calf Lateral Onset date: 9/27/25 Revision on: 09/28/2025 Revision by: Maryola Perion (RN)	date. Revision on: 09/28/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	skin integrity. Revision on: 09/28/2025 Revision by: Maryola Perion (RN) • TREATMENT PLAN: Administer treatment for SKIN TEAR to #92 - Skin Tear - Total Flap Loss Right Calf Lateral as per MD Order. Revision on: 09/28/2025 Revision by: Maryola Perion (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 09/28/2025 Revision by: Maryola Perion (RN)		
• Alteration in skin integrity with risk for infection or complications related to #91 - Pressure - Stage 2 - Left Heel Revision on: 09/27/2025 Revision by: Janina Lucero (RN)	• To minimize risk of #91 - Pressure - Stage 2 - Left Heel infection each day until fully healed. Revision on: 09/27/2025 Revision by: Janina Lucero (RN) Target Date: 01/26/2026 • To promote optimal healing of D#91 - Pressure - Stage 2 - Left Heel within the next review date. Revision on: 09/27/2025 Revision by: Janina Lucero (RN) Target Date: 01/26/2026	• TREATMENT PLAN: Administer treatment for #91 - Pressure - Stage 2 - Left Heel as per MD Order. Revision on: 09/27/2025 Revision by: Janina Lucero (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with #91 - Pressure - Stage 2 - Left Heel for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 09/27/2025 Revision by: Janina Lucero (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 09/22/2025 Revision by: Katherine Arca (RPN) • NUTRITIONAL SUPPLEMENT for Skin Healing in place; refer to Dietary Care Plan. Revision on: 09/22/2025 Revision by: Katherine Arca (RPN)	Dietitian (RD)	
• Increased risk for FALLS related to history of falls, left sided weakness, alcohol consumption, impaired mobility and balance, unsteady gait, antidepressant medication, self transferring.	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 08/09/2023	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM in decision making in fall prevention Plan of Care. Revision on: 11/08/2022 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within Ronalds reach, check that it is in working order	PCA	D/E/N

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN)		
		• ADAPTIVE AIDS: Place adaptive aid/needed objects (urinal, etc.) within easy reach of Ronald. Revision on: 08/30/2024 Revision by: Maryola Perion (RN)	PCA	
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair. Revision on: 03/01/2025 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Ensure Ronalds environment is clean and clear of clutter. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• FOOTWEAR: Ensure Ronald wears appropriate footwear at all times. Staff to provide Ronald non skid socks and to encourage him to wear them. Revision on: 08/30/2024 Revision by: Maryola Perion (RN)	PCA	
		• PURPOSEFUL ROUNDING: Conduct purposeful rounding to assess residents needs; for pain, positioning, peri-needs or possessions for safety. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA Registered Practical Nurse RN	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 08/12/2025 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM in decision making for GERD Management. Revision on: 08/12/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 08/12/2025 Revision by: Maryola Perion (RN)		
		• POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals.	PCA Registered Staff	
		• MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 08/12/2025 Revision by: Maryola Perion (RN)				
• Transfer Training Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Reduce assistance needed for transfers from Sara- mechanical lift to 2 person assist in next 6 months Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/26/2026	• 2:1 assist sit to stand at the parallel bar, slowly increase standing endurance from 5 to 30sec in next 1 month; 2-3 x a week; Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to use of diuretic medication. Revision on: 03/01/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date Revision on: 02/14/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 02/10/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. • PROMOTE FLUIDS: Promote Ronald to consume fluids; amount as per Nutrition Care Plan. Revision on: 02/10/2025 Revision by: Maryola Perion (RN)	Registered Staff	
• Potential to experience alteration in MOOD as exhibited by sad, pained,	• To decrease the episodic frequency of negative Mood	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed.		

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
worried facial expression related to Decline in Health Condition. Revision on: 03/01/2025 Revision by: Maryola Perion (RN)	symptoms by next review date. DRS score will be maintained to 0. Revision on: 01/25/2024 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	Revision on: 11/03/2023 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Ronald for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 11/03/2023 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Ronald's effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 11/03/2023 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 11/03/2023 Revision by: Maryola Perion (RN)		
• Maniacco, Ronald is experiencing colonization with Antibiotic Resistant Organism MRSA+ Nares February 17th 2025 Revision on: 02/18/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To lower risk of infection and prevent transmission of identified Antibiotic Resistant Organism through to the next review. Revision on: 10/15/2024 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald/SDM) with decision making for Antibiotic Resistant Organism treatment plan and update accordingly. Revision on: 10/15/2024 Revision by: Maryola Perion (RN) • HEALTH EDUCATION: Engage with Ronald/SDM to enhance their knowledge of infection control practices such as hand hygiene, visitation, PPEs, isolation, transmission, etc. for Antibiotic Resistant Organism. Revision on: 10/15/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of monitoring Ronald for signs/symptoms of secondary infection, overall health condition, etc. Revision on: 10/15/2024 Revision by: Maryola Perion (RN) • PPE PRECAUTIONS: Precaution identified as CONTACT for (MRSA to foot wound) and requires use of the following PPEs: Gloves, Gown, Mask, Faceshield, Goggles when providing direct care, handling soiled clothes and linens, disposing of incontinent product, etc. Revision on: 07/08/2025 Revision by: Danielle Loreto (RAI Coordinator)	Registered Staff Registered Staff Registered Staff Personal Support Workers	
• Potential to experience alteration in	• To treat and minimize	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM in decision making of		

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
CARDIAC FUNCTION related to; Hypertension, CHF, Pacemaker Revision on: 02/18/2025 Revision by: Danielle Loreto (RAI Coordinator)	signs/symptoms or complications associated with HTN through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	Cardiac Care Management for Hypertension. Revision on: 11/18/2022 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of Ronald with HTN for changes to health status and alteration or complications affecting cardiac function. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• MEDICATION: Administer medication for HTN as per MD Order and monitor for side effects. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	Registered Practical Nurse RN	
		• OXYGEN: Administer Oxygen as per MD order. Revision on: 11/18/2022 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• PACEMAKER In Situ: Resident has a pacemaker and see schedule for the follow up appointment. Revision on: 03/01/2025 Revision by: Maryola Perion (RN)		
• Ronald has potential to experience a safety hazard/burn injury related to personal SMOKING habits, Hx of burn to Rt. upper chest. Revision on: 01/13/2025 Revision by: Maryola Perion (RN)	• Ronald will be safe when choosing to smoke through to the next review Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve (Ronald/SDM) in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) and identify the designated area/s where smoking is permitted. Revision on: 11/18/2022 Revision by: Maryola Perion (RN)	Social Worker	
		• HEALTH TEACHING: engage with resident and support their effort to explore smoking cessation options (Nicotine Transdermal [Clear] PAT (Patch) 21mg/day REMOVE OLD PATCH AND APPLY 1 NEW PATCH DAILY). Revision on: 10/17/2025 Revision by: Maryola Perion (RN)		
		• SMOKING CONTRACT: Ronald has agreed to follow safe smoking rules and accepts the consequences of breaking those agreed upon rules by signing the smoking contract (refer to chart). Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)	Social Worker Administrator	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of SOCIALLY Inappropriate (history of disruptive behavior when drinking), drinking alcohol in his room, resisting care (meal, medication or bath/shower), verbal abuse (calling names) related to alcohol consumption, short term memory loss. Revision on: 08/27/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by next review date. ABS score will be maintained to 0. Revision on: 03/01/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 11/18/2022 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Ronald for indications to change in or for escalating expressive behaviour risk. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • TRIGGERS leading to VERBAL (calling names, etc.) as expression of behaviour include (frustration, misunderstanding care intention, etc.) Revision on: 08/27/2024 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Ronald is heard calling others names; calmly remind him to lower his voice and that chosen words are not appropriate. Attempt to resolve his concern. Report episode to Registered Staff. Revision on: 08/27/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusal to bathe, to eat, medication, etc.) as expression of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 04/16/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Ronald is refusing to (bathe, to eat, medication, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 04/16/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate disruptive vocalizations, etc. as expression of behaviour includes (decreased insight, poor judgement, etc.) Revision on: 04/12/2023 Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If Ronald is noted to make loud disruptive noises in dining room/program, etc. gently redirect him to focus on task at hand or escort to quieter area. Revision on: 11/07/2022	BSO - Internal BSO - External Social Worker	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of SOCIALLY Inappropriate (history of disruptive behavior when drinking), drinking alcohol in his room, resisting care (meal, medication or bath/shower), verbal abuse (calling names) related to alcohol consumption, short term memory loss. Revision on: 08/27/2024 Revision by: Maryola Perion (RN)		Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Alteration in skin integrity related to Hx of contact dermatitis Revision on: 07/06/2024 Revision by: Maryola Perion (RN)	• To promote intact skin integrity through to the target date. Revision on: 07/06/2024 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hx of contact dermatitis for changes to health status and alteration or complications affecting skin integrity. Revision on: 07/06/2024 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• MEDICATION: Administer medication as per MD Order. Monitor effectiveness and for side effects. Revision on: 07/06/2024 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Altered VISION related to minimal vision in left eye, eyeglasses for reading. Revision on: 04/16/2024 Revision by: Maryola Perion (RN)	• Ronald will use glasses for vision correction daily through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM for decision making pertaining to change in visual status as needed. Revision on: 04/16/2024 Revision by: Maryola Perion (RN)		
		• EYEGLASSES: Ronald wears eyeglasses for reading. Assist to clean eyeglasses as needed and store on night table when sleeping.	PCA	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/26/2026	Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential for falls related to Age and Alcohol use/Post-fall interventions to mitigate falls risk related to Age and Alcohol use	• To decrease the number of falls throughout this review period Feb.20/24 to May 20/24 Target Date: 01/26/2026	• Conduct intentional rounding every hour to assess the resident for pain , peri-needs, position , possessions and safety Revision on: 10/16/2024 Revision by: Maryola Perion (RN) • Encourage resident to wear non-skid footwear during transfer. • Ensure call bell/phone/TV remote/ bed control/shoes/Wheelchair are within easy reach for the resident • Remind resident to call for help when needed.		
• Ronald has potential for recurrence of SUBSTANCE ABUSE, withdrawal symptoms, mood/behaviour disturbances related to history of Alcoholism, alcohol intoxication coming from LOA, drinking alcohol in his room. Revision on: 01/29/2024 Revision by: Maryola Perion (RN)	• Ronald will remain free of non-prescribed (alcohol) through next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• SET BOUNDARIES: Discuss behavioural limits and expectations with Ronald. Be very clear with limits to establish behaviour boundaries. Revision on: 05/02/2023 Revision by: Maryola Perion (RN) • ROOM CHECK: Check Ronald's room/belongings for (alcohol, etc.) each upon expected use, etc.. If any found report to Charge Nurse/DOC/ED/SW. Revision on: 05/02/2023 Revision by: Maryola Perion (RN)	Social Worker Director of Care Executive Director	
• Ron DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 4/6 Revision on: 08/07/2023 Revision by: Mitchell Atkinson (Recreation Aide)	• Ron will participate in Independent/Self-Directed activities monthly through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• FRIENDLY VISIT: Provide Ron with one to one visits as tolerated. Touch base to maintain contact and to discuss potential interest in upcoming programs. • INVITATION: Offer friendly invites to structured programs scheduled in the home. Such as main floor socials, TV programs, special events, etc. Revision on: 05/08/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as; Watching/listening to TV, listening to music, patio socializing/enjoying	ACT ACT	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		outdoors, visiting with residents/team members, etc. Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)		
		• ONE to ONE: Provide him with individual visits for conversation, reading, reminiscing, music, humor, etc. Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
		• SOCIAL INTERACTION: Promote the opportunity for Ronald to make friendships and sit with friends during activities. Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
• COGNITIVE LOSS; alteration in thought processes memory loss, difficulty concentrating, poor judgement related to short term memory loss. Revision on: 07/31/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Ronald will be supported to maintain cognitive function through the review date. Current CPS is 2. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• ORIENTATION: Gently reorient to place, time as needed when Ronald is feeling lost or in confused state. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• ENVIRONMENT: Provide environmental clue to promote Ronalds ability to locate room and navigating home area (name plate) outside of room. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Use of PASD (one 1/4 bed rails to left side) to assist resident with Activity of Daily Living (bed mobility and transfer). Revision on: 07/31/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Ronald will be effectively supported with use of one 1/4 bed rail to the left side to optimize Activity of Daily Living (bed mobility and transfer) each day through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of one 1/4 bed rail. Revision on: 11/15/2022 Revision by: Suzanne Azar (RN)		
		• MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use one 1/4 bed rail as to support appropriate bed mobility and transfer. Revision on: 11/15/2022 Revision by: Suzanne Azar (RN)		
		• BED RAIL (One PARTIAL): 1/4 Rail to LEFT side in USE as a PASD to assist resident with bed mobility, transfer in/out of bed. Monitor every shift. Revision on: 11/15/2022 Revision by: Suzanne Azar (RN)	PCA	D/E/N
• Sleep Patterns.	• To promote adequate	• REST PATTERN: Preferred bedtime: Between 20:00-21:00, usual wake time:	PCA	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 02/09/2023 Revision by: Maryola Perion (RN)	rest/sleep for Ronald based on identified sleep patterns/preferences each night through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	Between 6:00-7:00 Revision on: 12/15/2022 Revision by: Maryola Perion (RN) • SLEEPWEAR: Ronald prefers to wear his own clothes. Revision on: 12/15/2022 Revision by: Maryola Perion (RN)	PCA	
• Potential for CONSTIPATION related to decreased mobility, etc. Revision on: 11/25/2022 Revision by: Maryola Perion (RN)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • Ronald will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald/SDM) for decision making regarding constipation management. Revision on: 11/25/2022 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan.	Registered Staff Registered Staff	
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA) with Left side weakness Revision on: 11/18/2022 Revision by: Maryola Perion (RN)	• To treat and minimize signs/ symptoms or complications associated with CEREBROVASCULAR ACCIDENT (CVA) with Left side weakness through to the next review date. Revision on: 08/09/2023	• COMMUNICATION: Involve/ collaborate with (Ronald)/ SDM in decision making of neurological care management for CEREBROVASCULAR ACCIDENT (CVA) with Left side weakness Revision on: 11/18/2022 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for CEREBROVASCULAR ACCIDENT (CVA) with Left side weakness as per MD order. Monitor effectiveness and for side effects. Revision on: 11/18/2022	PCA	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A

Last Care Plan Review Completed: **08/20/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with CEREBROVASCULAR ACCIDENT (CVA) with Left side weakness for changes to health status and alteration or complications affecting neurological function. Revision on: 11/18/2022 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, etc.) Revision on: 11/18/2022 Revision by: Maryola Perion (RN)	• To promote Ronald understanding of treatment regime and possible side effects of medication taken through to the next review. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with (Ronald)/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 11/18/2022 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 11/18/2022 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• SPIRITUAL BELIEFS: Ronald is of the Catholic Faith. Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)	• To provide Ronald spiritual support as interested through to the next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• PERSONAL CHOICE: Respect Ronald's right to decline participation in Spiritual Program. Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
• Potential for BOWEL INCONTINENCE related to left sided weakness, impaired	• Ronald will have bowel incontinence managed every	• MONITORING: Utilize holistic perspective of continuous monitoring of Ronald for changes to health status, alteration of continence level or bowel function.		

Focus	Goal	Interventions	Position	Freq/Resolved
mobility. Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)	shift through to the next review period. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • BOWEL Continence level is TOTAL INCONTINENCE. Report change to level as noted. Revision on: 02/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Ronald wears Blue brief on Days, Evening and Night shift. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA	
• Expressed Wishes and Beliefs related to Ronald's Medical Treatment and End of Life Care Revision on: 11/14/2022 Revision by: Mitchell Atkinson (Recreation Aide)	• To support and honor Ronald's expressed wishes and beliefs through to the End of Life. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• CPR: Ronald wishes express NO CPR and NO TRANSFER to hospital. Revision on: 02/19/2025 Revision by: Maryola Perion (RN) • FUNERAL Arrangements: Simple Choice Cremations on Dougall Avenue- 519-254-2585 Revision on: 03/01/2025 Revision by: Maryola Perion (RN)	Social Worker ST	
• Strength Revision on: 11/08/2022 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• Ronald to increase strength of B/L UE from 3+/5 to 4/5 in 3 months. Revision on: 01/24/2024 Revision by: Shina Wadhwa (PT - Physiotherapist) Target Date: 01/26/2026	• Ronald to perform strength exe. using 1-3lbs. wt., 1set,10 rps., 2-3/wk as tolerated, per rehab treatment. Revision on: 05/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Ambulation. Revision on: 11/08/2022 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• To maintain walking endurance over 3 months Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• ON HOLD: Gait training with High wheeled walker, 2 person assist with 2nd person helping with w/c as well. Distance as best tolerated, 4-5 x a week; Revision on: 08/19/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A

Last Care Plan Review Completed: **08/20/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/26/2026			
• Nutrition Risk Level	• Ronald will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • Will weigh within Realistic weight range of RWR 70 -78 kg/BMI 22.5 - 25 through to next review date. Revision on: 01/06/2025 Revision by: Debora Choi (Dietitian (RD)) Target Date: 01/26/2026 • Ronald will be adequately hydrated aeb drinking at least 80% of TFR: 1695 ml/day (25 ml/kg using 67.8 kg weight) through to next review date. Revision on: 10/30/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/26/2026	• NUTRITION RISK: Ronald is high risk level. Revision on: 10/30/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DIET ORDER: Ronald will receive regular diet, minced texture Revision on: 10/21/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FLUID CONSISTENCY: Ronald drinks REGULAR/THIN Level 0 Fluids. Revision on: 11/07/2022 Revision by: Anna Slack (Registered Dietitian) • FLUID TARGET: Encourage Ronald to drink a minimum of 1356 ml/day Revision on: 10/30/2025 Revision by: Holly Laasanen (Dietitian (RD)) • ADAPTIVE AIDS: lipped plate for meals, Kennedy cup for fluids Revision on: 10/14/2025 Revision by: Holly Laasanen (Dietitian (RD)) • COMFORT NUTRITION: Ronald will be offered meals/fluids and his intake will be as tolerated/as desired. Revision on: 10/30/2025 Revision by: Holly Laasanen (Dietitian (RD)) • MEDPASS SUPPLEMENTS: 90 ml of Resource 2.0 TID Revision on: 10/14/2025 Revision by: Holly Laasanen (Dietitian (RD)) • LABELLED SNACK AM: ice cream cup daily to promote weight stability Revision on: 09/30/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD) PCA Diet PCA PCA PCA PCA RN PCA	D/E
• URINARY (Mixed) INCONTINENCE related to left sided weakness, frequent urinary incontinence. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI	• Ronald will have urinary incontinence managed every shift through to the next review period. Revision on: 08/09/2023	• MONITORING: Utilize holistic perspective of continuous monitoring of Ronald for toileting needs, changes to health status and alteration of continence level. Revision on: 11/07/2022 Revision by: Katie Wolters-Savo (RAI Coordinator) • CHECK and CHANGE: RONALD experiences TOTAL incontinence and requires	PCA	

Focus	Goal	Interventions	Position	Freq/Resolved
Coordinator)	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	checks every and change each time noted to be soiled. Revision on: 02/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • INCONTINENCE PRODUCT: Ronald wears Blue brief on Days, Evening and Night shift. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • ADAPTIVE EQUIPMENT/AID: Resident uses urinal to be labelled and changed per order. Revision on: 11/03/2023 Revision by: Maryola Perion (RN)	PCA PCA	

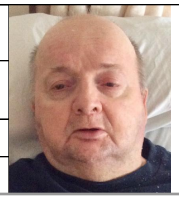
Diagnosis Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imaging of lung(R91), Hemiplegia of unspecified type of non-dominant side(G81.91), Fracture of rib, closed(S22.300), Fracture of C5 - C7 vertebra, closed(S12.210), Abdominal aortic aneurysm, without mention of rupture(I71.4), Cyst of kidney, acquired(N28.1), Resistance to methicillin(U82.1), Congestive heart failure(I50.0), Presence of cardiac pacemaker(Z95.00), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Post-traumatic wound infection, not elsewhere classified(T79.3)

Allergies	No Known Allergies	**D.O.B.**	08/25/1935	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Benign hypertension(I10.0), Bradycardia, unspecified(R00.1), Cerebral infarction, unspecified(I63.9), Abnormal findings on diagnostic imag...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Maniacco, Ronald (922131005272)	**Admission Date**	11/07/2022	**Location**	4 410 A
Last Care Plan Review Completed:	**08/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity related to MASD # 72 right trochanter/ right abdominal fold Revision on: 10/14/2025 Revision by: Maryola Perion (RN)	• To promote intact skin integrity through healing of MASD until the next review date. Revision on: 10/11/2025 Revision by: Jane Del Rosario (RPN) Target Date: 12/08/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MASD for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/11/2025 Revision by: Jane Del Rosario (RPN)	Registered Practical Nurse RN	
		• TX: Administer treatment as per MD Order. Revision on: 10/14/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse Registered Practical Nurse	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/11/2025 Revision by: Jane Del Rosario (RPN)		
• Alteration in skin integrity with risk for infection or complications related to BLISTER TO LOWER RIGHT CALF secondary to Immobility Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)	• To minimize risk of BLISTER TO LOWER RIGHT CALF infection each day until fully healed. Revision on: 09/23/2025 Revision by: Katherine Arca (RPN) Target Date: 12/08/2025	• TREATMENT PLAN: Administer treatment for BLISTER TO LOWER RIGHT CALF as per MD Order. Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)		
		• HEALTH EDUCATION: Engage with (Resident Name)/SDM to enhance his/her comprehension of suggested treatment and possible complications associated with BLISTER TO LOWER RIGHT CALF Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)		
	• To promote optimal healing of BLISTER TO LOWER RIGHT CALF within (specify date of expected healing or end of treatment date or next review date *** and remember to also alter the goal target date to the same). Revision on: 09/23/2025 Revision by: Katherine Arca (RPN) Target Date: 12/08/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with BLISTER TO LOWER RIGHT CALF for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)		
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)		

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A



Last Care Plan Review Completed: 09/08/2025

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to BLISTER TO LOWER RIGHT CALF secondary to Immobility Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)		• NUTRITIONAL SUPPLEMENT for Skin Healing in place; refer to Dietary Care Plan. Revision on: 09/23/2025 Revision by: Katherine Arca (RPN)	Dietitian (RD)	
• Edward is experiencing episode of INFECTION Due to leg wound Onset date: (9/11/2025) Revision on: 09/11/2025 Revision by: Rana Maghnieh (RPN)	• To effectively treat and manage leg wound INFECTION without further complications Revision on: 09/11/2025 Revision by: Rana Maghnieh (RPN) Target Date: 12/08/2025	• MEDICATIONS: Administer ABX therapy for infection as per MD/NP order. Revision on: 09/11/2025 Revision by: Rana Maghnieh (RPN) • MONITORING: Utilize holistic perspective of monitoring resident with Wound INFECTION for overall health condition, until stable. Revision on: 09/11/2025 Revision by: Rana Maghnieh (RPN) • VITAL SIGNS: Monitor VITAL SIGNS every shift until ABX therapy completed Revision on: 09/11/2025 Revision by: Rana Maghnieh (RPN)		
• Alteration in skin integrity with risk for infection or complications related to Venous ulcer to Bilateral LOWER LEGS secondary to Immobility Revision on: 09/09/2025 Revision by: Katherine Arca (RPN)	• To minimize risk of Venous ulcer to Bilateral LOWER LEGS infection each day until fully healed. Revision on: 09/09/2025 Revision by: Katherine Arca (RPN) Target Date: 12/08/2025 • To promote optimal healing of OPEN LESION TO Venous ulcer to Bilateral LOWER LEGS within 12/8/2025 Revision on: 09/09/2025	• TREATMENT PLAN: Administer treatment Venous Ulcer to bilateral legs as per MD Order. Revision on: 09/09/2025 Revision by: Katherine Arca (RPN) • HEALTH EDUCATION: Engage with (Resident Name)/SDM to enhance his/her comprehension of suggested treatment and possible complications associated with Venous Ulcer to bilateral legs Revision on: 09/09/2025 Revision by: Katherine Arca (RPN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Venous Ulcer to bilateral legs for changes to health status, wound infection and alteration or complications affecting skin integrity. Revision on: 09/09/2025		

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A

Last Care Plan Review Completed: **09/08/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity with risk for infection or complications related to Venous ulcer to Bilateral LOWER LEGS secondary to Immobility Revision on: 09/09/2025 Revision by: Katherine Arca (RPN)	Revision by: Katherine Arca (RPN) Target Date: 12/08/2025	Revision by: Katherine Arca (RPN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 09/09/2025 Revision by: Katherine Arca (RPN) • NUTRITIONAL SUPPLEMENT for Skin Healing in place; refer to Dietary Care Plan. Revision on: 09/09/2025 Revision by: Katherine Arca (RPN)	Dietitian (RD)	
• Increased risk for FALLS related to: History of falls, Use of Psychotropic medications, Impaired mobility and balance, Unsteady gait, self transferring. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM in decision making in fall prevention Plan of Care. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair, walker Revision on: 06/06/2025 Revision by: Maryola Perion (RN) • ENVIRONMENT: Secure environment (reduce clutter) to reduce fall risk for Edward. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • BED: place bed in lowest position to lower risk for injury. Revision on: 07/23/2021 Revision by: Maryola Perion (RN) • FOOTWEAR: Ensure resident wears appropriate footwear for transfers, ambulation. Revision on: 06/05/2020 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA PCA	D/E/N
• Potential for Acute PAIN and alteration in comfort level related to Gout, Impaired	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through	• COMMUNICATION: Involve/collaborate with Edward/SDM about pain management, goals of treatment, plan of care and treatment options. Revision on: 03/06/2025		

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Mobility, buttock pain, Groin pain, Body Pain, Leg pain. Most Current RAI Pain Score is 0. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	to the next review. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025 • Promote RAI Pain Score of 0 through to the next review. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) Target Date: 12/08/2025	Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • NON VERBAL CUES of PAIN for (Edward McGuin) include - specify (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 07/17/2025 Revision by: Tola Omolade (ADOC) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse PCA Registered Practical Nurse RN	
• Alteration in skin integrity with risk for infection or complications related to #69 - Skin Tear - Total Flap Loss Right Calf Lateral Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	• To promote optimal healing of SKIN TEAR within the target date. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) Target Date: 12/08/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with #69 - Skin Tear - Total Flap Loss Right Calf Lateral for changes to health status and alteration or complications affecting skin integrity. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) • TREATMENT PLAN: Administer treatment for #69 - Skin Tear - Total Flap Loss Right Calf Lateral as per MD Order. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)		
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest, Withdrawn.	• Team members will support Edward in decreasing social isolation by participating in activities of personal choice 15-	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; friendly/1: 1 visits, comedy corner, games (bingo, Monopoly), reading groups, music programs (country, rock), Happy Hour, special events, spiritual programs, TV/movies (The Three Stooges & sports), etc.		

