



VNA Health at Home – Home Care  
2464 Fortune Drive, Suite 110  
Lexington, KY 40509  
P: 859-277-5111 F: 859-278-0597

### Fax Lead Sheet

DATE: 6/25/2025

ATTENTION: NICK T.

COMPANY: McGrath Medical wound care

FAX NO: 859-399-6697

PHONE NO: 859-492-1579 OR 859-285-9562

RE: Referral - H. Fint

MESSAGE:  
Please see attached referral for H. Fint.

- Intake form
- Patient Information Report
- Nursing Start of Care note

NUMBER OF PAGES: 27 (Including Lead Sheet)

FROM: VNA Health at Home

PHONE NO: 859-277-5111

**THANK YOU!**

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RETURN FAX NUMBER: 859-278-0597 or 888-218-1137

## McGRATH MEDICAL WOUND CARE

## INTAKE FORM

Personal InformationFull Name\* Harry L. FintPhone Number: (502) 439-5739 Email Address: \_\_\_\_\_Address: 140 Township St. Lawrenceburg, Ky 40342

Best Time To Contact:

Preferred Days:

Preferred Time:

Please use the below space to share notes such as veteran status, senior, in home or in office visit preferences etc.

Notes: Patient C Home Health Agency - VNA Health at Home.Emergency Contacts

HOPE Fint (daughter)

(502) 400-1725

POA Contact DetailsContact Name: Harry Fint Jr.Phone Number: (502) 343-5550Relationship: Son

Email Address: \_\_\_\_\_

\*READ DISCLAIMER TO PATIENT\*

## Rep Information

Full Name / Rep#

Phone Number:

Email:

**NICK Troiani  
859-825-8319**

Questions?

Call (859) 492-1579 OR (859) 285-9536

[www.mcgrathmedicalwoundcare.com](http://www.mcgrathmedicalwoundcare.com)

**Patient Information Report**

Patient: FINT, HARRY L.  
MR No: 04200051925201  
Legacy MR No:

Insured ID: TTR8K83JM21

Primary Payor:

MEDICARE PDGM

<b>Assigned Branch</b>	VISITING NURSES ASSOCIATION HEALTH AT HOME LEXINGTON	<b>Assigned Team</b>	TEAM A	<b>Location</b>
<b>Patient Nickname</b>		Patient ID	519252	SSN 402-68-3406

<b>Referral Details</b>				
Referral Date	06/20/2025	Referral Type	READMISSION	Referral Taken By DONEEN ORR
Referral Source		Referring Facility		Referring Facility Contact

<b>Facility</b>	SAINT JOSEPH HOSPITAL LEXINGTON	<b>Discharge Planner</b>
<b>Care Type and Effective Dates (P=Primary)</b>		
HOME HEALTH 06/20/2025 - (P)		
RSP2 06/20/2025 -		

<b>Demographics</b>
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<b>Patient Info</b>				
Gender	MALE	DOB	10/23/1946	Race
Preferred Language				
Primary Phone	5028395738	Alt Phone		Email
<b>Primary Address</b>				
Street		City	State	Zip
140 TOWNSHIP SQ		LAWRENCEBURG	KY	40342-
Phone	MSA #	CBSA	Floor	County
(502) 839-5738				ANDERSON
Travel Directions				Room

<b>Current Service Location: CLIENT'S HOME/RESIDENCE</b>				
Street		City	State	Zip
140 TOWNSHIP SQ		LAWRENCEBURG	KY	40342-
Phone	MSA #	CBSA	Floor	County
(502) 839-5738				ANDERSON
Travel Directions				Room

<b>Patient Contacts</b>				
<b>Contact Name</b>	<b>Relationship</b>	<b>Contact Type</b>	<b>Contact Relationship Type</b>	
HARRY FINT JR	SON	EMERGENCY CONTACT		
<b>Home Phone</b>	<b>Primary Phone</b>	<b>Alternate Phone</b>	<b>Address</b>	
	(502) 343-5550			
<b>Contact Name</b>	<b>Relationship</b>	<b>Contact Type</b>	<b>Contact Relationship Type</b>	
HOPE FINT	DAUGHTER	EMERGENCY CONTACT	PRIMARY CAREGIVER	
<b>Home Phone</b>	<b>Primary Phone</b>	<b>Alternate Phone</b>	<b>Address</b>	
	(502) 600-1725			

<b>Payor Source Info</b>			
<b>Payor Source Type</b>	<b>Payor Type</b>	<b>Payor Source</b>	<b>Is patient in an HMO (HHCAHPS)?</b>
PRIMARY	MEDICARE	MEDICARE PDGM	N
Medicare No.	Medicare A Effective	Medicare B Effective	Admission Source
7TR8K83JM21			4 - TRANSFER FROM A HOSPITAL FACILITY
Medicaid No.	Medicaid Effective	Physician Medicaid No.	Physician Name
			HUTCHINSON, ROBBY

<b>Private Payor Type Info</b>		
Claim No.	Policy No.	Insured ID

**Patient Information Report**

<b>Patient:</b> FINT, HARRY L <b>MR No:</b> 04200051925201 <b>Legacy MR No:</b>	<b>Insured ID:</b> 7TR6K63JM21	<b>Primary Payer:</b>	<b>MEDICARE PDGM</b>
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<b>Insured Name</b>	<b>Insured Relation</b>	<b>Insured Address</b>		
		<b>Insured City</b>	<b>Insured State</b>	<b>Insured Zip</b>
		<b>Insured Phone</b>		
<b>Employer Name</b>	<b>Employer ID</b>	<b>Employer Address</b>		
		<b>Employer City</b>	<b>Employer State</b>	<b>Employer Zip</b>
		<b>Employer Phone</b>		

<b>Program Name</b>	<b>Obtained Date</b>	<b>Obtained By/ Authorized By</b>	<b>Authorization No/ Active</b>	<b>Start Date/ End Date</b>
<b>Primary Care Physician</b>				
Primary Physician			<b>NPI #</b>	<b>Date Last Seen</b>
HUTCHINSON, ROBBY			1750383204	
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
360 AMSDEN AVENUE SUITE # 202		VERSAILLES	KY	40383
<b>Phone</b>	<b>Fax</b>	<b>Pager</b>		
(859)873-9188	(859)873-0870			
<b>Secondary Physician</b>				
<b>Requested Date of Evaluation</b>				
06/21/2025		<b>Admitting Discipline</b>	<b>Completed SOC Visit?</b>	
Requested Date of Add-On Evaluation		SN	N	
<b>Add-On Discipline</b>				

<b>Case Manager</b>	<b>Team Member(s)</b>
MANDI MCBRIDE, RN	CHERYL COOK, LPN
	JEREMY PARSONS, OT
	MEGAN KIFER, PTA
	WALTER LUTTRELL, PT
<b>Weight</b>	<b>Height</b>
N	
<b>Pregnant</b>	<b>Paperwork Received By Patient</b>
N	

<b>Acuity Status</b>	<b>Disaster Status</b>	<b>Evacuation Location</b>	<b>Was Adv Dir Info Left With Caregiver?</b>
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<b>Type</b>	<b>Location</b>	<b>Contents</b>	<b>Contact Name</b>	<b>Contact Phone</b>	<b>Was Adv Dir Info Left With Caregiver?</b>
<b>Inpatient Events (Associated with Your Agency)</b>					
<b>Inpatient Facility</b>		<b>Hospital Admit Date</b>	<b>Hospital Discharge Date</b>	<b>Surgery Date</b>	<b>Inpatient MR No.</b>
SAINT JOSEPH HOSPITAL LEXINGTON		06/15/2025	06/20/2025		Reason for Admission

**Patient Information Report**

Patient: FINT, HARRY L  
MR No: 04200051925201  
Legacy MR No:

Insured ID: 7TR8K83JM21

Primary Payor:

MEDICARE PDGM

**Home Health Care Survey**

Is care related to surgical discharge?	Does patient have end-stage renal disease?	Number of ADLs for which patient is not independent?
Has patient requested "No Publicity" status?	Is maternity care the primary reason for home health care?	Primary Spoken Language
N	N	

**ICD-10 Diagnoses/Procedures**

Order	Code	Description	Onset / Exac.	O/E Date	Type	Sym. Ctrl. Rtg.	OASIS Item
1	K31.819	ANGIODYPLASIA OF STOMACH AND DUODENUM WITHOUT BLEEDING	E	06/19/2025	D		M1021

## Visit Note Report

Client: FINT, HARRY L MR No: 04200051925201 Legacy MR No:  
 Client DOB: 10/23/1946 Primary Payor: MEDICARE PDGM  
 Insured ID: 7TR8K83JM21

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

General: FINT, HARRY L. 04200051925201							
Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:			
06/21/2025	1	RN00 - RN OASIS ADMISSION	042	<input checked="" type="checkbox"/>			
Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:	
398680	TERESA HUGHES RN	NA	0.00	0	0	0	
(M0090) Date Assessment Completed: 6/21/2025							
(M0080) Discipline of Person Completing Assessment: RN							

## Time:

TRAVEL TIME	DRIVE START TIME	06/21/2025 03:07 PM	DRIVE END TIME	06/21/2025 03:07 PM
IN-HOME TIME	BEGAN	06/21/2025 03:07 PM	INCOMPLETE	06/21/2025 03:51 PM
DOCUMENTATION TIME	RESUMED	06/22/2025 04:05 PM	INCOMPLETE	06/22/2025 04:49 PM
DOCUMENTATION TIME	RESUMED	06/24/2025 08:53 PM	COMPLETED	06/24/2025 09:26 PM
Total In-Home Time:	0.72 Hours			
Total Doc Time:	1.25 Hours			
Total Time:	1.97 Hours			

ICD-10 Diagnoses/Procedures						OASIS Item
Order	Code	Description	O/E	O/E Date	Type	Sym. Ctrl. Rtg.
1	K31.819	ANGIODYPLASIA OF STOMACH AND DUODENUM WITHOUT BLEEDING	E	06/19/2025	D	2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring.

Vital Signs					Instrument Problems
	Reading	Time Recorded	Details		
Temperature	98.5	06/21/2025 03:38 PM	TEMPORAL		N
Pulse	93	06/21/2025 03:38 PM	RADIAL		N
Pulse Characteristics:			WNL		
Respirations	18	06/21/2025 03:38 PM			N
Respiration Characteristics:			WNL		
Blood Pressure	107 / 82	06/21/2025 03:38 PM	SITTING ARM - RT		N
Height	75	06/21/2025 03:19 PM			N

Emergency Preparedness		
Evacuation Location	Acuity Status	Disaster Status
BROTHERS HOME	3 - WITHIN WEEK	AMBULATORY W/ ASSIST

Contact Info		
Contact:	Contact Type:	Relationship:
HOPE FINT	EMERGENCY CONTACT	DAUGHTER
Address:		
Home Ph:	Alternate Ph:	Email:
Primary Ph: 5026001726		
Caregiver/Representative Type:	PRIMARY CAREGIVER	

**Visit Note Report**

Client: FINT, HARRY L  
 Client DOB: 10/23/1946  
 Insured ID: 7TR8K83JM21

MR No: 04200051925201 Legacy MR No:  
 Primary Payer: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

