HOMESTEAD
POST ACUTE

1608 Versailles Road
Lexington, KY 40504
Phone: 859-252-0871
Fax: 859-255-2467

To: McGrath Wound Care Date: 8/21/25

From: Elvita T. Fax: 859-399-6697

Re: M. Braun No. of Pages_____

☐ Urgent ☑ For Review ☐ Please Comment ☐ Please Reply

Notes:

	Instructions	Start Date
Lidocaine 4 %	1 patch, Transdermal, Every 24 Hours Scheduled, Remove & Discard patch within 12 hours or as directed by MD	Start Date: **July 31, 2025**

Changes to Medications

	Instructions	Start Date
HYDROcodone-acetaminophen 10-325 MG per tablet Commonly known as: NORCO What changed: • **when to take this** • **reasons to take this**	1 tablet, Oral, Every 4 Hours PRN	

Continue These Medications

	Instructions	Start Date
acetaminophen 325 MG tablet Commonly known as: TYLENOL	650 mg, Oral, Every 8 Hours	
B-12 1000 MCG tablet	1,000 each, Daily	
CALCIUM 1200+D3 PO	1 each, Daily	
cetirizine 10 MG tablet Commonly known as: zyrTEC	TAKE ONE TABLET BY MOUTH DAILY	
diltIAZem CD 240 MG 24 hr capsule Commonly known as: CARDIZEM CD	240 mg, Oral, Daily	
folic acid 1 MG tablet Commonly known as: FOLVITE	1 mg, Oral, Daily	
hydrOXYzine 25 MG tablet Commonly known as: ATARAX	25 mg, Oral, Nightly PRN	
melatonin 5 MG tablet tablet	5 mg, Oral, Nightly PRN	
methocarbamol 500 MG tablet Commonly known as: ROBAXIN	250 mg, Oral, 3 Times Daily PRN	
mirtazapine 7.5 MG tablet Commonly known as: REMERON	7.5 mg, Oral, Nightly	
multivitamin with minerals tablet tablet	1 each, Daily	
omeprazole 20 MG capsule Commonly known as: priLOSEC	20 mg, Oral, Daily	
ondansetron 4 MG tablet Commonly known as: Zofran	4 mg, Oral, Every 8 Hours PRN	

	Instructions	Start Date
polyethylene glycol 17 g packet Commonly known as: MIRALAX	17 g, Oral, Daily PRN	

Allergies

Allergen	Reactions
• Lisinopril	Cough
• Phenobarbital *Blisters*	Other (See Comments)
• Tizanidine	Hallucinations
• Cymbalta [Duloxetine Hcl]	Anxiety and Hallucinations

Discharge Disposition:
Skilled Nursing Facility (DC - External)

Diet:
Hospital:
Diet Order
Procedures
- Diet: Regular/House; Texture: Soft to Chew (NDD 3); Soft to Chew: Ground Meat; Fluid Consistency: Thin (IDDSI 0)

Activity:

Restrictions or Other Recommendations:

CODE STATUS:
Code Status and Medical Interventions: No CPR (Do Not Attempt to Resuscitate); Limited Support; No intubation (DNI)
Ordered at: 07/24/25 1911
Code Status (Patient has no pulse and is not breathing):
No CPR (Do Not Attempt to Resuscitate)
Medical Interventions (Patient has pulse or is breathing):
Limited Support
Medical Intervention Limits:
No intubation (DNI)
Level Of Support Discussed With:
Patient

Future Appointments

Date	Time	Provider	Department	Center
8/18/2025	2:30 PM	Coleman, Lindsie, APRN	MGE RH WALL	LEX

Additional Instructions for the Follow-ups that You Need to Schedule

Discharge Follow-up with PCP As directed

Currently Documented PCP:
Holestol, Bjorn L, MD
PCP Phone Number:
859-277-5771
Follow Up Details: 1 week after discharged from rehab

Discharge Follow-up with Specified Provider: As directed
with ID/Dr. Miedler
To: with ID/Dr. Miedler
Follow Up Details: per his rec

Andrea L. Lyons, MD
07/30/25

Time Spent on Discharge: *I spent 39 minutes on this discharge activity which included: face-to-face encounter with the patient, reviewing the data in the system, coordination of the care with the nursing staff as well as consultants, documentation, and entering orders.*

Electronically signed by Lyons, Andrea L, MD at 07/30/25 1130

Routing History

Date/Time	From	To	Method
07/30/25 1130	Lyons, Andrea L, MD	Holestol, Bjorn L, MD	In Basket

ED to Hosp-Admission (Current) on 7/24/2025 *Note shared with patient*

Additional Details

Note status
Signed

Visit Information

	Department
7/24/2025 1:23 PM	BAPTIST HEALTH LEXINGTON 4G

Facility #:
Date: Aug 20, 2025
Time: 12:45:05 ET

Homestead Post Acute
Progress Notes *NEW*

Facility Code: 30
User: Elvia Taulbee

Primary Physician: All Progress Note Type: Physician Progress Note (Narrative) Effective Date Range: Effective Time Range: All Created Date Range: All Created Time Range: All Author: All Department: All