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
ISE Score: 5/6 Revision on: 09/03/2025 Revision by: Laura Morris (Restorative Care Aide)	30 times per month by the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	Revision on: 09/25/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as reading independently, watching/listening to TV, visiting with residents/team members, family/friend visits, listening to music (country, rock, Stomping Tom), etc. Revision on: 08/08/2023 Revision by: Elsie Calumpang (RN)		
		• HELPFUL HINTS: Identify Helpful Hints to ease communication while providing care/interactions for animals, building a house, Edward enjoys participating in group/SD programs with his brother. TV/movies - (Jerry Springer, Maury, hockey {Montreal Canadiens}, Three Stooges). etc. Revision on: 01/26/2021 Revision by: Kameron Stewart (Activities/Rec Therapy)	ACT	
		• ONE to ONE: Provide him with individual visits for conversation (NHL), reading, reminiscing, iPad (games), etc. Revision on: 08/14/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Alteration in skin integrity related to MASD to left buttock. Revision on: 11/20/2024 Revision by: Janina Lucero (RN)	• To promote intact skin integrity through healing of MASD by the next review date. Revision on: 11/20/2024 Revision by: Janina Lucero (RN) Target Date: 12/08/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MASD for changes to health status and alteration or complications affecting skin integrity. Revision on: 11/20/2024 Revision by: Janina Lucero (RN)	Registered Practical Nurse RN	
		• TOPICAL TX: Apply topical treatment to left buttock as MD Order. Revision on: 11/20/2024 Revision by: Janina Lucero (RN)	Registered Practical Nurse Registered Practical Nurse	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 11/20/2024 Revision by: Janina Lucero (RN)		
• Risk for/Impaired SKIN INTEGRITY related to Incontinence, Impaired Mobility,	• To protect and maintain skin integrity each day through to the	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered	PCA	

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Use of incontinent product, Bilateral lower leg edema. Revision on: 06/19/2024 Revision by: Maryola Perion (RN)	next review. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	Staff as noted. • HEALTH EDUCATION: Engage resident/SDM in health education regarding prevention of skin impairment. Encourage resident to go back to bed after meals and at bedtime for offloading. Revision on: 03/07/2025 Revision by: Chelsea Campbell-Wright (ADOC)		
		• EQUIPMENT: Edward has his own pressure relieving cushion (Systam) to offload pressure. Ensure it is inflated properly. The floor nurse and staff make sure the resident is using that cushion while he is sitting in the chair. Air mattress has been provided to help with offloading. Revision on: 04/01/2023 Revision by: Janina Lucero (RN)	PCA	
		• POSITIONING: Encourage Edward to turn, reposition at least every 2 hours when sitting in his chair and bed as per Edwards preference to offload pressure. Revision on: 03/07/2025 Revision by: Chelsea Campbell-Wright (ADOC)	PCA	Q2h
• Edward is enrolled in ACTIVE RANGE OF MOTION nursing restorative program and has the potential to show improvement to mobility function related to personal motivation to participate in exercise program, ability to follow directions and functional ability to safely perform exercises. Revision on: 05/29/2024 Revision by: Alyssa Egan (Interim ADOC)	• LONG TERM GOAL: To improve ED's AROM strength to be able to optimally self perform ADLs Revision on: 09/17/2024 Revision by: Haley Barisic (Quality Improvement Coordinator) Target Date: 12/08/2025	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Edward when partaking in AROM Nursing Restorative Program. Revision on: 06/17/2024 Revision by: Maryola Perion (RN)		
		• TIME SPENT: Enter amount of time in MINUTES that Edward performed AROM exercises using stepper. Revision on: 05/29/2024 Revision by: Alyssa Egan (Interim ADOC)	Restorative Care Aide	DEqshiftNprn
• Potential for Expressive Behaviour of resisting care, refusing to go to sleep/back	• To decrease the episodic frequency of resisting care by	• COMMUNICATION: Involve/collaborate with Edward/SDM about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
to his bed at night, wandering in hallway and entering just into the doorway of every residents room related to Mental Illness Schizophrenia, Anxiety disorder, Manic-depressive disorder, Bipolar Affective disorder, Depression. Revision on: 11/14/2023 Revision by: Maryola Perion (RN)	the next review date. ABS score will be less than 1. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) Target Date: 12/08/2025	needed. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Edward for indications to change in or for escalating expressive behaviour risk. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing medication, care, to sleep/go back to bed at night, etc.) as expression of behaviour include (misunderstanding care needs, poor judgment, etc.) Revision on: 09/27/2023 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Edward is refusing to (refusing medication, care, to sleep/go back to bed at night, etc.) re-approach in 10-15 minutes. Document care resisted and inform Physician when needed. Revision on: 09/27/2023 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for therapeutic treatment as per MD Order. Monitor effectiveness and for side effects. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	BSO - Internal BSO - External Social Worker Registered Staff Registered Practical Nurse RN	
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, unpleasant mood in the morning , insomnia/change in usual sleep pattern, sad, pain worried facial expression, related to Depression, Bipolar Disorder Revision on: 09/27/2023 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be less than 2. Revision on: 09/04/2025 Revision by: Maryola Perion (RN) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Edward for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Edward's effort to maintain control. Encourage him/her to express self, state preferences and make safe choices for care and activities. Revision on: 01/27/2021		

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision by: Maryola Perion (RN) • SLEEP/REST: Promote adequate sleep and rest to stability of Edward's mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 04/06/2023 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		
• Potential for CONSTIPATION related to (decreased mobility, etc.) Revision on: 07/03/2023 Revision by: Maryola Perion (RN)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025 • Edward will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with (Edward/SDM) for decision making regarding constipation management. Revision on: 07/03/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	
• Strength Revision on: 04/29/2021 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• Edward to increase strength of B/L UE from grade 3/5 to grade 4/5 in 3 months. Revision on: 09/04/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/08/2025	• Strength exe. with use of 1-2lbs. wt for B/L UE and LE, 1set,10 rps., 2-3/wk as tolerated. Encourage Edward to perform Cervical ext., Rowing, Chest exp. with shoulder flex. 1set,10rps.,3/wk as tolerated. in 3 months. Revision on: 03/20/2024 Revision by: Shina Wadhwa (PT - Physiotherapist)	PT - Physiotherapist PTA	

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Balance. Revision on: 04/29/2021 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• To increase standing endurance from 35 sec to 60 sec in next 3 months Revision on: 09/04/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 12/08/2025	• Edward to perform balance exercises in standing +1A,1set,10rps.,2-3/wk as tolerated, per rehab treatment. Revision on: 03/06/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Expressed Wishes and Beliefs related to Edward's Medical Treatment and End of Life Care Revision on: 04/26/2021 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To support and honor Edward expressed wishes and beliefs through to the End of Life. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• CPR: Edward wishes to have CPR and TRANSFER to hospital. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	All	
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to Diuretic medication usage s/t lower leg edema, episodes of diarrhea/LBMs. Revision on: 03/09/2021 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. • PROMOTE FLUIDS: Promote Edward to consume fluids; amount as per Nutrition Care Plan. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	Diet Registered Staff	
• Potential for muscular dysfunction, contractures and bone deformity related to Gout. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Gout through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• COMMUNICATION: Involve/ collaborate with Edward/SDM in decision making of musculoskeletal care management. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		

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Last Care Plan Review Completed: 09/08/2025

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 12/08/2025	• MEDICATION: Administer medication for management of Gout as per MD order. Monitor effectiveness and for side effects. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of Gout for discomfort/ complications or changes to health status.v Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in ENDOCRINE FUNCTION related to HYPOTHYROIDISM	• To treat and/or minimize signs/symptoms of HYPOTHYROIDISM through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/ collaborate with Edward/SDM in decision making of thyroid care management. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with HYPOTHYROIDISM for changes to health status and alteration or complications affecting endocrine function. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for HYPOTHYROIDISM as per MD order. Monitor effectiveness and for side effects. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and		

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		as needed. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		
• Potential for BOWEL INCONTINENCE related to: Impaired Mobility. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• Edward will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Total Incontinence. Report change to level as noted. Revision on: 03/06/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Edward uses a Beige brief on Days, Evening and Night shifts. He uses mesh pants. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• URINARY (Functional) INCONTINENCE related to: Diuretic medication usage, Impaired Mobility. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• Edward will receive support to use toilet and promote urinary continence each shift through to the next review. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • URINARY Continence level is Total Incontinence. Report change to level as noted. Revision on: 03/06/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Edward uses a Beige brief on Days, Evening and Night shifts. He uses mesh pants. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
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Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• URINARY (Functional) INCONTINENCE related to: Diuretic medication usage, Impaired Mobility. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		• TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA	
• Altered COMMUNICATION as exhibited by limitations to (self expression, mumbled speech, etc.) related to soft/weak voice, minimal difficulty hearing, Cognitive decline. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• Edward will be supported to maintain current communication abilities to express self, comprehend information each day through to the review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025 • Edward will be able to make basic needs known on a daily basis through the review date Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM for decision making about strategies needed to support effective communication. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Edward's primary language is English. He is able to speak/understand English. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: Edward needs constant cueing or demonstrative instruction in tasks and activities. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	ACT	
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to Cognitive Decline. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• Edward will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo	• ORIENTATION: Gently reorient to person, place, time as needed when Edward is feeling lost or in confused state. Revision on: 05/21/2020 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 07/23/2021	PCA	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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Focus	Goal	Interventions	Position	Freq/Resolved
	(RAI Coordinator) Target Date: 12/08/2025	Revision by: Maryola Perion (RN) • ENVIRONMENT: Provide environmental clue to promote resident ability to locate room and navigating home area (i.e. name plate, etc.) outside of room. Revision on: 07/05/2023 Revision by: Maryola Perion (RN)		
• Potential for altered genitourinary function or complications related to diagnosis of BENIGN PROSTATIC HYPERTROPHY (BPH). Revision on: 01/27/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with BPH through to next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM in decision making for BPH care management. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Benign Prostatic Hypertrophy for changes to health status and alteration or complications affecting urinary function. Revision on: 01/27/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication as per MD order and monitor for side effects and effectiveness. Revision on: 01/27/2021 Revision by: Maryola Perion (RN)		
• SPIRITUAL BELIEFS: Edward is of the Salvation Army Faith. Revision on: 08/14/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide Edward spiritual support as interested through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• PERSONAL CHOICE: Respect Edward's right to decline participation in Spiritual Programs. Attempt to actively engage him if he decides to attend. Revision on: 05/04/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and/or minimize discomfort/ complications associated with GERD through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM in decision making for GERD Management. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • POSITIONING: Encourage resident to avoid lying down for at least one hour after	Registered Staff Registered Staff PCA	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		eating; elevate head of bed, encourage resident to sit/stand upright after meals.	Registered Staff	
		• MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	Registered Staff	
• Potential to experience alteration in CARDIAC FUNCTION related to: Hypertension Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and minimize signs/symptoms or complications associated with Hypertension through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• COMMUNICATION: Involve/collaborate with Edward/SDM in decision making of Cardiac Care Management for Hypertension. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• MEDICATION: Administer medication for Hypertension as per MD Order and monitor for side effects. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Practical Nurse RN	
• Altered ability to complete Activities of Daily Living (ADLs) related to: Impaired Decision Making, Anxiety, Depression, Manic-Depressive, Hypertension. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• Edward will feel supported in coping with changing functional abilities due to disease diagnosis through the review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• BATHING: Edward prefers (shower) on (Tuesdays and Fridays on Day shift). Edward participates by (providing a wash cloth and cues). Two staff (MAXIMAL) assistance for bathing. Two staff side to side for transfer. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
	• Edward will maintain current self sufficiency in ADL abilities in ambulation through the review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• BED MOBILITY: Edward requires one to two staff to provide weight bearing assistance to turn and reposition him in bed. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Edward is able to (lift arms and legs with cueing). Two staff MAXIMAL assistance for dressing UPPER & LOWER body. Revision on: 06/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Edward is able to eat by himself with set up from staff. He requires staff cueing and encouragement or one staff assistance at times.	PCA	

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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 12/08/2025	Eats in the dining room on fl.4 Revision on: 03/06/2025 Revision by: Maryola Perion (RN)		
		• LOCOMOTION: Edward is using a wheelchair as his mode of locomotion and requires one staff to propel him on and off the unit for longer distances. He is able to propel his wheelchair on short distances. He will at times walk by himself using his walker which is not safe, encouraging Edward to use his wheelchair. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Edward needs one staff assist to comb his hair, wash/dry his face/hands and shave. He requires two staff maximal assistance to provide peri care when having incontinent episodes. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide Extensive assistance to apply sanitizer or to use wipes for hand hygiene. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Edward requires two staff maximal assistance to transfer on/off the toilet, adjusts his clothes, brief change and provide peri care. Revision on: 09/04/2025 Revision by: Maryola Perion (RN)	PCA	
		• TRANSFERRING: Edward requires two staff side by side transfer to and from bed/recliner to wheelchair. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Edward has no teeth, requires one staff to set him up for oral hygiene or one staff assistance when needed. Revision on: 03/06/2025 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: PSW to complete toenail care every bath/shower day or as needed. Report long toe nails or other abnormalities as noted. Revision on: 05/21/2020 Revision by: Maryola Perion (RN)	PCA	

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Last Care Plan Review Completed:	**09/08/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: Impaired Decision Making, Anxiety, Depression, Manic-Depressive, Hypertension. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)		• SHAVING - Edward prefers to be shaved on his shower days and as needed. Revision on: 06/19/2024 Revision by: Maryola Perion (RN)	PCA	D
• Sleep Patterns. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To promote adequate rest/sleep for Edward based on identified sleep patterns/preferences each night through to the next review date. Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025	• REST PATTERN: Preferred bedtime: No specific time, usual wake time: up between 0600 and 0700. He sometimes sleeps in his own recliner. Revision on: 03/11/2023 Revision by: Elsie Calumpang (RN) • SLEEPWEAR: Edward prefers to wear his own clothes. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA PCA	
• Nutrition Risk Level (diet details)	• Edward will be adequately nourished aeb consuming >75% at meals and snacks through to next review date.	• LABELLED SNACK PM: provide assorted fruit & cheese instead of standard cookies, etc. to support wound healing Revision on: 09/23/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D

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Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 10/03/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 12/08/2025 • Will weigh within Realistic weight range of 110 - 115kg/BMI 41- 44kg through to next review date. Revision on: 12/13/2024 Revision by: Debora Choi (Dietitian (RD)) Target Date: 12/08/2025 • Edward will be adequately hydrated aeb drinking at least 1743ml per day based on 75% of total fluid requirement of 20-25 ml/kg, through to next review date. Revision on: 03/17/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 12/08/2025 • Will meet estimated nutritional requirements of 1978-2198kcal @ 18-20 kcal/kg, 88-110g protein @ 0.8-1.0g/kg through to next review date. Revision on: 09/10/2024 Revision by: Alexandra Breau (Dietitian (RD)) Target Date: 12/08/2025	• NUTRITION RISK: Edward is moderate risk level Revision on: 03/03/2025 Revision by: Brittany Hyde (Registered Dietitian)	Dietitian (RD)	
		• DIET ORDER: Edward will receive regular diet, regular texture Revision on: 10/19/2021 Revision by: Anna Slack (Registered Dietitian)	Diet Food Services Aide PCA	
		• FLUID CONSISTENCY: Edward drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/19/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: Encourage Edward to drink a minimum 1684 mL per day Revision on: 03/17/2025 Revision by: Brittany Hyde (Registered Dietitian)	PCA	
		• DINING INSTRUCTIONS: remove crust off bread/toast, outer crust of pizza, cut food especially meat into small pieces. provide minced fruit When cutting hot dog or sausages in a bun - cut meat part only not the bun Revision on: 10/11/2022 Revision by: Anna Slack (Registered Dietitian)	Diet Food Services Aide Registered Practical Nurse	
		• ADAPTIVE AIDS: rimmed plate and sippy cup Revision on: 03/19/2024 Revision by: Anna Slack (Registered Dietitian)	PCA	
		• FOOD INTOLERANCE: Edward has an intolerance to milk. Reaction to this is diarrhea. Provide Lactaid milk only. Revision on: 09/23/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Restorative Care Aide	
		• MEDPASS SUPPLEMENTS: Boost Carb Smart once daily to support wound healing Extra hydration - 125 ml water TID Revision on: 09/23/2025 Revision by: Holly Laasanen (Dietitian (RD))		
		• Provide bowel/high fibre prune juice at breakfast as needed for constipation Revision on: 09/10/2024 Revision by: Alexandra Breau (Dietitian (RD))	Diet PCA	PRN

Allergies	No Known Allergies	**D.O.B.**	08/04/1954	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, uns...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Edward (922131005294)	**Admission Date**	10/23/2019	**Location**	4 401 A
Last Care Plan Review Completed:	**09/08/2025**				

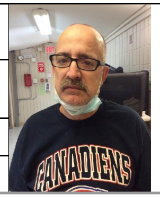
Diagnosis

Benign hypertension(I10.0), Other depressive episodes(F32.8), Anxiety disorder, unspecified(F41.9), Bipolar affective disorder, unspecified(F31.9), Other manic episodes(F30.8), Schizophrenia, unspecified(F20.9), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Hypothyroidism, unspecified (E03.9), Gout, unspecified, unspecified site(M10.99), Hyperplasia of prostate(N40), Mixed disorder of acid-base balance(E87.4), Lymphoedema, not elsewhere classified(I89.0), Multiple open wounds of lower leg, complicated(S81.71)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Acute PAIN and alteration in comfort level related to headache, chest pain, Left foot pain, lower back pain, , painful arc, ankle pain. Most Current LTCF Pain Score is 0/3. 10/24/25: toothache in his bottom left molars, redness along the lower gums with no drainage. Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025 • Promote LTCF Pain Score of 0 through to the next review. Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM about pain management, goals of treatment, plan of care, prognosis and treatment options. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	Registered Staff RN Registered Practical Nurse Registered Practical Nurse RN	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to low motivation, disinterest. ISE Score: 5/6 Revision on: 09/28/2025 Revision by: Laura Morris (Restorative Care Aide)	• Team members will support Peter in decreasing social isolation by participating in activities of personal choice 10-20 times per month by the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; Friendly/1:1 visits, discussion groups, games, intergenerational (pen pals), music, patio time, outings, reading groups, reminiscing groups, Resident Council & Food Committee, socials, special events, spiritual, tuck shop, TV/movies, etc. Revision on: 01/23/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as smoking on the patio, watching/listening to TV (sports, hockey, Montreal Canadiens)(TV: Maury & Steve Wilkos), visiting with residents/team members, family/friend visits, patio socializing/enjoying outdoors, etc. Revision on: 01/23/2023 Revision by: Mitchell Atkinson (Recreation Aide) • HELPFUL HINTS: Identify Helpful Hints to ease communication while providing care/interactions: Peter used to be a landscaper. He looks out for his brother, Edward. Music: rock, country TV: Mash, sports (hockey - Montreal Candadiens), Maury, Steve Wilkos Revision on: 01/23/2023	ACT ACT ACT	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B



Last Care Plan Review Completed:	**09/24/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to low motivation, disinterest. ISE Score: 5/6 Revision on: 09/28/2025 Revision by: Laura Morris (Restorative Care Aide)		Revision by: Mitchell Atkinson (Recreation Aide) • ONE to ONE: Provide him with individual visits for conversation, reminiscing, sports talk (NHL - Montreal), music, humor, etc. Revision on: 01/23/2023 Revision by: Mitchell Atkinson (Recreation Aide) • FAMILY INVOLVEMENT: Moderate involvement. Revision on: 01/23/2023 Revision by: Mitchell Atkinson (Recreation Aide)	ACT ACT	
• Peter has the potential to experience a safety hazard/burn injury related to personal SMOKING habits. Has history of burning his Rt.palm. Revision on: 09/24/2025 Revision by: Maryola Perion (RN)	• Peter will be safe when choosing to smoke through to the next review Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve Peter/SDM in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) and identify the designated area/s where smoking is permitted. Revision on: 01/24/2021 Revision by: Maryola Perion (RN) • SMOKING CONTRACT: Peter has agreed to follow safe smoking rules and accepts the consequences of breaking those agreed upon rules by signing the smoking contract. Revision on: 01/24/2021 Revision by: Maryola Perion (RN)	Social Worker Social Worker Administrator	
• Alteration in skin integrity related to rash to coccyx. Revision on: 09/14/2025 Revision by: Navkiran Kaur (Registered Practical Nurse)	• To promote intact skin integrity through healing of rash to coccyx Revision on: 09/24/2025 Revision by: Maryola Perion (RN) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with (Peter)/SDM in decision making for treatment of bruise as skin issue. Revision on: 09/15/2025 Revision by: Danielle Loreto (RAI Coordinator) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with rash to coccyx for changes to health status and alteration or complications affecting skin integrity. Revision on: 09/14/2025 Revision by: Navkiran Kaur (Registered Practical Nurse) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN		

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B

Last Care Plan Review Completed: **09/24/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
		using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 09/15/2025 Revision by: Danielle Loreto (RAI Coordinator) • TREATMENT: refer to TAR and administer as ordered. Revision on: 09/15/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Increased risk for FALLS related to: Taking antipsychotic medication, Hypertension, History of falls, Impaired balance, places self on floor. Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM in decision making in fall prevention Plan of Care. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 11/16/2022 Revision by: Maryola Perion (RN) • ENVIRONMENT: Secure environment: reduce clutter, etc. to reduce fall risk for Peter. Revision on: 01/13/2025 Revision by: Maryola Perion (RN) • FOOTWEAR: Ensure resident wears appropriate footwear for transfers, ambulation. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse) • SUPPLEMENT: Vitamin D supplement as per MD order to maintain bone density to prevent injuries.	PCA PCA PCA Registered Staff	D/E/N
• Nutrition: Inadequate oral intake related to refusal of meals Revision on: 05/06/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Oral intake will be adequate to maintain nutritional status through to next review date Target Date: 12/24/2025 • Electrolytes will be within normal limits through to next review date Target Date: 12/24/2025	• Provide diet interventions as per Nutrition Risk Level Revision on: 05/06/2025 Revision by: Danielle Loreto (RAI Coordinator) • Education provided to Resident/SDM on risk factors and potential consequences associated with food/beverage/snack choices Revision on: 05/06/2025 Revision by: Danielle Loreto (RAI Coordinator) • If interventions are not successful. Honor Peter's right to refuse food and fluids. Revision on: 05/06/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of SEXUAL in nature (history of inappropriate behaviour towards staff, using the call bell to have staff come into his room as he was exposing himself), Resisting care or to eat, thinks people are out to "kill him", refusing to use his C-pap machine, verbal abuse (yelling), refusing to eat/meals related to Schizophrenia, Depression. Revision on: 04/23/2025 Revision by: Maryola Perion (RN)	• To promote safety for Peter and/or others during each episode of sexual behavior through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025 • To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be less than 2. Revision on: 09/24/2025 Revision by: Maryola Perion (RN) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter about identified Risk of Expressive Behaviour, discuss safety of staff and other residents Revision on: 03/18/2021 Revision by: Chelsea Campbell-Wright (IPAC LEAD) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Peter for indications to change in or for escalating expressive behaviour risk. Revision on: 11/18/2021 Revision by: Maryola Perion (RN) • TRIGGERS leading to PHYSICAL (Hitting, Punching,) as expression of behaviour include (anger, frustration, confusion.) Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • PHYSICAL Behaviour: If Peter is attempting to strikeout; move back from his reach. Calmly indicate that care will continue when he/she is calm/ready. Seek Registered Staff assistance. Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to VERBAL (yelling, etc.) as expression of behaviour include (loss of control, frustration, misunderstanding care intention, etc.) Revision on: 01/09/2024 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If Peter is heard yelling, etc. others names; calmly remind to lower his voice and that chosen words are not appropriate. Attempt to resolve his concern. Report episode to Registered Staff. Revision on: 01/09/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusal to eat, using his C-pap, etc.) as expression of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 04/28/2023 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Peter is refusing to (eat, using his C-pap, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 04/28/2023 Revision by: Maryola Perion (RN)	BSO - Internal BSO - External Social Worker	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B

Last Care Plan Review Completed:	**09/24/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of SEXUAL in nature (history of inappropriate behaviour towards staff, using the call bell to have staff come into his room as he was exposing himself), Resisting care or to eat, thinks people are out to "kill him", refusing to use his C-pap machine, verbal abuse (yelling), refusing to eat/meals related to Schizophrenia, Depression. Revision on: 04/23/2025 Revision by: Maryola Perion (RN)		• SOCIALLY Inappropriate Behaviour: If Peter is noted to placing him self on the floor. If noted please report to the nurse. If found on floor inform nurse for follow up Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • SEXUAL Behaviour: If Peter is noted to using the call bell to have staff come into his room as he was exposing himself, calmly inform him that he can do that act in the privacy of his own room away from staff, curtain closed. Report episode to Registered Staff. Revision on: 05/11/2021 Revision by: Leslie Meloche (Activities/Rec Therapy) • MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 04/28/2023 Revision by: Maryola Perion (RN)	PCA Registered Practical Nurse RN	
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to use of diuretic, Episodes of LBMs, decreased food and fluid intake. Revision on: 04/22/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with (Peter)/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration Revision on: 04/11/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. • PROMOTE FLUIDS: Promote Peter to consume fluids; amount as per Nutrition Care Plan. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	Diet Registered Staff Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Risk for/Impaired SKIN INTEGRITY related to Ageing process, dry skin, use of incontinent product, incontinent episodes. Revision on: 04/11/2025 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Sleep Patterns. Potential for alteration in sleep patterns related to awake at night time, sleep apnea. Revision on: 02/10/2025 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for Peter based on identified sleep patterns/preferences each night through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• PREFERENCE: C-pap machine to be put at bedtime. Make sure the resident is wearing a C-PAP machine while sleeping. Document if refusing. Revision on: 02/10/2025 Revision by: Maryola Perion (RN)		
		• REST PATTERN: Preferred bedtime: No specific time, usual wake time: Between 6:00-7:00. He usually sleeps in his own recliner. Revision on: 03/11/2023 Revision by: Elsie Calumpang (RN)	PCA	
		• SLEEPWEAR: Peter prefers to wear his own clothes. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
• Potential for BOWEL INCONTINENCE related to episodes of LBMs Revision on: 01/13/2025 Revision by: Maryola Perion (RN)	• Peter will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. Revision on: 01/13/2025 Revision by: Maryola Perion (RN)	Registered Staff	
		• BOWEL Continence level is USUALLY Continent. Report change to level as noted. Revision on: 01/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 01/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Peter uses a Large Pull-Up on Days, Evening and Night shifts. Revision on: 01/14/2025 Revision by: Maryola Perion (RN)	PCA	
• URINARY (Mixed) INCONTINENCE	• Peter will have urinary	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for		

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
related to Use of Diuretic Revision on: 08/12/2024 Revision by: Maryola Perion (RN)	incontinence managed every shift through to the next review period. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	toileting needs, changes to health status and alteration of continence level. Revision on: 08/12/2024 Revision by: Maryola Perion (RN) • URINARY Continence level is Occasionally Incontinent. Report change to level as noted. Revision on: 10/09/2024 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Peter uses a Large Pull-UP on Days, Evening and Night shifts. Revision on: 01/14/2025 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential for Altered VISION related to wearing Eyeglasses. Revision on: 07/09/2024 Revision by: Maryola Perion (RN)	• Peter supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM for decision making pertaining to change in visual status as needed. Revision on: 04/10/2024 Revision by: Maryola Perion (RN) • EYEGLASSES: Peter wears eyeglasses. Assist to clean eyeglasses as needed and Peter is able to store his own glasses when sleeping. Revision on: 07/09/2024 Revision by: Maryola Perion (RN)	 PCA	
• Potential to experience FOOT/FEET complications related to diabetic diagnosis. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	• To maintain adequate Foot/Feet/Toenail care and minimize episodes of inflammation, infection or complications through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter in decision making for footcare treatment plan. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN) • TREATMENT PLAN: Peter requires footcare/treatment on shower days and PRN. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	Footcare Nurse - Internal	
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES Revision on: 02/10/2022	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to	• COMMUNICATION: Involve/ collaborate with (Peter)/SDM in decision making of diabetes care management. Revision on: 02/10/2022 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. • MEDICATION: Administer medication for DIABETES as per MD order. Monitor effectiveness and for side effects. Revision on: 02/10/2022 Revision by: Maryola Perion (RN) • RESCUE MEDICATION: Administer GLUCAGON for hypoglycemia as per MD order. • LAB WORK: Monitor lab and diagnostic results for (fasting blood glucose and/or HbA1c) and report results to MD as needed. Follow up as indicated. Revision on: 02/10/2022 Revision by: Maryola Perion (RN)	Registered Staff Registered Staff	
• Potential to experience alteration in MOOD as exhibited by repetitive questions, persistent anger with self or others, repetitive anxious complaints, sad, pained, worried facial expression, unpleasant mood in the morning, repetitive physical movement, insomnia/change in usual sleep pattern. related to Diagnosis of schizophrenia, depression, Pain. Revision on: 02/10/2022 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0.. Revision on: 09/24/2025 Revision by: Maryola Perion (RN) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • HEALTH EDUCATION: Provide education and support to Peter/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Peter for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Peter's effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 09/24/2025 Revision by: Maryola Perion (RN) • SLEEP/REST: Promote adequate sleep and rest to stability of Peter's mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 02/10/2022	RN Registered Practical Nurse	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by repetitive questions, persistent anger with self or others, repetitive anxious complaints, sad, pained, worried facial expression, unpleasant mood in the morning, repetitive physical movement, insomnia/change in usual sleep pattern. related to Diagnosis of schizophrenia, depression, Pain. Revision on: 02/10/2022 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in CARDIAC FUNCTION related to: Atrial Fibrillation, Hypertension, Heart Murmur Revision on: 05/20/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Atrial Fibrillation, Hypertension, Heart Murmur through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM in decision making of Cardiac Care Management for Atrial Fibrillation, Hypertension, Heart Murmur. Revision on: 05/20/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Atrial Fibrillation, Hypertension, Heart Murmur for changes to health status and alteration or complications affecting cardiac function. Revision on: 05/20/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for Atrial Fibrillation, Hypertension, Heart Murmur as per MD Order and monitor for side effects. Revision on: 05/20/2021 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Expressed Wishes and Beliefs related to Peter's Medical Treatment and End of Life	• To support and honor Peter's expressed wishes and beliefs	• CPR: Peter wishes Attempt CPR: transfer to hospital decisions to be made as needed - see PoET Individualized Summary for details.		

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Care Revision on: 05/20/2021 Revision by: Maryola Perion (RN)	through to the End of Life. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • SPIRITUAL/RELIGIOUS needs: Salvation Army Church to come in at bedside Revision on: 09/19/2025 Revision by: Maryola Perion (RN) • FUNERAL Arrangements: Janisse Funeral Home 1139 Ouellette Ave, Windsor, ON N9A 4K1 Revision on: 09/19/2025 Revision by: Maryola Perion (RN)	Social Worker ST	
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, etc.) related to Usually understood/understand. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	• Peter will be supported to maintain current communication abilities to (express self, comprehend information, etc.) each day through to the review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025 • Peter will be able to make basic needs known on a daily basis through the review date	• COMMUNICATION: Involve/collaborate with Peter/SDM for decision making about strategies needed to support effective communication. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Peter's primary language is English. He is able to speak/understand English. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: Peter needs (intermittent) cueing or demonstrative instruction in tasks and activities. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	ACT	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, etc.) related to Usually understood/understand. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025			
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to short term memory loss, Modified independence with decision making. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	• Peter will be supported to maintain cognitive function through the review date. Current CPS is 3/6. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• ORIENTATION: Gently reorient to (person, place, time) as needed when Peter is feeling lost or in confused state. Revision on: 02/21/2021 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	 PCA	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and/or minimize discomfort/ complications associated with GERD through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• COMMUNICATION: Involve/collaborate with Peter/SDM in decision making for GERD Management. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse) • POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals. • MEDICATION: Administer medication for GERD as per MD order. Monitor	Registered Staff Registered Staff PCA Registered Staff Registered	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse)		effectiveness and for side effects.	Staff	
• Potential for altered hematologic symptoms or complications related to diagnosis of ANEMIA. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and/or minimize complications associated with ANEMIA through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with ANEMIA for complications or changes to health status.	Registered Staff	
		• LAB WORK: Monitor blood lab work and report results to MD as needed. Follow up as indicated.	Registered Staff	
		• MEDICATION: Administer medication for ANEMIA as per MD Order. Monitor effectiveness and for side effects.	Registered Staff	
• Altered ability to complete Activities of Daily Living (ADLs) related to: Amputation bilateral hand fingers, Hypertension, Schizophrenia, Depression. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse)	• Peter will feel supported in coping with changing functional abilities due to disease diagnosis through the review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• BATHING: Peter prefers (tub bath) on (Wednesdays and Sundays on Evening shift). Peter participates by (providing a wash cloth and washing the upper part of the body). One staff (LIMITED TO EXTENSIVE) assistance for bathing. Nail care to be provided on shower/bath day. Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
	• Peter will be supported to maintain current self participation in ADL care for	• BED MOBILITY: Peter is able to turn and reposition himself independently while in bed. Revision on: 05/20/2021 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Peter is able to dress upper and lower body Independently, requires assistance from one person LIMITED to put his socks on, tie his shoes when needed and assist with his pants.	PCA	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	dressing, personal hygiene, toilet use, bath and assisted to ensure all ADL care tasks are met each day through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator) • EATING: Peter is able to eat Independently with one staff to cut his food when requested. Eats in the main dining room. Peter comes to the main dining room before scheduled services and prefers to have his meal at that time. Revision on: 03/11/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• LOCOMOTION: Peter is able to walk independently in his room, corridor, on and off unit. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Peter is able to comb his hair, brush his teeth, washing/drying face and hands. He requires one staff to shave him. May require limited assistance at times when confused or fatigued. Peter is able to ask for assistance. Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TOILET USE: Peter is able to use toilet Independently but may require one staff limited assistance to provide peri care after a bowel movement or to assist with changing his incontinent product. One staff to assist in pulling up his pants or tying sweat strings or assist with zipper when requested by Peter. Revision on: 06/26/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TRANSFERRING: Peter is able to transfer self Independently from a sitting to standing position. Revision on: 02/21/2021 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Peter has his own teeth but is missing some, is able to perform oral care Independently with staff to set him up. Revision on: 07/13/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• FOOT CARE: Registered staff to complete during shower days.	PCA	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B

Last Care Plan Review Completed:	**09/24/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: Amputation bilateral hand fingers, Hypertension, Schizophrenia, Depression. Revision on: 12/01/2019 Revision by: Maryola Perion (Registered Nurse)		Revision on: 12/28/2022 Revision by: Katherine Arca (RPN) • SHAVING - Peter will have beard, mustache shaven on his shower days or when needed. Revision on: 04/28/2023 Revision by: Maryola Perion (RN)	PCA	D
• SPIRITUAL BELIEFS: Peter is of the Salvation Army Faith. Revision on: 11/19/2019 Revision by: Megan Pipe (Restorative Care Aide)	• To provide Peter spiritual support as interested through to the next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• PERSONAL CHOICE: Respect Peter's right to decline participation in Spiritual Programs. Attempt to actively engage him if he decides to attend. Revision on: 05/27/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Nutrition Risk Level (diet details)	• Peter will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 01/23/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/24/2025	• LABELLED SNACK HS: assorted sandwich daily Revision on: 09/11/2025 Revision by: Holly Laasanen (Dietitian (RD)) • LABELLED SNACK PM: PB and crackers daily Revision on: 09/11/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN PCA Registered Practical Nurse	E D