<b>Caregiver Availability/Schedule:</b> 24/7 <b>Contact:</b> HARRY FINT JR <b>Contact Type:</b> EMERGENCY CONTACT <b>Relationship:</b> SON <b>Address:</b> <b>Home Ph:</b> <b>Alternate Ph:</b> <b>Email:</b> <b>Primary Ph:</b> 5023435550 <b>Caregiver/Representative Type:</b> <b>Caregiver Availability/Schedule:</b> <hr/> <b>PATIENT IDENTIFIER</b> <u>INDICATE TWO PATIENT IDENTIFIERS USED TO IDENTIFY THE PATIENT:</u> <u>PATIENT NAME</u> <u>DATE OF BIRTH</u> <u>VISUAL RECOGNITION</u> <u>PATIENT ADDRESS</u> <u>VERIFIED CURRENT LOCATION AND RETURN PHONE NUMBER OF THE PATIENT.</u> <u>OK</u> <b>CLIENT DEMOGRAPHICS</b> <u>DOES PATIENT HAVE PRIMARY CAREGIVER (HELPS WITH ADL OR IADL NEEDS)?</u> <u>NO</u> <u>DOES THE PATIENT/CG HAVE A SMART PHONE/TABLET/LAPTOP THAT THEY WOULD CONSENT TO USE FOR VIRTUAL VISITS WHICH MAY INCLUDE DOWNLOADING AN APP?</u> <u>NO</u> <u>(Q8Q1)(M0100) THIS ASSESSMENT IS CURRENTLY BEING COMPLETED FOR THE FOLLOWING REASON:</u> <u>1 - START OF CARE - FURTHER VISITS PLANNED</u> <u>(E)(M0102) IS THE DATE OF PHYSICIAN-ORDERED START OF CARE / RESUMPTION OF CARE KNOWN?</u> <u>NA - NO SPECIFIC SOC/ROC DATE ORDERED BY PHYSICIAN</u> <u>(M0104) DATE OF REFERRAL: INDICATE THE DATE THAT THE WRITTEN OR VERBAL REFERRAL FOR INITIATION OR RESUMPTION OF CARE WAS RECEIVED BY THE HHA.</u> <u>6/20/2025</u> <u>(A1005) ARE YOU OF HISPANIC, LATINO/A, OR SPANISH ORIGIN? CHECK ALL THAT APPLY.</u> <u>A. NO, NOT OF HISPANIC, LATINO/A, OR SPANISH ORIGIN</u> <u>(A1010) WHAT IS YOUR RACE? CHECK ALL THAT APPLY.</u> <u>A. WHITE</u> <u>(A1110A) WHAT IS YOUR PREFERRED LANGUAGE?</u> <u>ENGLISH</u> <u>(A1110B) DO YOU NEED OR WANT AN INTERPRETER TO COMMUNICATE WITH A DOCTOR OR HEALTH CARE STAFF?</u> <u>0. NO</u> <u>POST: INDIANA PHYSICIAN ORDERS FOR SCOPE TREATMENT:</u> <u>PATIENT DOES NOT MEET CRITERIA FOR POST</u> <b>HOMEBOUND STATUS</b> <u>THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME BECAUSE: (MARK ALL THAT APPLY)</u> <u>BECAUSE OF ILLNESS OR INJURY, PATIENT NEEDS AID OF SUPPORTIVE DEVICES - WHEELCHAIR</u> <u>ASSISTANCE OF ANOTHER PERSON IN ORDER TO LEAVE PLACE OF RESIDENCE</u> <u>THE PATIENT HAS NORMAL INABILITY TO LEAVE THE HOME AND LEAVING THE HOME TAKES CONSIDERABLE AND TAXING EFFORT BECAUSE:</u> <u>SHORTNESS OF AIR WITH MINIMAL EXERTION</u> <u>GAIT DEFICIT</u>		
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**Visit Note Report**

Client: FINT, HARRY L  
 Client DOB: 10/23/1946  
 Insured ID: 7TR8K83JM21

MR No: 04200051925201 Legacy MR No:  
 Primary Payor: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

**Assessment****LIMITED AMBULATION****FALL RISK**

ARE ENVIRONMENTAL BARRIERS PRESENT THAT PREVENT/RESTRICT THE PATIENT FROM LEAVING HOME?

NO

STRUCTURAL AND FUNCTIONAL LIMITATIONS: IMPAIRED BODY FUNCTIONS THAT EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL IMPACT THE PLAN OF CARE:

STRUCTURES OF THE CARDIOVASCULAR SYSTEM (S)

STRUCTURES OF THE RESPIRATORY SYSTEM (S)

STRUCTURES RELATED TO THE METABOLIC AND ENDOCRINE SYSTEMS (S)

STRUCTURES RELATED TO MOVEMENT (S)

SKIN AND RELATED STRUCTURES (S)

SENSORY FUNCTIONS AND PAIN (F)

ACTIVITY LIMITATIONS: SKILLED SERVICES, LISTED IN FIELD 21 OF PLAN OF CARE ORDER, ARE NEEDED IN THE FOLLOWING MANNER:

COMMUNICATION/LEARNING

MOBILITY/WELLNESS AND EXERCISE

SELF-CARE OF HEALTH CONDITIONS/MEDICATION MANAGEMENT

DOMESTIC LIFE/ADLS

INTERPERSONAL INTERACTIONS AND RELATIONSHIPS

**FINANCIAL**

(C1) (M0150) CURRENT PAYMENT SOURCES FOR HOME CARE: (MARK ALL THAT APPLY.)

1 - MEDICARE (TRADITIONAL FEE-FOR-SERVICE)

**HEALTH HISTORY**

WAS THE PATIENT DISCHARGED FROM AN INPATIENT FACILITY WITHIN THE LAST 14 DAYS?

YES

(C1) (PRA) (M1000) FROM WHICH OF THE FOLLOWING INPATIENT FACILITIES WAS THE PATIENT DISCHARGED WITHIN THE PAST 14 DAYS? (MARK ALL THAT APPLY.)

3 - SHORT-STAY ACUTE HOSPITAL (IPPS)

IS DATE OF INPATIENT DISCHARGE KNOWN?

YES

(M1005) INPATIENT DISCHARGE DATE (MOST RECENT): MONTH/DAY/YEAR

6/20/2025

(D) (M1028) ACTIVE DIAGNOSES- COMORBIDITIES AND CO-EXISTING CONDITIONS – CHECK ALL THAT APPLY

2 - DIABETES MELLITUS (DM)

(PRA) (M1033) RISK FOR HOSPITALIZATION: WHICH OF THE FOLLOWING SIGNS OR SYMPTOMS CHARACTERIZE THIS PATIENT AS AT RISK FOR HOSPITALIZATION? (MARK ALL THAT APPLY.)

3 - MULTIPLE HOSPITALIZATIONS (2 OR MORE) IN THE PAST 6 MONTHS

4 - MULTIPLE EMERGENCY DEPARTMENT VISITS (2 OR MORE) IN THE PAST 6 MONTHS

7 - CURRENTLY TAKING 5 OR MORE MEDICATIONS

8 - CURRENTLY REPORTS EXHAUSTION

WAS HEIGHT ASSESSED?

YES

(M1060A) HEIGHT (IN INCHES). RECORD MOST RECENT HEIGHT MEASURE SINCE THE MOST RECENT SOC/ROC, WHILE MEASURING IF THE NUMBER IS X.1 - X.4 ROUND DOWN; X.5 OR GREATER ROUND UP

75

WAS WEIGHT ASSESSED?

NOT ASSESSED

REASON WHY WEIGHT NOT ASSESSED (MARK ALL THAT APPLY)

IMMOBILITY

INDICATE CLIENT/CAREGIVER KNOWLEDGE DEFICITS: (SELECT ALL THAT APPLY)

**Visit Note Report**

Client: FINT, HARRY L  
 Client DOB: 10/23/1946  
 Insured ID: 7TR8K83JM21

MR No: 04200051925201 Legacy MR No:  
 Primary Payor: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

**ASSESSMENT**

TECHNICAL PROCEDURES - CLIENT  
 PATHOPHYSIOLOGY OF DISEASE - CLIENT  
 SIGNS AND SYMPTOMS TO REPORT - CLIENT  
 WHO AND WHEN TO CALL FOR HELP - CLIENT  
 SPECIAL DIET/FLUID RESTRICTIONS OR REQUIREMENTS - CLIENT  
 BASIC PRINCIPLES OF CARE - CLIENT  
 PROPER EQUIPMENT USE - CLIENT  
 HOME SAFETY/EMERGENCY PROCEDURES - CLIENT  
 REGULATORY INFORMATION (PATIENT RIGHTS, ADVANCE DIRECTIVES, ETC.) - CLIENT  
 MEDICATIONS - CLIENT

(B1300) HEALTH LITERACY (FROM CREATIVE COMMONS (C)): HOW OFTEN DO YOU NEED TO HAVE SOMEONE HELP YOU WHEN YOU READ INSTRUCTIONS, PAMPHLETS, OR OTHER WRITTEN MATERIAL FROM YOUR DOCTOR OR PHARMACY?

3. OFTEN

INITIAL ASSESSMENT PERFORMED. PATIENT MEETS ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES. PROCEED TO COMPREHENSIVE ASSESSMENT. AGREE.

YES

(A1250) TRANSPORTATION (NAHC (C)): HAS LACK OF TRANSPORTATION KEPT YOU FROM MEDICAL APPOINTMENTS, MEETINGS, WORK, OR FROM GETTING THINGS NEEDED FOR DAILY LIVING?

C. NO

**ENVIRONMENTAL**

(QM) (M1100) PATIENT LIVING SITUATION: WHICH OF THE FOLLOWING BEST DESCRIBES THE PATIENT'S RESIDENTIAL CIRCUMSTANCE AND AVAILABILITY OF ASSISTANCE? (CHECK ONE BOX ONLY).

B - PATIENT LIVES WITH OTHER PERSON(S) IN THE HOME

(QM) (M1100B) PATIENT LIVES WITH OTHER PERSON(S) IN THE HOME: WHICH OF THE FOLLOWING BEST DESCRIBES THE PATIENT'S AVAILABILITY OF ASSISTANCE AT THEIR RESIDENCE?

06 - AROUND THE CLOCK

**EYES/EARS/NOSE/THROAT**

INDICATE HEENT ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NECK STIFFNESS  
 HEARING AIDS  
 POOR DENTITION

(B1000) ABILITY TO SEE IN ADEQUATE LIGHT (WITH GLASSES OR OTHER VISUAL APPLIANCES)

1. IMPAIRED - SEES LARGE PRINT, BUT NOT REGULAR PRINT IN NEWSPAPERS/BOOKS

(B0200) ABILITY TO HEAR (WITH HEARING AID OR HEARING APPLIANCES IF NORMALLY USED)

2. MODERATE DIFFICULTY - SPEAKER HAS TO INCREASE VOLUME AND SPEAK DISTINCTLY

**PAIN**

IS PATIENT UNCOMFORTABLE BECAUSE OF PAIN?

YES

INDICATE WHICH PAIN INTENSITY SCALE USED:

NUMERIC PAIN SCALE

PAIN SCORE (0-10):

8

INDICATE LOCATION OF PAIN (MARK ALL THAT APPLY):

SHOULDERS  
 BACK  
 RIGHT LOWER EXTREMITY  
 LEFT LOWER EXTREMITY  
 RIGHT FOOT  
 LEFT FOOT

## Visit Note Report

Client: FINT, HARRY L  
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MR No: 04200051925201 Legacy MR No:  
 Primary Payer: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

<b>PAIN ASSESSMENT</b>	
<p><b>HOW DOES THE PATIENT DESCRIBE THE CHARACTER OF PAIN: (MARK ALL THAT APPLY)</b></p> <p>BURNING      NUMBNESS      SORE      TENDER      TINGLING</p> <p><b>INDICATE FREQUENCY OF PAIN INTERFERING WITH FUNCTION OR QUALITY OF LIFE:</b></p> <p>ALL OF THE TIME</p> <p><b>INDICATE DURATION OF PATIENT'S PAIN:</b></p> <p>CONTINUOUS</p> <p><b>INDICATE WHAT RELIEVES PAIN:</b></p> <p>REST      POSITIONING      PRESCRIPTION PAIN MEDICATIONS</p> <p><b>INDICATE WHAT EXACERBATES PAIN: (MARK ALL THAT APPLY)</b></p> <p>TRANSITIONAL MOVEMENT      ALL ACTIVITY</p> <p>(J0510) PAIN EFFECT ON SLEEP: ASK PATIENT: "OVER THE PAST 5 DAYS, HOW MUCH OF THE TIME HAS PAIN MADE IT HARD FOR YOU TO SLEEP AT NIGHT?"      4. ALMOST CONSTANTLY</p> <p>(J0520) PAIN INTERFERENCE WITH THERAPY ACTIVITIES: ASK PATIENT: "OVER THE PAST 5 DAYS, HOW OFTEN HAVE YOU LIMITED YOUR PARTICIPATION IN REHABILITATION THERAPY SESSIONS DUE TO PAIN?"      0. DOES NOT APPLY - I HAVE NOT RECEIVED REHABILITATION THERAPY IN THE PAST 5 DAYS</p> <p>(J0530) PAIN INTERFERENCE WITH DAY-TO-DAY ACTIVITIES: ASK PATIENT: "OVER THE PAST 5 DAYS, HOW OFTEN HAVE YOU LIMITED YOUR DAY-TO-DAY ACTIVITIES (EXCLUDING REHABILITATION THERAPY SESSIONS) BECAUSE OF PAIN?"      4. ALMOST CONSTANTLY</p> <p>ARE THERE ANY ADDITIONAL DETAILS THAT NEED TO BE PROVIDED TO DESCRIBE THE CLIENT'S PAIN?      NO</p> <p><b>INTEGUMENTARY</b></p> <p><b>BRADEN COPYRIGHT USE ONLY</b></p> <p><b>BRADEN ASSESSMENT</b></p> <p><b>SENSORY PERCEPTION - ABILITY TO RESPOND MEANINGFULLY TO PRESSURE-RELATED DISCOMFORT</b>    NO IMPAIRMENT - RESPONDS TO VERBAL COMMANDS. HAS NO SENSORY DEFICIT WHICH WOULD LIMIT ABILITY TO FEEL OR VOICE PAIN OR DISCOMFORT.</p> <p><b>MOISTURE - DEGREE TO WHICH SKIN IS EXPOSED TO MOISTURE</b>    OFTEN MOIST - SKIN IS OFTEN BUT NOT ALWAYS MOIST. LINEN MUST BE CHANGED AS OFTEN AS 3 TIMES IN 24 HOURS.</p> <p><b>ACTIVITY - DEGREE OF PHYSICAL ACTIVITY</b>    CHAIRFAST - ABILITY TO WALK SEVERELY LIMITED OR NON-EXISTENT. CANNOT BEAR OWN WEIGHT AND/OR MUST BE ASSISTED INTO CHAIR OR WHEELCHAIR.</p> <p><b>MOBILITY - ABILITY TO CHANGE AND CONTROL BODY POSITION</b>    VERY LIMITED - MAKES OCCASIONAL SLIGHT CHANGES IN BODY OR EXTREMITY POSITION BUT UNABLE TO MAKE FREQUENT OR SIGNIFICANT CHANGES INDEPENDENTLY.</p> <p><b>NUTRITION - USUAL FOOD INTAKE PATTERN</b>    ADEQUATE - EATS OVER HALF OF MOST MEALS. EATS A TOTAL OF 4 SERVINGS OF PROTEIN (MEAT, DAIRY PRODUCTS) PER DAY. OCCASIONALLY WILL REFUSE A MEAL, BUT WILL USUALLY TAKE A SUPPLEMENT WHEN OFFERED, OR IS ON A TUBE FEEDING OR TPN REGIMENT, WHICH PROBABLY MEETS MOST OF NUTRITIONAL NEEDS.</p> <p><b>FRICITION AND SHEAR</b>    PROBLEM - REQUIRES MODERATE TO MAXIMUM ASSISTANCE IN MOVING. COMPLETE LIFTING WITHOUT SLIDING AGAINST SHEETS IS IMPOSSIBLE. FREQUENTLY SLIDES DOWN IN BED OR CHAIR, REQUIRING FREQUENT REPOSITIONING WITH MAXIMUM ASSISTANCE. SPASTICITY, CONTRACTURES, OR AGITATION LEADS TO ALMOST CONSTANT FRICTION.</p>	

**Visit Note Report**

Client: FINT, HARRY L  
 Client DOB: 10/23/1946  
 Insured ID: 7TR8K63JM21

MR No: 04200051925201 Legacy MR No:  
 Primary Payor: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

<u>ASSESSMENT</u>	
<u>TOTAL SCORE (PATIENTS WITH A TOTAL SCORE OF 12 OR LESS ARE CONSIDERED TO BE AT HIGH RISK OF DEVELOPING PRESSURE ULCERS):</u> <b>14</b>	
<u>INDICATE THE BRADEN RISK LEVEL PRESENTED:</u> <b>MODERATE RISK (13 - 14)</b>	
<u>(D) (CC) (QM) (M1306) DOES THE PATIENT HAVE AT LEAST ONE UNHEALED PRESSURE ULCER/INJURY AT STAGE 2 OR HIGHER OR DESIGNATED AS UNSTAGEABLE? (EXCLUDES STAGE 1 PRESSURE INJURIES AND ALL HEALED PRESSURE ULCERS/INJURIES)</u> <b>1 - YES</b>	
<u>(D) (QM) (PRA) (M1311 A1) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT STAGE 2: PARTIAL THICKNESS LOSS OF DERMIS PRESENTING AS A SHALLOW OPEN ULCER WITH A RED OR PINK WOUND BED, WITHOUT SLOUGH, MAY ALSO PRESENT AS AN INTACT OR OPEN/RUPTURED BLISTER.</u> <b>1</b>	
<u>(D) (QM) (PRA) (M1311 B1) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT STAGE 3: FULL THICKNESS TISSUE LOSS. SUBCUTANEOUS FAT MAY BE VISIBLE BUT BONE, TENDON, OR MUSCLE IS NOT EXPOSED. SLOUGH MAY BE PRESENT BUT DOES NOT OBSCURE THE DEPTH OF TISSUE LOSS. MAY INCLUDE UNDERMINING AND TUNNELING.</u> <b>0</b>	
<u>(D) (QM) (PRA) (M1311 C1) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT STAGE 4: FULL THICKNESS TISSUE LOSS WITH EXPOSED BONE, TENDON, OR MUSCLE. SLOUGH OR ESCHAR MAY BE PRESENT ON SOME PARTS OF THE WOUND BED. OFTEN INCLUDES UNDERMINING AND TUNNELING.</u> <b>0</b>	
<u>(D) (QM) (PRA) (M1311 D1) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT UNSTAGEABLE: NON-REMOVABLE DRESSING/DEVICE; KNOWN BUT NOT STAGEABLE DUE TO NON-REMOVABLE DRESSING/DEVICE.</u> <b>0</b>	
<u>(D) (QM) (PRA) (M1311 E1) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT UNSTAGEABLE: SLOUGH AND/OR ESCHAR: KNOWN BUT NOT STAGEABLE DUE TO COVERAGE OF WOUND BED BY SLOUGH AND/OR ESCHAR.</u> <b>0</b>	
<u>(D) (OM) (PRA) (M1311 F1) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT UNSTAGEABLE: DEEP TISSUE INJURY.</u> <b>0</b>	
<u>(D) (QM) (PRA) (M1322) CURRENT NUMBER OF STAGE 1 PRESSURE INJURIES: INTACT SKIN WITH NON-BLANCHABLE REDNESS OF A LOCALIZED AREA USUALLY OVER A BONY PROMINENCE. DARKLY PIGMENTED SKIN MAY NOT HAVE A VISIBLE BLANCHING; IN DARK SKIN TONES ONLY IT MAY APPEAR WITH PERSISTENT BLUE OR PURPLE HUES.</u> <b>0</b>	
<u>(D) (QM) (PRA) (M1324) STAGE OF MOST PROBLEMATIC UNHEALED PRESSURE ULCER/INJURY THAT IS STAGEABLE: (EXCLUDES PRESSURE ULCER/INJURY THAT CANNOT BE STAGED DUE TO A NON-REMOVABLE DRESSING/DEVICE, COVERAGE OF WOUND BED BY SLOUGH AND/OR ESCHAR, OR DEEP TISSUE INJURY.)</u> <b>2 - STAGE 2</b>	
<u>(C1) (PRA) (M1330) DOES THIS PATIENT HAVE A STASIS ULCER?</u> <b>0 - NO</b>	
<u>(CC) (QM) (PRA) (M1340) DOES THIS PATIENT HAVE A SURGICAL WOUND?</u> <b>0 - NO</b>	
<u>INDICATE INTEGUMENTARY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)</u> <b>BRUISING</b> <b>RASH</b> <b>WOUND(S)</b>	
<u>CARDIOVASCULAR</u>	
<u>CARDIOVASCULAR ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)</u> <b>ARRHYTHMIA</b> <b>EDEMA</b> <b>HYPERTENSION</b> <b>OTHER (SPECIFY)</b>	
<u>INDICATE LOCATION OF EDema:</u> <b>LOWER RIGHT</b>	

**Visit Note Report**

Client: FINT, HARRY L  
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 Insured ID: 7TR8K83JM21

MR No: 04200051925201 Legacy MR No:  
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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

**ASSESSMENT****LOWER LEFT**

INDICATE OTHER CARDIOVASCULAR ISSUE(S):

CHF

**RESPIRATORY**

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

O2 USE

SHORTNESS OF BREATH

INDICATE RATE/ROUTE OF O2 ADMINISTRATION:

2L NC

(QM) (PRA) (M1400) WHEN IS THE PATIENT DYSPNEIC OR NOTICEABLY SHORT OF BREATH?

3 - WITH MINIMAL EXERTION (FOR EXAMPLE, WHILE EATING, TALKING, OR PERFORMING OTHER ADLS) OR WITH AGITATION

**GENITOURINARY**

INDICATE GENITOURINARY ASSESSMENT: (MARK ALL THAT APPLY)

WNL

(QM) (M1600) HAS THIS PATIENT BEEN TREATED FOR A URINARY TRACT INFECTION IN THE PAST 14 DAYS?

1 - YES

(C1) (QM) (PRA) (M1610) URINARY INCONTINENCE OR URINARY CATHETER PRESENCE:

0 - NO INCONTINENCE OR CATHETER (INCLUDES ANURIA OR OSTOMY FOR URINARY DRAINAGE)

**GASTROINTESTINAL**

INDICATE GASTROINTESTINAL ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

WNL

INDICATE DATE OF LAST BOWEL MOVEMENT:

6/20/2025

(QM) (M1620) BOWEL INCONTINENCE FREQUENCY:

0 - VERY RARELY OR NEVER HAS BOWEL INCONTINENCE

(C1) (PRA) (M1630) OSTOMY FOR BOWEL ELIMINATION: DOES THIS PATIENT HAVE AN OSTOMY FOR BOWEL ELIMINATION THAT (WITHIN THE LAST 14 DAYS): A) WAS RELATED TO AN INPATIENT FACILITY STAY; OR B) NECESSITATED A CHANGE IN MEDICAL OR TREATMENT REGIMENT?

0 - PATIENT DOES NOT HAVE AN OSTOMY FOR BOWEL ELIMINATION.

**NUTRITIONAL**

INDICATE NUTRITIONAL ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

PATIENT HAS AN ILLNESS OR CONDITION WHICH MADE HIM/HER CHANGE THE KIND AND/OR AMOUNT OF FOOD THEY EAT

PATIENT HAS TOOTH OR MOUTH PROBLEMS THAT MAKE IT HARD FOR THEM TO EAT

PATIENT EATS ALONE MOST OF THE TIME

PATIENT TAKES 3 OR MORE PRESCRIBED OR OVER THE COUNTER DRUGS PER DAY

PATIENT NOT ALWAYS PHYSICALLY ABLE TO SHOP, COOK, AND/OR FEED SELF

TOTAL NUTRITION ASSESSMENT SCORE:

8

BASED ON THE SCORE, THE NUTRITIONAL RISK LEVEL IS:

PATIENT IS AT A HIGH NUTRITIONAL RISK

DID THE PATIENT SCORE 6 OR ABOVE ON THE NUTRITIONAL ASSESSMENT?