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
	• Will weigh within realistic GWR 70-80 kg through to next review date. Revision on: 06/02/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/24/2025		RN	
		• NUTRITION RISK: Peter is moderate risk level Revision on: 05/10/2022 Revision by: Anna Slack (Registered Dietitian)	Dietitian (RD) Dietary Manager	
		• DIET ORDER: Peter will receive regular diet, regular texture. Revision on: 02/17/2021 Revision by: Anna Slack (Registered Dietitian)	Diet Food Services Aide PCA	
	• Peter will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 1800 ml/day (25 ml/kg using 72 kg weight) through to next review date. Revision on: 06/02/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/24/2025	• FLUID CONSISTENCY: Peter drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/27/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	
		• FLUID TARGET: Encourage Peter to drink a minimum of 1440 ml/day Revision on: 06/02/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• FOOD INTOLERANCE: Regular milk (reaction: loose stools). Offer Lactaid milk. Revision on: 09/18/2025 Revision by: Holly Laasanen (Dietitian (RD))	Diet PCA Restorative Care Aide	
		• MEDPASS SUPPLEMENTS: 1 bottle Boost Carb Smart once daily with 0800 medpass per Peter's request Revision on: 09/19/2025 Revision by: Holly Laasanen (Dietitian (RD))	Diet	
		• DIABETIC CARE: Encourage drinking water more often than juice Use sweetener instead of sugar in coffee/tea/hot cereal Limit to single portion of desserts Revision on: 09/19/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	

Allergies	No Known Allergies	**D.O.B.**	06/17/1965	**Physician**	Albert Patrick Ng
Diagnosis	Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressiv...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	McGuin, Peter (922131005303)	**Admission Date**	11/12/2019	**Location**	4 401 B
Last Care Plan Review Completed:	**09/24/2025**				

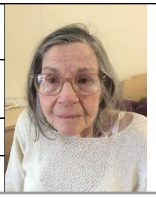
Diagnosis

Gastro-oesophageal reflux disease without oesophagitis(K21.9), Cardiac murmur, unspecified(R01.1), Atrial fibrillation, unspecified(I48.90), Iron deficiency anaemia, unspecified(D50.9), Depressive episode, unspecified(F32.9), Schizophrenia, unspecified(F20.9), Benign hypertension(I10.0), Traumatic amputation of two or more fingers alone (complete)(partial)(S68.2), Venous insufficiency (chronic)(peripheral)(I87.2), Other lipid storage disorders(E75.5), Other specified acquired deformities of limbs, hand(M21.84), Disorders of initiating and maintaining sleep [insomnias](G47.0), Type 2 diabetes mellitus with poor control, so described(E11.64)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Persistent PAIN and alteration in comfort level related to Osteoarthritis, Osteoporosis, history of pain to left hip related old hip fracture, pelvic fracture, carpal tunnel syndrome, right rib pain, Left leg, right hip/leg pain, chronic hip pain, Rotator cuff syndrome, Left wrist fracture (8/4/24), left shoulder pain, potential fracture 5th digit left hand (11/8/24). Left hip pain and pelvic pain post fall December 2nd 2024 Most Current RAI Pain Score is 0. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Emma/SDM about pain management, goals of treatment, plan of care and treatment options. Revision on: 08/17/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	RN Registered Practical Nurse Registered Practical Nurse RN	
• Sleep Patterns Revision on: 05/19/2025 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for Emma based on identified sleep patterns/preferences each night through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• PREFERENCE: Please let Emma sleep in in the Morning and to get her up when she is ready. Revision on: 11/12/2024 Revision by: Maryola Perion (RN) • REST PATTERN: Emma does not have a preferred bedtime. She will mention she goes to bed "when dark". No specific time to wake up in the morning (to let her sleep in). Will nap periodically throughout the day. Revision on: 11/12/2024 Revision by: Maryola Perion (RN)	PCA	
• Increased risk for FALLS related to history of fall with Hx of fracture (left wrist), right sided foot drop, mobility impairment, unsteady gait, will self transfer. Revision on: 02/16/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo	• COMMUNICATION: Involve/collaborate with (Emma)/SDM in decision making in fall prevention Plan of Care. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within Emma's reach, check that it is in working order and remind/encourage to use it.	PCA	D/E/N

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A



Last Care Plan Review Completed:	**08/27/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	(RAI Coordinator) Target Date: 01/26/2026	Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: Wheelchair, walker Revision on: 11/19/2024 Revision by: Maryola Perion (RN) • ENVIRONMENT: Secure environment (reduce clutter etc.) to reduce fall risk for Emma. Revision on: 11/19/2024 Revision by: Maryola Perion (RN) • BED: Staff to place Emma's bed in lowest position to lower risk for injury. Revision on: 06/20/2023 Revision by: Chelsea Campbell-Wright (IPAC LEAD) • FOOTWEAR: Ensure Emma wears appropriate footwear at all times. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • HIP PROTECTORS: Emma wears hip protectors at all times to safeguard against injury. Report to Registered Staff if not wearing. Revision on: 08/20/2024 Revision by: Prabhjot Maan (ADOC) • ALARMS: Requires Bed/Chair Clip alarm when in bed/wheelchair, padded bed alarm in place when in bed. Check placement and working order. Staff respond when alarm is heard. Bed alarm placed and informed staff to monitor when alarm ring Revision on: 02/19/2025 Revision by: Ravinder Kaur (Registered Nurse) • PURPOSEFUL ROUNDING: Conduct purposeful rounding=. She will walk with and without her walker or use her wheelchair as a walker. She can be resistive to allow the team to assist her with ambulation. Increase monitoring when ambulating unsafely and refusing assistance. Revision on: 11/19/2024 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA PCA RN PCA Registered Practical Nurse RN	D/E/N D/E/N
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to disinterest, low motivation.	• To support Emma's Psycho-Social well being through to the next review.	• STRUCTURED ACTIVITIES: Invite Emma to programs of personal interest; friendly/1:1 visits, manicures and hand massages, music programs, trivia, special events, TV/movie programs, etc. Revision on: 02/05/2025		

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
ISE Score: 3/6 Revision on: 02/05/2025 Revision by: Laura Morris (Restorative Care Aide)	Emma will be encouraged to participate in 15-20x group and/or 1:1 activities, per month, through the next review date. Revision on: 07/29/2025 Revision by: Megan Pipe (Recreation Aide) Target Date: 01/26/2026	Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as watching/listening to TV, listening to music/radio, visiting with residents/team members, etc. Revision on: 04/17/2023 Revision by: Mitchell Atkinson (Recreation Aide) • ONE to ONE: Provide her with individual visits for conversation, reading, reminiscing, music, humor, etc. Revision on: 04/17/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SOCIAL INTERACTION: Promote the opportunity for Emma to make friendships and sit with friends during activities. Revision on: 04/17/2023 Revision by: Mitchell Atkinson (Recreation Aide)	ACT ACT ACT	
• Potential to experience complications and side effects impacting quality of life related to use of use of multi pharmacy medications, antipsychotic.. Revision on: 11/19/2024 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Emma using polypharmacy & antipsychotic medication for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 11/19/2024 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Risk for Impaired SKIN INTEGRITY related to incontinence, impaired mobility, RT pinky finger - deformity / swelling. Revision on: 11/12/2024 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Bowel Incontinence related to Alzheimer's disease, Impaired mobility. Revision on: 08/17/2024 Revision by: Maryola Perion (RN)	• Emma will have bowel incontinence managed every shift through to the next review period. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of Emma for changes to health status, alteration of continence level or bowel function. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• BOWEL Continence level is Occasionally Incontinent. Report change to level as noted. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	PCA	
		• BOWEL MOVEMENT: Monitor Emma for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• INCONTINENCE PRODUCT: Emma wears White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, unpleasant mood in the morning, repetitive questions, verbalizations and health complaints, sad, pained, worried facial expression, tearful/crying, repetitive physical movement related to Alzheimer's disease, Inability to cope with change, Pain. Revision on: 08/17/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 04/04/2023 Revision by: Maryola Perion (RN)		
		• HEALTH EDUCATION: Provide education and support to (Emma)/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 04/04/2023 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
		• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Emma for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 04/04/2023 Revision by: Maryola Perion (RN)		
		• RESIDENT STRENGTHS: Build on Emma's effort to maintain control. Encourage her to express self, state preferences and make safe choices for care and activities. Revision on: 07/03/2023 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor	Registered	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, unpleasant mood in the morning, repetitive questions, verbalizations and health complaints, sad, pained, worried facial expression, tearful/crying, repetitive physical movement related to Alzheimer's disease, Inability to cope with change, Pain. Revision on: 08/17/2024 Revision by: Maryola Perion (RN)		its effectiveness and for side effects. Revision on: 11/19/2024 Revision by: Maryola Perion (RN)	Staff	
• Potential for Expressive Behaviour of wandering, verbally abusive, physically abusive (scraped/ scratch right hand of PSW while giving care, yelling/grabbing/hitting kicking and insulting/name calling staff during care), socially inappropriate, resisting care related to Alzheimer's Dementia. Revision on: 08/17/2024 Revision by: Maryola Perion (RN)	• To promote safety for Emma and/or others during each episode of Expressive Behaviour through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be less than 3. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)	• COMMUNICATION: Involve/collaborate with Emma/SDM about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Emma for indications to change in or for escalating expressive behaviour risk. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to PHYSICAL Hitting, Kicking, Scratching, grabbing, etc. as expression of behaviour includes loss of control, frustration as she believes resident DC is her father, anger, frustration, confusion, Sundowning, Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator) • PHYSICAL Behaviour: If Emma is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance.	BSO - Internal BSO - External Social Worker	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 01/26/2026	If resident is with residents DC, Ensure his safety. Try to distract resident and engage her so that she stops holding onto him. Reapproach and ensure safety. Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to VERBAL (is heard yelling, swearing, insulting, calling others names) as expression of behaviour includes loss of control, frustration as she believes resident DC is her father. Revision on: 11/06/2024 Revision by: Danielle Loreto (RAI Coordinator) • VERBAL Behaviour: If Emma is heard yelling, swearing, insulting, calling others names; calmly remind to lower her voice and that chosen words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Revision on: 08/17/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of refusing to change clothing, refusal to bathe, refusal to eat, refusing medication, etc. as expression of behaviour includes confusion, misunderstanding care needs, poor judgement, etc. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Emma is refusing to bathe, change clothes, take medications, eat, etc. re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate (spitting on floor, peeing in the garbage can, etc.) as expression of behaviour includes confusion, decreased insight, poor judgement, etc. Revision on: 07/03/2023 Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If Emma is noted to spitting on floor, peeing in the garbage can, etc. clean area using appropriate PPE. Report episode to Registered Staff.	PCA	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of wandering, verbally abusive, physically abusive (scraped/ scratch right hand of PSW while giving care, yelling/grabbing/hitting kicking and insulting/name calling staff during care), socially inappropriate, resisting care related to Alzheimer's Dementia. Revision on: 08/17/2024 Revision by: Maryola Perion (RN)		Revision on: 07/03/2023 Revision by: Maryola Perion (RN) • WANDERING: Permit Emma to safely roam in common area. Redirect away from exit doors, elevator or other resident rooms as needed. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 11/19/2024 Revision by: Maryola Perion (RN) • BSO RECOMMENDATIONS: Physical: hitting, kicking, scratching Triggers: Anger, frustration, confusion, sundowning, pain, infection Verbal: Yelling, insulting staff and residents,swearing, accusatory toward staff Triggers: Pain, unmet needs, confusion, sundowning Socially Inappropriate: Screaming, throwing food, making disruptive noises in public areas Triggers:Anger, confusion, delusional, pain, infection Resistant to care: Refusing care (bath, changing of clothes and brief) meals, medication Trigger: Misunderstanding of care needs, confusion, pain Recommendations: Move away from her reach. Use stop and go approach. Re approach when the resident is calm/ready. 2 staff for care due to the resident's accusatory tendencies. Monitor for pain and infection. Attempt to resolve her concerns. Distract with conversation from her personhood. Offer validation, reassurance and support when the resident is verbalizing negative thoughts or wanting to leave to find her parents. The team is able to redirect her at times when they are able to validate her feelings and are not dismissing her thoughts. When refusing to bathe or change her clothes, reapproach in 10-15 minutes and report to registered staff. The resident will cry and accuse staff of keeping her from her father, this could be signs of delusions. Report to registered staff. When the resident is agitated keep residents at a safe distance. Emma likes to watch tv (hockey), hand massages and likes to pray. Emma likes to attend some main floor programs such as Happy hour,	Registered Practical Nurse RN	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of wandering, verbally abusive, physically abusive (scraped/ scratch right hand of PSW while giving care, yelling/grabbing/hitting kicking and insulting/name calling staff during care), socially inappropriate, resisting care related to Alzheimer's Dementia. Revision on: 08/17/2024 Revision by: Maryola Perion (RN)		Bingo and manicures and hand massages. Revision on: 03/26/2025 Revision by: Leslie Meloche (Recreation Aide)		
• Potential for CONSTIPATION related to daily use of medication with binding effect, decreased mobility, etc. Revision on: 08/14/2024 Revision by: Maryola Perion (RN)	• Emma will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 08/14/2024 Revision by: Maryola Perion (RN) Target Date: 01/26/2026 • To minimize the potential for episodes/ complications of	• COMMUNICATION: Involve/collaborate with (Emma/SDM) for decision making regarding constipation management. Revision on: 08/14/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation.	Registered Staff	
		• FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan.	Registered Staff	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	constipation through to the next review date. Revision on: 08/14/2024 Revision by: Maryola Perion (RN) Target Date: 01/26/2026	• NUTRITION increased fibre intervention in place. See Nutrition Care Plan.	Diet Registered Staff	
		• BOWEL PROTOCOL: In place as per MD order	Registered Staff	
• Altered ability to complete Activities of Daily Living (ADLs) related to Alzheimer's Dementia, HTN, OA, Mobility impairment, Osteoporosis, Right sided foot drop, Carpal tunnel. Revision on: 06/17/2024 Revision by: Laura Seibel (Dietitian (RD))	• Emma will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • Emma will have ALL ADL care tasks met each day through the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• BATHING: Emma prefers (shower/tub bath) on (Mondays and Fridays on Evening shift). Emma participates by (providing a wash cloth and washing the upper part of the body). Two staff (Maximal) assistance for bathing. Two staff side to side transfer. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• BED MOBILITY: Emma is able to turn and reposition herself in bed without assistance or oversight from the team during the day. She may require one to two staff assistance at times during the night shift. Revision on: 08/30/2024 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Emma is able to assist with cueing and instruction. Two staff to provide (MAXIMAL) assistance for dressing UPPER & LOWER body. Revision on: 05/19/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Emma is able to eat independently once set up by the team. Eats in the main dining room - 1st floor. Emma will refuse to eat in the dining room. One staff supervision required when eating in her room. Revision on: 11/19/2024 Revision by: Maryola Perion (RN)	PCA	
		• LOCOMOTION: Emma requires the use of a wheelchair with one staff member to assist in propelling her on the unit. One staff member walks with her and encourages Emma to use her wheelchair. She will walk with and without her walker or use her wheelchair as a walker. She can be resistive to allow the team to assist her with ambulation. Increase monitoring when ambulating unsafely and refusing assistance.	PCA	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Alzheimer's Dementia, HTN, OA, Mobility impairment, Osteoporosis, Right sided foot drop, Carpal tunnel. Revision on: 06/17/2024 Revision by: Laura Seibel (Dietitian (RD))		Revision on: 05/19/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: Emma is able to wash her face and brush her hair with staff to set her up and provide cueing and encouragement or one staff assistance at times. She requires one to two team members to assist with providing peri care. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) • TOILET USE: Emma requires two team members maximal assist in transferring her onto and off of the toilet and assist with adjusting and reapplying a new incontinence product and peri care. Emma will at times walk to the bathroom by herself without asking for assistance. Revision on: 05/19/2025 Revision by: Maryola Perion (RN) • TRANSFERRING: Emma requires two team members, 2 person side by side to and from her bed to the wheelchair. Emma will try to self transfer. Revision on: 02/16/2025 Revision by: Maryola Perion (RN) • ORAL CARE: Emma has her own teeth remaining and is not missing any. SHe is able to brush her teeth with set up, cuing and encouragement from the team. Revision on: 08/07/2024 Revision by: Maryola Perion (RN) • RESIDENT PREFERENCE with ADL activities as follow: FEMALE CAREGIVERS ONLY Revision on: 03/31/2023 Revision by: Maryola Perion (RN)	PCA PCA PCA RN PCA PCA	
• Altered COMMUNICATION as exhibited by limitations to (self expression, comprehension, etc.) related to Alzheimer's disease, Minimal difficulty hearing. Revision on: 09/30/2023 Revision by: Maryola Perion (RN)	• Emma will be supported to maintain current communication abilities to (express self, comprehend information) each day through to the review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• PRIMARY LANGUAGE: Emma's primary language is (English. She is able to speak/understand English. Revision on: 09/30/2023 Revision by: Maryola Perion (RN) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.. Revision on: 11/20/2024 Revision by: Maryola Perion (RN) • INSTRUCTION GUIDANCE: Emma needs intermittent cueing or demonstrative		

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	• Emma will be supported to make basic needs known each day through to the review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	instruction in tasks and activities. Revision on: 09/30/2023 Revision by: Maryola Perion (RN)		
• Altered VISION related to able to read larger print but not regular print, use of eyeglasses. Revision on: 09/30/2023 Revision by: Maryola Perion (RN)	• Emma will use glasses for vision correction when reading through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Emma/SDM for decision making pertaining to change in visual status as needed. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• EYEGLASSES: Emma wears eyeglasses. Assist to clean eyeglasses as needed. Revision on: 09/30/2023 Revision by: Maryola Perion (RN)	PCA	
		• READING: Emma uses large print material to aid with reading. Glasses also available but often refuses to use. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS	• To treat and minimize signs/symptoms or complications associated with OSTEOARTHRITIS through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/ collaborate with (Emma)/SDM in decision making of musculoskeletal care management. Revision on: 07/03/2023 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for management of OSTEOARTHRITIS as per MD order. Monitor effectiveness and for side effects. Revision on: 07/03/2023 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of OSTEOARTHRITIS for discomfort/ complications or changes to health status. Revision on: 07/03/2023 Revision by: Maryola Perion (RN)		
		• PAIN MANAGEMENT for OSTEOARTHRITIS prescribed and in place; refer to Pain Care Plan. Revision on: 07/03/2023		

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS		Revision by: Maryola Perion (RN)		
• SPIRITUAL BELIEFS: Emma is of the Catholic Faith. Revision on: 04/17/2023 Revision by: Mitchell Atkinson (Recreation Aide)	• To provide Emma spiritual support as interested through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• SPIRITUAL PROGRAMS: Encourage her to attend spiritual programs of her choice including; Hymn Sing, Catholic Mass, bible study, spiritual discussion, etc. Revision on: 04/17/2023 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Codeine, Morphine, Demerol Revision on: 04/04/2023 Revision by: Maryola Perion (RN)	• Emma will be protected from exposure to allergen each day through next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making and health teaching about ALLERGY to Codeine, Morphine, Demerol. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Codeine, Morphine, Demerol allergy for changes to health status and complications mortality. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • ALLERGY ALERT: Emma has ALLERGY to (Codeine, Morphine, Demerol). Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • MD/PHARMACY ALERT: Notify the MD and Pharmacy of Emm's Allergy to Codeine, Morphine, Demerol and minimize risk for exposure to allergen. Revision on: 04/04/2023		

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Codeine, Morphine, Demerol Revision on: 04/04/2023 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN)		
• Emma is at high risk for ELOPEMENT related to exit seeking, wanted to go home Revision on: 03/29/2023 Revision by: Maryola Perion (RN)	• To promote Emma safety and minimize risk for episode of elopement each day through next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• ALERT: Emma has potential to attempt elopement. If heard making requests to leave the building or seen attempting to use exit doors report to Supervisor immediately. Revision on: 03/29/2023 Revision by: Maryola Perion (RN) • ELOPEMENT ALERT: Redirect Emma away from elevator or exit doors as needed. Revision on: 03/29/2023 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience alteration in CARDIAC FUNCTION related to; Hyperlipidaemia , Hypertension	• To treat and minimize signs/symptoms or complications associated with HTN/hyperlipidemia through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with SDM in decision making of Cardiac Care Management for Hyperlipidaemia , Hypertension. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Emma with HTN, hyperlipidemia for changes to health status and alteration or complications affecting cardiac function. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication for HTN, hyperlipidemia as per MD Order and monitor for side effects. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • OXYGEN: Administer Oxygen as per MD order. Revision on: 04/04/2023	Registered Practical Nurse RN Registered Practical	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in CARDIAC FUNCTION related to; Hyperlipidaemia , Hypertension		Revision by: Maryola Perion (RN)	Nurse RN	
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS.	• To treat and minimize complications associated with OSTEOPOROSIS through to the next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/ collaborate with SDM in decision making of osteoporosis care management. Revision on: 04/04/2023 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for osteoporosis management. Monitor effectiveness and for side effects. • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of osteoporosis for discomfort/ complications or changes to health status.	Registered Staff Registered Staff	
• Nutrition Risk Level	• Emma will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026 • Will weigh within GWR 45-55 kg through to next review date. Revision on: 07/24/2025 Revision by: Holly Laasanen	• NUTRITION RISK: Emma is moderate risk level. Revision on: 04/12/2023 Revision by: Anna Slack (Registered Dietitian) • DIET ORDER: Emma will receive regular diet, regular texture Revision on: 03/22/2023 Revision by: Anna Slack (Registered Dietitian) • FLUID CONSISTENCY: Emma drinks REGULAR/THIN Level 0 Fluids. Revision on: 03/22/2023 Revision by: Anna Slack (Registered Dietitian) • FLUID TARGET: Encourage Emma to drink a minimum of 1200 ml per day. Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD) Dietary Manager Diet Food Services Aide PCA Diet PCA PCA	

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level	(Dietitian (RD)) Target Date: 01/26/2026 • Emma will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 1500 ml/day (30 ml/kg using 50.5 kg weight) through to next review date. Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/26/2026	• EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily. • DINING INSTRUCTIONS: - Encourage oatmeal at breakfast Revision on: 08/30/2024 Revision by: Laura Seibel (Dietitian (RD)) • HIGH CALORIE/PROTEIN AM SNACK: ice cream daily (115 ml fluid) Revision on: 03/13/2025 Revision by: Holly Laasanen (Dietitian (RD)) • MEDPASS SUPPLEMENTS: 60 ml Resource 2.0 TID Revision on: 07/24/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietary aide PCA Registered Practical Nurse PCA	 Nour
• URINARY (Mixed) INCONTINENCE related to Alzheimer's Dementia, Impaired mobility, history of bladder tumor. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Emma will have urinary incontinence managed every shift through to the next review period. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of Emma for toileting needs, changes to health status and alteration of continence level. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • URINARY Continence level is Totally Incontinent. Report change to level as noted. Revision on: 08/07/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Emma wears White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	 PCA PCA	
• COGNITIVE LOSS; alteration in thought processes memory loss, difficulty concentrating, poor judgement, etc. related to Alzheimer's Dementia Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Emma will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• COMMUNICATION: Involve/collaborate with Emma/SDM in decision making of Cognitive Loss for Alzheimer's Dementia. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ORIENTATION: Gently reorient to place, time as needed when Emma is feeling lost or in confused state. Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ENVIRONMENT: Provide environmental clue to promote Emma's ability to locate room and navigating home area (Name plate) outside of room.		

Allergies	Codeine, Morphine, Demerol	**D.O.B.**	08/01/1928	**Physician**	Albert Patrick Ng
Diagnosis	Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tun...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Pajot, Emma (922131005504)	**Admission Date**	09/30/2023	**Location**	4 414 A
Last Care Plan Review Completed:	**08/27/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Expressed Wishes and Beliefs related to Emma's Medical Treatment and End of Life Care Revision on: 03/22/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To support and honor Emma's expressed wishes and beliefs through to the End of Life. Revision on: 10/02/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/26/2026	• CPR: Emma wishes express NO CPR, however TRANSFER to hospital decision will be made at the time. Revision on: 11/05/2024 Revision by: Jiss Mathew (RN)		

Diagnosis

Alzheimer's disease, unspecified(G30.9), Benign hypertension(I10.0), Hyperlipidaemia, unspecified(E78.5), Primary generalized (osteo)arthrosis(M15.0), Osteoporosis, unspecified(M81.9), Carpal tunnel syndrome(G56.0), Wrist or foot drop (acquired)(M21.3), Other and unspecified injury of muscle(s) and tendon(s) of the rotator cuff of shoulder(S46.08), Other and unspecified injury of sciatic nerve at hip and thigh level(S74.08), Other specified disorders of bladder(N32.8), Abnormal findings on diagnostic imaging of lung(R91), Unspecified fracture of neck of femur, closed(S72.090), Other chronic pain(R52.2), Rotator cuff syndrome(M75.1), Fracture of other and unspecified parts of wrist and hand, closed(S62.800)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• John is experiencing signs and symptoms of INFECTION (Inability to urinate, pain, congestion, lethargic, Low oxygen saturation). Onset date: 10/27/25 10/28: Sent to the ER for further assessment Revision on: 10/28/2025 Revision by: Maryola Perion (RN)	• To have infection adequately managed and treated without further complications by target date. Revision on: 10/28/2025 Revision by: Maryola Perion (RN) Target Date: 11/03/2025	• COMMUNICATION: Involve/collaborate with (John/SDM) with decision making for infection treatment plan and update accordingly. Revision on: 10/28/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of monitoring resident for signs/symptoms, hydration status, overall health condition, process of healing, etc. until stable. Revision on: 10/28/2025 Revision by: Maryola Perion (RN) • VITAL SIGNS: Monitor VITAL SIGNS every shift as per order. Revision on: 10/28/2025 Revision by: Maryola Perion (RN) • MEDICATIONS: Administer medication/oxygen as per MD/NP order. Revision on: 10/28/2025 Revision by: Maryola Perion (RN)		
• Potential Risk for Delirium, OR Acute Change in Cognitive Functioning related to signs of DELIRIUM (confused about time, stated to PSW that he was not out of bed for 3 days). Onset date: 10/24/25 Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	• To promote early identification of changes in John's condition and prevent onset of Delirium through to the target date. Revision on: 10/25/2025 Revision by: Maryola Perion (RN) Target Date: 10/31/2025	• SYMPTOM OBSERVATION/REPORTING: Resident at High Risk for Delirium; Report observed changes to resident's cognitive function, physical function, eating/drinking habits or behaviour to Registered Staff immediately as noted. • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of John for indications of DELIRIUM including dehydration, poor appetite, vomiting, diarrhea, blood loss, acute flare up of chronic condition, etc.. Revision on: 10/25/2025 Revision by: Maryola Perion (RN) • ORIENTATION: Gently reorient to person, place, time as needed when Jonh is feeling lost or in a confused state. Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	PCA Recreation Aide Diet PCA	
• Potential for chronic pain related to pinched nerve in the back, chronic back pain complaints L4- L5 LAMINECTOMY, Paraesthesia BILATERAL FEET, MS, Left ear cancer, aching pain just around the RUQ and LUQ of his abdomen. Most	• To promote resident comfort and effectively manage Chronic pain each day through to the next review. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025	• Application of the hot pack over the Low back for 15 mint, wrapped in 3-4 layers, Check skin status every 2-3 mins,2-3/wk as tolerated. • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control.	RN Registered Practical Nurse	

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng	
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B	

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Current ltcf Pain Score is 3. Revision on: 10/24/2025 Revision by: Maryola Perion (RN)	• Promote RAI Pain Score of 0 through to the next review. Target Date: 11/18/2025	• POSITIONING: Position in chair/bed for optimal comfort. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• REST: accommodate resident rest and relaxation preference (breaks between activities, remaining in bed when needed, etc.). Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Altered VISION related to previous left eye surgery in the past with cauterized veins, use of glasses, dry eyes. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)	• John supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• EYEGLASSES: John wears eyeglasses. Assist to clean eyeglasses as needed and store (on night table) when sleeping. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• READING: John uses (large print material) to aid with reading. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• MEDICATION: Administer ophthalmic medication as as per MD Order for dry eyes/cataract surgery. Monitor its effectiveness and for side effects. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)		
• Altered VISION related to Cataract surgery Left eye on Oct. 9, 2025 Revision on: 10/10/2025 Revision by: Maryola Perion (RN)	• To treat and minimize complications of (Cataract surgery) through to next review date. Revision on: 10/10/2025 Revision by: Maryola Perion (RN) Target Date: 11/06/2025	• HEALTH TEACHING: Engage with (John)/SDM to enhance their knowledge of (cataract surgery) affecting vision. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer ophthalmic medication as as per MD Order. Monitor its effectiveness and for side effects.	Registered Staff	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest and adjusting to new environment.	• Team members will support John in decreasing social isolation by participating in activities of personal choice for	• STRUCTURED ACTIVITIES: Invite John to programs of personal interest; mens club, cards (euchre), movies, happy hour, special events and outings etc. Revision on: 09/17/2025 Revision by: Laura Morris (Restorative Care Aide)		

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
ISE score: 4/6 Revision on: 09/17/2025 Revision by: Laura Morris (Restorative Care Aide)	5-10 times per month by the next review date. Revision on: 09/17/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 11/18/2025 • To support John's Psycho-Social well being through to the next review. Revision on: 09/17/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 11/18/2025	• SELF-DIRECTED ACTIVITIES: Encourage John to engage in self-directed activities such as (watching TV in own room, puzzles, conversing with peers, etc.). Revision on: 09/17/2025 Revision by: Laura Morris (Restorative Care Aide) • ONE to ONE: Provide John with individual visits for (conversation, and reminiscing, etc.) Revision on: 09/17/2025 Revision by: Laura Morris (Restorative Care Aide)		
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES (Insulin-Dependent). Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Target Date: 11/18/2025	• COMMUNICATION: Involve/ collaborate with John/SDM in decision making of diabetes care management. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. • Diabetic/Diagnostic Aid DEV (Device): Monitor glucose level as specified in manufacture instruction. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for DIABETES as per MD order. Monitor effectiveness and for side effects. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	Registered Staff RN Registered Practical Nurse	
• Potential to experience alteration in CARDIAC FUNCTION related to; Hypertension Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with Hypertension through to the next review date.	• COMMUNICATION: Involve/collaborate with (John)/SDM in decision making of Cardiac Care Management for Hypertension. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with		

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer medication for (specify Etiology/Diagnosis) as per MD Order and monitor for side effects.	Registered Practical Nurse RN	
• Potential to experience alteration in RESPIRATORY FUNCTION related to COPD, ASTHMA Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To treat and minimize signs/symptoms or complications associated with COPD, ASTHMA each day through to next review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• COMMUNICATION: Involve/collaborate with (John)/SDM in decision making of Respiratory Management for Asthma, COPD. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with COPD, ASTHMA for changes to health status and alteration or complications affecting respiratory function. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing. • MEDICATION: Administer medication for Asthma, COPD as per MD order and monitor for side effects. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA	
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (turning and repositioning). Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• John will be effectively supported with use of two 1/4 bed rails to optimize Activity of Daily Living (turning and repositioning) each day through to the next review date. Revision on: 09/01/2025 Revision by: Suzanne Azar (RN) Target Date: 11/18/2025	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of two 1/4 bed rails. Revision on: 09/01/2025 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use (two 1/4 bed rails) as to support appropriate bed mobility. Revision on: 09/01/2025 Revision by: Suzanne Azar (RN) • BED RAIL (TWO PARTIAL): 1/4 Rails in USE as a PASD to assist resident with bed mobility. Monitor every shift. Revision on: 09/01/2025	PCA	D/E/N