YES - COMPLETE THE LEVEL II NUTRITIONAL RISK ASSESSMENT

1. WEIGHT LOSS DURING LAST 3 MONTHS

D. NO WEIGHT LOSS AT ALL = 3 POINTS

2. LIVES INDEPENDENTLY

A. NO = 0 POINTS

3. TAKES MORE THAN 3 PRESCRIPTION DRUGS PER DAY

ABX = 0 POINTS

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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

**ASSESSMENT****DIURETIC = 0 POINTS**

4. HAS SUFFERED PSYCHOLOGICAL STRESS OR ACUTE DISEASE IN THE PAST 3 MONTHS

B. NO = 2 POINTS

**5. MOBILITY**

A. BED OR CHAIR BOUND = 0 POINTS

**6. NEUROPSYCHOLOGICAL PROBLEMS**

C. NO PSYCHOLOGICAL PROBLEMS = 2 POINTS

**7. PRESSURE SORES OR SKIN ULCERS**

A. YES = 0 POINTS

**8. HOW MANY MEALS DOES THE CLIENT EAT DAILY?**

C. 3 MEALS = 3 POINTS

**9. SNACKS DURING DAY/NIGHT**

A. YES = 1 POINT

**10. SELECTED CONSUMPTION MARKERS FOR PROTEIN INTAKE: DAIRY PRODUCTS (MILK, CHEESE, YOGURT, ICE CREAM, ETC.)**

B. 2 SERVINGS/DAY = 2 POINTS

**10. SELECTED CONSUMPTION MARKERS FOR PROTEIN INTAKE: MEAT PRODUCTS (BEEF, CHICKEN, FISH, TURKEY)**

B. 2 SERVINGS/DAY = 2 POINTS

**10. SELECTED CONSUMPTION MARKERS FOR PROTEIN INTAKE: LEGUME/EGGS**

A. 1 SERVING/DAY = 1 POINT

**11. HAS FOOD INTAKE DECLINED OVER PAST 3 MONTHS DUE TO LOSS OF APPETITE, DIGESTIVE PROBLEMS, OR SWALLOWING DIFFICULTIES?**

C. NO LOSS OF APPETITE = 2 POINTS

**12. FLUID INTAKE CONSUMED PER DAY**

B. MORE THAN 4 CUPS = 1 POINT

**13. MODE OF FEEDING**

C. SELF-FED WITHOUT ANY PROBLEM = 2 POINTS

**14. LEVEL OF UNDERSTANDING OF THEIR CURRENT DIET**

B. FAIR UNDERSTANDING = 1 POINT

**15. DOES THE CLIENT VIEW HIM/HERSELF AS HAVING ANY NUTRITIONAL PROBLEMS?**

B. DO NOT KNOW OR MODERATE MALNUTRITION = 1 POINT

**16. IN COMPARISON WITH OTHER PEOPLE OF THE SAME AGE, HOW DOES THE CLIENT CONSIDER THEIR HEALTH STATUS?**

B. AS GOOD = 1 POINT

**TOTAL MALNUTRITION INDICATOR SCORE:**

24

**BASED ON THE MALNUTRITION INDICATOR SCORE, THE PATIENT'S RISK FOR MALNUTRITION IS:**

WELL NOURISHED

**(K05201) NUTRITIONAL APPROACHES: CHECK ALL OF THE NUTRITIONAL APPROACHES THAT APPLY ON ADMISSION.**

D. THERAPEUTIC DIET (E.G., LOW SALT, DIABETIC, LOW CHOLESTEROL)

**ENDOCRINE/IMMUNOLOGIC/HEMATOPOIETIC****INDICATE IMMUNOLOGIC ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)**

WNL

**INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)**

ANTICOAGULANT THERAPY

DIABETES

THYROID PROBLEMS

**PSYCHIATRIC**

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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

<b>ASSESSMENT</b>		
<b>DOES THE PATIENT TAKE A PSYCHOTROPIC MEDICATION?</b>		
NO		
<b>WERE BEHAVIORAL SCALES ASSESSMENTS COMPLETED?</b>		
YES		
<b>INDICATE WHICH PSYCHIATRIC SCALES ASSESSMENTS WERE COMPLETED (MARK ALL THAT APPLY):</b>		
YESAVAGE GERIATRIC DEPRESSION SCALE		
<b>WAS THE YESAVAGE GERIATRIC DEPRESSION SCALE COMPLETED?</b>		
YES		
<b>ARE YOU BASICALLY SATISFIED WITH YOUR LIFE?</b>		
YES		
<b>HAVE YOU DROPPED MANY OF YOUR ACTIVITIES AND INTERESTS?</b>		
YES (SCORE ONE POINT)		
<b>DO YOU FEEL THAT YOUR LIFE IS EMPTY?</b>		
NO		
<b>DO YOU OFTEN GET BORED?</b>		
NO		
<b>ARE YOU IN GOOD SPIRITS MOST OF THE TIME?</b>		
YES		
<b>ARE YOU AFRAID THAT SOMETHING BAD IS GOING TO HAPPEN TO YOU?</b>		
NO		
<b>DO YOU FEEL HAPPY MOST OF THE TIME?</b>		
YES		
<b>DO YOU OFTEN FEEL HELPLESS?</b>		
NO		
<b>DO YOU PREFER TO STAY AT HOME RATHER THAN GO OUT AND DO NEW THINGS?</b>		
NO		
<b>DO YOU FEEL YOU HAVE MORE PROBLEMS WITH MEMORY THAN MOST?</b>		
NO		
<b>DO YOU THINK IT IS WONDERFUL TO BE ALIVE NOW?</b>		
YES		
<b>DO YOU FEEL PRETTY WORTHLESS THE WAY YOU ARE NOW?</b>		
NO		
<b>DO YOU FEEL FULL OF ENERGY?</b>		
NO (SCORE ONE POINT)		
<b>DO YOU FEEL THAT YOUR SITUATION IS HOPELESS?</b>		
NO		
<b>DO YOU THINK THAT MOST PEOPLE ARE BETTER OFF THAN YOU ARE?</b>		
NO		
<b>YESAVAGE GERIATRIC DEPRESSION SCALE - TOTAL SCORE</b>		
2		
<b>YESAVAGE GERIATRIC DEPRESSION SCALE - RISK</b>		
NORMAL		
<b>COGNITIVE/BEHAVIORAL/NEURO</b>		
(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.		
0 - ALERT/ORIENTED, ABLE TO FOCUS AND SHIFT ATTENTION, COMPREHENDS AND RECALLS TASK DIRECTIONS INDEPENDENTLY.		

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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:

0 - NEVER

(QM) (M1720) WHEN ANXIOUS (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:

0 - NONE OF THE TIME

(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED); (MARK ALL THAT APPLY)

2 - IMPAIRED DECISION-MAKING: FAILURE TO PERFORM USUAL ADLs OR IADLs, INABILITY TO APPROPRIATELY STOP ACTIVITIES, JEOPARDIZES SAFETY THROUGH ACTIONS

(QM) (M1745) FREQUENCY OF DISRUPTIVE BEHAVIOR SYMPTOMS (REPORTED OR OBSERVED) ANY PHYSICAL, VERBAL, OR OTHER DISRUPTIVE/DANGEROUS SYMPTOMS THAT ARE INJURIOUS TO SELF OR OTHERS OR JEOPARDIZE PERSONAL SAFETY.

2 - ONCE A MONTH

(C0100) SHOULD BRIEF INTERVIEW FOR MENTAL STATUS (C0200-C0500) BE CONDUCTED? ATTEMPT TO CONDUCT INTERVIEW WITH ALL PATIENTS.

1. YES

(C0200) REPETITION OF THREE WORDS: ASK PATIENT "I AM GOING TO SAY THREE WORDS FOR YOU TO REMEMBER. PLEASE REPEAT THE WORDS AFTER I HAVE SAID ALL THREE. THE WORDS ARE: SOCK, BLUE, AND BED. NOW TELL ME THE THREE WORDS." AFTER THE PATIENT'S FIRST ATTEMPT, REPEAT THE WORDS USING CUES ("SOCK, SOMETHING TO WEAR; BLUE, A COLOR; BED, A PIECE OF FURNITURE"). YOU MAY REPEAT THE WORDS UP TO TWO MORE TIMES. NUMBER OF WORDS REPEATED AFTER FIRST ATTEMPT.

3. THREE

(C0300A) TEMPORAL ORIENTATION (ORIENTATION TO YEAR, MONTH, AND DAY): ASK PATIENT: "PLEASE TELL ME WHAT YEAR IT IS RIGHT NOW." ABLE TO REPORT CORRECT YEAR?

3. CORRECT

(C0300B) TEMPORAL ORIENTATION (ORIENTATION TO YEAR, MONTH, AND DAY): ASK PATIENT: "WHAT MONTH ARE WE IN RIGHT NOW?" ABLE TO REPORT CORRECT MONTH?

2. ACCURATE WITHIN 5 DAYS

(C0300C) TEMPORAL ORIENTATION (ORIENTATION TO YEAR, MONTH, AND DAY): ASK PATIENT: "WHAT DAY OF THE WEEK IS TODAY?" ABLE TO REPORT CORRECT DAY OF THE WEEK?

1. CORRECT

(C0400A) RECALL: ASK PATIENT: "LET'S GO BACK TO AN EARLIER QUESTION. WHAT WERE THOSE THREE WORDS THAT I ASKED YOU TO REPEAT?" IF UNABLE TO REMEMBER A WORD, GIVE A CUE (SOMETHING TO WEAR; A COLOR; A PIECE OF FURNITURE) FOR THAT WORD. ABLE TO RECALL "SOCK"?

2. YES, NO CUE REQUIRED

(C0400B) RECALL: ASK PATIENT: "LET'S GO BACK TO AN EARLIER QUESTION. WHAT WERE THOSE THREE WORDS THAT I ASKED YOU TO REPEAT?" IF UNABLE TO REMEMBER A WORD, GIVE A CUE (SOMETHING TO WEAR; A COLOR; A PIECE OF FURNITURE) FOR THAT WORD. ABLE TO RECALL "BLUE"?

2. YES, NO CUE REQUIRED

(C0400C) RECALL: ASK PATIENT: "LET'S GO BACK TO AN EARLIER QUESTION. WHAT WERE THOSE THREE WORDS THAT I ASKED YOU TO REPEAT?" IF UNABLE TO REMEMBER A WORD, GIVE A CUE (SOMETHING TO WEAR; A COLOR; A PIECE OF FURNITURE) FOR THAT WORD. ABLE TO RECALL "BED"?

2. YES, NO CUE REQUIRED

### BIMS SCORING SCRIPTS

15

(C0500) BIMS SUMMARY SCORE: ADD SCORES FOR QUESTIONS C0200-C0400 AND FILL IN TOTAL SCORE (00-15). ENTER 99 IF THE PATIENT WAS UNABLE TO COMPLETE THE INTERVIEW.

15.0

### INDICATE LEVEL OF COGNITIVE IMPAIRMENT

13 - 15: COGNITIVELY INTACT

(E1) (D0150) PATIENT MOOD INTERVIEW (PHQ-2 TO 9) PFIZER®: DETERMINE IF THE PATIENT IS RARELY/NEVER UNDERSTOOD VERBALLY, IN WRITING, OR USING ANOTHER METHOD. IF RARELY/NEVER UNDERSTOOD, CODE D0150A1 AND D0150B1 AS 9. NO RESPONSE, LEAVE D0150A2 AND D0150B2 BLANK. END THE PHQ-2 INTERVIEW, AND LEAVE D0160 TOTAL SEVERITY SCORE BLANK. OTHERWISE, SAY TO PATIENT: "OVER THE LAST 2 WEEKS, HAVE YOU BEEN BOthered BY ANY OF THE FOLLOWING PROBLEMS? READ AND SHOW THE PATIENT A CARD WITH SYMPTOM FREQUENCY CHOICES.

(D0150A1) SYMPTOM PRESENCE: LITTLE INTEREST OR PLEASURE IN DOING THINGS

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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

0. NO

(D0150B1) SYMPTOM PRESENCE: FEELING DOWN, DEPRESSED, OR HOPELESS

0. NO

DID THE PATIENT RESPOND WITH A SYMPTOM PRESENCE OF "NOT ASSESSED/NO INFORMATION" OR A SYMPTOM FREQUENCY OF "7 - 11 DAYS" OR "12 - 14 DAYS"?

NO - END PHQ INTERVIEW

(D0160) ADD SCORES FOR ALL FREQUENCY RESPONSES FOR SYMPTOM FREQUENCY. TOTAL SCORE MUST BE BETWEEN 00 AND 27. ENTER 99 IF UNABLE TO COMPLETE INTERVIEW (I.E., SYMPTOM FREQUENCY IS BLANK FOR 3 OR MORE REQUIRED ITEMS)

0

(C1310A) SIGNS AND SYMPTOMS OF DELIRIUM (FROM CAM (C)): CODE AFTER COMPLETING BRIEF INTERVIEW FOR MENTAL STATUS AND REVIEWING MEDICAL RECORD - ACUTE ONSET OF MENTAL STATUS CHANGE, IS THERE EVIDENCE OF AN ACUTE CHANGE IN MENTAL STATUS FROM PATIENT'S BASELINE?

0. NO

(C1310B) INATTENTION - DID THE PATIENT HAVE DIFFICULTY FOCUSING ATTENTION, FOR EXAMPLE, BEING EASILY DISTRACTIBLE OR HAVING DIFFICULTY KEEPING TRACK OF WHAT WAS BEING SAID?

0. BEHAVIOR NOT PRESENT

(C1310C) DISORGANIZED THINKING - WAS THE PATIENT'S THINKING DISORGANIZED OR INCOHERENT (RAMBLING OR IRRELEVANT CONVERSATION, UNCLEAR OR ILLLOGICAL FLOW OF IDEAS, OR UNPREDICTABLE SWITCHING FROM SUBJECT TO SUBJECT)?

0. BEHAVIOR NOT PRESENT

(C1310D) ALTERED LEVEL OF CONSCIOUSNESS - DID THE PATIENT HAVE ALTERED LEVEL OF CONSCIOUSNESS, AS INDICATED BY ANY OF THE FOLLOWING CRITERIA? VIGILANT - STARTLED EASILY TO ANY SOUND OR TOUCH; LETHARGIC - REPEATEDLY DOZED OFF WHEN BEING ASKED QUESTIONS, BUT RESPONDED TO VOICE OR TOUCH; STUPOROUS - VERY DIFFICULT TO AROUSE AND KEEP AROUSED FOR THE INTERVIEW; COMATOSE - COULD NOT BE AROUSED

0. BEHAVIOR NOT PRESENT

(D0700) SOCIAL ISOLATION: HOW OFTEN DO YOU FEEL LONELY OR ISOLATED FROM THOSE AROUND YOU?

1. RARELY

INDICATE CLIENT'S MENTAL STATUS: (MARK ALL THAT APPLY)

ALERT

ORIENTED TO PERSON

ORIENTED TO PLACE

ORIENTED TO TIME

ABLE TO FOLLOW SIMPLE COMMANDS

INDICATE ABNORMAL NEUROLOGIC FINDINGS: (MARK ALL THAT APPLY)

WNL

FUNCTIONAL

COMPLETE MAHC-10 FALLS RISK ASSESSMENT

OK

SELECT APPROPRIATE RISK FACTORS. EACH SELECTION = 1 POINT

AGE 65+

DIAGNOSIS (3 OR MORE COEXISTING)

INCONTINENCE -- INABILITY TO MAKE IT TO THE BATHROOM OR COMMODE IN TIMELY MANNER INCLUDES FREQUENCY, URGENCY, AND/OR NOCTURIA

IMPAIRED FUNCTIONAL MOBILITY -- MAY INCLUDE PATIENTS WHO NEED HELP WITH IADLS OR ADLs OR HAVE GAIT OR TRANSFER PROBLEMS, ARTHRITIS, PAIN, FEAR OF FALLING, FOOT PROBLEMS, IMPAIRED SENSATION IMPAIRED COORDINATION OR IMPROPER USE OF ASSISTIVE DEVICES.

ENVIRONMENTAL HAZARDS -- MAY INCLUDE POOR ILLUMINATION, EQUIPMENT TUBING, INAPPROPRIATE FOOTWEAR, PETS, HARD TO REACH ITEMS, UNEVEN FLOOR SURFACES, CLUTTER, OUTDOOR ENTRY AND EXITS, LIVES ALONE, BATHROOM ADAPTIVE EQUIPMENT NEEDS, THROW RUGS.

POLY PHARMACY (4 OR MORE PRESCRIPTIONS - ANY TYPE) -- ALL PRESCRIPTIONS INCLUDING PRESCRIPTIONS FOR OTC MEDS. DRUGS HIGHLY ASSOCIATED WITH FALL RISK INCLUDE BUT NOT LIMITED TO, SEDATIVES, ANTIDEPRESSANTS, TRANQUILIZERS, NARCOTICS, ANTIHYPERTENSIVES, CARDIAC MEDS, CORTICOSTEROIDS, ANTI-ANXIETY DRUGS, ANTICHOLINERGIC DRUGS, AND HYPOGLYCEMIC DRUGS.

PAIN AFFECTING LEVEL OF FUNCTION -- PAIN AFFECTS AN INDIVIDUAL'S DESIRE OR ABILITY TO MOVE, PAIN IS A FACTOR IN PATIENT'S DEPRESSION AND/OR COMPLIANCE WITH SAFETY RECOMMENDATIONS.

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ASSESSMENT	
<u>ACCORDING TO THE MAHC 10 FALL RISK ASSESSMENT, THIS PATIENT'S SCORE IS:</u> <b>7</b> <u>BASED ON THE SCORE, THE PATIENT IS:</u> <b>RISK OF FALLING</b> <u>INDICATE FUNCTIONAL ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)</u> <b>DECREASED STRENGTH</b> <b>SWELLING</b> <u>DURABLE MEDICAL EQUIPMENT RECOMMENDED: (MARK ALL THAT APPLY)</u> <b>POWER WHEELCHAIR</b> <b>HAND HELD SHOWER</b> <b>LONG BATH SPONGE</b> <b>HOSPITAL BED</b> <b>TRAPEZE</b> <b>MECHANICAL LIFT</b> <b>TRANSFER BOARD</b> <b>GAIT BELT</b> <b>REACHER</b> <b>GRAB BARS</b> <b>GLUCOMETER</b> <b>OXYGEN</b>	
<u>(C1) (QM) (PRA) (M1800) GROOMING: CURRENT ABILITY TO TEND SAFELY TO PERSONAL HYGIENE NEEDS (SPECIFICALLY: WASHING FACE AND HANDS, HAIR CARE, SHAVING OR MAKE UP, TEETH OR DENTURE CARE, OR FINGERNAIL CARE).</u> <b>2 - SOMEONE MUST ASSIST THE PATIENT TO GROOM SELF</b> <u>(E)(GG0130B1) SELF-CARE ORAL HYGIENE SOC/ROC PERFORMANCE: THE ABILITY TO USE SUITABLE ITEMS TO CLEAN TEETH, DENTURES (IF APPLICABLE), THE ABILITY TO INSERT AND REMOVE DENTURES INTO AND FROM MOUTH, AND MANAGE DENTURE SOAKING AND RINSING WITH USE OF EQUIPMENT. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON, CODING, SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</u> <b>02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT</b> <u>(QM) (M1810) CURRENT ABILITY TO DRESS UPPER BODY SAFELY (WITH OR WITHOUT DRESSING AIDS) INCLUDING UNDERGARMENTS, PULLOVERS, FRONT-OPENING SHIRTS AND BLOUSES, MANAGING ZIPPERS, BUTTONS, AND SNAPS:</u> <b>2 - SOMEONE MUST HELP THE PATIENT PUT ON UPPER BODY CLOTHING</b> <u>(E)(GG0130F1) SELF-CARE UPPER BODY DRESSING SOC/ROC PERFORMANCE: THE ABILITY TO DRESS AND UNDRESS ABOVE THE WAIST, INCLUDING FASTENERS, IF APPLICABLE. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON, CODING, SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</u> <b>02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT</b> <u>(QM) (M1820) CURRENT ABILITY TO DRESS LOWER BODY SAFELY (WITH OR WITHOUT DRESSING AIDS) INCLUDING UNDERGARMENTS, SLACKS, SOCKS OR NYLONS, SHOES:</u> <b>2 - SOMEONE MUST HELP PATIENT PUT ON UNDERGARMENTS, SLACKS, SOCKS OR NYLONS, AND SHOES</b> <u>(E)(GG0130G1) SELF-CARE LOWER BODY DRESSING SOC/ROC PERFORMANCE: THE ABILITY TO DRESS AND UNDRESS BELOW THE WAIST, INCLUDING FASTENERS, DOES NOT INCLUDE FOOTWEAR. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON, CODING, SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</u> <b>02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT</b>	

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(E)(GG0130H1) SELF-CARE PUTTING ON/TAKING OFF FOOTWEAR SOC/ROC PERFORMANCE: THE ABILITY TO PUT ON AND TAKE OFF SOCKS AND SHOES OR OTHER FOOTWEAR THAT IS APPROPRIATE FOR SAFE MOBILITY; INCLUDING FASTENERS, IF APPLICABLE. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

**02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT**

(QM) (M1870) FEEDING OR EATING: CURRENT ABILITY TO FEED SELF MEALS AND SNACKS SAFELY. NOTE: THIS REFERS ONLY TO THE PROCESS OF EATING, CHEWING, AND SWALLOWING, NOT PREPARING THE FOOD TO BE EATEN.

**0 - ABLE TO INDEPENDENTLY FEED SELF**

(E)(GG0130A1) SELF-CARE EATING SOC/ROC PERFORMANCE: THE ABILITY TO USE SUITABLE UTENSILS TO BRING FOOD AND/OR LIQUID TO THE MOUTH AND SWALLOW FOOD AND/OR LIQUID ONCE THE MEAL IS PLACED BEFORE THE PATIENT. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

**05. SETUP OR CLEAN-UP ASSISTANCE - HELPER SETS UP OR CLEANS UP; PATIENT COMPLETES ACTIVITY. HELPER ASSISTS ONLY PRIOR TO OR FOLLOWING THE ACTIVITY**

(QM) (M1830) BATHING: CURRENT ABILITY TO WASH ENTIRE BODY SAFELY, EXCLUDES GROOMING (WASHING FACE, WASHING HANDS AND SHAMPOOING HAIR)

**6 - UNABLE TO PARTICIPATE EFFECTIVELY IN BATHING AND IS BATHED TOTALLY BY ANOTHER PERSON.**

(E)(GG0130E1) SELF-CARE SHOWER/BATHE SELF SOC/ROC PERFORMANCE: THE ABILITY TO BATHE SELF, INCLUDING WASHING, RINSING, AND DRYING SELF (EXCLUDES WASHING OF BACK AND HAIR). DOES NOT INCLUDE TRANSFERRING IN/OUT OF TUB/SHOWER. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

**01. DEPENDENT - HELPER DOES ALL OF THE EFFORT. PATIENT DOES NONE OF THE EFFORT TO COMPLETE THE ACTIVITY. OR, THE ASSISTANCE OF 2 OR MORE HELPERS IS REQUIRED FOR THE PATIENT TO COMPLETE THE ACTIVITY**

(QM) (M1840) TOILET TRANSFERRING: CURRENT ABILITY TO GET TO AND FROM THE TOILET OR BEDSIDE COMMODE SAFELY AND TRANSFER ON AND OFF TOILET/COMMODE.

**4 - IS TOTALLY DEPENDENT IN TOILETING.**

(E)(GG0170F1) MOBILITY TOILET TRANSFER SOC/ROC PERFORMANCE: THE ABILITY TO GET ON AND OFF A TOILET OR COMMODE. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

**01. DEPENDENT - HELPER DOES ALL OF THE EFFORT. PATIENT DOES NONE OF THE EFFORT TO COMPLETE THE ACTIVITY. OR, THE ASSISTANCE OF 2 OR MORE HELPERS IS REQUIRED FOR THE PATIENT TO COMPLETE THE ACTIVITY**

(QM) (M1845) TOILETING HYGIENE: CURRENT ABILITY TO MAINTAIN PERINEAL HYGIENE SAFELY, ADJUST CLOTHES AND/OR INCONTINENCE PADS BEFORE AND AFTER USING TOILET, COMMODE, BEDPAN, URINAL. IF MANAGING OSTOMY, INCLUDE CLEANING AREA AROUND STOMA, BUT NOT MANAGING EQUIPMENT.

**3 - PATIENT DEPENDS ENTIRELY UPON ANOTHER PERSON TO MAINTAIN TOILETING HYGIENE.**

(E)(GG0130C1) SELF-CARE TOILETING HYGIENE SOC/ROC PERFORMANCE: THE ABILITY TO MAINTAIN PERINEAL HYGIENE, ADJUST CLOTHES BEFORE AND AFTER VOIDING OR HAVING A BOWEL MOVEMENT. IF MANAGING AN OSTOMY, INCLUDE WIPING THE OPENING BUT NOT MANAGING EQUIPMENT. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

**01. DEPENDENT - HELPER DOES ALL OF THE EFFORT. PATIENT DOES NONE OF THE EFFORT TO COMPLETE THE ACTIVITY. OR, THE ASSISTANCE OF 2 OR MORE HELPERS IS REQUIRED FOR THE PATIENT TO COMPLETE THE ACTIVITY**

(QM) (M1850) TRANSFERRING: CURRENT ABILITY TO MOVE SAFELY FROM BED TO CHAIR, OR ABILITY TO TURN AND POSITION SELF IN BED IF PATIENT IS BEDFAST.