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
• Use of PASD (two 1/4 bed rails) to assist resident with Activity of Daily Living (turning and repositioning). Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)		Revision by: Suzanne Azar (RN)		
• Risk for Impaired SKIN INTEGRITY related to Frailty, occasional incontinence, discoloured lower extremities. Use of Cytotoxic Medication Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To protect and maintain skin integrity each day through to the next review. Target Date: 11/18/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted. • CYTOTOXIC MEDICATION RISK: John has potential to experience skin irritation (redness, burning, itchiness, etc.), report observed symptoms to Registered Staff immediately as noted. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA PCA	
• Altered COMMUNICATION as exhibited by limitations to self expression, comprehension. Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• John will be supported to maintain current communication abilities to express self, comprehend information each day through to the review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• PRIMARY LANGUAGE: John primary language is English. He is (able speak/understand) English. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • INSTRUCTION GUIDANCE: John needs (intermittent) cueing or demonstrative instruction in tasks and activities. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• COGNITIVE LOSS; alteration in thought processes (memory loss, difficulty concentrating, altered judgement, etc.) related to short term memory loss Revision on: 09/09/2025	• John will be supported to make independent choice and safe decisions each day through to the review date. Current CPS is 2.	• ORIENTATION: Gently reorient to (person, place, time) as needed when John is feeling lost or in confused state. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Shina Wadhwa (Physical Therapist)	Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025			
• Increased risk for FALLS related to impaired mobility Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Target Date: 11/18/2025	• COMMUNICATION: Involve/collaborate with (John)/SDM in decision making in fall prevention Plan of Care. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: walker, wheelchair Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment: reduce clutter, night light, bathroom signage, toilet height, quiet environment, etc.) to reduce fall risk for John Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear for transfers Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA	
		• SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to Limited Mobility, Multiple Sclerosis, COPD, Hypertension, Diabetes Mellitus. Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• John will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025	• BATHING: John prefers (shower) on (Monday and Thursday) in morning. John is able to clean is upper body and needs the team to wash his lower body (extensive). Nail care to be provided on shower day. Revision on: 08/26/2025 Revision by: Katherine Arca (RPN)	PCA	
		• BED MOBILITY: Joh is able to (assist minimally). One staff to provide LIMITED to	PCA	

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
	• John will be supported to maintain current self participation in ADL care and assisted to ensure all ADL care needs are met each day through to the next review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	extensive assistance for bed mobility. He may require two staff at times. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
		• DRESSING: John is able to assist by lifting his arms and legs. On staff extensive assistance to dress his upper body and lower body. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: John eats independently with set up support. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• LOCOMOTION: John independent with locomotion in his wheelchair. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• PERSONAL HYGIENE: John is able to complete his own personal hygiene care. At times may need 1 team member to assist. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• HAND HYGIENE: John is able to independently complete task of Hand Hygiene each day. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• TOILET USE: John requires Sara lift from wheelchair to toilet. To use the toilet in the Main shower room. PRN MAXI LIFT, blue toileting sling. Revision on: 10/20/2025 Revision by: Katherine Arca (RPN)	PCA	
		• TRANSFERRING: John's transfer is 2 team members MAXI lift from bed to electric wheelchair, Sling size is blue. Sara lift from wheelchair to toilet. To use the toilet in the Main shower room. Revision on: 10/17/2025 Revision by: Katherine Arca (RPN)	PCA	
		• ORAL CARE: John has upper dentures. John can complete his care with set up. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• SHAVING -1 team member to assist John with his shaving Revision on: 08/29/2025	PCA	D

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Limited Mobility, Multiple Sclerosis, COPD, Hypertension, Diabetes Mellitus. Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)		Revision by: Maryola Perion (RN)		
• Expressed Wishes and Beliefs related to John Medical Treatment and End of Life Care Revision on: 09/09/2025 Revision by: Shina Wadhwa (Physical Therapist)	• To support and honor John expressed wishes and beliefs through to the End of Life. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• CPR: Attempt CPR: transfer to hospital decisions to be made as needed - see PoET Individualized Summary for details. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to (use of diuretic, etc.) Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025	• COMMUNICATION: Involve/collaborate with (John)/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. • PROMOTE FLUIDS: Promote John to consume fluids; amount as per Nutrition Care	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
		Plan. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
• BOWEL Continence - John is continent and has self recognition of urge to defecate. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• John to remain continent of bowels through next review date Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025	• BOWEL Continence level is CONTINENT. Report change to level as noted. • TOILETING: John requires two staff to transfer him to the toilet. Staff to document accordingly. Report changes to urination or continence level to Registered Staff as noted. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA PCA	
• URINARY Continence - John is continent and has self recognition of urge to void. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• John will maintain continence level through next review date Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025	• URINARY Continence Level is: CONTINENT • TOILETING: John requires two staff to transfer him to the toilet. Staff to document accordingly. Report changes to urination or continence level to Registered Staff as noted. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential to experience alteration in MOOD as exhibited by repetitive anxious complaints related to change from retirement to long term care, history of depression. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	• John will be supported to maintain mood stability as evidenced by DRS score at a range of 0-2 by the review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025 • To decrease the episodic frequency of (negative Mood symptoms by the next review date. DRS score will be maintained to 1.	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of John for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • RESIDENT STRENGTHS: Build on John effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by repetitive anxious complaints related to change from retirement to long term care, history of depression. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)	Revision on: 08/29/2025 Revision by: Maryola Perion (RN) Target Date: 11/18/2025			
• Transfer Training Revision on: 08/25/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increased independence in sit to stand at the standing bar from 2 assist to 1 assist in next 3 months; Revision on: 08/25/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 11/18/2025	• 2:1 assist sit to stand at the Neurogym standing bar; Include Marching, Mini squats x 10 reps, 4-5 x a week; Revision on: 08/25/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Strength Training Revision on: 08/25/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increased strength in B/L LE from 3/5 to 3+/5 in next 3 months; Revision on: 08/25/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 11/18/2025	• B/L UE and LE strengthening with 1-2lbs, 10 reps/exs, 1-2sets or as best capable, 4-5 x a week; Bike or peddlers for 10-15 mins, 2-3 x a week; Revision on: 08/25/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Nutrition Risk Level	• John will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Labelled Item AM Snack: 1 boiled egg daily Revision on: 10/23/2025 Revision by: Holly Laasanen (Dietitian (RD)) • Labelled Item Lunch: 200 ml tomato juice per his preference Revision on: 09/09/2025	PCA Registered Practical Nurse RN PCA Registered	D D

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
	Target Date: 11/18/2025 • Will weigh within GWR/IBW/Realistic weight range of 120-130kg through to next review date. Revision on: 08/27/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 11/18/2025 • (resident name) will be adequately hydrated aeb drinking at least 75% of total fluid requirement @ 20 ml/kg, through to next review date. Revision on: 08/27/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 11/18/2025 • Will meet estimated nutritional requirements of 25-30 kcal/kg, protein @ 0.8-1g/kg through to next review date. Revision on: 08/27/2025 Revision by: Brittany Hyde (Registered Dietitian) Target Date: 11/18/2025	Revision by: Holly Laasanen (Dietitian (RD)) • LABELLED SNACK PM: Instead of standard snack, provide: Cheese and crackers Mon/Wed/Fri Half assorted sandwich on wheat Tues/Saturday Greek yogurt Thursday/Sunday Revision on: 09/23/2025 Revision by: Holly Laasanen (Dietitian (RD)) • NUTRITION RISK: John is moderate risk level. Revision on: 08/27/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIET ORDER: John will receive regular diet, regular texture Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • FLUID CONSISTENCY: John drinks REGULAR/THIN Level 0 Fluids. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • FLUID TARGET: Encourage John to drink a minimum of 1900 ml per day. Revision on: 08/27/2025 Revision by: Brittany Hyde (Registered Dietitian) • FOOD ALLERGY/INTOLERANCE: Lactose intolerant Provide lactaid milk Revision on: 08/27/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIABETIC CARE: -At breakfast, serve 1 slice of toast with peanut butter and sugar-free jam, 1 bowl of hot cereal with sweetener instead of brown sugar, and protein food on the menu (e.g., eggs, cheese). -Encourage water to drink as well as tea/coffee with Lactaid milk (no sugar). -If he would like fruit juice, dilute with water or provide diet juice. -Special-labelled tomato juice at lunch only. -Single portions at meals. -Encourage fruit for dessert when he likes the fruit option available.	Practical Nurse RN PCA Registered Practical Nurse RN Dietitian (RD) PCA PCA PCA Restorative Care Aide PCA	D

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level		Revision on: 10/23/2025 Revision by: Holly Laasanen (Dietitian (RD))		
• Sleep Patterns; Potential for alteration in quality of sleep or sleep pattern related to NEW HOME Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote adequate rest/sleep for John based on identified sleep patterns/preferences each night through to the next review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• PREFERENCE: Ensure that the main door to the room is slightly closed and to ensure that the bathroom door is also closed at night as the light is bothersome and hard for John to sleep. A memo was created to be left on the nursing station and in the med room for a reminder as per JOhn's request. Revision on: 08/31/2025 Revision by: Maryola Perion (RN)		
		• REST PATTERN: Preferred bedtime 2100, usual wake time 0500 and daytime naps at his discretion. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Target Date: 11/18/2025	• COMMUNICATION: Involve/collaborate with (John)/SDM in decision making for GERD Management. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 08/29/2025 Revision by: Maryola Perion (RN)		
		• POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals.	PCA Registered Staff	
		• MEDICATION: Administer medication for GERD as per MD order. Monitor	Registered	

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)		effectiveness and for side effects.	Staff	
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: MULTIPLE SCLEROSIS (MS)	• To treat and minimize signs/ symptoms or complications associated with MULTIPLE SCLEROSIS (MS) through to the next review date. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MULTIPLE SCLEROSIS (MS) for changes to health status and alteration or complications affecting neurological function. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy) Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To monitor effectiveness and for side effects of medication used each day through to the next review date Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 11/18/2025	• COMMUNICATION: Involve/collaborate with (John)/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 08/29/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Diagnosis

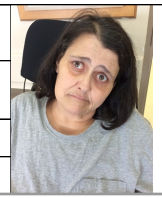
Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Paraesthesia of skin(R20.2), Chronic intractable pain (R52.1), Carcinoma in situ of skin of ear and external auricular canal(D04.2), Chronic obstructive pulmonary disease, unspecified(J44.9)

Allergies	No Known Allergies	**D.O.B.**	02/08/1953	**Physician**	Albert Patrick Ng
Diagnosis	Multiple sclerosis(G35), Other specified diabetes mellitus without (mention of) complication(E13.9), Benign hypertension(I10.0), Asthma, unspecified, without stated status asthmaticus(J45.90), Ga...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Rawlings, John (922131005657)	**Admission Date**	08/20/2025	**Location**	4 424 B

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Loretta has LOA PRN order no additional directions by MD Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse)	• To promote Loretta's safety each day through next review date. Revision on: 06/22/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• ALERT: LOA PRN no additional directions by MD. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse)		
• Loretta DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 4/6 Revision on: 10/26/2025 Revision by: Laura Morris (Restorative Care Aide)	• Loretta will participate in activities 10-15x per month through to the next review date. Revision on: 12/11/2024 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/20/2026	• SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as smoking on the patio, watching/listening to TV, visiting with residents/team members, patio socializing/enjoying outdoors, adult colouring, crafts, computer use, community outings, listening to music, etc. Revision on: 10/26/2021 Revision by: Mitchell Atkinson (Recreation Aide)	ACT	
		• FRIENDLY VISIT: Provide her one to one visits as tolerated. Touch Base to maintain contact and to converse about topics of interest, identify up-coming special events, etc. Revision on: 02/04/2020 Revision by: Megan Pipe (Restorative Care Aide)	ACT	
		• INVITATION: Offer friendly invite to structured programs scheduled in the home. Loretta sometimes will attend arts & crafts, games - Bingo, main floor socials, Happy Hour, special events, etc. Revision on: 01/01/2024 Revision by: Mitchell Atkinson (Recreation Aide)		
• Risk for/Impaired Skin Integrity r/t: Shear/Friction, Impaired Mobility, Diabetes Mellitus, Bladder Incontinence, Use of incontinent product, swelling on right leg/ankle, 2+ edema to L-lower ext mainly on ankle.. Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
		• ROHO cushion pressure reduction device applied to chair when up. Health teaching provided to resident in regards to not having excess materials such as pillows and soaker pad on the ROHO. Revision on: 07/11/2024 Revision by: Janina Lucero (RN)	PCA	
		• AIR MATTRESS: Resident has air mattress for pressure relief. The PSI SETTING should be on alternating. Report issue with inflation to Registered Staff immediately	PCA RN Registered	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A



Last Care Plan Review Completed: 09/08/2025

Focus	Goal	Interventions	Position	Freq/Resolved
		as noted. Revision on: 03/05/2025 Revision by: Janina Lucero (RN)	Practical Nurse	
		• POSITIONING: Encourage Loretta to turn, reposition at least every 2 hours when in bed as per Loretta preference to offload pressure related to pressure injury to left buttock. Revision on: 04/20/2025 Revision by: Jenny Liu (RAI Coordinator)	PCA	Q2h
• Loretta is experiencing colonization with Antibiotic Resistant Organism (MRSA rectal and nose) as of confirmed date: Oct. 23/25 Revision on: 10/24/2025 Revision by: Suzanne Azar (RN)	• To lower risk of infection and prevent transmission of identified Antibiotic Resistant Organism through to the next review. Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with resident with decision making for Antibiotic Resistant Organism treatment plan and update accordingly. Revision on: 10/24/2025 Revision by: Suzanne Azar (RN) • HEALTH EDUCATION: Engage with resident to enhance their knowledge of infection control practices (Specify; hand hygiene, visitation, PPEs, isolation, transmission, etc.) for Antibiotic Resistant Organism. Revision on: 10/24/2025 Revision by: Suzanne Azar (RN) • MONITORING: Utilize holistic perspective of monitoring resident for signs/symptoms of secondary infection, overall health condition. Revision on: 10/24/2025 Revision by: Suzanne Azar (RN) • PPE PRECAUTIONS: Precaution identified as CONTACT for MRSA rectal and nose, and requires use of the following PPEs (Gloves, Gown) when providing direct care, handling soiled clothes and linens, disposing of incontinence product. Revision on: 10/24/2025 Revision by: Suzanne Azar (RN)		
• Alteration in skin integrity related to BRUISE to left eyebrow Revision on: 10/22/2025 Revision by: Katherine Arca (RPN)	• To promote intact skin integrity through healing of BRUISE to left eyebrow Revision on: 10/22/2025 Revision by: Katherine Arca (RPN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (resident name)/SDM in decision making for treatment of bruise as skin issue. Revision on: 10/22/2025 Revision by: Katherine Arca (RPN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/22/2025 Revision by: Katherine Arca (RPN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN		

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity related to BRUISE to left eyebrow Revision on: 10/22/2025 Revision by: Katherine Arca (RPN)		using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/22/2025 Revision by: Katherine Arca (RPN)		
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to poor oral and fluid intake, episodes of LBMs. Revision on: 10/16/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 10/21/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with Loretta/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • PROMOTE FLUIDS: Promote Loretta to consume fluids; amount as per Nutrition Care Plan. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	Diet Registered Staff Registered Staff All	
• Alteration in skin integrity with risk for infection or complications related to MASD #50 on Groin/Peri area Revision on: 10/10/2025 Revision by: Jane Del Rosario (RPN)	• To promote optimal healing of MASD #50 on Groin/Peri area until the next review date. Revision on: 10/10/2025 Revision by: Jane Del Rosario (RPN) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MASD #50 on Groin/Peri area for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/10/2025 Revision by: Jane Del Rosario (RPN) • WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/10/2025 Revision by: Jane Del Rosario (RPN)		
• Potential for Persistent PAIN and alteration in comfort level related to chronic leg pain, lower back pain,diabetes mellitus, stroke, hx of sacral fracture, Rt. hip pain.	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 04/05/2024	• COMMUNICATION: Involve/collaborate with Loretta/SDM) about pain management, goals of treatment, plan of care and treatment options. The Resident can manage with pain with level 5/10. Revision on: 03/07/2025 Revision by: Maryola Perion (RN)		

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
right ankle pain, pain and swelling on the right leg, RT kidney 11.4cm, lower pole nonobstructing calculus 5mm, LT kidney 11.5cm, multiple non obstructive calculi up to 6mm, chest pain. Most Current RAI Pain Score is 1. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026 • Promote RAI Pain Score of 0 through to the next review. Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	RN Registered Practical Nurse Registered Practical Nurse RN	
• Individualized Fall Prevention and Injury Reduction Plan Revision on: 08/11/2025 Revision by: Blanche Erika Bureros (Registered Practical Nurse)	• To decrease the number of falls for throughout this review period. Target Date: 01/20/2026	• Encourage and remind resident to ask for assistance. Revision on: 08/11/2025 Revision by: Blanche Erika Bureros (Registered Practical Nurse)		
• Potential for BOWEL INCONTINENCE related to Impaired Mobility Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	• Loretta will receive support to (use toile) and promote optimal bowel continence each day through to the next review. Revision on: 08/02/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Totally Incontinent. Report change to level as noted. Revision on: 10/25/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 08/02/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Loretta uses a White Brief on Days, Evening and Night shifts. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• URINARY INCONTINENT related to	• Loretta will have urinary	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for		

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Dysuria, Impaired Mobility, Loretta will remove her own catheter and will ask Registered staff to put a new one when she wants to. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	incontinence managed every shift through to the next review period. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	changes to health status and alteration of continence level. Revision on: 03/11/2020 Revision by: Maryola Perion (RN)		
		• URINARY Continence level is Totally Incontinent. Loretta is able to remove her catheter and will become incontinent. Report change to level as noted. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Loretta uses a White Brief on Days, Evening and Night shifts. Revision on: 08/02/2025 Revision by: Maryola Perion (RN)	PCA	
		• TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA	
• Increased risk for FALLS related to: Impaired mobility & Balance, Seizure disorder, Anxiety Disorder, History of falls, unsteady gait, Hx of Stroke with Rt. side hemiplegia Revision on: 06/19/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• PURPOSEFUL ROUNDING: Conduct purposeful rounding every two hours to assess resident's needs; for pain, positioning, peri-needs or possessions for safety.	PCA Registered Practical Nurse RN	
		• COMMUNICATION: Involve/collaborate with Loretta/SDM in decision making in fall prevention Plan of Care. Revision on: 11/17/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. education provided to Loretta to use call bell when self transferring to the toilet when needed . Revision on: 06/25/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: wheelchair, Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment personal belongings within reach to reduce	PCA	

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Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to: Impaired mobility & Balance, Seizure disorder, Anxiety Disorder, History of falls, unsteady gait, Hx of Stroke with Rt. side hemiplegia Revision on: 06/19/2025 Revision by: Danielle Loreto (RAI Coordinator)		fall risk for Loretta. She has been provided with a reaching stick to aid her. She is particular about her belongings and her room can be cluttered and is not accepting always at reducing it. Revision on: 06/25/2025 Revision by: Danielle Loreto (RAI Coordinator) • FOOTWEAR: Loretta's preference is to not wear shoes. Revision on: 06/25/2025 Revision by: Danielle Loreto (RAI Coordinator) • SPECIAL CONSIDERATION: Loretta has bolsters in her bed that do note prevent her movement in and out of bed. They assist with positioning when in bed. Revision on: 06/25/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA PCA	
• Potential Risk for Delirium, OR Acute Change in Cognitive Functioning related to increased confusion, laughing to self, talking, rambling Revision on: 06/18/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote early identification of changes in Loretta Renaud condition and prevent onset of Delirium Revision on: 06/18/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/20/2026	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Loretta for indications of DELIRUM including dehydration, poor appetite, vomiting, diarrhea, blood loss, acute flare up of chronic condition- CHF, DM, infection, etc.. Revision on: 06/18/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Behaviour problem (verbal aggression/abuse, resisting care, disruptive behavior, socially inappropriate- calling staff name, using cursive language, making false accusations), kicked another resident r/t: Anxiety Disorder, Depression, Brain Injury Revision on: 06/07/2025 Revision by: Maryola Perion (RN)	• To decrease episodic frequency of Expressive Behaviour by next review date. ABS score will be less than 4. Revision on: 10/25/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with Loretta about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 02/20/2023 Revision by: Haley Barisic (Quality Lead) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Loretta for indications to change in or for escalating expressive behaviour risk. Revision on: 02/20/2023 Revision by: Haley Barisic (Quality Lead) • PHYSICAL Behaviour: Review with Loretta that she cannot kick other residents. If	BSO - Internal BSO - External Social Worker	

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		she becomes agitated with the other resident, to remove herself from the situation, not engage and notify a team member for help. Revision on: 06/07/2025 Revision by: Maryola Perion (RN) • TRIGGERS leading to VERBAL (yelling, screaming, calling names, making threats to other residents) as expression of behaviour include (frustration, misunderstanding care intention) Revision on: 03/17/2025 Revision by: Danielle Loreto (RAI Coordinator) • VERBAL Behaviour: When Loretta is yelling or cursing at staff; do not use re-direction as this increases her agitation. Walk away; leave her safely by using stop and go approaches then go back when she is calm or switch places with the staff member standing at the door to try another staff giving the care. Loretta may do better with another person when she is upset or agitated. If resident is noted threatening another resident ask her to remove herself from the area. Remind her that threats are taken seriously and that if she is feeling frustrated to come and talk to the team. Speak to Loretta if it is reported that she has made any threats to the other residents. Monitor her interactions with resident N.C. due to resident threatening her. Separate residents and increase monitoring Inform DOC if threats are made. Monitor interactions with resident in 422 as resident has been fixated on resident and being verbally expressive and following resident around. If noted, redirect Loretta from this resident. If she will not comply move other resident. If not successful inform the charge nurse. Ensure safety Revision on: 04/03/2025 Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to take medication , refused bath/shower, eat, etc.) as expression of behaviour include (cause: misunderstanding care needs, poor judgment,loss of control, being misunderstood, certain residents.) Revision on: 05/01/2025		

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Behaviour problem (verbal aggression/abuse, resisting care, disruptive behavior, socially inappropriate- calling staff name, using cursive language, making false accusations), kicked another resident r/t: Anxiety Disorder, Depression, Brain Injury Revision on: 06/07/2025 Revision by: Maryola Perion (RN)		Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Loretta is refusing to (refusing to take medication , refused bath/shower, eat, etc.) re-approach when resident is calm. Complete tasks slowly. Active listening. Report episode to Registered Staff. Revision on: 05/01/2025 Revision by: Maryola Perion (RN) • TRIGGERS leading to SOCIALLY Inappropriate (disruptive vocalizations, making false accusations.) as expression of behaviour include (confusion, decreased insight, poor judgement, limitation in communication, over stimulation, etc.) Revision on: 07/12/2023 Revision by: Jenny Liu (RAI Coord Back-up) • SOCIALLY Inappropriate Behaviour: If Loretta is noted to (calling staff name, make false accusations.) staff to tell her behaviors not acceptable, needs to be stopped. report to registered staff as needed. Revision on: 07/12/2023 Revision by: Jenny Liu (RAI Coord Back-up) • ENVIRONMENT:Loretta is most calm with door closed, quiet area, small groups, to allow her to wake up on her own time (ex.after breakfast). Revision on: 03/15/2023 Revision by: Leslie Meloche (Activities/Rec Therapy) • MEDICATION: Administer medication for therapeutic treatment as per MD Order. Monitor effectiveness and for side effects. Revision on: 07/12/2023 Revision by: Jenny Liu (RAI Coord Back-up) • ONE to ONE Care: See Registered Staff for update. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) • SPECIAL CONSIDERATIONS: The resident is High Intensity for preferred accommodation.Loretta is to have 2 people provide care at all times due to accusatory behavior. Revision on: 09/29/2024 Revision by: Ranjita Yadav (RPN) • BSO: Loretta is on HIN in a private room due to her unpredictable and expressive behaviors. SPECIAL CONSIDERATIONS: Loretta is to have 2 people provide care at	Registered Practical Nurse RN All	

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Focus	Goal	Interventions	Position	Freq/Resolved
• Behaviour problem (verbal aggression/abuse, resisting care, disruptive behavior, socially inappropriate- calling staff name, using cursive language, making false accusations), kicked another resident r/t: Anxiety Disorder, Depression, Brain Injury Revision on: 06/07/2025 Revision by: Maryola Perion (RN)		all times due to accusatory behavior. Allow Loretta to wake on her own time (after breakfast) TRIGGERS leading to VERBAL (yelling, screaming, calling names) as an expression of behavior include (cause: frustration, limitation in self-expression, pain, misunderstanding care intention) waiting for staff to complete tasks When Loretta is angry and yelling at staff Use the stop-and-go approach and calmly ask her to lower her voice when her words are not appropriate. Attempt to resolve her concern. Report episode to Registered Staff. Complete tasks slowly and use active listening. Ensure residents are kept at a safe distance when she is angry. Provide reassurance and comfort. Loretta displays pain by having angry outbursts due to chronic pain. Try not to make Loretta wait for tasks to be done when possible as this is a trigger for her. Loretta enjoys coloring and sketching as well as some other crafts. Loretta also enjoys the outdoors, computers, reading, listening to Garth Brooks, playing bingo and making decorations for holidays such as Christmas. These activities can help Loretta if she is agitated. BSO SSW to continue with visits and provide coloring supplies to resident Ensure residents are kept at a distance when she is angry. provide reassurance, comfort, active listening to concerns, validate feelings The resident displays pain by having angry outbursts and being disruptive due to chronic pain. Treat pain as ordered. Revision on: 09/17/2025 Revision by: Leslie Meloche (Recreation Aide)		
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye. Revision on: 05/01/2025 Revision by: Maryola Perion (RN)	• Loretta will be protected from exposure to allergen each day through next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with Loretta/SDM in decision making and health teaching about her ALLERGY. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications mortality. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • ALLERGY ALERT: Loretta has ALLERGY to (Loxapine, Haldol, Sulfa Antibiotics,		

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
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Focus	Goal	Interventions	Position	Freq/Resolved
		Contrast Dye). Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 05/01/2025 Revision by: Maryola Perion (RN)		
		• Registered staff to ensure MD's and Pharmacy aware of Loretta's allergy and ensure she does not receive it. Revision on: 12/01/2018 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• RESCUE MEDICATION: Administer EPINEPHRINE as per MD/NP Order. Monitor effectiveness and immediately notify MD/NP of use.	Registered Staff	
• Potential to experience alteration in MOOD as exhibited by (persistent anger with self or others (upset when others are loud or copy what she is doing), repetitive anxious complaints, unpleasant mood in the morning, sad, pained, worried facial expression, crying), NSGAR - 9, " Resident stated she has nothing to live for and she wishes she would have a seizure and die" related to Depression, Anxiety, Brain Injury. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative mood by next to the review date. DRS score will be less than of 1. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with Loretta/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• HEALTH EDUCATION: Provide education and support to Loretta/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
		• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Loretta for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• RESIDENT STRENGTHS: Build on Loretta's effort to maintain control. Encourage her to express self, state preferences and make safe choices for care and activities. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• SUICIDAL IDEATIONS: Report to Registered Staff IMMEDIATELY if Loretta expresses thoughts to harm to self.		

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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by (persistent anger with self or others (upset when others are loud or copy what she is doing), repetitive anxious complaints, unpleasant mood in the morning, sad, pained, worried facial expression, crying), NSGAR - 9, " Resident stated she has nothing to live for and she wishes she would have a seizure and die" related to Depression, Anxiety, Brain Injury. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)		Orders do NOT allow Loretta to sign out at this time due to safety concerns. Revision on: 04/27/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in RESPIRATORY FUNCTION related to Chronic Obstructive Pulmonary Disorder (COPD), Low Oxygen saturation. Revision on: 01/19/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with COPD each day through to next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with Loretta/SDM in decision making of Respiratory Management for COPD. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with COPD for changes to health status and alteration or complications affecting respiratory function. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	PCA	

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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in RESPIRATORY FUNCTION related to Chronic Obstructive Pulmonary Disorder (COPD), Low Oxygen saturation. Revision on: 01/19/2025 Revision by: Maryola Perion (RN)		• OXYGEN: Administer Oxygen as per MD order. Review O2 safety with Loretta, to remind Loretta portable cannot be brought outside when going to smoke or when planning to be around others who are smoking. Revision on: 01/19/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication inhalers for COPD as per MD order and monitor for side effects. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
• Strength Revision on: 10/03/2023 Revision by: Shina Wadhwa (PT - Physiotherapist)	• Increased strength of Rt LE from 3+/5 to 4/5 in next 3 months Revision on: 10/30/2025 Revision by: Shina Wadhwa (PT - Physiotherapist) Target Date: 01/20/2026	• Strengthening exs for Lt LE and UE from 1-2 lbs ankle weights 10 reps, 1 set, 2-3 x a week AAROM exs for RT UE and LE,10 reps, 1 set, 2-3 x a week Revision on: 06/04/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• SPIRITUAL BELIEFS: Loretta is not religious. Revision on: 10/02/2023 Revision by: Mitchell Atkinson (Recreation Aide)	• To provide Loretta spiritual support as interested through to the next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• PERSONAL CHOICE: Respect Loretta's right to decline participation in Spiritual Programs. Revision on: 11/09/2019 Revision by: Megan Pipe (Restorative Care Aide)	ACT	
• Altered ability to complete Activities of Daily Living (ADLs) related to Impaired mobility, Brain Injury, Seizure Disorder, Depression, Anxiety, Chronic Pain, Hx Stroke with Rt. sided Hemiplegia. 2 staff for all care due to behavior issues Revision on: 02/20/2023	• Loretta will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo	• BATHING: Loretta prefers (shower/tub bath) on (Tuesdays and Saturdays on Evening shift). Loretta participates by (providing a wash cloth to wash her face and washing the upper part of the body). One staff (MAXIMAL) assistance for bathing. May Require a Maxi lift for transfer with one to two staff to assist. Nail care to be provided on shower/bath day. Revision on: 10/10/2025 Revision by: Tola Omolade (ADOC)	PCA	

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Revision by: Haley Barisic (Quality Lead)	(RAI Coordinator) Target Date: 01/20/2026 • Loretta will be supported to maintain current self participation in ADL care and assisted to ensure all ADL care tasks are met each day through to the next review date. Revision on: 03/07/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• BED MOBILITY: Loretta is able to turn and reposition self independently while in the bed. May require one to two staff Extensive assistance at times when she is drowsy, lethargic or weak. Bed Rails in place to aim with bed mobility Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	PCA	
		• DRESSING: Loretta is able to (assist minimally by lifting her arms and legs). One staff to provide (EXTENSIVE) assistance for dressing UPPER & LOWER body. She may require two staff maximal assistance when she is drowsy, tired or weak. Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	PCA	
		• EATING: Loretta requires set-up, help cutting up her food, ++ encouragement, and PRN assistance for meals (usually able to self-feed). She eats in the main dining room 1st floor OR 4th floor dining room. Revision on: 10/23/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• LOCOMOTION: Loretta is able to propel her manual wheelchair on and off the unit. She may require one staff member to push her wheelchair when she is weak, lethargic or as needed. She will still use her electrical wheelchair in spite of the health teachings being provided due to safety. Loretta can go out with responsible person as needed per MD. Revision on: 08/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• PERSONAL HYGIENE: Loretta is able to comb/brush her hair, wash/dry her face, hands, oral care but requires one staff when she is weak or lethargic. She require one staff assistance with peri care. Revision on: 10/25/2025 Revision by: Maryola Perion (RN)	PCA	
		• HAND HYGIENE: 1 staff to provide reminder assistance to use hand sanitizer or wipes for hand hygiene. Revision on: 10/15/2021 Revision by: Maryola Perion (RN)	PCA	
		• TOILET USE: Loretta requires the use of one person assist. Maxi lift used for transfer as needed.	PCA	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Impaired mobility, Brain Injury, Seizure Disorder, Depression, Anxiety, Chronic Pain, Hx Stroke with Rt. sided Hemiplegia. 2 staff for all care due to behavior issues Revision on: 02/20/2023 Revision by: Haley Barisic (Quality Lead)		She is transferring herself all the time and requires one staff assistance. She requires one staff in changing and cleaning her in bed due to incontinence and not safe to be toileted and may require MAXIMAL assistance. Encourage Loretta to ask for assistance with toileting needs. Revision on: 10/10/2025 Revision by: Tola Omolade (ADOC)		
		• TRANSFERRING: Loretta requires one staff for transfer. Maxi lift for as needed use. However she transfers herself all the time despite the risk. Encourage Loretta to ask for assistance. Revision on: 10/10/2025 Revision by: Tola Omolade (ADOC)	PCA	
		• TRANSFER LIFT/SLING: One person assist, maxi lift as needed, medium sling size needed for transfers. Revision on: 10/10/2025 Revision by: Tola Omolade (ADOC)		
		• ORAL CARE: Loretta is not able to do her own oral hygiene independently, Need one person to assist, Some teeth missing, broken or loose. Revision on: 08/03/2025 Revision by: Ravinder Kaur (Registered Nurse)	PCA	
		• RESIDENT PREFERENCE with ADL activities as follows: Resident wishes to be woken up for all meals. Revision on: 12/28/2022 Revision by: Meghan Sears (ADOC)	PCA	
		• SPECIFIC RESIDENT Request: Resident wants to be checked by staff regularly at night time because she is scared of if she is not breathing. Revision on: 01/18/2023 Revision by: Jenny Liu (RAI Coord Back-up)	PCA	
• Use/ Application of table top PASD for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility, physical aggression related to impaired mobility, risk of falls. Revision on: 09/24/2021 Revision by: Haley Cadarian (Quality Lead)	• Loretta will be effectively supported with use of BED RAILS; LAP TABLE; SEAT BELT; TILT; PASD to optimize Activity of Daily Living such as recreation activities, meals, bed mobility, transferring and	• HEALTH EDUCATION: Engage with Resident/SDM to enhance their knowledge of possible benefits and challenges associated with Use of PASD. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• PASD BED RAIL two 1/4 Bed Rail in USE as a PASD to assist resident with bed mobility and repositioning. Monitor every shift. Revision on: 05/04/2025	PCA	D/E/N

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	comfort each day through to the next review date. Revision on: 07/11/2024 Revision by: Janina Lucero (RN) Target Date: 01/20/2026	Revision by: Jiss Mathew (RN) • SEAT BELT in USE as a PASD to support resident with safety. Monitor every shift. Revision on: 11/16/2022 Revision by: Alyssa Egan (Staff Development Coordinator) • TILTED CHAIR in USE as a PASD to support Loretta with positioning/comfort/offloading. Monitor every shift. Revision on: 12/18/2024 Revision by: Danielle Loreto (RAI Coordinator)	PCA PCA	D/E/N D/E/N
• Loretta has has potential to experience a safety hazard/burn injury related to personal SMOKING habits. Revision on: 07/30/2021 Revision by: Maryola Perion (RN)	• Loretta will be safe when choosing to smoke through to the next review. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve Loretta/SDM in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) and identify the designated area/s where smoking is permitted. Revision on: 01/20/2021 Revision by: Maryola Perion (RN) • HEALTH TEACHING: engage with resident and support their effort to explore smoking cessation options (including interventions as prescribed by MD). Revision on: 01/20/2021 Revision by: Maryola Perion (RN) • SMOKING CONTRACT: Loretta has agreed to follow safe smoking rules and accepts the consequences of breaking those agreed upon rules by signing the smoking contract. Revision on: 01/20/2021 Revision by: Maryola Perion (RN)	Social Worker Social Worker Administrator	
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS. Revision on: 04/30/2021 Revision by: Maryola Perion (RN)	• To treat and minimize complications associated with OSTEOPOROSIS through to the next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/ collaborate with Loretta/SDM in decision making of osteoporosis care management. Revision on: 04/30/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for osteoporosis management. Monitor effectiveness and for side effects. • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of osteoporosis for discomfort/ complications or changes to health status.	 Registered Staff Registered Staff	
• Expressed Wishes and Beliefs related to	• To support and honor Loretta's	• CPR: Loretta's wishes to have CPR and TRANSFER to hospital.	All	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Loretta's Medical Treatment and End of Life Care Revision on: 04/30/2021 Revision by: Maryola Perion (RN)	expressed wishes and beliefs through to the End of Life. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	Revision on: 11/17/2019 Revision by: Maryola Perion (Registered Nurse)		
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder	• To treat and minimize signs/ symptoms or complications associated with (specify Etiology or diagnosis) through to the next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/ collaborate with Loretta/ SDM in decision making of neurological care management for CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	PCA	
		• LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder as per MD order. Monitor effectiveness and for side effects. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder for changes to health status and alteration or complications affecting neurological function. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
		• Observe SWALLOWING: Inform Registered staff of changes or any signs of difficulty in swallowing (coughing during eating, drooling, etc.).	PCA Registered Staff	
		• SEIZURE Disorder: If seizure activity occurs alert registered staff immediately; place on side, protect from injury, maintain open airway.	PCA Registered Staff	
		• SEIZURE Disorder: Loretta has potential for seizure activity, injury related to seizure disorder. Inform MD as it occurs.	All	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA), SEIZURE Disorder		Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • COMMUNICATION: Involve/ collaborate with Loretta/SDM in decision making of diabetes care management. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • CBG MONITORING: Monitor CAPILLARY BLOOD GLUCOSE (CBG) as per MD order. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for DIABETES as per MD order. Monitor effectiveness and for side effects. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • RESCUE MEDICATION: Administer GLUCAGON for hypoglycemia as per MD order. • LAB WORK: Monitor lab and diagnostic results for (fasting blood glucose and/or HbA1c) and report results to MD as needed. Follow up as indicated	Registered Staff	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of (specify; multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026 • To promote Loretta's understanding of treatment regime and possible side effects of medication taken through to the next review. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with Loretta/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
• Altered VISION related to: Right eye almost blind (per Loretta), See large print. Revision on: 02/06/2021	• Loretta will be able to function safely in her environment through next review date.	• READING: Loretta uses large print material to aid with reading. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	PCA	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026			
• Altered COMMUNICATION as exhibited by limitations to (comprehension, etc.) related to Seizure Disorder, Brain Injury, Hx of Stroke with Rt. side hemiplegia. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	• Loretta will be supported to maintain current communication abilities to (express self, comprehend information, etc.) each day through to the review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026 • Loretta will be able to make basic needs known each day through to the review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• PRIMARY LANGUAGE: Loretta's primary language is English. She is able to speak/understand English. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
• Alteration in thought processes (memory loss, difficulty concentrating, poor judgement, etc.) related to Seizure Disorder, Brain Injury, Hx of Stroke with Rt. side hemiplegia. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	• Loretta will be supported to maintain cognitive function through the review date. Current CPS is 3. Revision on: 08/13/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• ORIENTATION: Gently reorient to person, place, time as needed when Loretta is feeling lost or in confused state. Revision on: 02/06/2021 Revision by: Maryola Perion (RN)		
• Sleep Patterns. Revision on: 12/01/2018	• To promote adequate rest/sleep for Loretta based on	• REST PATTERN: Preferred bedtime: No specific time, usual wake time: No specific time	PCA	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (Registered Nurse)	identified sleep patterns/preferences each night through to the next review date. Revision on: 05/06/2025 Revision by: Tola Omolade (ADOC) Target Date: 01/20/2026	Revision on: 02/06/2021 Revision by: Maryola Perion (RN) • SLEEPWEAR: Loretta prefers to wear johnny shirt or night gown Revision on: 02/06/2021 Revision by: Maryola Perion (RN)	PCA	
• Nutrition Risk Level (diet details)	• Loretta will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 04/05/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026 • Will weigh within Realistic weight range of 58 - 63kg/BMI 22-24 through to next review date. Revision on: 12/09/2024 Revision by: Debora Choi (Dietitian (RD)) Target Date: 01/20/2026 • Loretta will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 1515 ml/day (25 ml/kg using 60.6 kg weight) through to next review date. Revision on: 08/12/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/20/2026	• LABELLED SNACK HS: jello daily (99 ml fluid) Revision on: 08/12/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	E
		• LABELLED SNACK PM: 355 ml diet gingerale daily Revision on: 08/12/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D
		• NUTRITION RISK: Loretta is high risk level. Revision on: 11/03/2020 Revision by: Anna Slack (Registered Dietitian)	Dietitian (RD) Dietary Manager	
		• DIET ORDER: Loretta will receive regular diet, regular texture. Special instructions: encourage softer options and provide crustless bread/toast. Revision on: 05/01/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• FLUID CONSISTENCY: Loretta drinks REGULAR/THIN Level 0 Fluids. Revision on: 05/01/2025 Revision by: Holly Laasanen (Dietitian (RD))	Diet PCA	
		• FLUID TARGET: Encourage Loretta to drink a minimum of 1212 ml per day. Revision on: 08/12/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily.	Dietary aide PCA	
		• ADAPTIVE AIDS: rimmed plate and sippy cup Revision on: 04/27/2021 Revision by: Olivia Kuhlmann (Dietetic Intern)	Diet PCA	

Allergies	Loxapine, Haldol, Sulfa Antibiotics, Contrast Dye	**D.O.B.**	04/04/1974	**Physician**	Albert Patrick Ng
Diagnosis	Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitu...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Renaud, Loretta (922131005029)	**Admission Date**	06/28/2025	**Location**	4 415 A
Last Care Plan Review Completed:	**09/08/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)		• FOOD ALLERGY/INTOLERANCE: Loretta has an INTOLERANCE to: milk (beverage). Reactions to this food/fluid - diarrhea. Loretta drinks Lactaid milk only. Revision on: 08/12/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Restorative Care Aide	
		• HIGH CALORIE/PROTEIN PM SNACK: Crustless PB&J sandwich Mon/Wed/Fri Soft cookie Tues/Sat Crackers and cheese Thurs/Sun Revision on: 10/23/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D
		• MEDPASS SUPPLEMENTS: 90 ml of Resource 2.0 QID with medpass Revision on: 10/23/2025 Revision by: Holly Laasanen (Dietitian (RD))		
		• LABELLED SNACK AM: 591 ml bottle of Powerade daily Revision on: 10/28/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	

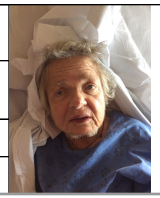
Diagnosis

Seizure disorder, so described(R56.80), Other specified diseases of pancreas(K86.8), Other specified disorders of brain(G93.88), Other depressive episodes(F32.8), Other specified diabetes mellitus without (mention of) complication(E13.9), Anxiety disorder, unspecified(F41.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Embolism and thrombosis of other specified veins(I82.8), Other chronic pain(R52.2), Hemiplegia of unspecified type of dominant side(G81.90), Stroke, not specified as haemorrhage or infarction(I64), Fatigue fracture of vertebra, sacral and sacrococcygeal region(M48.48), Osteoporosis, unspecified(M81.9), Hepatomegaly, not elsewhere classified(R16.0), Retention of urine(R33), Status epilepticus, unspecified(G41.9), Schizophrenia, unspecified(F20.9), Phlebitis and thrombophlebitis of superficial vessels of lower extremities(I80.0)

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Alteration in skin integrity related to #3 - MASD - IAD Sacrum Revision on: 10/16/2025 Revision by: Maryola Perion (RN)	• To promote intact skin integrity through healing of MASD by the target date. Revision on: 10/16/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with MASD for changes to health status and alteration or complications affecting skin integrity. Revision on: 10/16/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed. Revision on: 10/16/2025 Revision by: Maryola Perion (RN)		
• Increased risk for FALLS related to club foot, history of falls, unsteady gait and balance, non compliant with the use of her walker. Fall on 10/15/2025 Revision on: 10/15/2025 Revision by: Jane Del Rosario (RPN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• PURPOSEFUL ROUNDING: Conduct purposeful rounding every hour during the day and evening and every 2 hours overnight to assess resident's needs; for pain, positioning, peri-needs or possessions for safety.	PCA Registered Practical Nurse RN	
		• Staff monitor Penny frequently, once saw she is walking in hallway or to her room, staff have to follow her incase she lost balance to fall or put herself on the floor.		
		• COMMUNICATION: Involve/collaborate with (Penny)/SDM in decision making in fall prevention Plan of Care. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)		
		• CALL BELL: Place call bell within Penny's reach, check that it is in working order and remind/encourage to use it. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	D/E/N
		• ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: Commode over the toilet, encourage to use her walker. Revision on: 01/28/2025 Revision by: Maryola Perion (RN)	PCA	
		• ENVIRONMENT: Secure environment: reduce clutter, etc. to reduce fall risk for Penny. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure Penny wears appropriate footwear at all times.	PCA	

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Family history of alcohol abuse(Z81.1), Homelessness(Z59.0), Psychological abuse(T74.3)				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A



Last Care Plan Review Completed: **10/20/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to club foot, history of falls, unsteady gait and balance, non compliant with the use of her walker. Fall on 10/15/2025 Revision on: 10/15/2025 Revision by: Jane Del Rosario (RPN)		Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • HIP PROTECTORS: "Penny Smith" wears hip protectors at all times, to safeguard against injury. Report to Registered Staff if not wearing. Revision on: 06/11/2025 Revision by: Tola Omolade (ADOC) • ALARMS: Requires Chair and bed alarm. Check placement and working order. Staff respond when alarm is heard. Revision on: 07/18/2025 Revision by: Tola Omolade (ADOC) • SUPPLEMENT: Administer supplement/medication as per MD order to maintain bone density to prevent injuries. Revision on: 01/28/2025 Revision by: Maryola Perion (RN)	PCA PCA	D/E/N D/E/N
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Altered Mood. ISE Score: 6/6 Revision on: 10/09/2025 Revision by: Laura Morris (Restorative Care Aide)	• Team members will support Penny in decreasing social isolation by participating in activities of personal choice 20-25 times per month by the next review date. Revision on: 07/10/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/20/2026	• STRUCTURED ACTIVITIES: Invite her to programs of personal interest; friendly/1:1 visits, discussion groups, exercise fun & fitness, physical games, Happy Hour, manicures & hand massages, music programs, special events, etc. Revision on: 01/25/2024 Revision by: Mitchell Atkinson (Recreation Aide) • SELF-DIRECTED ACTIVITIES: Encourage her to engage in self-directed activities such as watching/listening to TV, listening to music/radio, visiting with residents/team members, coloring etc. Revision on: 04/24/2025 Revision by: Kameron Stewart (Recreation Aide) • ONE to ONE: Provide her with individual visits for conversation, reading, reminiscing, music, humour, coloring/painting etc. Revision on: 04/24/2025 Revision by: Kameron Stewart (Recreation Aide)		

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Family history of alcohol abuse(Z81.1), Homelessness(Z59.0), Psychological abuse(T74.3)				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
Last Care Plan Review Completed:	**10/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Altered Mood. ISE Score: 6/6 Revision on: 10/09/2025 Revision by: Laura Morris (Restorative Care Aide)		• SOCIAL INTERACTION: Promote the opportunity for Penny to make friendships and sit with friends during activities. Revision on: 12/11/2023 Revision by: Mitchell Atkinson (Recreation Aide)		
• Alteration in skin integrity related to RASH to: #5 - MASD - IAD Groin Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	• To promote intact skin integrity through healing of RASH by the next review date Revision on: 07/23/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with #5 - MASD - IAD Groin for changes to health status and alteration or complications affecting skin integrity. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
		• WEEKLY ASSESSMENT: Assess and evaluate skin condition weekly and PRN using PCC Skin/Wound Record App. Report signs of impaired healing to Wound Care Lead and MD as needed Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	Registered Staff	
• Potential for PAIN and alteration in comfort level related to Hypertension, Dementia. Most Current RAI Pain Score is 0/3. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	• Promote RAI Pain Score of 0 through to the next review. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (Penny)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 07/25/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control.	RN Registered Practical Nurse	
		• MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically	Registered Practical	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for PAIN and alteration in comfort level related to Hypertension, Dementia. Most Current RAI Pain Score is 0/3. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)		needed. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	Nurse RN	
• Potential for Expressive Behaviour of WANDERING, VERBAL, PHYSICAL (kicked another resident, punching while giving care), SOCIALLY Inappropriate (consuming her own feces , after she spread in on the floor of her room July 12, 2025) RESISTANCE to care need, SEXUAL nature related to History of ETOH, Dementia. Revision on: 07/13/2025 Revision by: Jenny Liu (RAI Coordinator)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be less than 7. Revision on: 10/20/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Penny for indications to change in or for escalating expressive behaviour risk. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • TRIGGERS leading to PHYSICAL Hitting, Punching the team, swinging, kicking another resident as expression of behaviour includes frustration, fearfulness, confusion, invasion of personal space, miss understanding task at hand, other residents entering room/personal space. Revision on: 08/07/2024 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: If Penny is attempting to strikeout; move back from her reach. Calmly indicate that care will continue when she is calm/ready. Seek Registered Staff assistance. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • TRIGGERS leading to VERBAL yelling, screaming, calling names as expression of behaviour include frustration, limitation in self expression, misunderstanding care intention. Other residents entering room/personal space. Revision on: 01/31/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) • VERBAL Behaviour: If Penny is heard yelling, swearing or calling others names; calmly remind to lower her voice and that chosen words are not appropriate. Attempt to resolve his/her concern. Report episode to Registered Staff. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Family history of alcohol abuse(Z81.1), Homelessness(Z59.0), Psychological abuse(T74.3)				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of WANDERING, VERBAL, PHYSICAL (kicked another resident, punching while giving care), SOCIALLY Inappropriate (consuming her own feces , after she spread in on the floor of her room July 12, 2025) RESISTANCE to care need, SEXUAL nature related to History of ETOH, Dementia. Revision on: 07/13/2025 Revision by: Jenny Liu (RAI Coordinator)		• TRIGGERS leading to RESISTANCE to Care Needs of refusing to change clothing, refusal to bathe, refusal to eat, refusing medication, etc. as expression of behaviour include confusion, misunderstanding care needs, poor judgement, fearfulness, paranoid thought process, etc. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • RESISTANCE to Care Need: If Penny is declining to bathe, change clothes, take medications, eat, etc. re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • SOCIALLY Inappropriate Behaviour: If Penny is noted to make loud disruptive or disrobe or "dig" into her brief, will eat own feces. gently redirect her to focus on task at hand, to move to quieter area, etc., or distraction activity assist with reapplying clothing and assist with cleaning hands/adjusting clothing and incontinence products. Revision on: 06/09/2025 Revision by: Danielle Loreto (RAI Coordinator) • SPECIAL CONSIDERATIONS:The resident is in High Intensity for preferred accommodation. Revision on: 05/02/2025 Revision by: Ranjita Yadav (RPN) • BSO RECOMMENDATIONS:Verbal: Swearing, yelling, calling names. Triggers: Pain, environmental noise, invasion of personal space, other residents touching her stuff (coloring supplies). Recommendations: Utilize art work as a form of distraction and to change her mood as needed. If the resident is insulting don't take it personally. Use humor to re-direct statements. Internal BSO has placed a sign on her door to keep door closed at all times so residents don't wander into her room. Refusing Care: Refusing to change, shower. Triggers: Pain, confusion. Recommendations: Suggest no more than 2 team members at a time for care to prevent over stimulation. One team member speaks in a soft tone the steps being done with the other team member standing by but not speaking. Encourage independence as much as possible during care. Ask resident to take off her own clothes. Ask resident to hold cloths/towels during care to prevent physical expressions..		

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of WANDERING, VERBAL, PHYSICAL (kicked another resident, punching while giving care), SOCIALLY Inappropriate (consuming her own feces , after she spread in on the floor of her room July 12, 2025) RESISTANCE to care need, SEXUAL nature related to History of ETOH, Dementia. Revision on: 07/13/2025 Revision by: Jenny Liu (RAI Coordinator)		Physical: Striking out, hitting. Triggers:Confusion, misunderstanding care needs. Recommendations: Use the stop and go approach. Reapproach when the resident is calm/ready. Report the episode to registered staff. Penny likes to sit by the window in the dining room and colour or watch tv. The resident enjoys attending main floor programs such as Bingo or happy hour. Revision on: 10/13/2025 Revision by: Leslie Meloche (Recreation Aide)		
• Gait Training Revision on: 01/21/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Reduce fall risk by improving foot clearance by while walking in next 3 months; Revision on: 01/21/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/20/2026	• 1:1 Assist Ambulation with RW; distance as best tolerated, Cue for improved foot clearance, 1-2 x a week; Revision on: 10/14/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential to experience alteration in MOOD as exhibited by persistent anger with self or others, repetitive anxious	• To decrease the episodic frequency of negative Mood symptoms by the next review	• COMMUNICATION: Involve/collaborate with (Penny)/SDM) about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 05/02/2024		

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
complaints, unpleasant mood in the morning, repetitive physical movements, taking Antidepressant medication, Suicidal ideation saying "I want to kill myself" (12/6/24) related to Dementia . Revision on: 12/07/2024 Revision by: Maryola Perion (RN)	date. DRS score will be less than 1. Revision on: 10/20/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	Revision by: Maryola Perion (RN) • HEALTH EDUCATION: Provide education and support to (Penny)/SDM pertaining to Mood Disturbance, symptom management, treatment and possible availability of community resources as needed. Revision on: 05/02/2024 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Penny for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • RESIDENT STRENGTHS: Build on Penny's effort to maintain control. Encourage him/her to express self, state preferences and make safe choices for care and activities. Revision on: 05/02/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • SUICIDAL IDEATIONS: Report to Registered Staff IMMEDIATELY if Penny expresses thoughts to harm to self. Revision on: 12/07/2024 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse	
• Strengthening Exs Revision on: 09/16/2024 Revision by: Shina Wadhwa (Physical Therapist)	• To increase strength in RT LE from 3+/5 to 4/5 in next 3 months Revision on: 10/14/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/20/2026	• B/L LE strengthening exs with 1lb, 10 reps, 1 set or as best tolerated, 2-3 x a week; Gentle ROM exs for B/L Shoulders, within pain range, 10 reps, 2-3 x a week; Revision on: 07/15/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Potential for BOWEL INCONTINENCE related to Dementia, Impaired Mobility. Revision on: 07/25/2024	• Penny will have bowel incontinence managed every shift through to the next review	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function.	Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
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Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	period. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• BOWEL Continence level is Total Incontinence. Report change to level as noted. Revision on: 01/28/2025 Revision by: Maryola Perion (RN)	PCA	
		• BOWEL MOVEMENT: Monitor Penny for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• INCONTINENCE PRODUCT: Penny uses a Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, use of anti-psychotic medications, etc.) Revision on: 05/02/2024 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 05/02/2024 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (Penny)/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)		
		• MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Potential for CONSTIPATION related to decreased mobility, etc. Revision on: 04/28/2024 Revision by: Maryola Perion (RN)	• Penny will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 04/28/2024 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (Penny/SDM) for decision making regarding constipation management. Revision on: 04/28/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation.	Registered Staff	
	• To minimize the potential for episodes/ complications of constipation through to the next review date.	• FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan.	Registered Staff	

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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for CONSTIPATION related to decreased mobility, etc. Revision on: 04/28/2024 Revision by: Maryola Perion (RN)	Revision on: 04/28/2024 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• BOWEL PROTOCOL: In place as per MD order	Registered Staff	
• SPIRITUAL BELIEFS: Penny is of the Protestant Faith. Revision on: 12/11/2023 Revision by: Mitchell Atkinson (Recreation Aide)	• To provide Penny spiritual support as interested through to the next review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• PERSONAL CHOICE: Respect Penny's right to decline participation in Spiritual Program. Please attempt to engage/encourage her participation if she chooses to attend spiritual programs. Revision on: 12/11/2023 Revision by: Mitchell Atkinson (Recreation Aide)		
• Nutrition Risk Level	• Penny will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026 • Will weigh within realistic weight range of 55-65 kg through to next review date. Revision on: 10/07/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/20/2026	• NUTRITION RISK: Penny is moderate risk level. Revision on: 11/02/2023 Revision by: Assia Akhdar (Dietetic Intern) • DIET ORDER: Penny will receive regular diet, regular texture Revision on: 10/30/2023 Revision by: Anna Slack (Registered Dietitian) • FLUID CONSISTENCY: Penny drinks REGULAR/THIN Level 0 Fluids. Revision on: 10/30/2023 Revision by: Anna Slack (Registered Dietitian) • FLUID TARGET: Encourage Penny to drink a minimum of 1500 ml/day Revision on: 10/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD) PCA PCA PCA	

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Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level	• Penny will be adequately hydrated aeb drinking at least 99% of total fluid requirement: 1520 ml/day (25 ml/kg using 60.8 kg weight) through to next review date. Revision on: 10/07/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/20/2026			
• Penny is at high risk for ELOPEMENT related to Dementia and history of elopement. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To promote Pennys safety and minimize risk for episode of elopement each day through next review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• ALERT: Penny has potential to attempt elopement. If heard making requests to leave the building or seen attempting to use exit doors report to Supervisor immediately. Resides on a secured home area. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ELOPEMENT ALERT: Redirect Penny away from elevator or exit doors as needed. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)	 PCA	
• COGNITIVE LOSS; alteration in thought processes memory loss, difficulty concentrating, altered judgement related to progression of Dementia (Short term and long-term memory loss), history of ETOH. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Penny will be supported to maintain cognitive function through the review date. Current CPS is 3/6 Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (Penny)/SDM in decision making of Cognitive Loss for Dementia. Revision on: 05/02/2024 Revision by: Maryola Perion (RN) • ORIENTATION: Gently reorient to person, place, time as needed when Penny is feeling lost or in confused state. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)	 PCA	
• Sleep Patterns; Potential for alteration in	• To promote adequate	• REST PATTERN: Wakes up at approximately 0600hrs and resides between 1800-	PCA	

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Focus	Goal	Interventions	Position	Freq/Resolved
sleep patterns related to new environment. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	rest/sleep for Penny based on identified sleep patterns/preferences each night through to the next review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	2000hrs Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential to experience alteration in CARDIAC FUNCTION related to; Hypertension	• To treat and minimize signs/symptoms or complications associated with Hypertension through to the next review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (Penny)/SDM in decision making of Cardiac Care Management for (specify diagnosis). Revision on: 07/25/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of Penny with Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication for Hypertension as per MD Order and monitor for side effects. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	Registered Practical Nurse RN	
• URINARY (Mixed) INCONTINENCE related to Dementia. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Penny will have urinary incontinence managed every shift through to the next review period. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 05/02/2024 Revision by: Maryola Perion (RN) • URINARY Continence level is Total Incontinence. Report change to level as noted. Revision on: 01/28/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Penny uses a Blue brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA PCA PCA	

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• URINARY (Mixed) INCONTINENCE related to Dementia. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)				
• Risk for Impaired SKIN INTEGRITY related to incontinence and impaired mobility. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To protect and maintain skin integrity each day through to the next review. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Altered COMMUNICATION as exhibited by limitations to self expression, comprehension related to Dementia, history of ETOH. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Penny will be supported to make basic needs known each day through to the review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (Penny)/SDM for decision making about strategies needed to support effective communication. Revision on: 05/02/2024 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Penny communicates best in English. She is able to speak/understand English. Revision on: 05/02/2024 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to Dementia, History of falls, club foot. Revision on: 10/26/2023	• Penny will be supported to cope with changing functional abilities and have ADL care needs met each day through to	• BATHING: Penny prefers (shower/tub bath) on (Wednesdays and Sundays on Day shift). Penny participates by (providing a washcloth and cues). One staff (EXTENSIVE) assistance for bathing. Nail care to be provided on shower/bath day. Revision on: 07/05/2025	PCA	

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Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Katie Wolters-Savo (RAI Coordinator)	the next review date. Revision on: 07/25/2024 Revision by: Maryola Perion (RN) Target Date: 01/20/2026 • Penny will have ALL ADL care needs met each day through the next review date. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: Penny is able to turn and reposition herself independently when in bed. She may require maximal assistance at times from one to two staff. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • DRESSING: Penny is able to (assist by lifting her arms and legs) one staff to provide (EXTENSIVE) assistance for dressing UPPER & LOWER body. She may require two staff maximal assistance at times depending on her behaviors. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • EATING: Penny is able to eat independently with cueing and encouragement from the team once set up. Eats in the Wildflower Lane. Revision on: 07/25/2024 Revision by: Maryola Perion (RN) • LOCOMOTION: Penny is able to ambulate independently with staff supervision using her walker. She may require one staff extensive assistance at times. Staff will continue to encourage Penny to use her walker when ambulating as she will refuse at times. Revision on: 10/20/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: Penny requires one to two team member weight bearing assist to assist with washing her face, brushing her teeth/denture and providing pericare. Revision on: 10/25/2024 Revision by: Maryola Perion (RN) • HAND HYGIENE: 1 staff to provide EXTENSIVE assistance to use soap/water, apply sanitizer, rub hands together, dry hands, etc. for hand hygiene. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • TOILET USE: Penny requires one to two team to guide her to the bathroom and Extensive assistance from one staff with checking and changing her incontinence product and providing peri care. Two staff physical assistance at times depending on her behavior.	PCA PCA PCA PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Family history of alcohol abuse(Z81.1), Homelessness(Z59.0), Psychological abuse(T74.3)				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
Last Care Plan Review Completed:	**10/20/2025**				

Care Plan Report

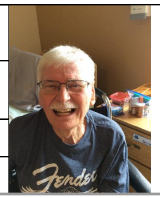
Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Dementia, History of falls, club foot. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • TRANSFERRING: Penny requires one staff assist for transferring. Penny will self transfer. 2 staff assist at times during morning care depending on her behaviour: ambulates independently and refusing the walker: is able to get in and out of bed/chair on her own. Continue to encourage her to ask for assistance. Revision on: 05/03/2024 Revision by: Lara Ismail (RN) • ORAL CARE: Penny has a full upper denture and her own teeth remaining on her lower palate. She requires the team to assist with brushing her teeth and denture as well as storing her denture. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ADAPTIVE EQUIPMENT/ASSISTIVE DEVICE: Penny uses Commode over the toilet to assist with participation in ADL care. Revision on: 05/17/2024 Revision by: Maryola Perion (RN)	PCA RN PCA PCA	
• Expressed Wishes and Beliefs related to Penny's Medical Treatment and End of Life Care Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To support and honor Penny's expressed wishes and beliefs through to the End of Life. Revision on: 01/17/2024 Revision by: Katie Wolters-Savo (RAI Coordinator) Target Date: 01/20/2026	• CPR: Penny wishes to have CPR and TRANSFER to hospital. Revision on: 10/26/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Family history of alcohol abuse(Z81.1), Homelessness(Z59.0), Psychological abuse(T74.3)				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
Last Care Plan Review Completed:	**10/20/2025**				