**3 - UNABLE TO TRANSFER SELF AND IS UNABLE TO BEAR WEIGHT OR PIVOT WHEN TRANSFERRED BY ANOTHER PERSON**

(E)(GG0170A1) MOBILITY ROLL LEFT AND RIGHT SOC/ROC PERFORMANCE: THE ABILITY TO ROLL FROM LYING ON BACK TO LEFT AND RIGHT SIDE, AND RETURN TO LYING ON BACK ON THE BED. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

**02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT**

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Assessment			
<p>(E)(GG0170B1) MOBILITY SIT TO LYING SOC/ROC PERFORMANCE: THE ABILITY TO MOVE FROM SITTING ON SIDE OF BED TO LYING FLAT ON THE BED. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT</b></p> <p>(E)(GG0170C1) MOBILITY LYING TO SITTING ON SIDE OF BED SOC/ROC PERFORMANCE: THE ABILITY TO MOVE FROM LYING ON THE BACK TO SITTING ON THE SIDE OF THE BED WITH NO BACK SUPPORT. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT</b></p> <p>(E)(GG0170D1) MOBILITY SIT TO STAND SOC/ROC PERFORMANCE: THE ABILITY TO COME TO A STANDING POSITION FROM SITTING IN A CHAIR, WHEELCHAIR, OR ON THE SIDE OF THE BED. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>09. NOT APPLICABLE - NOT ATTEMPTED AND THE PATIENT DID NOT PERFORM THIS ACTIVITY PRIOR TO THE CURRENT ILLNESS, EXACERBATION OR INJURY</b></p> <p>(E)(GG0170E1) MOBILITY CHAIR/BED-TO-CHAIR TRANSFER SOC/ROC PERFORMANCE: THE ABILITY TO TRANSFER TO AND FROM A BED TO A CHAIR (OR WHEELCHAIR). CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>01. DEPENDENT - HELPER DOES ALL OF THE EFFORT. PATIENT DOES NONE OF THE EFFORT TO COMPLETE THE ACTIVITY. OR, THE ASSISTANCE OF 2 OR MORE HELPERS IS REQUIRED FOR THE PATIENT TO COMPLETE THE ACTIVITY</b></p> <p>(E)(GG0170G1) MOBILITY CAR TRANSFER SOC/ROC PERFORMANCE: THE ABILITY TO TRANSFER IN AND OUT OF A CAR OR VAN ON THE PASSENGER SIDE. DOES NOT INCLUDE THE ABILITY TO OPEN/CLOSE DOOR OR FASTEN SEAT BELT. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>01. DEPENDENT - HELPER DOES ALL OF THE EFFORT. PATIENT DOES NONE OF THE EFFORT TO COMPLETE THE ACTIVITY. OR, THE ASSISTANCE OF 2 OR MORE HELPERS IS REQUIRED FOR THE PATIENT TO COMPLETE THE ACTIVITY</b></p> <p>(C1) (QM) (PRA) (M1860) AMBULATION/LOCOMOTION: CURRENT ABILITY TO WALK SAFELY, ONCE IN A STANDING POSITION, OR USE A WHEELCHAIR, ONCE IN A SEATED POSITION, ON A VARIETY OF SURFACES.</p> <p><b>5 - CHAIRFAST, UNABLE TO AMBULATE AND IS UNABLE TO WHEEL SELF.</b></p> <p>(E)(GG0100B) INDOOR MOBILITY (AMBULATION) PRIOR FUNCTIONING: EVERYDAY ACTIVITIES: INDICATE THE PATIENT'S USUAL ABILITY WITH EVERYDAY ACTIVITIES PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY. CODE THE PATIENT'S NEED FOR ASSISTANCE WITH WALKING FROM ROOM TO ROOM (WITH OR WITHOUT A DEVICE SUCH AS CANE, CRUTCH OR WALKER) PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY.</p> <p><b>2. NEEDED SOME HELP - PATIENT NEEDED PARTIAL ASSISTANCE FROM ANOTHER PERSON TO COMPLETE ANY ACTIVITIES</b></p> <p>(E)(GG0170I1) MOBILITY WALK 10 FEET SOC/ROC PERFORMANCE: ONCE STANDING, THE ABILITY TO WALK AT LEAST 10 FEET IN A ROOM, CORRIDOR, OR SIMILAR SPACE. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>09. NOT APPLICABLE - NOT ATTEMPTED AND THE PATIENT DID NOT PERFORM THIS ACTIVITY PRIOR TO THE CURRENT ILLNESS, EXACERBATION OR INJURY</b></p> <p>(E)(GG0170M1) MOBILITY 1 STEP (CURB) SOC/ROC PERFORMANCE: THE ABILITY TO GO UP AND DOWN A CURB OR UP AND DOWN ONE STEP. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p> <p><b>09. NOT APPLICABLE - NOT ATTEMPTED AND THE PATIENT DID NOT PERFORM THIS ACTIVITY PRIOR TO THE CURRENT ILLNESS, EXACERBATION OR INJURY</b></p> <p>(E)(GG0170P1) MOBILITY PICKING UP OBJECT SOC/ROC PERFORMANCE: THE ABILITY TO BEND/STOOP FROM A STANDING POSITION TO PICK UP A SMALL OBJECT, SUCH AS A SPOON, FROM THE FLOOR. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY, SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.</p>			

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**01. DEPENDENT - HELPER DOES ALL OF THE EFFORT. PATIENT DOES NONE OF THE EFFORT TO COMPLETE THE ACTIVITY. OR, THE ASSISTANCE OF 2 OR MORE HELPERS IS REQUIRED FOR THE PATIENT TO COMPLETE THE ACTIVITY**

(GG017Q1) MOBILITY DOES PATIENT USE WHEELCHAIR/SCOOTER?

1 - YES

(E)(GG0170R1) MOBILITY WHEEL 50 FEET WITH TWO TURNS SOC/ROC PERFORMANCE: ONCE SEATED IN WHEELCHAIR/SCOOTER, THE ABILITY TO WHEEL AT LEAST 50 FEET AND MAKE TWO TURNS. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT

(GG0170RR1) MOBILITY INDICATE THE TYPE OF WHEELCHAIR OR SCOOTER USED.

2 - MOTORIZED

(E)(GG0170S1) MOBILITY WHEEL 150 FEET SOC/ROC PERFORMANCE: ONCE SEATED IN WHEELCHAIR/SCOOTER, THE ABILITY TO WHEEL AT LEAST 150 FEET IN A CORRIDOR OR SIMILAR SPACE. CODE THE PATIENT'S USUAL PERFORMANCE AT SOC/ROC FOR EACH ACTIVITY USING THE 6-POINT SCALE. IF ACTIVITY WAS NOT ATTEMPTED AT SOC/ROC, CODE THE REASON. CODING: SAFETY AND QUALITY OF PERFORMANCE - IF HELPER ASSISTANCE IS REQUIRED BECAUSE PATIENT'S PERFORMANCE IS UNSAFE OR OF POOR QUALITY. SCORE ACCORDING TO AMOUNT OF ASSISTANCE PROVIDED.

02. SUBSTANTIAL/MAXIMAL ASSISTANCE - HELPER DOES MORE THAN HALF THE EFFORT. HELPER LIFTS OR HOLDS TRUNK OR LIMBS AND PROVIDES MORE THAN HALF THE EFFORT

(GG0170SS1) MOBILITY INDICATE THE TYPE OF WHEELCHAIR OR SCOOTER USED.

2 - MOTORIZED

(E)(GG0100C) STAIRS PRIOR FUNCTIONING: EVERYDAY ACTIVITIES: INDICATE THE PATIENT'S USUAL ABILITY WITH EVERYDAY ACTIVITIES PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY. CODE THE PATIENT'S NEED FOR ASSISTANCE WITH INTERNAL OR EXTERNAL STAIRS (WITH OR WITHOUT A DEVICE SUCH AS CANE, CRUTCH, OR WALKER) PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY.

2. NEEDED SOME HELP - PATIENT NEEDED PARTIAL ASSISTANCE FROM ANOTHER PERSON TO COMPLETE ANY ACTIVITIES

(E)(GG0100A) SELF CARE PRIOR FUNCTIONING: EVERYDAY ACTIVITIES: INDICATE THE PATIENT'S USUAL ABILITY WITH EVERYDAY ACTIVITIES PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY. CODE THE PATIENT'S NEED FOR ASSISTANCE WITH BATHING, DRESSING, USING THE TOILET, AND EATING PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY.

2. NEEDED SOME HELP - PATIENT NEEDED PARTIAL ASSISTANCE FROM ANOTHER PERSON TO COMPLETE ANY ACTIVITIES

(GG0110) FUNCTIONAL ABILITIES AND GOALS PRIOR DEVICE USE: INDICATE DEVICES AND AIDS USED BY THE PATIENT PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY. CHECK ALL THAT APPLY.

B - MOTORIZED WHEELCHAIR AND/OR SCOOTER

(F)(GG0100D) FUNCTIONAL COGNITION PRIOR FUNCTIONING: EVERYDAY ACTIVITIES: INDICATE THE PATIENT'S USUAL ABILITY WITH EVERYDAY ACTIVITIES PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY. CODE THE PATIENT'S NEED FOR ASSISTANCE WITH PLANNING REGULAR TASKS, SUCH AS SHOPPING OR REMEMBERING TO TAKE MEDICATION PRIOR TO THE CURRENT ILLNESS, EXACERBATION, OR INJURY.

2. NEEDED SOME HELP - PATIENT NEEDED PARTIAL ASSISTANCE FROM ANOTHER PERSON TO COMPLETE ANY ACTIVITIES

#### MEDICATIONS

(CCY)(M2001) DRUG REGIMEN REVIEW: DID A COMPLETE DRUG REGIMEN REVIEW IDENTIFY POTENTIAL CLINICALLY SIGNIFICANT MEDICATION ISSUES?

0 - NO - NO ISSUES FOUND DURING REVIEW

(QM) (M2010) PATIENT/CAREGIVER HIGH RISK DRUG EDUCATION: HAS THE PATIENT/CAREGIVER RECEIVED INSTRUCTION ON SPECIAL PRECAUTIONS FOR ALL HIGH-RISK MEDICATIONS (SUCH AS HYPOGLYCEMICS, ANTICOAGULANTS, ETC.) AND HOW AND WHEN TO REPORT PROBLEMS THAT MAY OCCUR?

1 - YES

(QM) (M2020) MANAGEMENT OF ORAL MEDICATIONS: PATIENT'S CURRENT ABILITY TO PREPARE AND TAKE ALL ORAL MEDICATIONS RELIABLY AND SAFELY, INCLUDING ADMINISTRATION OF THE CORRECT DOSAGE AT THE APPROPRIATE TIMES/INTERVALS. EXCLUDES INJECTABLE AND IV MEDICATIONS. (NOTE: THIS REFERS TO ABILITY, NOT COMPLIANCE OR WILLINGNESS.)

3 - UNABLE TO TAKE MEDICATION UNLESS ADMINISTERED BY ANOTHER PERSON.

(M2030) MANAGEMENT OF INJECTABLE MEDICATIONS: PATIENT'S CURRENT ABILITY TO PREPARE AND TAKE ALL PRESCRIBED INJECTABLE MEDICATIONS RELIABLY AND SAFELY, INCLUDING ADMINISTRATION OF CORRECT DOSAGE AT THE APPROPRIATE TIMES/INTERVALS. EXCLUDES IV MEDICATIONS.

3 - UNABLE TO TAKE INJECTABLE MEDICATION UNLESS ADMINISTERED BY ANOTHER PERSON.

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**ASSESSMENT**

(N0415) HIGH-RISK DRUG CLASSES USE AND INDICATION: CHECK IF THE PATIENT IS TAKING ANY MEDICATIONS BY PHARMACOLOGICAL CLASSIFICATION, NOT HOW IT IS USED, IN THE FOLLOWING CLASSES:

**F1. ANTIBIOTIC****H1. OPIOID****J1. HYPOGLYCEMIC (INCLUDING INSULIN)**

(N0415F2) CHECK IF THERE IS AN INDICATION NOTED FOR ALL MEDICATIONS IN THE ANTIBIOTIC CLASS

**0. NO**

(N0415H2) CHECK IF THERE IS AN INDICATION NOTED FOR ALL MEDICATIONS IN THE OPIOID CLASS

**0. NO**

(N0415J2) CHECK IF THERE IS AN INDICATION NOTED FOR ALL MEDICATIONS IN THE HYPOGLYCEMIC CLASS (INCLUDING INSULIN)

**0. NO**MEDICATION COMPLIANCE REVIEW FINDINGS (MARK ALL THAT APPLY):**PATIENT/CAREGIVER COMPLIANT WITH ALL MEDICATION ADMINISTRATION****VERIFIED ACCURATE MEDICATION LIST IN THE HOME****PROVIDER**

IS THIS ASSESSMENT BEING PERFORMED FOR A MEDICARE PAYMENT EPISODE THAT DETERMINES A CASE MIX GROUP (THERAPY NEED)?