Allergies	No Known Allergies	**D.O.B.**	10/30/1953	**Physician**	Albert Patrick Ng
Diagnosis	Unspecified dementia(F03), Benign hypertension(I10.0), Family history of alcohol abuse(Z81.1), Homelessness(Z59.0), Psychological abuse(T74.3)				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Smith, Penny (922131005533)	**Admission Date**	10/26/2023	**Location**	4 411 A
Last Care Plan Review Completed:	**10/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• william is experiencing an episode of INFECTION (green, crusty discharge on the Left eye). Onset date: 10/23/25 Revision on: 10/24/2025 Revision by: Maryola Perion (RN)	• To have infection adequately managed and treated without further complications by the target date. Revision on: 10/24/2025 Revision by: Maryola Perion (RN) Target Date: 11/03/2025	• COMMUNICATION: Involve/collaborate with (William/SDM) with decision making for infection treatment plan and update accordingly. Revision on: 10/24/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of monitoring resident for (signs/symptoms, hydration status, overall health condition, process of healing, etc.) until stable. Revision on: 10/24/2025 Revision by: Maryola Perion (RN) • VITAL SIGNS: Monitor VITAL SIGNS every shift as per order. Revision on: 10/24/2025 Revision by: Maryola Perion (RN) • MEDICATIONS: Administer medication as per MD/NP order. Revision on: 10/26/2025 Revision by: Maryola Perion (RN)		
• Potential for altered hematologic symptoms or complications related to large amount nasal bleeding. Revision on: 10/22/2025 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with large amount nasal bleeding each day through to the next review date. Revision on: 10/22/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with large amount nasal bleeding for complications or changes to health status. Revision on: 10/22/2025 Revision by: Maryola Perion (RN)	Registered Staff	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to adjusting to disinterest. ISE Score: 2/6 Revision on: 10/09/2025 Revision by: Laura Morris (Restorative Care Aide)	• To support Bill's Psycho-Social well being through to the next review. Bill will participate in 5-10 group and or 1:1 programs each month to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; friendly/1: 1 visits, discussion groups, reading circle, music programs, special events, sparkling specs, etc. Revision on: 11/13/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as watching/listening to TV, listening to music/radio, visiting with residents/team members, etc. Revision on: 08/11/2023 Revision by: Mitchell Atkinson (Recreation Aide) • ONE to ONE: Provide him with individual visits for conversation, reading,		

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng	
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site (M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A	
Last Care Plan Review Completed:	**10/20/2025**					

Focus	Goal	Interventions	Position	Freq/Resolved
		reminiscing, music, humor, etc. Revision on: 08/11/2023 Revision by: Mitchell Atkinson (Recreation Aide) • SOCIAL INTERACTION: Promote the opportunity for Bill to make friendships and sit with friends during activities. Revision on: 08/11/2023 Revision by: Mitchell Atkinson (Recreation Aide)		
• Risk for choking related to coughing noted during intake Revision on: 10/07/2025 Revision by: Katherine Arca (RPN)	• To maintain safe swallowing through to next review date Target Date: 01/20/2026 • To obtain or maintain adequate intake to meet estimated nutritional requirements through to next review date Target Date: 01/20/2026 • To prevent or reduce choking episodes as medically feasible through to next review date Target Date: 01/20/2026 • To prevent or reduce choking or aspiration as feasible while respecting decisions concerning resident's choice for diet texture through to next review date Target Date: 01/20/2026	• Provide diet/texture interventions as per Nutrition Risk Level • Assessed for appropriate diet texture by (Specify eg. RD, SLP) (Date) • Referred to MD for medication review (Date)		
• Potential for acute PAIN and alteration in comfort level related to impaired mobility, Gout, GERD, Corticobasal Ganglia Degeneration, Hx of Fractured left pinky finger, buttocks pain. Most Current RAI	• To promote resident comfort and effectively manage ACUTE pain as episode occurs through to the next review. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord	• COMMUNICATION: Involve/collaborate with (William)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain	RN Registered	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Pain Score is 0/3. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	Back-up) Target Date: 01/20/2026 • Promote RAI Pain Score of 0 through to the next review. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	Practical Nurse Registered Practical Nurse RN	
• Increased risk for FALLS related to impaired mobility, shaking, unsteady gait, Dementia, Cataract, Gout, history of falls. Revision on: 11/08/2024 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with William/SDM in decision making in fall prevention Plan of Care. Revision on: 08/18/2023 Revision by: Chelsea Campbell-Wright (ADOC) • CALL BELL: Place call bell within William's (Bill) reach, check that it is in working order and remind/encourage to use it. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: Wheelchair, commode over toilet Revision on: 07/13/2024 Revision by: Jenny Liu (RAI Coord Back-up) • ENVIRONMENT: Secure environment: reduce clutter etc. to reduce fall risk for William. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • BED: place bed in lowest position to lower risk for injury. Revision on: 05/07/2024 Revision by: Maryola Perion (RN) • FOOTWEAR: Ensure William's (Bill) wears appropriate footwear at all times. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • SPECIAL CONSIDERATION to PREVENT FALLS: Ensure recliner chair remote is mounted at all times. Resident participates in the Optimal Mobility Program. AAROM exercises bilateral U+LE 5-10 reps, Sitting balance- unsupported x 10+ seconds, increasing tolerance each time, ensure proper positioning, right hamstring and bicep	PCA PCA PCA PCA PCA PCA	D/E/N

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to impaired mobility, shaking, unsteady gait, Dementia, Cataract, Gout, history of falls. Revision on: 11/08/2024 Revision by: Maryola Perion (RN)		stretching bilateral 30s, 3 reps/xcise PT- 3x week Revision on: 08/26/2025 Revision by: Courtney Cipparone (PT - Physiotherapist) • FLOOR MAT: Position right side of bed to lower risk of injury. Revision on: 05/11/2025 Revision by: Katherine Arca (RPN) • ALARM: Requires chair alarm. Check placement and working order. Staff respond when alarm is heard. Revision on: 10/17/2025 Revision by: Tola Omolade (ADOC) • SUPPLEMENT: Vitamin D supplement as per MD order to maintain bone density to prevent injuries. • PURPOSEFUL ROUNDING: Conduct purposeful rounding to assess residents needs; for pain, positioning, peri-needs or possessions for safety. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA PCA Registered Staff PCA Registered Practical Nurse RN	D/E/N
• Sleep Patterns; Potential for alteration in sleep patterns related to Dementia. Revision on: 08/07/2024 Revision by: Maryola Perion (RN)	• To promote adequate rest/sleep for William (Bill) based on identified sleep patterns/preferences each night through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• REST PATTERN: William (Bill) prefers to wake up around 8:30am and resides around 11:30pm. Naps periodically throughout the day. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Potential to experience alteration in MOOD as exhibited by repetitive questions and verbalizations, persistent anger and with self or others, repetitive health and non health complaints, unpleasant mood in the morning, sad, pained, worried facial expressions frustrations, repetitive physical	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	• COMMUNICATION: Involve/collaborate with William (Bill)/SDM about MOOD Disturbance, discuss contributing factors, and plan of care needs/options as needed. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of William (Bill) for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life.		

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
movements, getting upset when unable to do certain tasks related to Dementia, Progressive Supranuclear Palsy. Revision on: 08/07/2024 Revision by: Maryola Perion (RN)	Target Date: 01/20/2026	Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • RESIDENT STRENGTHS: Build on William's (Bill) effort to maintain control. Encourage him to express self, state preferences and make safe choices for care and activities. Revision on: 02/07/2024 Revision by: Maryola Perion (RN) • FAMILY SUPPORT: William (Bill) enjoys visits from wife, family members and friends. Revision on: 05/07/2024 Revision by: Maryola Perion (RN)		
• Potential for BOWEL INCONTINENCE related to decreased mobility, Dementia. Revision on: 05/07/2024 Revision by: Maryola Perion (RN)	• William (Bill) will have bowel incontinence managed every shift through to the next review period. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of William (Bill) for changes to health status, alteration of continence level or bowel function. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • BOWEL Continence level is Total Incontinence. Report change to level as noted. Revision on: 05/07/2024 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: William (Bill) White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA	
• URINARY (Mixed) INCONTINENCE related to Dementia, BPH. Revision on: 05/07/2024 Revision by: Maryola Perion (RN)	• William (Bill) will have urinary incontinence managed every shift through to the next review period. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of William (Bill) for toileting needs, changes to health status and alteration of continence level. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • URINARY Continence level is Total incontinence. Report change to level as noted. Revision on: 05/07/2024 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: William (Bill) White brief on Days, Evening and Night shifts. Revision on: 03/11/2025	PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision by: Maryola Perion (RN) • TOTAL INCONTINENCE MANAGEMENT: Resident has TOTAL Urinary Incontinence; Requires check and change every 2 hours and as needed.	PCA	
• Risk for Impaired SKIN INTEGRITY related to incontinence, impaired mobility, use of incontinent products. Revision on: 05/07/2024 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Potential for Expressive Behaviour of RESISTANCE to care need, yelling and calling out in the dining room, Disruptive behavior, shaking his hands and saying, "No, No, No.", constant calling the bell, yelling at staff with no specific reason related to Dementia, Progressive Supranuclear Palsy. Revision on: 05/07/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (William)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 11/08/2023 Revision by: Maryola Perion (RN) • TRIGGERS leading to VERBAL (yelling, screaming, etc.) as expression of behaviour include (limitation in self expression, misunderstanding care intention, etc.) Revision on: 02/26/2024 Revision by: Maryola Perion (RN) • VERBAL Behaviour: If William is heard yelling, screaming; calmly remind to lower his voice and that chosen words are not appropriate. Attempt to resolve his concern. Report episode to Registered Staff. Revision on: 02/26/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to eat, refusing medication, etc.) as expression of behaviour include misunderstanding care needs, poor judgement, etc. Revision on: 07/30/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If William is declining to eat, take medication, etc. re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 07/30/2024 Revision by: Maryola Perion (RN)	BSO - Internal Social Worker	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of RESISTANCE to care need, yelling and calling out in the dining room, Disruptive behavior, shaking his hands and saying, "No, No, No.", constant calling the bell, yelling at staff with no specific reason related to Dementia, Progressive Supranuclear Palsy. Revision on: 05/07/2024 Revision by: Maryola Perion (RN)		• TRIGGERS leading to SOCIALLY Inappropriate (disruptive vocalizations, etc.) as expression of behaviour includes confusion, decreased insight, poor judgement, etc.) Revision on: 01/26/2024 Revision by: Maryola Perion (RN) • SOCIALLY Inappropriate Behaviour: If William is noted to (make loud disruptive noises in dining room/program, etc.) gently redirect him to focus on task at hand, to move to a quieter area (room), etc. Revision on: 01/26/2024 Revision by: Maryola Perion (RN) • BSO RECOMMENDATIONS: (specify intervention in easy to follow instruction) Verbal: Yelling "no,no", calling out, repeatedly using call bell and not being able to communicate his needs. Triggers: Confusion, loss of control. Recommendations: Attempt to resolve his concerns. Allow resident time to respond to questions or use his white board for communication. Resistance to Care: Refusing Care, showers. Triggers: Misunderstanding care needs. Revision on: 03/13/2024 Revision by: Leslie Meloche (Recreation Aide)		
• Potential for altered bone density related to diagnosis of OSTEOPOROSIS. Revision on: 02/28/2024 Revision by: Maryola Perion (RN)	• To treat and minimize complications associated with OSTEOPOROSIS through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• COMMUNICATION: Involve/ collaborate with (William)/SDM in decision making of osteoporosis care management. Revision on: 02/28/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for osteoporosis management. Monitor effectiveness and for side effects. • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of osteoporosis for discomfort/ complications or changes to health status.	Registered Staff Registered Staff	
• Altered VISION related to active cataract and wears eyeglasses. Revision on: 02/07/2024	• William (Bill) will use glasses for vision correction daily through to the next review date.	• COMMUNICATION: Involve/collaborate with William (Bill)/SDM for decision making pertaining to change in visual status as needed. Revision on: 08/01/2023		

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A

Last Care Plan Review Completed: **10/20/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Maryola Perion (RN)	Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	Revision by: Katie Wolters-Savo (RAI Coordinator) • EYEGLASSES: William (Bill) wears eyeglasses. Assist to clean eyeglasses as needed and store on night table when sleeping. Revision on: 11/08/2024 Revision by: Maryola Perion (RN)	PCA	
• COGNITIVE LOSS; alteration in thought processes difficulty concentrating, poor judgement related to Corticobasal Ganglia Degeneration, Progressive Supranuclear Palsy, Dementia. Revision on: 02/07/2024 Revision by: Maryola Perion (RN)	• William is severely impaired in cognition and will have needs interpreted and met each day through to the review date. CPS score is 6. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with William (Bill)/SDM in decision making of Cognitive Loss for Progressive Supranuclear Palsy, Dementia. USe simple and direct questions to facilitate simple and direct answers. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • ORIENTATION: Gently reorient to place, time as needed when William's (Bill) is feeling lost or in confused state. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential to experience complications and side effects impacting quality of life related to use of multi-pharmacy, etc.) Revision on: 11/11/2023 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (William)/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using poly-pharmacy, etc. for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Potential for muscular dysfunction, contractures and bone deformity related to GOUT. Revision on: 11/11/2023 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with GOUT through to the next review date. Revision on: 12/01/2024	• COMMUNICATION: Involve/ collaborate with (William)/SDM in decision making of musculoskeletal care management. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of GOUT as per MD order. Monitor effectiveness and for side effects.		

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A

Last Care Plan Review Completed: **10/20/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GOUT for discomfort/ complications or changes to health status. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT for GOUT prescribed and in place; refer to Pain Care Plan. Revision on: 11/11/2023 Revision by: Maryola Perion (RN)		
• SPIRITUAL BELIEFS: Bill is of the Orthodox Faith. Revision on: 08/11/2023 Revision by: Mitchell Atkinson (Recreation Aide)	• To provide Bill spiritual support as interested through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• PERSONAL CHOICE: Respect Bill's right to decline participation in Spiritual Program. Please attempt to engage him if he chooses to attend spiritual programs. Revision on: 08/11/2023 Revision by: Mitchell Atkinson (Recreation Aide)		
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To treat and/or minimize complications associated with GERD each day through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (William)/SDM in decision making for GERD Management. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals. • MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	PCA Registered Staff Registered Staff	
• Potential for altered genitourinary function or complications related to diagnosis of BENIGN PROSTATIC HYPERTROPHY (BPH).	• To treat and minimize signs/symptoms or complications associated with BPH through to next review	• COMMUNICATION: Involve/collaborate with (William (Bill))/SDM in decision making for BPH care management. Revision on: 02/07/2024 Revision by: Maryola Perion (RN)		

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A

Last Care Plan Review Completed:	**10/20/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of William (Bill) with Benign Prostatic Hypertrophy for changes to health status and alteration or complications affecting urinary function. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication as per MD order and monitor for side effects and effectiveness Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential to experience alteration in CARDIAC FUNCTION related to; Hypertension	• To treat and minimize signs/symptoms or complications associated with Hypertension through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with (William)/SDM in decision making of Cardiac Care Management for Hypertension. Revision on: 11/11/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of William (Bill) with Hypertension for changes to health status and alteration or complications affecting cardiac function. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • MEDICATION: Administer medication for Hypertension as per MD Order and monitor for side effects. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	Registered Practical Nurse RN	
• Potential for CONSTIPATION related to decreased mobility, history of constipation. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026 • William (Bill) will have regular soft formed bowel movements every 1-2 days through to the next review.	• COMMUNICATION: Involve/collaborate with (William (Bill)/SDM) for decision making regarding constipation management. Revision on: 05/07/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A

Last Care Plan Review Completed: **10/20/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for CONSTIPATION related to decreased mobility, history of constipation. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026			
• Altered COMMUNICATION as exhibited by limitations to self expression, comprehension related to Progressive Supranuclear Palsy, Dementia, Aphasia. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• William (Bill) will be able to make basic needs known each day through to the review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• COMMUNICATION: Involve/collaborate with William (Bill)/SDM for decision making about strategies needed to support effective communication. Allow time for responses. Allow for simple and direct requests. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • PRIMARY LANGUAGE: William (Bill)'s primary language is English. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator) • SUPPORTIVE TECHNIQUES: Allow time to respond, repeat as needed, ask yes/no questions, uses simple words/phrases, etc.. Revision on: 02/07/2024 Revision by: Maryola Perion (RN)		
• Altered ability to complete Activities of Daily Living (ADLs) related to Corticobasal Ganglia Degeneration (2019), BPH, HTN, Gout, GERD, Progressive Supranuclear Palsy, Dementia. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• William (Bill) will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026 • William (Bill) will have ALL ADL care tasks met each day through	• BATHING: William (Bill) prefers (shower) on (Wednesdays and Sundays on Evening shift). Two staff (TOTAL) assistance bathing. Requires the use of a Maxi lift with two staff to assist for transfer. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: William (Bill) requires maximal assistance from one to two team members to turn and reposition in bed. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • DRESSING: William is unable to assist and requires two staff to provide TOTAL assistance for dressing UPPER & LOWER body.	PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	the next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • EATING: William is unable to assist and requires 1 Staff to provide TOTAL assist for eating. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • LOCOMOTION: William is using a wheelchair as his aid for locomotion. 1 staff to provide TOTAL assistance for locomotion (on and/or off unit) to propel him. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: William is unable to assist. He requires one staff total assistance to comb his hair, brush his teeth, shave, wash and drying face and hands. Two staff for peri care. Revision on: 07/23/2025 Revision by: Maryola Perion (RN) • HAND HYGIENE: 1 staff to provide Total assist to use soap/water, apply sanitizer, rub hands together, dry hands, etc. for hand hygiene. Revision on: 04/27/2025 Revision by: Maryola Perion (RN) • TOILET USE: William (Bill) requires two staff with the use a sara lift yellow sling to go into the commode. Bill requires one staff to support his right side while being transferred with sara to the commode per PT assessment. If not being toileted, two staff with the use of a Maxi lift to transfer him back to bed to change his incontinent product and to provide peri care. Revision on: 11/05/2024 Revision by: Maryola Perion (RN) • TRANSFERRING: William requires MAXI LIFT transfer when transferring him to and from bed to wheelchair with two staff assistance. Revision on: 05/07/2024 Revision by: Maryola Perion (RN) • TRANSFER LIFT/SLING: Maxi Lift and a Medium (yellow) size sling needed for transfer. When resident is to use bathroom, a toileting sling is to be used, Medium (yellow) size Sling. Revision on: 08/03/2024 Revision by: Janina Lucero (RN)	PCA PCA PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A

Last Care Plan Review Completed:	**10/20/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Corticobasal Ganglia Degeneration (2019), BPH, HTN, Gout, GERD, Progressive Supranuclear Palsy, Dementia. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		• ORAL CARE: William (Bill) has his own teeth and is missing one tooth. He is dependent on one team member to assist with brushing his teeth. Revision on: 08/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
		• SHAVING - William (Bill) requires the team to assist with shaving him on his bath days and as needed. Revision on: 11/11/2023 Revision by: Maryola Perion (RN)	PCA	D
		• ADAPTIVE EQUIPMENT/ASSISTIVE DEVICE: William uses toilet commode to assist with participation in ADL care. Revision on: 07/31/2024 Revision by: Maryola Perion (RN)	PCA	
		• LAUNDRY Request: Family wishes to do laundry. Revision on: 08/15/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	PCA	
• Expressed Wishes and Beliefs related to William (Bill) Medical Treatment and End of Life Care Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To support and honor William (Bill) expressed wishes and beliefs through to the End of Life. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• CPR: William (Bill) wishes express NO CPR, however TRANSFER to hospital decision will be made at the time. Revision on: 08/01/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
		• FUNERAL Arrangements: Families First 2130 Front Rd Lasalle, ON N9J2B9 519-969-5841 Revision on: 07/23/2025 Revision by: Maryola Perion (RN)	Social Worker ST	

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level	• Bill will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 12/01/2024 Revision by: Jenny Liu (RAI Coord Back-up) Target Date: 01/20/2026	• Labelled Item Lunch: cheese and crackers (4 days per week) Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	D
		• NUTRITION RISK: Bill is moderate risk level. Revision on: 10/08/2025 Revision by: Brittany Hyde (Registered Dietitian)	Dietitian (RD)	
	• Will weigh within realistic GWR 55-65 kg through to next review date. Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/20/2026	• DIET ORDER: Bill will receive regular diet, regular texture - see dining instructions Revision on: 10/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• FLUID CONSISTENCY: Bill drinks REGULAR/THIN Level 0 Fluids at risk per POA request (Bill refuses thickened fluids). See Response to Referral - Nutrition Services note dated 2/3/2025. Revision on: 10/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
	• Bill will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 1500 ml/day (27 ml/kg using 55.3 kg weight) through to next review date. Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/20/2026	• FLUID TARGET: Encourage Bill to drink a minimum of 1200 ml per day Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• EXTRA FLUIDS: Offer a minimum of 125ml high moisture food or fluid outside of meals and snacks daily.	Dietary aide PCA	
		• DINING INSTRUCTIONS: Cut food into small pieces Add sauce/gravy when available to moisten food Provide small sips of fluids from a cup (no straws) Revision on: 10/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	Registered Practical Nurse	
		• HIGH CALORIE/PROTEIN PM SNACK: cottage cheese and assorted fruit daily Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	D
		• HIGH CALORIE/PROTEIN IN MEALS: Offer 2 boiled eggs with breakfast daily Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	BLD

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Care Plan Report

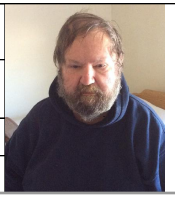
Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level		• LABELLED SNACK: William receives 1 side salad with dinner per his preference Revision on: 07/08/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	

Diagnosis Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Progressive supranuclear ophthalmoplegia [Steele-Richardson-Olszewski](G23.1), Unspecified dementia(F03), Fracture of unspecified part of phalanx of finger, closed(S62.690), Cataract, unspecified(H26.9), Osteoporosis, unspecified(M81.9)

Allergies	No Known Allergies	**D.O.B.**	06/15/1945	**Physician**	Albert Patrick Ng
Diagnosis	Other specified degenerative diseases of nervous system(G31.8), Benign neoplasm of prostate(D29.1), Benign hypertension(I10.0), Gout, unspecified, unspecified site(M10.99), Gastro-oesophageal ref...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Sochaski, William (922131005518)	**Admission Date**	08/01/2023	**Location**	4 406 A
Last Care Plan Review Completed:	**10/20/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Gino has potential for complications, s/sx related to diagnosis of COPD, cough. Revision on: 10/10/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with COPD each day through to next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with (Gino)/SDM in decision making of Respiratory Management for COPD. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with COPD for changes to health status and alteration or complications affecting respiratory function. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up)		
		• POSITIONING: To manage shortness of breath (SOB) elevate head of the bed to improve breathing as needed. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
		• OXYGEN: If required Administer Oxygen as per MD order. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator)		
		• MEDICATION: Administer medication for COPD/cough as per MD order and monitor for side effects. Revision on: 10/21/2025 Revision by: Maryola Perion (RN)		
• Gino DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 4/6 Revision on: 09/04/2025 Revision by: Laura Morris (Restorative Care Aide)	• Gino participates in Independent/Self-Directed activities monthly through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as smoking on the patio, family/friend visits, community outings, listening to music (classical, jazz, rock, 100.7) watching TV (documentaries), word puzzles (crosswords), journaling, reading, etc. Revision on: 05/27/2020 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
		• FRIENDLY VISIT: Provide him one to one visits as tolerated. Touch Base to maintain contact and to converse about topics of interest, identify up-coming special events, etc. Revision on: 11/15/2019 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
		• INVITATION: Offer friendly invite to structured programs scheduled in the home. He enjoys; Discussion groups, games - Bingo, Calendar Club, Java Music Club, Happy Hour, special events, TV - movie night, etc. Revision on: 08/02/2022	ACT	

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng	
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Other specified diabetes mellitus without (mention of) complication(E13.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Sch...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Spadafora, Gino (92213101084)	**Admission Date**	08/09/2019	**Location**	4 419 A	
Last Care Plan Review Completed:	**09/12/2025**					

Focus	Goal	Interventions	Position	Freq/Resolved
• Gino DECLINES PARTICIPATION in structured programs related to personal choice. ISE Score: 4/6 Revision on: 09/04/2025 Revision by: Laura Morris (Restorative Care Aide)		Revision by: Mitchell Atkinson (Recreation Aide)		
• Potential for CONSTIPATION Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To minimize the potential for episodes/ complications of constipation through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025 • Gino will have regular soft formed bowel movements every 1-2 days through to the next review. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Gino for decision making regarding constipation management. Revision on: 03/06/2021 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for constipation management and changes to health status and symptoms/ complications of constipation. • FLUIDS: Encourage resident to meet daily beverage minimums. See Nutrition Care Plan. • BOWEL PROTOCOL: In place as per MD order	Registered Staff Registered Staff Registered Staff	
• Potential for Persistent PAIN and alteration in comfort level related to Osteoarthritis, Stroke and rental stenosis and cysts to testicles, back pain. Most Current LTCF Pain Score is 0.	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 01/13/2025	• COMMUNICATION: Involve/collaborate with (Gino)/SDM) about pain management, goals of treatment, plan of care and treatment options. Revision on: 03/13/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of	RN	

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Other specified diabetes mellitus without (mention of) complication(E13.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Sch...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Spadafora, Gino (92213101084)	**Admission Date**	08/09/2019	**Location**	4 419 A
Last Care Plan Review Completed:	**09/12/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025 • Promote LTCF Pain Score of 0 through to the next review. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up)	Registered Practical Nurse Registered Practical Nurse RN	
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, antidepressant, use of anti-psychotic medications) Revision on: 01/03/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with (Gino)/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 07/19/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (anti-psychotic medication, poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 10/28/2022 Revision by: Jenny Liu (RAI Coord Back-up) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Risk for/Impaired Skin Integrity r/t: Thin fragile Skin, Diagnosis of Diabetes Mellitus, use of containment product Revision on: 01/03/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To protect and maintain skin integrity each day through to the next review. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Increased risk for FALLS related to: Orthostatic Hx of Hypotension, history of falls, Anti-psychotic and anti-depressant medication, dizziness	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period.	• COMMUNICATION: Involve/collaborate with (Gino)/SDM in decision making in fall prevention Plan of Care. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)		

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Other specified diabetes mellitus without (mention of) complication(E13.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Sch...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Spadafora, Gino (92213101084)	**Admission Date**	08/09/2019	**Location**	4 419 A
Last Care Plan Review Completed:	**09/12/2025**				

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Revision on: 01/03/2025 Revision by: Danielle Loreto (RAI Coordinator)	Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• CALL BELL: Place call bell within reach of Gino, check that it is in working order and remind/encourage to use it. Gino may not remember how to use it. Revision on: 11/16/2022 Revision by: Meghan Sears (ADOC)	PCA	D/E/N
		• ENVIRONMENT: Secure environment (reduce clutter, quiet environment, etc.) to reduce fall risk for Gino. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	PCA	
		• FOOTWEAR: Ensure resident wears appropriate footwear. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries. Revision on: 09/12/2025 Revision by: Maryola Perion (RN)		
• Potential for altered hematologic symptoms or complications related to diagnosis of B12 deficiency Revision on: 04/10/2024 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with B12 deficiency each day through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with (Gino)/SDM in decision making of hematologic care management for B12 deficiency. Revision on: 04/10/2024 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with B12 deficiency for complications or changes to health status. Revision on: 04/10/2024 Revision by: Maryola Perion (RN)		
		• LAB WORK: Monitor blood lab work and report results to MD as needed. Follow up as indicated.	Registered Staff	
		• MEDICATION: Administer medication for B12 deficiency as per MD Order. Monitor effectiveness and for side effects. Revision on: 04/10/2024 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in NEUROLOGICAL FUNCTION related to: CEREBROVASCULAR ACCIDENT (CVA), TRANSIENT ISCHEMIC ATTACK (TIAs) (2007)	• To treat and minimize signs/ symptoms or complications associated with CEREBROVASCULAR ACCIDENT (CVA), TRANSIENT	• MEDICATION: Administer medication as per MD order. Monitor effectiveness and for side effects. Revision on: 09/12/2025 Revision by: Maryola Perion (RN)	Registered Staff	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with		

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Revision on: 01/09/2024 Revision by: Maryola Perion (RN)	ISCHEMIC ATTACK (TIAs) (2007) through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	CEREBROVASCULAR ACCIDENT (CVA), TRANSIENT ISCHEMIC ATTACK (TIAs) (2007) for changes to health status and alteration or complications affecting neurological function. Revision on: 01/09/2024 Revision by: Maryola Perion (RN)		
		• SEIZURE Disorder: If seizure activity occurs alert registered staff immediately; place on side, protect from injury, maintain open airway.	PCA Registered Staff All	
		• SEIZURE Disorder: Gino has potential for seizure activity, injury related to seizure disorder. Inform MD as it occurs. Revision on: 01/09/2024 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in MOOD as exhibited by sad, pained, worried facial expressions related to pain, Schizophrenia. Revision on: 01/09/2024 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with social worker discuss contributing factors, and plan of care needs/options as needed. Revision on: 01/09/2024 Revision by: Maryola Perion (RN)	Registered Staff	
		• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Gino for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 01/09/2024 Revision by: Maryola Perion (RN)		
		• MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects. Revision on: 01/09/2024 Revision by: Maryola Perion (RN)		
• Gino has potential to experience a safety hazard/burn injury related to personal SMOKING habits. Revision on: 10/11/2023 Revision by: Maryola Perion (RN)	• Gino will be safe when choosing to smoke through to the next review Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve Gino/SDM in review of smoking legislation (No smoking inside the home or within 9 meters from any doorway) and identify the designated area/s where smoking is permitted. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	Social Worker	
		• STORAGE: Smoking materials are kept with the nurse and Gino will ask the nurse when going for a cigarette. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator)	Clerk	

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• Gino has potential to experience a safety hazard/burn injury related to personal SMOKING habits. Revision on: 10/11/2023 Revision by: Maryola Perion (RN)		• SMOKING CONTRACT: Gino has agreed to follow safe smoking rules and accepts the consequences of breaking those agreed upon rules by signing the smoking contract. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	Social Worker	
• Potential for altered genitourinary function or complications related to Cysts in testicles and stenosis of the kidneys. Return from hospital: 7/26/23 Revision on: 07/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• To treat and minimize signs/symptoms or complications associated with cysts to testicles and stenosis of kidney's through to next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of Gino with rental stenosis and cysts to testicles for changes to health status and alteration or complications affecting urinary function. Revision on: 07/27/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)		
• Potential to experience alteration in CARDIAC FUNCTION related to: Hypertension, Hx of Orthostatic Hypotension. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Hypertension, Orthostatic Hypotension through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Gino/SDM in decision making of Cardiac Care Management for Hypertension, Orthostatic Hypotension. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hypertension, Orthostatic Hypotension for changes to health status and alteration or complications affecting cardiac function. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Staff	
		• MEDICATION: Administer medication for hypertension as per MD Order and monitor for side effects. Revision on: 09/12/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Potential for Expressive Behaviour of resisting care related to Mental Illness	• To decrease the episodic frequency of Expressive	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Gino for indications to change in or for escalating expressive behaviour risk.	Registered Staff	

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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
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(Schizophrenia, Schizoaffective disorder, Auditory Hallucinations) Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 09/12/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • TRIGGERS leading to RESISTANCE to Care Needs of refusal to eat, bathe, refusing medication, etc. as expression of behaviour includes misunderstanding care needs, poor judgement, etc. Revision on: 10/02/2024 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Gino is refusing to eat, bathe, medication, etc. re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 10/02/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for therapeutic treatment as per MD Order. Monitor effectiveness and for side effects. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	Registered Practical Nurse RN	
• Altered VISION related to related to: Bilateral Cataracts Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	• Gino will be able to function safely in his environment through next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• Adapt environment to Gino's individual needs to ensure he is able to recognize objects in the environment. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
• COGNITIVE LOSS; alteration in thought processes (memory loss, poor judgement, etc.) related to Cardiovascular Accident (CVA) Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	• Gino will be supported to maintain cognitive function through the review date. Current CPS is 1. Revision on: 09/12/2025 Revision by: Maryola Perion (RN) Target Date: 12/12/2025	• ORIENTATION: Gently reorient to (person, place, time) as needed when Gino is feeling lost or in confused state. Revision on: 07/19/2023 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	PCA	
• Potential to experience alteration in ENDOCRINE FUNCTION related to	• To treat and/or minimize signs/symptoms of (	• COMMUNICATION: Involve/ collaborate with (Gino)/SDM in decision making of thyroid care management.		