**YES**

(M2200) THERAPY NEED: IN THE HOME HEALTH PLAN OF CARE FOR THE MEDICARE PAYMENT EPISODE FOR WHICH THIS ASSESSMENT WILL DEFINE A CASE MIX GROUP, WHAT IS THE INDICATED NEED FOR THERAPY VISITS (TOTAL OF REASONABLE AND NECESSARY PHYSICAL, OCCUPATIONAL, AND SPEECH-LANGUAGE PATHOLOGY VISITS COMBINED)? (ENTER ZERO "000" IF NO THERAPY VISITS INDICATED.)

**0****CARE MANAGEMENT**

(PRA) (M2102F) TYPES AND SOURCES OF ASSISTANCE: DETERMINE THE LEVEL OF CAREGIVER ABILITY AND WILLINGNESS TO PROVIDE ASSISTANCE FOR SUPERVISION AND SAFETY (FOR EXAMPLE, DUE TO COGNITIVE IMPAIRMENT), IF ASSISTANCE IS NEEDED.

**2 - NON-AGENCY CAREGIVER(S) NEED TRAINING/ SUPPORTIVE SERVICES TO PROVIDE ASSISTANCE**

(Q0110A) SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS: CHECK ALL OF THE FOLLOWING TREATMENTS, PROCEDURES, AND PROGRAMS THAT APPLY ON ADMISSION.

**C1. OXYGEN THERAPY**

INDICATE TYPE OF ADMINISTRATION OF OXYGEN THERAPY ON ADMISSION

**C2. CONTINUOUS**

PATIENT MEETS THE FOLLOWING CRITERIA FOR TELEHEALTH SERVICES

**NOT APPLICABLE – PATIENT DOES NOT MEET CRITERIA OR HAVE A NEED FOR TELEHEALTH SERVICES**

**Wound Assessment**

Historical wounds are retained as inactive and wound numbers continuously increment for subsequent episodes and admissions.

**Anatomical Figures****Anatomical View**

Wound # / Location / Type / Source Question	Answer
<b>MALE POSTERIOR</b>	
CHARGE STAGE	0
ONSET DATE	06/19/2025
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	26
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1 X 0.4 X 0.1
SURFACE AREA (SQ CM)	0.4
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	NONE

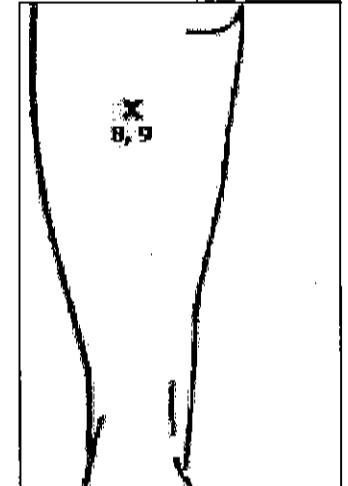
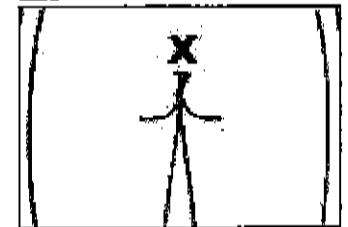
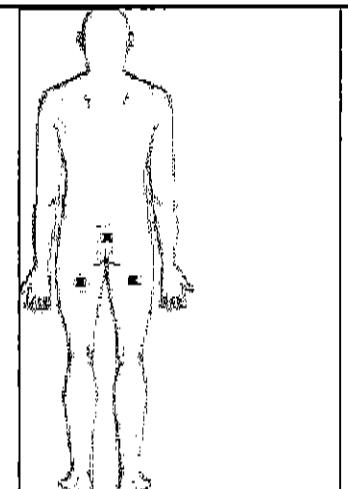
## Visit Note Report

Client: FINT, HARRY L  
 Client DOB: 10/23/1946  
 Insured ID: 7TR8K83JM21

MR No: 04200051925201 Legacy MR No:  
 Primary Payor: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

EDGES	DISTINCT
SHAPE	ELONG
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SCANT
ODOR	NONE
EPITHELIALIZATION	<25%
NECROTIC TISSUE TYPE	NONE
NECROTIC TISSUE AMOUNT	NONE
TOTAL NECROTIC TISSUE SLOUGH	0-25%
TOTAL NECROTIC TISSUE ESCHAR	0-25%
EDGE / SURROUNDING TISSUE - MACERATION	ABSENT
UNDERMINING	NONE
TUNNELING	NO
SKIN COLOR SURROUNDING WOUND	NORM
PERIPHERAL TISSUE EDEMA	NONE
PERIPHERAL TISSUE INDURATION	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO
STATE	ACUTE
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	WOUND CARE NOT PROVIDED: AWAITING ORDERS



**Wound Images**  
N/A

#5 - PROXIMAL LEG E - TRAUMA/SURGICAL - RCHB  
 Onset Date: 05/14/2025

CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	26
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1.3 X 0.2 X 0.1
SURFACE AREA (SQ CM)	0.26
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	NONE
EDGES	DISTINCT
SHAPE	ELONG
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SCANT
ODOR	NONE
EPITHELIALIZATION	<25%
NECROTIC TISSUE TYPE	NONE
NECROTIC TISSUE AMOUNT	NONE
TOTAL NECROTIC TISSUE SLOUGH	0-25%
TOTAL NECROTIC TISSUE ESCHAR	0-25%
EDGE / SURROUNDING TISSUE - MACERATION	ABSENT
UNDERMINING	NONE
TUNNELING	NO
SKIN COLOR SURROUNDING WOUND	NORM
PERIPHERAL TISSUE EDEMA	NONE

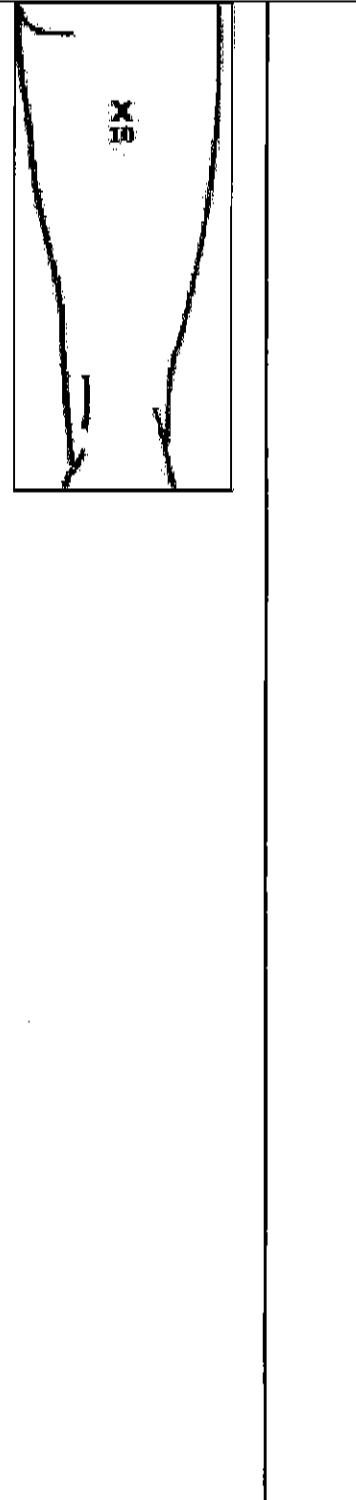
**Visit Note Report**

Client: FINT, HARRY L  
 Client DOB: 10/23/1946  
 Insured ID: 7TR8K83JM21

MR No: 04200051925201 Legacy MR No:  
 Primary Payor: MEDICARE PDGM

Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

PERIPHERAL TISSUE INDURATION	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO
STATE	ACUTE
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	WOUND CARE NOT PROVIDED: AWAITING ORDERS

**Wound Images**

N/A

NO PROXIMAL OR DISTAL TRAUMA SUPERFICIAL WOUND	
Obs Date: 06/19/2025	
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	26
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	0.4 X 0.2 X 0.1
SURFACE AREA (SQ CM)	0.08
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	NONE
EDGES	DISTINCT
SHAPE	ELONG
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SCANT
ODOR	NONE
EPITHELIALIZATION	<25%
NECROTIC TISSUE TYPE	NONE
NECROTIC TISSUE AMOUNT	NONE
TOTAL NECROTIC TISSUE SLOUGH	0-25%
TOTAL NECROTIC TISSUE ESCHAR	0-25%
EDGE / SURROUNDING TISSUE - MACERATION	ABSENT
UNDERMINING	NONE
TUNNELING	NO
SKIN COLOR SURROUNDING WOUND	NORM
PERIPHERAL TISSUE EDEMA	NONE
PERIPHERAL TISSUE INDURATION	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO
STATE	ACUTE
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	WOUND CARE NOT PROVIDED: AWAITING ORDERS

**Wound Images**

N/A

NO PROXIMAL OR DISTAL TRAUMA SUPERFICIAL WOUND	
Obs Date: 06/19/2025	
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	26

## Visit Note Report

Client: FINT, HARRY L  
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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1.3 X 0.2 X 0.1
SURFACE AREA (SQ CM)	0.26
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	NONE
EDGES	DISTINCT
SHAPE	ELONG
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SCANT
ODOR	NONE
EPITHELIALIZATION	<25%
NECROTIC TISSUE TYPE	NONE
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UNDERMINING	NONE
TUNNELING	NO
SKIN COLOR SURROUNDING WOUND	NORM
PERIPHERAL TISSUE EDEMA	NONE
PERIPHERAL TISSUE INDURATION	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO
STATE	ACUTE
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	WOUND CARE NOT PROVIDED: AWAITING ORDERS

**Wound Images**  
N/A

**Narrative:**  
 PATIENT IS A 78 YEAR OLD MALE WHO LIVES IN A SINGLE FAMILY HOME WITH HIS DAUGHTER AND SON. UPON ARRIVAL PATIENT WAS LYING IN BED WITH NO ACUTE DISTRESS NOTED. PATIENT WAS ADMITTED TO THE HOSPITAL AND DIAGNOSED WITH UTI. SN RECONCILED MEDS WITH DISCHARGE SUMMARY. NO ISSUES NOTED. SN PERFORMED SKIN ASSESSMENT WITH STAGE 2 PRESSURE ULCER TO SACRUM AND ABRASIONS TO BILATERAL GLUTEAL FOLDS AND BACK OF THIGH. PATIENT HAS ESCORIASION IN GROIN AREA. PATIENT HAS LARGE FLAKEY AREA TO LEFT CALF AND SCABBED AREA TO RIGHT CALF. PATIENT HAS A HISTORY OF CIRRHOsis, CHF, CKD STAGE 3, CAD, ATRIAL FIB, COPD, DIABETES, DDD, NEUROPATHY AND RUPTURED DISC. PATIENT IS NON AMBULATORY. PATIENT USES POWER WHEELCHAIR FOR LOCOMOTION. ALL DIAGNOSES CONFIRMED WITH MD. PATIENTS DAUGHTER MANAGES MEDICATIONS. SN INSTRUCTED PAIENT AND DAUGHTER ON MEDICATION COMPLIANCE AND THE IMPORTANCE OF TAKING MEDICATIONS AT THE SAME TIME EACH DAY. SN INSTRUCTED PATIENT AND CHILDREN ON S/S OF INFECTION, WOUND CARE AND WHEN TO CALL MD AND/OR HOME HEALTH AGENCY. SN INSTRUCTED PATIENT ON PATIENTS RIGHTS AND RESPONSIBILITIES, SAFETY MEASURES, FALL PREVENTION, EXPLANATION OF SERVICES AND EMERGENCY PREPAREDNESS PLAN. PATIENT IS HOMEBOUND RELATED TO CHAIRBOUND, SOA, OXYGEN DEPENDENCE, FALLS RISK AND REQUIRES ASSISTANCE TO LEAVE HOME. PATIENTS DAUGHTER AND SON MONITORS FSBS INDEPENDENTLY. SN INSTRUCTED PATIENT ON ADEQUATE NUTRITION AND HYDRATION. SN INSTRUCTED PATIENT TO CONTACT AGENCY WITH ANY QUESTIONS OR CONCERNs PRIOR TO NEXT VISIT. PATIENT VERBALIZED UNDERSTANDING OF ALL EDUCATION AND DENIES ANY QUESTIONS OR CONCERNs AT THIS TIME.