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HYPOTHYROIDISM	HYPOTHYROIDISM) through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	Revision on: 07/19/2023 Revision by: Maryola Perion (RN) • HEALTH TEACHING: Engage with Gino/SDM to enhance his comprehension of (specify: treatment, possible complications, disease trajectory, etc.) associated with HYPOTHYROIDISM. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with HYPOTHYROIDISM for changes to health status and alteration or complications affecting endocrine function. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up) • MEDICATION: Administer medication for HYPOTHYROIDISM as per MD order. Monitor effectiveness and for side effects. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up) • LAB WORK: Monitor lab and diagnostic results and report results to MD as needed. Follow up as indicated. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse PCA	
• Use of PASD (Left side 1/4 bedrails) to assist resident with Activity of Daily Living (transfer and turning and repositioning) Revision on: 02/09/2022 Revision by: Jenny Liu (RAI Coord Back-up)	• Gino will be effectively supported with use of (1/4 bedrails) to optimize Activity of Daily Living (transfer and bed mobility) each day through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• MONITORING: Utilize holistic perspective of monitoring resident for continued benefit to use (Left bedrails) as to support appropriate (transfer and bed mobility). Revision on: 02/09/2022 Revision by: Jenny Liu (RAI Coord Back-up) • BED RAIL (One PARTIAL): (1/4 to LEFT side) in USE as a PASD to assist resident with (bed mobility, transfer in/out of bed). Monitor every shift. Revision on: 10/11/2023 Revision by: Maryola Perion (RN)	PCA	D/E/N
• Expressed Wishes and Beliefs related to Gino Medical Treatment and End of Life Care Revision on: 02/13/2021	• To support and honor Gino expressed wishes and beliefs through to the End of Life. Revision on: 01/13/2025	• CPR: DO NOT ATTEMPT CPR: Transfer to hospital decision will be made as needed - see PoET Individualized Summary for details. Revision on: 06/08/2025 Revision by: Maryola Perion (RN)		

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng
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Revision by: Jenny Liu (RAI Coord Back-up)	Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025			
• URINARY INCONTINENCE Revision on: 02/08/2020 Revision by: Kenya Mosely (Registered Practical Nurse)	• Gino will have urinary incontinence managed every shift through to the next review period. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)		
		• URINARY Continence level is occasionally Incontinent. Report changes to level as noted. Revision on: 03/13/2025 Revision by: Maryola Perion (RN)	PCA	
		• INCONTINENCE PRODUCT: Gino uses a PUXXL on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA	
• SPIRITUAL BELIEFS: Gino is of the Roman Catholic Faith. Revision on: 11/15/2019 Revision by: Shayna Lee Wonsch (Activation Manager)	• To provide Gino spiritual support as interested through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• PERSONAL CHOICE: Respect Gino's right to decline participation in Spiritual Programs at this time. Revision on: 11/15/2019 Revision by: Shayna Lee Wonsch (Activation Manager)	ACT	
• Potential for hypo/hyperglycemia and other complications related to diagnosis of Diabetes Mellitus (DM). Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and/or minimize episodes of hypo/hyperglycemia and other complications associated with DM through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/ collaborate with (Gino)/SDM in decision making of diabetes care management. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)		
		• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA or changes to health status.	Registered Staff	
		• CBG MONITORING: Monitor CAPILLARY BLOOD GLUCOSE (CBG) as per MD order.	Registered Staff	
		• MEDICATION: Administer medication for DIABETES as per MD order. Monitor		

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• Potential for hypo/hyperglycemia and other complications related to diagnosis of Diabetes Mellitus (DM). Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)		effectiveness and for side effects. Revision on: 07/11/2024 Revision by: Maryola Perion (RN) • LAB WORK: Monitor lab and diagnostic results for (fasting blood glucose and/or HbA1c) and report results to MD as needed. Follow up as indicated. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)		
• Potential for gastric discomfort/complications related to diagnosis of Gastroesophageal Reflux Disease (GERD). Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and/or minimize discomfort/ complications associated with GERD through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/collaborate with Gino/SDM in decision making for GERD Management. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of GERD for discomfort/ complications or changes to health status. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • POSITIONING: Encourage resident to avoid lying down for at least one hour after eating; elevate head of bed, encourage resident to sit/stand upright after meals. • MEDICATION: Administer medication for GERD as per MD order. Monitor effectiveness and for side effects.	Registered Staff Registered Staff PCA Registered Staff Registered Staff	
• Potential for pain, discomfort related to Dx of Osteoarthritis. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To treat and minimize signs/symptoms or complications associated with osteoarthritis through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• COMMUNICATION: Involve/ collaborate with (Gino)/SDM in decision making of musculoskeletal care management. Revision on: 07/19/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of Osteoarthritis for discomfort/ complications or changes to health status. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up)		

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• Potential for pain, discomfort related to Dx of Osteoarthritis. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)				
• ALLERGIC to: Cheese Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• Gino will remain free of allergen through next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications mortality. Revision on: 01/29/2023 Revision by: Jenny Liu (RAI Coord Back-up) • Staff to remain aware of allergen (cheese) and prevent contact with. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse) • Registered staff to ensure MD's and Pharmacy aware of Gino's allergy and ensure he does not receive it. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	All Registered Staff	
• BOWEL Continence - Gino is continent and has self recognition of urge to defecate. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• Gino to remain continent of bowels through next review date Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• BOWEL Continence level is CONTINENT. Report change to level as noted. • SELF TOILETING: Gino toilets self for bowel movements. Each shift ask if he/she had BOWEL MOVEMENT and if there has been any changes to continence level. Report changes to Registered Staff. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA PCA	
• Altered ability to complete Activities of Daily Living (ADLs) related to: Hypertension, OA, Schizoaffective disorder, Diabetes Mellitus. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• Gino will feel supported in coping with changing functional abilities due to disease diagnosis through the review date. Revision on: 01/13/2025	• BATHING: Gino prefers (shower) on (Tuesday & Friday on Afternoons). Gino participates by (providing a wash cloth and washing the upper part of the body). One staff (EXTENSIVE) assistance for bathing. Nail care to be provided on shower/bath day. PREFERENCE: FEMALE staff members only for shower days. Revision on: 08/26/2025	PCA	

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Last Care Plan Review Completed:	**09/12/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025 • Gino will maintain current self sufficiency in ADL abilities in all ADLs through the review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	Revision by: Katherine Arca (RPN) • BED MOBILITY: Gino is Independent with turning and repositioning without assistance or oversight from staff members. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • DRESSING: Gino is able to dress himself independently on his UPPER and LOWER body. He may require one staff member to provide LIMITED assistance at times for dressing his LOWER body if fatigued. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • EATING: Gino is Independent and he eats in the Petunia Lane dining room. He may ask for assistance with cutting and opening packages if he is not able to for himself. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • LOCOMOTION: Gino is able to walk Independently on and off the unit. Has a walker and may use it at times. Revision on: 09/12/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: Gino is able to wash his face, hands, comb his hair. He may require assistance with peri-care at times. He is able to request. Peri wipes is being provided for Gino. Revision on: 06/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • HAND HYGIENE: 1 staff to provide reminder assistance to use hand sanitizer/hand sanitizing wipes for hand hygiene. Revision on: 08/19/2021 Revision by: Chelsea Campbell-Wright (IPAC LEAD) • TOILET USE: Gino is able to go on/off the toilet, adjust his clothes, do his own peri care and change his incontinent product. Gino will ask the assistance of staff when needed.	PCA PCA PCA PCA PCA PCA	

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng
Diagnosis	Stroke, not specified as haemorrhage or infarction(I64), Other specified diabetes mellitus without (mention of) complication(E13.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Sch...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Spadafora, Gino (92213101084)	**Admission Date**	08/09/2019	**Location**	4 419 A
Last Care Plan Review Completed:	**09/12/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to: Hypertension, OA, Schizoaffective disorder, Diabetes Mellitus. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)		Revision on: 06/12/2025 Revision by: Maryola Perion (RN) • TRANSFERRING: Gino is Independent and able to transfer from a sitting to standing position. 1/4 bed rail (Left side) is used to assist with transferring as needed. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	PCA	
		• ORAL CARE: Gino is Independent and able to clean and store his dentures. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	PCA	
		• FOOT CARE: registered staff due to being diabetic. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA Registered Staff	
		• SHAVING - Gino will have (beard, mustache, face) shaven on bath/shower days and as needed. Revision on: 07/19/2023 Revision by: Maryola Perion (RN)	PCA	D
• Sleep Patterns. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	• To promote adequate rest/sleep for Gino's based on identified sleep patterns/preferences each night through to the next review date. Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025	• REST PATTERN: Preferred bedtime & usual wake time: No specific time Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
		• SLEEPWEAR: Gino prefers to wear his own clothes. Revision on: 11/08/2019 Revision by: Maryola Perion (Registered Nurse)	PCA	
• Nutrition Risk Level (diet details)	• Gino will be adequately nourished aeb consuming >75% at meals and snacks through to next review date.	• NUTRITION RISK: Gino is moderate risk level. Revision on: 12/23/2024 Revision by: Rachelle Ly (Dietitian (RD))	Dietitian (RD)	
		• DIET ORDER: Gino will receive regular diet, regular texture.	Diet	

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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
	Revision on: 01/13/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 12/12/2025 • Will weigh within realistic GWR 105-115 kg through to next review date. Revision on: 06/05/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/12/2025 • Gino will be adequately hydrated aeb drinking at least 80% of total fluid requirement: 2328 ml/day (20 ml/kg using 116.4 kg weight) through to next review date. Revision on: 06/05/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 12/12/2025	Revision on: 11/27/2020 Revision by: Anna Slack • FLUID CONSISTENCY: Gino drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/27/2021 Revision by: Olivia Kuhlmann (Dietetic Intern) • FLUID TARGET: Encourage Gino to drink a minimum of 1862 ml/day Revision on: 06/05/2025 Revision by: Holly Laasanen (Dietitian (RD)) • EXTRA FLUIDS: Offer a minimum of 200ml high moisture food or fluid outside of meals and snacks daily. Revision on: 09/25/2023 Revision by: Anna Slack (Registered Dietitian) • FOOD ALLERGY/INTOLERANCE: lactose intolerance, cheese itself (cheese cooked in food ok) Reactions to this food/fluid diarrhea. Drinks Lactaid milk only. Revision on: 05/10/2021 Revision by: Anna Slack (Registered Dietitian) • LOW CALORIE & DIABETIC CARE: Offer Gino low calorie foods at meals/snacks for weight management as per resident/SDM preference, such as diabetic juice, water to drink and single portions at meals only and encourage fruit for dessert and snacks. sweetener in place of sugar Revision on: 10/02/2024 Revision by: Rachelle Ly (Dietitian (RD))	Food Services Aide PCA Diet PCA PCA PCA Diet PCA Restorative Care Aide PCA	

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng
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Resident	Spadafora, Gino (92213101084)	**Admission Date**	08/09/2019	**Location**	4 419 A
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Diagnosis

Stroke, not specified as haemorrhage or infarction(I64), Other specified diabetes mellitus without (mention of) complication(E13.9), Chronic obstructive pulmonary disease, unspecified(J44.9), Schizoaffective disorder, unspecified(F25.9), Gastro-oesophageal reflux disease without oesophagitis(K21.9), Transient cerebral ischaemic attack, unspecified(G45.9), Fall other specified(W02.08), Schizophrenia, unspecified(F20.9), Orthostatic hypotension(I95.1), Benign hypertension(I10.0), Primary generalized (osteo)arthrosis(M15.0), Auditory hallucinations(R44.0), Hypothyroidism, unspecified(E03.9), Cataract, unspecified(H26.9), Constipation(K59.0), Type 2 diabetes mellitus without (mention of) complications(E11.9), Acute renal failure, unspecified(N17.9), Other specified symptoms and signs involving the circulatory and respiratory systems(R09.8), Hydrocele, unspecified(N43.3), Vitamin B12 deficiency anaemia, unspecified(D51.9)

Allergies	Cheese	**D.O.B.**	11/12/1956	**Physician**	Albert Patrick Ng
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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Mark S is experiencing episode of RESPIRATORY INFECTION Onset date: 10/28/2025. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse)	• To effectively treat and manage RESPIRATORY INFECTION without further complications by 11/07/25. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse) Target Date: 01/29/2026	• HEALTH EDUCATION: Engage with resident to enhance their knowledge of infection control practices hand hygiene, visitation, PPEs, droplet isolation, transmission,. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse) • MEDICATIONS: Administer medication/oxygen for Respiratory tract infection, as per MD/NP order. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse) • MONITORING: Utilize holistic perspective of monitoring resident with RESPIRATORY INFECTION for Fever,sore throat,cough , hydration status, overall health condition, process of healing, secondary infections, exacerbation of their chronic condition until stable. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse) • PPE PRECAUTIONS: Precaution identified as CONTACT & DROPLET for RESPIRATORY INFECTION and requires use of the following PPE: GOWN, MASK, GLOVES & FACESHIELD for direct care, handling soiled clothes and linens, disposing of incontinent product. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse) • VITAL SIGNS: Monitor VITAL SIGNS : Temp,BP,Pulse, Respi, Spo2. Revision on: 10/28/2025 Revision by: Ravinder Kaur (Registered Nurse)		
• Potential for Expressive Behaviour of resistive to care- history of sexual expression with female team members, history of choking a nurse, wandering, pulling fire alarm panel, Caught trying to pull the fire panel alarm and saying he wants some fun, inappropriate comment to staff, trying to feed other resident, touching other residents without invitation, grabbing a nurses lanyard and pulling it tight.	• To promote safety for MARK and/or others during each episode of (RESISTING CARE, treats to others, touching others, physical behaviours, verbal behaviours, socially inappropriate, sexual comments) through to the next review date. Revision on: 08/15/2025 Revision by: Danielle Loreto (RAI Coordinator)	• PHYSICAL Behaviour: If Mark is attempting to strikeout; move back from his reach. Calmly indicate that care will continue when he is calm/ready. Seek Registered Staff assistance. Revision on: 10/16/2025 Revision by: Maryola Perion (RN) • PHYSICAL Behaviour: Personal care to be provided by (2) staff. 1 team member to try and engage resident. If resident is resistive to care and cannot direct with 2 person approach team to ensure safety, leave and reapproach Revision on: 08/05/2025 Revision by: Danielle Loreto (RAI Coordinator) • PHYSICAL Behaviour:	PCA	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng	
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A	

Last Care Plan Review Completed: **10/29/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
multiple threats to strangle team members, wrapping a call bell around his own net to demonstrate how he could use it as a weapon, saying that there are many weapons in the housekeeping room, hitting team members, throw his personal belongings on the floor, threw boxes of brief to staff related to decrease cognitive impairment Revision on: 10/20/2025 Revision by: Jenny Liu (RAI Coordinator)	Target Date: 01/29/2026 • Mark will be supported to adjust to his new environment to lower risk of triggering former RESISTING CARE, treats to others, touching others, physical behaviours, verbal behaviours, socially inappropriate, sexual comments through to the next review. Revision on: 08/15/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	Resident has history of choking a nurse. On August 4th 2025- Grabbed keys around a nurses neck. The resident grab the keys and would not let go pulling and walking away making the strap around my neck tight. Intervention: Asked several times for resident to let go, then writer had to yell for help, two male staff and charge nurse assisted to remove keys without the quick release, from around writer's neck. Time, Frequency and # of Staff: 3 staff assisted incident was over in 2 to 3 minutes and then the resident said sorry for scaring you. Evaluation of Intervention: Resident was not redirectable did not follow direction and was laughing and smiling the whole time he was asked to please let go of the keys. History of choking a nurse prior to admission to the home. Making threats t choke residents and team member. Going up to residents and rubbing his hand across their necks. Demonstrating how a call bell can be used a weapon by placing it around his own next and asking the team to look at how it can be used. Removing call bell from the wall and taking it to the team and stating he could strangle them with it. IMMEDIATELY CONTACT THE CHARGE NURSE IF THESE BEHAVIOURS ARE PRESENT. CALL CODE WHITE IF THERE IS THREAT OR SUSPECTED THREAT. Revision on: 09/09/2025 Revision by: Danielle Loreto (RAI Coordinator) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing to change clothing, refusal to bathe, refusal to eat, refusing medication, etc.) as expression of behaviour include (confusion, misunderstanding care needs, poor judgement, etc.) Revision on: 07/24/2025 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Mark is declining to (bathe, change clothes, take		

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of resistive to care- history of sexual expression with female team members, history of choking a nurse, wandering, pulling fire alarm panel, Caught trying to pull the fire panel alarm and saying he wants some fun, inappropriate comment to staff, trying to feed other resident, touching other residents without invitation, grabbing a nurses lanyard and pulling it tight. multiple threats to strangle team members, wrapping a call bell around his own net to demonstrate how he could use it as a weapon, saying that there are many weapons in the housekeeping room, hitting team members, throw his personal belongings on the floor, threw boxes of brief to staff related to decrease cognitive impairment Revision on: 10/20/2025 Revision by: Jenny Liu (RAI Coordinator)		medications, eat, etc.) re-approach in 10-15 minutes. Report episode to Registered Staff. 2 team members minimum approach to all ADL care Revision on: 08/07/2025 Revision by: Danielle Loreto (RAI Coordinator) • SOCIALLY Inappropriate Behaviour: Mark has pulled the fire alarm panel and verbalized "I want to pull the alarm just for fun." (7/30/25) Inappropriate comments to staff members. Wanders into other residents rooms and yells at them. Will yell "HEY" at other residents in their rooms, or when in the shared areas. He is not easily redirected. Team to assess for unmet needs. May have to repeat information to him due to his cognitive loss. Resident has been fixated on calling for RPN K.A. over and over and asking where this team member is when not present. He will repeat her name over and over and has been noted saying that he loves her. If noted please try to redirect resident. Inform the charge nurse. Taking items and storing them in his room. Boxes of gloves, microfiber cloths from the house keeping carts. Monitor his room and remove items if noted. Provide education to Mark about taking items that are not his. Revision on: 09/29/2025 Revision by: Danielle Loreto (RAI Coordinator) • SOCIALLY Inappropriate Behaviour: Monitor Mark of his whereabouts and redirecting him to his room or to do an activity when he is walking/going to the fire panel alarm. Inform Registered Staff and seek assistance as needed. Encouraged him to use the colouring book and crossword puzzle. Redirect Mark to watch TV. If making inappropriate comments, redirect Mark and provide health teachings. Urinating in front of people. Escort resident to the washroom. Redirect him if noted starting to undo his pants. Revision on: 09/08/2025		

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
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Focus	Goal	Interventions	Position	Freq/Resolved
		Revision by: Danielle Loreto (RAI Coordinator) • WANDERING: Permit Mark to safely roam in common area. Redirect away from exit doors, elevator or other resident rooms as needed. Revision on: 07/24/2025 Revision by: Maryola Perion (RN) • SEXUAL Behaviour: If Mark is noted to (comments, touching females in the past, saying to the team he is having a threesome, making sexual comments to others) calmly assist him back to the his room. Revision on: 08/15/2025 Revision by: Danielle Loreto (RAI Coordinator) • SEXUAL Behaviour: Mark demonstrates habit of unwanted (kissing, touching, making sexual comments to others etc) of others (breasts, groin, buttocks, etc.) Report episode to Registered Staff. Revision on: 08/15/2025 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer medication for therapeutic treatment of Expressed Behaviour as per MD Order. Monitor effectiveness and for side effects. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • ONE to ONE Care: Started on August 7th 2025 on all shifts. See Registered Staff for update. SEPTEMBER 9TH 2025 STARTING AT 1900- Resident will have a security guard present 24 hours a day/ 7 days a week. Security guard responsibilities have been provided. Security guard will stay close by resident due to his unpredictable behaviour. Revision on: 09/09/2025 Revision by: Danielle Loreto (RAI Coordinator) • BSO RECOMMENDATIONS: (specify intervention in easy to follow instruction) The resident is being followed by Internal BSO. If the resident has something that is not his, briefly explain the importance of the item and encourage him to return it. If the risk is low, wait until the resident puts it down. Try to distract with an activity (watching tv, music, reading, cards, crosswords) or a	PCA Registered Practical Nurse RN	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
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Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Expressive Behaviour of resistive to care- history of sexual expression with female team members, history of choking a nurse, wandering, pulling fire alarm panel, Caught trying to pull the fire panel alarm and saying he wants some fun, inappropriate comment to staff, trying to feed other resident, touching other residents without invitation, grabbing a nurses lanyard and pulling it tight. multiple threats to strangle team members, wrapping a call bell around his own net to demonstrate how he could use it as a weapon, saying that there are many weapons in the housekeeping room, hitting team members, throw his personal belongings on the floor, threw boxes of brief to staff related to decrease cognitive impairment Revision on: 10/20/2025 Revision by: Jenny Liu (RAI Coordinator)		snack or drink. Two staff for care at all times. Do not go in the elevator alone with Mark. Ask another staff member to come along to main floor and they can go back to the floor. Don't let Mark box you in at anytime. Make sure you have a way to get away from him. Report anything unusual to registered staff immediately. Redirect Mark away from female residents if he is attempting to touch them. Monitor for any signs of pain such as pacing, restlessness and or wandering. Mark enjoys watching comedies on tv, attending all main floor programs, listening to music (Country & Western, Alabama, Oak Ridge Boys, Whitney Houston), playing cards (Crazy eights, Go Fish), reading, doing crosswords and colouring. Mark also likes to go outside and talk to residents and water the plants.give Mark some space allow him time before entering his room or asking him any questions. Revision on: 10/16/2025 Revision by: Ranjita Yadav (RPN)		

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Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience alteration in MOOD as exhibited by repetitive verbalizations/questions, restless related to Loss of Independence Revision on: 10/20/2025 Revision by: Jenny Liu (RAI Coordinator)	• Mark will be supported to maintain mood stability as evidenced by DRS score at a range of 0-2 by the review date. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	• ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Mark for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Mark effort to maintain control. Encourage him/her to express self, state preferences and make safe choices for care and activities. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • DISTRACTION ACTIVITIES: Mark can be calmed doing activities of interest including (encouraged him to use the colouring book and crossword puzzle, etc.) Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for MOOD stability as per MD Order. Monitor its effectiveness and for side effects . Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• STRONG PARTICIPATION in Activities ISE Score: 6/6 Revision on: 10/09/2025 Revision by: Laura Morris (Restorative Care Aide)	• Mark will be supported to maintain participation in activities 20-25 times per month by the next review date. Revision on: 10/09/2025 Revision by: Laura Morris (Restorative Care Aide) Target Date: 01/29/2026	• STRUCTURED ACTIVITIES: Invite Mark to programs of personal interest; trivia, bingo, happy hour, board games, movies, parties, mens club, special events, etc. Mark enjoys watching hockey and his favourite teams are Toronto Maple Leafs, Montreal Canadians and Windsor Spitfires. Revision on: 10/25/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage Mark to engage in self-directed activities such as reading, watching TV, word searches, visiting with other residents and staff. Mark also enjoys sweeping and cleaning up the patio. Revision on: 10/25/2025 Revision by: Laura Morris (Restorative Care Aide)		
• Storey, Mark requires temporary SAFETY CHECKS for behaviour and exit seeking, physical behaviours, attempts to choke a team member, making threats to choke	• Safety Check initiated on july/29/2025 as temporary measure to monitor resident each day until completed	• Check Mark location every 30 minutes. Revision on: 08/07/2025 Revision by: Danielle Loreto (RAI Coordinator) • Check Mark observed behaviour every 30 minutes for placing his hands on other	PCA PCA	Q1/2hr Q1/2hr

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residents and team members, attempts and actual pulling the fire alarm, (pulling the call bell out and making threats to the team to strangle them (2025-09-08)) Revision on: 09/09/2025 Revision by: Danielle Loreto (RAI Coordinator)	Revision on: 08/05/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	residents, making threats to the team to choke them. Revision on: 08/07/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential to experience (rash, hives, anaphylaxis, etc.) related to ALLERGY of Penicillin, Coffee (intolerance - stomach issues). Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	• Mark will be protected from exposure to allergen each day through next review date. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with (Mark)/SDM in decision making and health teaching about ALLERGY to Penicillin, Coffee. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with allergy for changes to health status and complications. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • ALLERGY ALERT: Mark has ALLERGY to Penicillin, Coffee. Prevent contact with and report if noted to experience symptoms (rash, hives, swelling, difficulty breathing, etc.). Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MD/PHARMACY ALERT: Notify the MD and Pharmacy of Mark Allergy to Penicillin, Coffee and minimize risk for exposure to allergen. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in CARDIAC FUNCTION related to: hypercholesterolaemia Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with hypercholesterolaemia through to the next review date. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with (Mark)/SDM in decision making of Cardiac Care Management for hypercholesterolaemia. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for hypercholesterolaemia as per MD Order and monitor for side effects. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
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Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for muscular dysfunction, contractures and bone deformity related to OSTEOARTHRITIS (hands & back). Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with OSTEOARTHRITIS through to the next review date. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• COMMUNICATION: Involve/ collaborate with (Mark)/SDM in decision making of musculoskeletal care management. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for management of OSTEOARTHRITIS as per MD order. Monitor effectiveness and for side effects. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of OSTEOARTHRITIS for discomfort/ complications or changes to health status. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • PAIN MANAGEMENT for OSTEOARTHRITIS prescribed and in place; refer to Pain Care Plan. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)		
• Increased risk for FALLS related to the use of antipsychotic medication. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	• To promote safety, minimize risk for falls and/or fall related injury each day through to the next review period. Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with (Mark)/SDM in decision making in fall prevention Plan of Care. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • ENVIRONMENT: Secure environment (reduce clutter, etc.) to reduce fall risk for Mark. Revision on: 07/24/2025 Revision by: Maryola Perion (RN) • FOOTWEAR: Ensure resident wears appropriate footwear for transfers, ambulation. Revision on: 07/24/2025 Revision by: Maryola Perion (RN) • SUPPLEMENT: Administer supplement as per MD order to maintain bone density to prevent injuries.	PCA PCA PCA	D/E/N

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
• Increased risk for FALLS related to the use of antipsychotic medication. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)		Revision on: 07/30/2025 Revision by: Maryola Perion (RN)		
• Potential for PAIN and alteration in comfort level related to osteoarthritis to hands and back pain. Back pain is chronic Most Current LTCF Pain Score is 0. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Target Date: 01/29/2026 • Promote RAI Pain Score of 0 through to the next review. Target Date: 01/29/2026	• MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. • NON VERBAL CUES of PAIN for Mark includes - (facial grimacing, tight fists, crying, sweating, wringing of hands, refusing to eat, wanting to go to bed, etc.) Report these to Registered staff when observed. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	RN Registered Practical Nurse PCA Registered Practical Nurse RN	
• Altered ability to complete Activities of Daily Living (ADLs) related to Intellectual Disability, Osteoarthritis, Back Pain, Diabetes Mellitus Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	• Mark will be supported to maintain current self participation in ADL care and assisted to ensure all ADL care needs are met each day through to the next review date. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	• BATHING: Mark is able to wash himself from head to toe once set up done by the team. Supervision provided to ensure safety. He is able to transfer on/off the shower chair. Shower/Bath days are Mondays and Thursdays on Day shift. 2 team members approach for all care. While 1 team member may perform the care as he is highly involved in his care the other team member MUST be present for safety of the team member performing the care due to possible physical, sexual expressions towards others. Nail care to be provided on shower/bath day.	PCA	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		Revision on: 10/20/2025 Revision by: Jenny Liu (RAI Coordinator) • BED MOBILITY: MARK is independent with his movement in bed. Team to monitor for changes	PCA	
		Revision on: 09/30/2025 Revision by: Alyssa Egan (Interim ADOC) • DRESSING: MARK is able to dress himself but needs reminders. At times if fatigued or he is using buttons, zippers. 2 team members approach for all care. While 1 team member may perform the care as he is highly involved in his care the other team member MUST be present for safety of the team member performing the care due to possible physical, sexual expressions towards others.	PCA	
		Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • EATING: MARK is able to eat independently with cue and set up from staff. 1 team member supervision due to behavior and safety. Requires redirection and assistance at times during meals.	PCA	
		Revision on: 08/11/2025 Revision by: Brittany Hyde (Registered Dietitian) • LOCOMOTION: Mark is able to walk independently with no gait aid with ambulation. He requires supervision from one staff on and off unit. Has a 1:1 in place.	PCA	
		Revision on: 08/07/2025 Revision by: Maryola Perion (RN) • PERSONAL HYGIENE: MARK is able to brush hair, wash face, and brush teeth. 2 team limited assistance with all other hygiene tasks 2 team members approach for all care. While 1 team member may perform the care as he is highly involved in his care the other team member MUST be present for safety of the team member performing the care due to possible physical, sexual expressions towards others.	PCA	
		Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • HAND HYGIENE: Mark is able to independently complete task of Hand Hygiene each day.	PCA	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Intellectual Disability, Osteoarthritis, Back Pain, Diabetes Mellitus Revision on: 07/30/2025 Revision by: Maryola Perion (RN)		Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • TOILET USE: Mark is able to transfer onto the toilet on his own. 2 team members approach for toileting when he needs assistance. While 1 team member may perform the care as he is highly involved in his care the other team member MUST be present for safety of the team member performing the care due to possible physical, sexual expressions towards others. Needs lots of encouragement to use the toilet and to change incontinent product. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • TRANSFERRING: Mark is independent with transferring. 2 team members approach should he require assistance to transfer. While 1 team member may perform the care as he is highly involved in his care the other team member MUST be present for safety of the team member performing the care due to possible physical, sexual expressions towards others. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • ORAL CARE: Mark has 3 teeth and the rest are missing. He can complete his own oral care but requires reminders. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • SHAVING -Mark requires the team member to shave him at this request. 2 team members approach for all care. While 1 team member may perform the care as he is highly involved in his care the other team member MUST be present for safety of the team member performing the care due to possible physical, sexual expressions towards others. Revision on: 08/20/2025 Revision by: Danielle Loreto (RAI Coordinator) • Two staff for all approaches.	PCA PCA PCA PCA	D