**Patient Goals:**

**Patient Goal**  
WOUNDS HEALED

**Interventions Provided:**

1. INSTRUCT PATIENT / CAREGIVER ON DISEASE MANAGEMENT INCLUDING SIGNS / SYMPTOMS TO MONITOR AND REPORT.

**Visit Note Report**

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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

DETAILS/COMMENTS: INSTRUCTED PATIENT / CAREGIVER ON IMMEDIATE ACTIONS TO PREVENT EXACERBATION AND/OR REHOSPITALIZATION  
INSTRUCTED PATIENT / CAREGIVER ON THE FOLLOWING DIETARY LIMITATIONS TO AVOID EXACERBATION OR REHOSPITALIZATION  
PROVIDED WRITTEN MEDICAL EMERGENCY CARE PLAN LOCATED IN PATIENT ORIENTATION HANDBOOK AND PATIENT VERBALIZED UNDERSTANDING FOR USE.  
INSTRUCTED PATIENT / CAREGIVER ON SIGNS / SYMPTOMS THAT REQUIRE A CALL TO THE AGENCY, PHYSICIAN, AND/OR 911.  
CONFIRMED PATIENT / CAREGIVER UNDERSTANDING OF WAYS TO MANAGE DISEASE TO AVOID EXACERBATION / REHOSPITALIZATION THROUGH TEACH-BACK.  
**2. INSTRUCT PATIENT / CAREGIVER ON MEDICATION REGIME INCLUDING PURPOSE, SIDE EFFECTS, INTERACTIONS, POTENTIAL INEFFECTIVE OR DUPLICATIVE DRUG THERAPY, AND NON-ADHERENCE.**  
DETAILS/COMMENTS: INSTRUCTED PATIENT / CAREGIVER REGARDING MEDICATION MANAGEMENT, INCLUDING PURPOSE, SCHEDULE, ROUTE, RATIONALE FOR COMPLIANCE, POSSIBLE SIDE EFFECTS, INTERACTIONS, AND WHEN AND WHAT TO REPORT TO THE AGENCY, PHYSICIAN, OR 911.  
ASSESSED MEDICATION REGIMEN FOR MEDICATION SAFETY INCLUDING DUPLICATIVE DRUG THERAPY, DRUG/DRUG INTERACTION, AND DRUG/FOOD INTERACTIONS  
REVIEWED MEDICATION SAFETY INFORMATION FROM THE PATIENT ORIENTATION HANDBOOK WITH THE PATIENT / CAREGIVER  
INSTRUCTED PATIENT / CAREGIVER ON THE PRECAUTIONS, SIGNS / SYMPTOMS TO REPORT AND WHO TO REPORT THEM TO FOR THE FOLLOWING HIGH RISK ALERT MEDICATIONS  
CONFIRMED PATIENT / CAREGIVER UNDERSTANDING OF MEASURES TO TAKE FOR SAFE MEDICATION ADMINISTRATION THROUGH TEACH-BACK.  
**3. INSTRUCT PATIENT / CAREGIVER ON ENVIRONMENTAL HAZARDS AND SAFETY ISSUES TO RESOLVE IMMEDIATE SAFETY OR CONCERNs.**  
DETAILS/COMMENTS: ASSESSED FOR ENVIRONMENTAL HAZARDS AND SAFETY ISSUES IN THE HOME.  
INSTRUCTED ON THE FOLLOWING HOME MODIFICATION(S) FOR MAXIMUM SAFETY AND INDEPENDENCE  
REVIEWED OXYGEN SAFETY AGREEMENT IN THE PATIENT ORIENTATION HANDBOOK WITH THE PATIENT / CAREGIVER  
**4. INSTRUCT PATIENT / CAREGIVER ON BASIC USE OF ASSISTIVE / ADAPTIVE DEVICES TO ENSURE PATIENT IS SAFE**  
DETAILS/COMMENTS: INSTRUCTED PATIENT / CAREGIVER IN SAFE USE OF ASSISTIVE DEVICES.  
INSTRUCTED PATIENT / CAREGIVER IN SAFE AND PROPER USE OF WHEELCHAIR RELATIVE TO PROPELLING, BRAKING AND TURNING.  
INSTRUCTED PATIENT / CAREGIVER IN SAFE USE OF ASSISTIVE/ADAPTIVE DEVICES AND TECHNIQUES FOR MAXIMUM SUPPORT AND INDEPENDENCE.  
INSTRUCTED PATIENT / CAREGIVER IN SAFE USE OF ASSISTIVE DEVICE FOR FUNCTIONAL MOBILITY SUCH AS AMBULATION, BED MOBILITY, TRANSFERS.  
PATIENT / CAREGIVER DEMONSTRATED / VERBALIZED UNDERSTANDING OF SAFE USE OF ASSISTIVE/ADAPTIVE DEVICES THROUGH TEACH-BACK.  
**5. DETERMINE SAFE EMERGENCY PREPAREDNESS PLAN**  
DETAILS/COMMENTS: EXPLORED AN EMERGENCY PREPAREDNESS PLAN WITH THE PATIENT / CAREGIVER  
COMPLETED THE WRITTEN EMERGENCY PREPAREDNESS PLAN IN THE PATIENT ORIENTATION HANDBOOK.  
**6. INSTRUCT PATIENT / CAREGIVER ON EXPLANATION OF SERVICES, ADVANCE DIRECTIVES, RIGHTS AND RESPONSIBILITIES, RIGHTS OF THE ELDERLY AND OBTAIN NECESSARY SIGNATURES.**  
DETAILS/COMMENTS: INSTRUCTED PATIENT / CAREGIVERS ON, AND PROVIDED IN WRITING, EXPLANATION OF SERVICES, ADVANCE DIRECTIVES, RIGHTS AND RESPONSIBILITIES, RIGHTS OF THE ELDERLY AND OBTAINED NECESSARY SIGNATURES.

**Visit Note Report**

**Client:** FINT, HARRY L  
**Client DOB:** 10/23/1946  
**Insured ID:** 7TR8K83JM21

**MR No:** 04200051925201      **Legacy MR No:**  
**Primary Payer:** MEDICARE PDGM

**Visit Date:** 06/21/2025    **Visit Number:** 1    **Visit Type:** RN00 - RN OASIS ADMISSION

PROVIDED IN WRITING AND COLLABORATED WITH PATIENT / CAREGIVER ON PLAN OF CARE

7. COLLABORATE WITH PATIENT / CAREGIVER REGARDING OTHER DISCIPLINES OR SUPPORT NETWORKS AVAILABLE IN THE COMMUNITY, TO HELP REACH PATIENT GOALS.

DETAILS/COMMENTS: INSTRUCTED PATIENT / CAREGIVER REGARDING THE FOLLOWING SUPPORT NETWORKS AVAILABLE IN THE COMMUNITY  
COLLABORATED WITH PATIENT / CAREGIVER ON THE FOLLOWING OTHER DISCIPLINES THAT MAY BE BENEFICIAL TO THE PLAN OF CARE

8. EXPLORE CURRENT INTERVENTIONS FOR PATIENT WITH SIGNS / SYMPTOMS OF DEPRESSION, AND MAKE APPROPRIATE INQUIRIES OR REFERRALS.

DETAILS/COMMENTS: PHYSICIAN WAS CONTACTED ABOUT THE PATIENT'S SIGNS / SYMPTOMS OF DEPRESSION.

**Goals Not Met**

1. PATIENT TOLERATED DIAGNOSTIC TEST / TREATMENT WITHOUT CONCERNs OR COMPLAINTs.  
EXCEPTION CODE: NOT APPLICABLE TO CLIENT'S POC

2. PATIENT / CAREGIVER WILL HAVE KNOWLEDGE OF THE PURPOSE AND USE OF TELEHEALTH TO REDUCE EMERGENT CARE AND RE-HOSPITALIZATIONS.  
EXCEPTION CODE: NOT APPLICABLE TO CLIENT'S POC

3. PATIENT / CAREGIVER WILL VERBALIZE AND DEMONSTRATE ABILITY TO SAFELY UTILIZE TELEHEALTH PROGRAM AND EQUIPMENT.  
EXCEPTION CODE: NOT APPLICABLE TO CLIENT'S POC

4. PATIENT / CAREGIVER VERBALIZES SIGNS / SYMPTOMS TO MONITOR AND REPORT AND MEASURES TO TAKE TO AVOID EXACERBATION AND REHOSPITALIZATION.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

5. PATIENT / CAREGIVER DEMONSTRATES ABILITY TO SAFELY ADMINISTER MEDICATIONS TO AVOID MEDICATION-RELATED HARM OR REHOSPITALIZATION.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

6. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF ENVIRONMENTAL HAZARDS AND SAFETY ISSUES AND HOW TO RESOLVE THEM.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

7. PATIENT / CAREGIVER WILL DEMONSTRATE APPROPRIATE AND SAFE USE OF ASSISTIVE / ADAPTIVE DEVICES TO PROMOTE HOME SAFETY AND AVOID INJURY.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

8. PATIENT / CAREGIVER WILL HAVE A SAFE EMERGENCY PREPAREDNESS PLAN.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

9. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF PATIENT RIGHTS AND RESPONSIBILITIES AND AGREES TO AND CONTRIBUTES TO THE PLAN OF CARE.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

10. PATIENT / CAREGIVER VERBALIZE CONTACT INFORMATION FOR AVAILABLE COMMUNICATION RESOURCES.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

11. PATIENTS WITH SIGNS / SYMPTOMS OF DEPRESSION WILL RECEIVE ADEQUATE SUPPORT TO INCREASE POSITIVE HEALTH BEHAVIORS AND IMPROVE DAY TO DAY FUNCTIONING.  
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

**Medication Understanding Changes**

Medication	Dose	Purpose	Directions for Use	Side effects/Interactions	Med Understanding Notes
ACETAMINOPHEN 500 MG TABLET	1000 mg	N	N	N	

## Visit Note Report

Client: FINT, HARRY L  
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Visit Date: 06/21/2025 Visit Number: 1 Visit Type: RN00 - RN OASIS ADMISSION

Medication Understanding Changes					
Medication	Dose	Purpose	Directions for Use	Side effects/Interactions	Med Understanding Notes
BUMETANIDE 2 MG TABLET	2 mg	N	N	N	
ELIQUIS 2.5 MG TABLET	2.5 mg	N	N	N	
ERGOCALCIFEROL (VITAMIN D2) 1,250 MCG (50,000 UNIT) CAPSULE	1250 mcg	N	N	N	
FLUTICASONE PROPIONATE 50 MCG/ACTUATION NASAL SPRAY,SUSPENSION	2 spray	N	N	N	
GABAPENTIN 100 MG CAPSULE	200 mg	N	N	N	
INSULIN GLARGINE (U-100) 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN	8 unit	N	N	N	
KLOR-CON M20 MEQ TABLET,EXTENDED RELEASE	20 mEq	N	N	N	
LEVOTHYROXINE 50 MCG CAPSULE	50 mcg	N	N	N	
LINEZOLID 600 MG TABLET	600 mg	N	N	N	
METHADONE 10 MG TABLET	10 mg	N	N	N	
NYSTATIN 1 BILLION UNIT POWDER	Per instructions	N	N	N	
OXYCODONE-ACETAMINOPHEN 10 MG-325 MG TABLET	1 tablet	N	N	N	
OXYGEN GAS FOR INHALATION	2 Liter	N	N	N	
PANTOPRAZOLE 40 MG TABLET,DELAYED RELEASE	40 mg	N	N	N	
RANOLAZINE ER 500 MG TABLET,EXTENDED RELEASE,12 HR	500 mg	N	N	N	
SENNNA LAX 8.6 MG TABLET	Per instructions	N	N	N	
SIMVASTATIN 40 MG TABLET	40 mg	N	N	N	
TAMSULOSIN 0.4 MG CAPSULE	0.4 mg	N	N	N	
VOLTAREN ARTHRITIS PAIN 1 % TOPICAL GEL	Per instructions	N	N	N	

Agent Signature:

Client Signature:

TERESA HUGHES RN 06/24/2025 09:25 PM

(Electronically Signed)

Last Modification Date:

Last Modified By:

## ADDENDUM

DOCUMENTATION OF THIS VISIT OCCURRED AFTER THE ACTUAL IN-HOME VISIT.  
 VISIT DATE: 6/21/25  
 PROVIDE DETAILS: NOTES AND ORDERS