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Intellectual Disability, Osteoarthritis, Back Pain, Diabetes Mellitus Revision on: 07/30/2025 Revision by: Maryola Perion (RN)		Two staff to be present at all times when providing ADLs/care to Mark due to his behaviors and for safety. Revision on: 08/07/2025 Revision by: Maryola Perion (RN)		
• Strength Training Revision on: 07/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increased strength for B/L LE from 3+/5 to 4/5 in next 3 months. Revision on: 10/14/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/29/2026	• Strengthening exs for B/L UE and LE, within pain limits, 1lbs to 2lbs, 10 reps, 1-2 sets, 2-3 x a week; Revision on: 07/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Balance Training Revision on: 07/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	• Increase Tinetti scores from 17 to 19 in next 3 months Revision on: 07/23/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/29/2026	• 1:1 balance training with wall bar. Include marching, heel raise, mini squats, front, side and back touches etc. 10 reps/exs, 2-3 x a week Revision on: 07/23/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition: Chewing difficulty related to only has 3 teeth Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To maintain safe chewing through to next review date Target Date: 01/29/2026	• Provide diet/texture interventions as per Nutrition Risk Level		
• Nutrition Risk Level	• Mark will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 10/09/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/29/2026 • Will weigh within realistic GWR 55-65 kg through to next review date. Revision on: 10/09/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/29/2026 • Mark will be adequately hydrated aeb drinking at least 82% of total fluid requirement: 1830 ml/day (30 ml/kg using 61 kg weight) through to next review date. Revision on: 10/09/2025 Revision by: Holly Laasanen (Dietitian (RD)) Target Date: 01/29/2026	• NUTRITION RISK: Mark is low risk level. Revision on: 07/28/2025 Revision by: Brittany Hyde (Registered Dietitian) • DIET ORDER: Mark will receive regular diet, regular texture. See dining instructions. Revision on: 07/22/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FLUID CONSISTENCY: Mark drinks REGULAR/THIN Level 0 Fluids. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • FLUID TARGET: Encourage Mark to drink a minimum of 1500 ml/day. Revision on: 10/09/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DINING INSTRUCTIONS: - Encourage softer options - Provide crustless bread/toast - Diabetic interventions: encourage water to drink, offer diet juice Revision on: 10/09/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FOOD INTOLERANCE: Coffee (too much causes diarrhea). He can have 1 coffee at breakfast only. Revision on: 07/22/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD) PCA PCA PCA Registered Practical Nurse PCA Restorative Care Aide	
• Sleep Patterns; Potential for alteration in	• To promote adequate	• REST PATTERN: Preferred bedtime (2200), usual wake time (0800) and daytime	PCA	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A

Last Care Plan Review Completed:	**10/29/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
quality of sleep or sleep pattern related to new location Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	rest/sleep for Mark based on identified sleep patterns/preferences each night through to the next review date. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	naps (specify). Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Target Date: 01/29/2026	• COMMUNICATION: Involve/ collaborate with (Mark)/SDM in decision making of diabetes care management. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. • MEDICATION: Administer medication for DIABETES as per MD order. Monitor effectiveness and for side effects. Revision on: 07/30/2025 Revision by: Maryola Perion (RN)	Registered Staff	
• Potential for BOWEL INCONTINENCE related to decreased ability to feel the urge Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Mark will have bowel incontinence managed every shift through to the next review period. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026	• BOWEL Continence level is Infrequently Incontinent. Report change to level as noted. Revision on: 07/30/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. • INCONTINENCE PRODUCT: Resident uses medium pull up Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA PCA PCA	
• URINARY (Mixed) INCONTINENCE related to decreased awareness, decreased understanding. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• (Resident name) will have urinary incontinence managed every shift through to the next review period. Target Date: 01/29/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • URINARY Continence level is infrequently incontinent. Report change to level as	PCA	

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
		noted. Revision on: 10/20/2025 Revision by: Jenny Liu (RAI Coordinator) • INCONTINENCE PRODUCT: Resident uses medium pull up on all shifts. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Risk for Impaired SKIN INTEGRITY related to Frailty	• To protect and maintain skin integrity each day through to the next review. Target Date: 01/29/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• Altered VISION related to need to use glasses Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Mark supported to use eyeglasses for vision correction daily through to the next review date. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	• EYEGLASSES: Mark wears eyeglasses. Assist to clean eyeglasses as needed and store (on night table.) when sleeping. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	PCA	
• Altered COMMUNICATION as exhibited by limitations to (comprehension) related to intellectual disability. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• Mark will continue to freely express self and adequately comprehend information each day through to the next review period. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	• COMMUNICATION: Involve/collaborate with Mark for decision making about strategies needed to support effective communication. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) • INSTRUCTION GUIDANCE: (Resident name) needs (intermittent) cueing or demonstrative instruction in tasks and activities. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		
• COGNITIVE LOSS; alteration in thought processes (difficulty concentrating, altered judgement, etc.) related to progression of intellectual disability Revision on: 07/21/2025	• Mark will be supported to make independent choice and safe decisions each day through to the review date. Current CPS is 3.	• ORIENTATION: Gently reorient to (person, place, time) as needed when Mark is feeling lost or in confused state. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

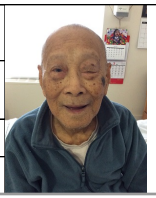
Focus	Goal	Interventions	Position	Freq/Resolved
Revision by: Danielle Loreto (RAI Coordinator)	Revision on: 07/30/2025 Revision by: Maryola Perion (RN) Target Date: 01/29/2026			
• Expressed Wishes and Beliefs related to Mark Medical Treatment and End of Life Care Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To support and honor Mark expressed wishes and beliefs through to the End of Life. Revision on: 07/21/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/29/2026	• CPR: Mark wishes Attempt CPR: transfer to hospital decisions to be made as needed - see PoET Individualized Summary for details. Revision on: 09/12/2025 Revision by: Danielle Loreto (RAI Coordinator)		

Diagnosis Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E78.0), Other idiopathic scoliosis, unspecified site(M41.29), Multiple system atrophy, cerebellar type [MSA-C] (G23.3), Lack or loss of sexual desire(F52.0), Primary generalized (osteo)arthrosis(M15.0)

Allergies	Penicillin, Coffee	**D.O.B.**	01/07/1967	**Physician**	Albert Patrick Ng
Diagnosis	Other specified diabetes mellitus without (mention of) complication(E13.9), Other chronic pain(R52.2), Mild mental retardation, other impairments of behaviour(F70.8), Pure hypercholesterolaemia(E...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Storey, Mark (922131005645)	**Admission Date**	07/21/2025	**Location**	4 409 A
Last Care Plan Review Completed:	**10/29/2025**				

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Risk for/Impaired SKIN INTEGRITY related to frequently incontinent with bladder, Use of incontinent product, Impaired mobility, Diabetes Mellitus. Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	• To protect and maintain skin integrity each day through to the next review. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• SKIN OBSERVATION: Observe skin condition with AM and PM care. Report any new or different observance than the residents' usual skin condition to Registered Staff as noted.	PCA	
• COGNITIVE LOSS; alteration in thought processes (memory loss, altered judgement, etc.) related to decline in cognitive status Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	• Tai will be supported to maintain current cognitive abilities through the review date. Current CPS is 2. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/03/2026	• ORIENTATION: Gently reorient to (person, place, time) as needed when Tai is feeling lost or in a confused state. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • PERSONAL ROUTINE: Provide consistency in care routine and activities. Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	All PCA	
• Potential for Persistent PAIN and alteration in comfort level related to Osteomyelitis of L3-L4, Diabetes Mellitus, Leg Pain, Back pain, Hx of Right Rotator Cuff tear, Neck pain, headache, lower back pain, difficulty swallowing regular food/ facial grimacing noticed when swallowing. Most Current LTCF score is 0 Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator)	• To promote resident comfort and effectively manage PERSISTENT pain each day through to the next review. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026 • Promote ltcf Pain Score of 0 through to the next review. Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai/SDM about pain management, goals of treatment, plan of care, prognosis and treatment options. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective to continually assess appropriateness of pain management regime and collaborate with Interdisciplinary Team to attain optimal resident satisfaction for pain control. Monitor for complaints of pain or signs of pain when eating. Ask resident if he is having pain- due to language barrier you can ask him to point to where the pain is. Inform nurse if pain is noted. Nurse to follow up on pain complaints. Revision on: 04/08/2025 Revision by: Danielle Loreto (RAI Coordinator) • MEDICATION: Administer analgesic medication as per MD order for pain relief/management. Request MD assistance to review pain management as clinically needed.	RN Registered Practical Nurse Registered Practical Nurse RN	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng	
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region (M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses					
Facility	Berkshire Care Centre			**Print Date**	10/30/2025	
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B	

Last Care Plan Review Completed: **10/03/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for Persistent PAIN and alteration in comfort level related to Osteomyelitis of L3-L4, Diabetes Mellitus, Leg Pain, Back pain, Hx of Right Rotator Cuff tear, Neck pain, headache, lower back pain, difficulty swallowing regular food/ facial grimacing noticed when swallowing. Most Current LTCF score is 0 Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator)		Revision on: 12/09/2020 Revision by: Maryola Perion (RN)		
• Potential to experience alteration in fluid volume or episode of DEHYDRATION related to decreased oral intake, facial grimacing with swallowing, Episodes of LBMs. Revision on: 06/07/2025 Revision by: Maryola Perion (RN)	• To promote fluid consumption and minimize risk for dehydration each day through to the next review date. Revision on: 04/06/2025 Revision by: Jenny Liu (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai/SDM in decision making for plan of Hydration/Fluid consumption and risks of dehydration. Revision on: 04/06/2025 Revision by: Jenny Liu (RAI Coordinator) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with altered fluid intake for changes to health status and risk for dehydration. Revision on: 04/06/2025 Revision by: Jenny Liu (RAI Coordinator) • PROMOTE FLUIDS: Promote Tai to consume fluids; amount as per Nutrition Care Plan. Revision on: 04/11/2025 Revision by: Maryola Perion (RN)	Diet Registered Staff Registered Staff	
• At Risk for SOCIAL ISOLATION and/or alteration to PSYCHO-SOCIAL well-being related to Disinterest, Rest/Sleep Patterns, Language Barrier (Vietnamese). ISE Score: 3/6 Revision on: 04/15/2025 Revision by: Laura Morris (Restorative Care	• To support Tai's Psycho-Social well being through to the next review. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• STRUCTURED ACTIVITIES: Invite him to programs of personal interest; 1:1 visits, exercise, games, music, outdoors, reading, reminiscing, socials, special events, etc. Revision on: 04/15/2025 Revision by: Laura Morris (Restorative Care Aide) • SELF-DIRECTED ACTIVITIES: Encourage him to engage in self-directed activities such as listening to music, crossword puzzles, family/friend visits, enjoying the outdoors, etc. Revision on: 02/16/2023	ACT	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B
Last Care Plan Review Completed:	**10/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Aide)		Revision by: Judy Woods (Activation aide) • ASSISTANCE: Provide assistance/encouragement to get him to scheduled activities - Invitations, portering to and from programs. Revision on: 06/26/2025 Revision by: Laura Morris (Restorative Care Aide) • HELPFUL HINTS: Identify Helpful Hints to ease communication while providing care/interactions - use translation when possible. Revision on: 09/06/2022 Revision by: Shayna Lee Wonsch • ONE to ONE: Provide him with individual visits for conversation, reminiscing, word searches, puzzles, etc. Revision on: 06/26/2025 Revision by: Laura Morris (Restorative Care Aide) • FAMILY INVOLVEMENT: High Involvement Revision on: 09/06/2022 Revision by: Shayna Lee Wonsch	ACT ACT	
• Potential for Expressive Behaviour of RESISTANCE to care need (refusing bath or shower, medication, to eat) related to Inability to COPE, Pain Revision on: 04/11/2025 Revision by: Maryola Perion (RN)	• To decrease the episodic frequency of Expressive Behaviour by the next review date. ABS score will be maintained to 0. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with (Tai)/SDM) about identified Risk of Expressive Behaviour, discuss triggering factors, and plan of care needs/options as needed. Revision on: 04/17/2024 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Tai for indications to change in or for escalating expressive behaviour risk. Revision on: 04/17/2024 Revision by: Maryola Perion (RN) • TRIGGERS leading to RESISTANCE to Care Needs of (refusing bath/shower, medication, to eat, etc.) as expression of behaviour include (misunderstanding care needs, poor judgement, etc.) Revision on: 04/11/2025 Revision by: Maryola Perion (RN) • RESISTANCE to Care Need: If Tai is refusing to have his bath/shower, medication, to eat, etc. re-approach in 10-15 minutes. Report episode to Registered Staff. Revision on: 04/11/2025 Revision by: Maryola Perion (RN)	BSO - Internal Social Worker Registered Staff	
• Potential to experience alteration in	• To decrease the episodic	• COMMUNICATION: Involve/collaborate with (Tai)/SDM) about MOOD Disturbance,		

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed:	**10/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
MOOD as exhibited by sad, pained, worried facial expressions (moaning, sad facial grimace) related to Pain, Lumbar region of spine(L3-L4) Osteomyelitis. Revision on: 04/11/2025 Revision by: Maryola Perion (RN)	frequency of negative Mood symptoms by the next review date. DRS score will be maintained to 0. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) Target Date: 01/03/2026	discuss contributing factors, and plan of care needs/options as needed. Revision on: 05/19/2023 Revision by: Maryola Perion (RN) • ASSESS/MONITOR: Utilize holistic perspective of continuous monitoring of Tai for indications to change in MOOD including labile mood or increase of symptoms that negatively impact residents quality of life. Revision on: 05/19/2023 Revision by: Maryola Perion (RN) • RESIDENT STRENGTHS: Build on Tai effort to maintain control. Encourage him/her to express self, state preferences and make safe choices for care and activities. Revision on: 05/19/2023 Revision by: Maryola Perion (RN) • SLEEP/REST: Promote adequate sleep and rest to stability of Tai's mood. Report changes in sleeping habits to Registered Staff as noted. Revision on: 04/11/2025 Revision by: Maryola Perion (RN)		
• Potential for Bowel Incontinence related to Impaired Mobility. Revision on: 07/12/2024 Revision by: Maryola Perion (RN)	• Tai will receive support to use toilet and promote optimal bowel continence each day through to the next review. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for changes to health status, alteration of continence level or bowel function. • BOWEL Continence level is Frequently Incontinent. Report change to level as noted. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • BOWEL MOVEMENT: Monitor resident for bowel movement each shift and document number of occurrences, size and consistency. Revision on: 03/17/2021 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Tai uses a White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	Registered Staff PCA PCA PCA	
• Increased risk for FALLS related to: Impaired Mobility, Osteomyelitis of L3-L4, Diabetes Mellitus, History of falls.	• To promote safety, minimize risk for falls and/or fall related injury each day through to the	• COMMUNICATION: Involve/collaborate with Tai/SDM in decision making in fall prevention Plan of Care. Revision on: 12/09/2020		

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed: **10/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
Revision on: 01/26/2024 Revision by: Maryola Perion (RN)	next review period. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	Revision by: Maryola Perion (RN) • CALL BELL: Place call bell within resident's reach, check that it is in working order and remind/encourage to use it. Revision on: 07/08/2023 Revision by: System Generated (F) • ADAPTIVE EQUIPMENT: Resident needs adaptive equipment: high/low bed, wheelchair. Revision on: 06/13/2025 Revision by: Chelsea Campbell-Wright (ADOC) • ENVIRONMENT: Secure environment reduce clutter to reduce fall risk for Tai Revision on: 01/18/2024 Revision by: Chelsea Campbell-Wright (ADOC) • FOOTWEAR: Ensure resident wears appropriate footwear for transfers, ambulation Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • SUPPLEMENT: Administer supplement/medication as per MD order to maintain bone density to prevent injuries. Revision on: 04/11/2025 Revision by: Maryola Perion (RN)	PCA PCA PCA PCA	D/E/N
• Potential to experience alteration in CARDIAC FUNCTION related to: Hypertension, Atrial Fibrillation. Revision on: 01/20/2024 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with Hypertension, Atrial Fibrillation through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai/SDM in decision making of Cardiac Care Management for Hypertension, Atrial Fibrillation. Revision on: 01/20/2024 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with Hypertension, Atrial Fibrillation for changes to health status and alteration or complications affecting cardiac function. Revision on: 01/20/2024 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for Hypertension, Atrial Fibrillation as per MD Order and monitor for side effects. Revision on: 01/20/2024 Revision by: Maryola Perion (RN)	Registered Practical Nurse RN	
• Ambulation/Gait training Revision on: 10/17/2023 Revision by: Shina Wadhwa (PT -	• To improve foot clearance while walking in next 3 months Revision on: 02/04/2025	• 1:1 assist gait training with RW for endurance and cue for foot clearance, proper posture, small laps, distance as best tolerated,2-3 x a week, Revision on: 07/30/2025	PT - Physiotherapist	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B
Last Care Plan Review Completed:	**10/03/2025**				

Focus	Goal	Interventions	Position	Freq/Resolved
Physiotherapist)	Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	Revision by: Shina Wadhwa (Physical Therapist)	PTA	
• Potential for altered hematologic symptoms or complications related to diagnosis of ANEMIA, hematuria, GI Bleed (7/14/23). Revision on: 07/22/2023 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with ANEMIA/hematuria each day through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai/SDM in decision making of hematologic care management for Anemia, hmeaturia. Revision on: 03/09/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident with ANEMIA, hematuria for complications or changes to health status. Revision on: 03/09/2023 Revision by: Maryola Perion (RN) • LAB WORK: Monitor blood lab work and report results to MD as needed. Follow up as indicated.	Registered Staff	
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES. Revision on: 07/22/2023 Revision by: Maryola Perion (RN)	• To treat and minimize signs/symptoms or complications associated with DIABETES each day through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • COMMUNICATION: Involve/ collaborate with Tai/SDM in decision making of diabetes care management. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of HYPOGLYCEMIA/ HYPERGLYCEMIA for changes to health status. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • CBG MONITORING: Monitor CAPILLARY BLOOD GLUCOSE (CBG) as per MD order. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • MEDICATION: Administer medication for DIABETES as per MD order. Monitor effectiveness and for side effects. Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	Registered Staff Registered Staff	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed: **10/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential for hypo/hyperglycemia and other complications related to diagnosis of DIABETES. Revision on: 07/22/2023 Revision by: Maryola Perion (RN)		• RESCUE MEDICATION: as per MD order. Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator) • LAB WORK: Monitor lab and diagnostic results for (fasting blood glucose and/or HbA1c) and report results to MD as needed. Follow up as indicated. Revision on: 10/03/2025 Revision by: Maryola Perion (RN)		
• URINARY (Functional) INCONTINENCE related to altered mobility, Hematuria Revision on: 03/09/2023 Revision by: Katie Wolters-Savo (RAI Coordinator)	• Tai will receive support to use toiletand promote urinary continence each shift through to the next review. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• MONITORING: Utilize holistic perspective of continuous monitoring of resident for toileting needs, changes to health status and alteration of continence level. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • URINARY Continence level is Frequently Incontinent. Report change to level as noted. Revision on: 04/11/2025 Revision by: Maryola Perion (RN) • INCONTINENCE PRODUCT: Tai uses a White brief on Days, Evening and Night shifts. Revision on: 03/11/2025 Revision by: Maryola Perion (RN)	PCA PCA	
• Potential for gastric discomfort/complications related to diagnosis of diabetic gastroparesis Revision on: 02/17/2023 Revision by: Maryola Perion (RN)	• To treat and/or minimize complications associated with diabetic gastroparesis each day through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with (Tai)/SDM in decision making for diabetic gastroparesis Management. Revision on: 07/22/2023 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident for management of diabetic gastroparesis for discomfort/ complications or changes to health status. Revision on: 02/17/2023 Revision by: Maryola Perion (RN)		

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Potential to experience FOOT/FEET complications related to diabetic diagnosis. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	• To maintain adequate Foot/Feet/Toenail care and minimize episodes of inflammation, infection or complications through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai in decision making for footcare treatment plan. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN) • TREATMENT PLAN: Tai requires footcare/treatment every shower day and PRN. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN) • PREFERENCE: Tai likes to have footcare treatment during shower days by registered staff. Revision on: 12/28/2022 Revision by: Katherine Arca (RPN)	Footcare Nurse - Internal Footcare Nurse - Internal	
• Strength Revision on: 04/29/2021 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• Tai to increase strength exe. for B/L UE≤ from grade 3+/5 to grade 4/5 in 3 months. Revision on: 07/03/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/03/2026	• Strength exe. with use of 1-2lbs. wt, for B/L UE and LE, 1set,10 rps., 2-3/week as tolerated. Revision on: 07/03/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Balance. Revision on: 04/29/2021 Revision by: Milap Patel (Reg.PHYSICAL THERAPIST)	• Increase Tinetti scores from 17 to 19 in next 3 months. Revision on: 10/02/2025 Revision by: Shina Wadhwa (Physical Therapist) Target Date: 01/03/2026	• Dynamic balance exe. at rail +1A,1set,10 rps.,2-3/week as tolerated. Revision on: 07/03/2025 Revision by: Shina Wadhwa (Physical Therapist)	PT - Physiotherapist PTA	
• Altered COMMUNICATION as exhibited by limitations to (self expression, etc.) related to Language barrier Revision on: 03/17/2021 Revision by: Maryola Perion (RN)	• Tai will continue to freely express self and adequately comprehend information each day through to the next review period. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai/SDM for decision making about strategies needed to support effective communication. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • PRIMARY LANGUAGE: Tai's primary language is Vietnamese. He is able to speak/understand English. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • INTERPRETER Required: Staff that speaks Vietnamese when needed. Staff that		

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed: **10/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered COMMUNICATION as exhibited by limitations to (self expression, etc.) related to Language barrier Revision on: 03/17/2021 Revision by: Maryola Perion (RN)	• Tai will be supported to maintain current communication abilities to express self, comprehend information, etc. each day through to the review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	speaks Vietnamese. Revision on: 10/18/2024 Revision by: Maryola Perion (RN)		
• Potential to experience complications and side effects impacting quality of life related to use of (multi-pharmacy, etc.) Revision on: 12/09/2020 Revision by: Maryola Perion (RN)	• To monitor effectiveness and for side effects of medication used each day through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• COMMUNICATION: Involve/collaborate with Tai/SDM in decision making and health teaching about medicinal regime and appropriate medication use. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • MONITORING: Utilize holistic perspective of continuous monitoring of resident using (poly-pharmacy, etc.) for changes to health status and alteration or complications affecting functioning or quality of life. Revision on: 12/09/2020 Revision by: Maryola Perion (RN) • MEDICATION REVIEW: Complete Medication Review with MD/NP Quarterly and as needed.	Registered Staff	
• Altered ability to complete Activities of Daily Living (ADLs) related to Impaired Mobility, Osteomyelitis of L3-L4, Diabetes Mellitus, Atrial Fibrillation. Revision on: 12/09/2020 Revision by: Maryola Perion (RN)	• Tai will be supported to cope with changing functional abilities and have ADL care needs met each day through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026 • Tai will be supported to maintain current self	• BATHING: Tai prefers (shower) on (Mondays and Fridays on Evening shift). Tai participates by (providing a wash cloth and washing the upper part of the body). One staff (EXTENSIVE) assistance for bathing. Nail care to be provided on shower/bath day. Revision on: 07/05/2025 Revision by: Danielle Loreto (RAI Coordinator) • BED MOBILITY: Tai is able to turn and reposition in bed independently without assistance from staff. If he is weak, he requires one to two staff limited to extensive assistance. Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator) • DRESSING: Tai requires one to two staff extensive to maximal assistance to	PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed: **10/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	participation in ADL care and assisted to ensure all ADL care tasks are met each day through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	change and remove his clothing. Revision on: 04/11/2025 Revision by: Maryola Perion (RN) • EATING: Tai is able to eat independently. Eats in the main dining room - 1st floor. See dining instructions in nutrition care plan. He may require one staff assistance to feed him if he is weak or unable to feed himself. Monitor and if this is consistent he will need to eat on floor 4 (currently no available seats at the main dining room assistive tables). Monitor for signs that resident may be having oral pain. Decreased intake present. If oral pain or throat pain are noted, inform the charge nurse. Revision on: 05/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) • LOCOMOTION: He requires the use of a wheelchair with one staff member to propel him on and off the unit. Revision on: 06/13/2025 Revision by: Chelsea Campbell-Wright (ADOC) • PERSONAL HYGIENE: Tai requires one to two staff extensive to maximal assistance. One staff member to comb his hair, brush his teeth, wash/dry his face and hands. Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator) • HAND HYGIENE: 1 staff to provide limited assistance to apply sanitizer or use wipes for hand hygiene. Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator) • TOILET USE: Tai requires extensive assistance from one to two staff to assist with transfer, change his incontinent product, provide peri care and to adjust his clothing. May require maximal assistance when fatigued. Revision on: 10/03/2025 Revision by: Maryola Perion (RN) • TRANSFERRING: Tai requires one staff extensive assistance to transfer him from a sitting to standing position. He is to be transferred to a wheelchair.	PCA PCA PCA PCA PCA	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed:	**10/03/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Altered ability to complete Activities of Daily Living (ADLs) related to Impaired Mobility, Osteomyelitis of L3-L4, Diabetes Mellitus, Atrial Fibrillation. Revision on: 12/09/2020 Revision by: Maryola Perion (RN)		Revision on: 06/13/2025 Revision by: Chelsea Campbell-Wright (ADOC) • ORAL CARE: Tai has upper and lower dentures. One staff member brushes his dentures and soak them in his denture cup. Denture cup on his bedside table. Salt water gargle QID PRN for sore gum. Revision on: 04/11/2025 Revision by: Maryola Perion (RN) • FOOT CARE: Footcare to be completed by PSW staff on shower days and PRN. Report long toe nails or other abnormalities as noted. Revision on: 01/25/2023 Revision by: Katherine Arca (RPN) • SHAVING - Tai requires one staff to shave him on his bath/shower days and as needed. Revision on: 10/14/2023 Revision by: Maryola Perion (RN)	PCA PCA PCA	D
• Expressed Wishes and Beliefs related to Tai's Medical Treatment and End of Life Care Revision on: 07/14/2020 Revision by: Joe Albano (RAI Coordinator)	• To support and honor Tai's expressed wishes and beliefs through to the End of Life. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• CPR: Tai wishes express DO NOT ATTEMPT CPR: Do not transfer to hospital, plan includes death at home - see PoET Individualized Summary Revision on: 07/04/2025 Revision by: Danielle Loreto (RAI Coordinator) • FUNERAL Arrangements: Families First Dougall Revision on: 10/03/2025 Revision by: Maryola Perion (RN)	Social Worker ST	
• SPIRITUAL BELIEFS: Tai is of the Buddhist Faith. Revision on: 12/05/2019 Revision by: Megan Pipe (Restorative Care Aide)	• To provide Tai spiritual support as interested through to the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI	• SELF-DIRECTED SPIRITUAL Activities: Tai engages in prayer, etc. Revision on: 02/16/2023 Revision by: Judy Woods (Activation aide)	ACT	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
Diagnosis	Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diab...See last page for a complete listing of the Resident's diagnoses				
Facility	Berkshire Care Centre			**Print Date**	10/30/2025
Resident	Trinh, Tai (922131005104)	**Admission Date**	03/21/2019	**Location**	4 425 B

Last Care Plan Review Completed: **10/03/2025**

Focus	Goal	Interventions	Position	Freq/Resolved
	Coordinator) Target Date: 01/03/2026			
• Sleep Patterns. Revision on: 04/20/2019 Revision by: Maryola Perion (Registered Nurse)	• To meet Tai's personal preferences for sleep patterns through the next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• REST PATTERN: Preferred bedtime: Around 9:30 pm, usual wake time: Around 7:00 am. Revision on: 03/17/2021 Revision by: Maryola Perion (RN)	PCA	
		• SLEEPWEAR: Tai prefers to wear Pyjamas Revision on: 12/12/2020 Revision by: Maryola Perion (RN)	PCA	
• Nutrition Risk Level (diet details)	• Tai will be adequately nourished aeb consuming >75% at meals and snacks through to next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• Labelled Item Dinner: Magic Cup daily Revision on: 08/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA Registered Practical Nurse RN	E
		• NUTRITION RISK: Tai is HIGH risk level. Revision on: 04/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	Dietitian (RD)	
	• Will weigh within Realistic weight range of 45-50 kg ~BMI 19-21 through to next review date. Revision on: 02/04/2025 Revision by: Danielle Loreto (RAI Coordinator) Target Date: 01/03/2026	• DIET ORDER: Tai will receive regular diet, regular texture at risk - POA has accepted risk (see dining instructions) Revision on: 03/20/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
		• FLUID CONSISTENCY: Tai drinks REGULAR/THIN Level 0 Fluids. Revision on: 04/15/2021 Revision by: Anna Slack (Registered Dietitian)	Diet PCA	
		• FLUID TARGET: Encourage Tai to drink a minimum 1305 ml/day. Tai drinks ice water from his water bottle throughout the day. Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA	
	• Tai will be adequately hydrated aeb drinking 100% of total fluid requirement: 1305 ml/day (30 ml/kg using 43.5 kg weight). Revision on: 06/27/2025 Revision by: Holly Laasanen (Dietitian (RD))	• DINING INSTRUCTIONS to minimize choking risk: -Encourage softer options -Cut food into small pieces -Add sauce/gravy when available to moisten food -Remove crust from bread/toast	Registered Practical Nurse	

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed: **10/03/2025**

Care Plan Report

Focus	Goal	Interventions	Position	Freq/Resolved
• Nutrition Risk Level (diet details)	Target Date: 01/03/2026	-Downgrade to minced texture PRN Revision on: 05/08/2025 Revision by: Holly Laasanen (Dietitian (RD)) • FOOD PREFERENCES: He likes eating soups. Revision on: 04/07/2025 Revision by: Holly Laasanen (Dietitian (RD)) • MEDPASS SUPPLEMENTS: Boost Carb Smart once daily with 1200 medpass Revision on: 08/07/2025 Revision by: Holly Laasanen (Dietitian (RD)) • DIABETIC CARE: Encourage beverages other than juice or dilute juice at meals/snacks. Revision on: 08/07/2025 Revision by: Holly Laasanen (Dietitian (RD))	PCA PCA	

Diagnosis Benign hypertension(I10.0), Atrial fibrillation, unspecified(I48.90), Need for assistance due to reduced mobility(Z74.0), Osteomyelitis of vertebra, thoracolumbar region(M46.25), Unspecified diabetes mellitus with poor control, so described(E14.64), Anaemia, unspecified(D64.9), Laceration of muscle(s) and tendon(s) of the rotator cuff of shoulder(S46.00), Other specified diseases of stomach and duodenum(K31.88), Haemorrhage of anus and rectum(K62.5), Gastrointestinal haemorrhage, unspecified(K92.2)

Allergies	No Known Allergies	**D.O.B.**	03/11/1929	**Physician**	Albert Patrick Ng
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Last Care Plan Review Completed:	**10/03/2025**				