Resident Name :	Brown, Mildred (10047)	**Location :**	500-B 523 0	**Admission Date :**	07/30/2025
Medical Record # :	10047	**Gender :**	F	**Date of Birth :**	01/31/1934
Physician :	Doodnauth, Davanand	**Pharmacy :**	Med Care Pharmacy		
Allergies :	Lisinopril, PHENobarbital, tiZANIdine, Cymbalta				
Diagnoses :	No Medical Diagnosis Found				

Effective Date: 08/11/2025 16:26 Type: Physician Progress Note (Narrative)

Note Text : SERVICE DATE: 8/11/2025
PATIENT: BROWN, MILDRED (1/31/1934)
FACILITY: HOMESTEAD NURSING CARE Paul Ilkanich, MD

PHYSICAL MEDICINE AND REHABILITATION

NOTE TEXT

PHYSICAL MEDICINE & REHABILITATION FOLLOW UP

CHIEF COMPLAINT: right knee fracture

HPI: Patient seen and examined. patient follow-up for right knee pain, patient's not having any worsening pain in her right knee today, stable overall, continues on current regimen. Patient follow-up for hip fracture, patient's hip is not hurting, but she is complaining of periodic right knee pain, that is dull and achy. She does have a history of COPD, breathing well without any shortness of breath. She has a history of hypertension, no headache or vision change. She has a history of osteoarthritis no other bony pain. She does have generalized muscle weakness currently tolerating therapy. She does need assistance with personal care

Review of Systems: (gained from chart review, interview of patient and (or) family and discussion with staff) - As per HPI above. Otherwise 10 systems were reviewed and were negative.

PAST MEDICAL HISTORY: OA, HTN, cancer endo, COPD, GERD, renal insufficiency, RLS, mac degeneration, cognitive impairment
PAST SURGICAL HISTORY: appendectomy, back surgery, breast lumpectomy, hysterectomy
FAMILY HISTORY: Arthritis, Cancer, Heart attack, Leukemia, OA
SOCIAL HISTORY: Negative alcohol, tobacco, drug use
PLOF:PTA, patient lived with family member, friends, or others, in a 1 story home, used a walker only in bathroom, required constant SUP

Pain Medications: APAP 650mg PO q8h
oxycodone 5 mg tab PO q8h PRN

Allergies: Cymbalta, lisinopril, phenobarbital, tizanidine

Physical Examination:
General Awake, well developed, well-nourished, NAD.
Eyes: Conjunctivae are anicteric, lids are normal. EOMI

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Ears, Nose, Mouth, Throat: External inspection of ears and nose is normal.
Hearing is grossly intact
Respiratory: Normal respiratory effort. No accessory muscle use. No audible wheezing.
Skin: No visible skin lesions or rashes noted in exposed BUE or BLE.
MSK: No masses noted in b/l UE and LE.
ROM: WFL BUE and BLE
Muscle strength: 4- BUE and BLE
Neuro: Grossly normal tone.
Psych: Normal mood. Normal affect. Patient responds appropriately to examiner. No depressive symptoms

Data:
-Laboratory data from facility/OSH were personally reviewed and revealed WBC 9.51, Hb 12.2, PLT 176, Na 138, K 4.7, Cr 0.82
-Imaging from facility/OSH were personally reviewed and revealed Comminuted and angulated intertrochanteric right hip fractureon hip XR
-Laboratory data personally interpreted in the context of the patient
-Imaging personally interpreted in the context of the patient

Assessment/Plan:
Right hip fracture status post IM nail, complicated by pain
-weight bearing is tolerated giving nailing.
-will monitor clinical status/ vitals closely.
-Will continue to monitor pain, especially as the patient progresses through rehab and make any adjustments as necessary

COPD
- Reviewed not currently on any inhalers/nebulizers will monitor for need as she progresses the rehab
-Will monitor vitals closely as there is high risk for development of pneumonia requiring antibiotics and possible readmission to the hospital thereby hindering the rehabilitative process
-Monitor pulse ox
-No current contraindication to therapy

Hypertension
- Continue diltiazem, pressures reviewed and currently stable
-Monitor blood pressure before during and after therapy, adjust antihypertensives as needed, careful collaboration with therapy for fluctuations including ongoing orthostasis which could result in significant injuries as a result of a syncopal episode.

Generalized muscle weakness
-Continue therapy as scheduled/monitor for need for PT/OT for strengthening
-Patient was encouraged to perform independent exercises and that is appropriate/safe

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Diagnoses :	No Medical Diagnosis Found				

-Will continue to monitor for declines in strength and make any adjustments as necessary as they may hinder the rehabilitative process

Need for assistance with personal care
-Continue nursing therapy
-Will continue to monitor for need for additional assistance and make adjustments as necessary

#Deconditioning/Gait instability - Patient is high risk for functional impairment without therapy and adequate pain control. Patient has high risk for developing contractures, pressure ulcers, poor healing or fall if not receiving adequate therapy and pain control.
#Patient will continue all of their medications per primary care physician.
Patients rehab and medical needs were discussed with nursing staff and therapy.
#Discharge planning. Pending therapy progress. Will continue discussion with Therapy team, family and SW.
#Pain - Continue current pain regimen as above

Patient will continue subacute rehabilitation with as needed PT and OT. PT will work on strengthening, endurance training, neuromotor training, gait training, balance training and stair climbing. OT will work on ADL and functional mobility training.

Advanced Care Plan: Full Code

POA/surrogate decision maker: reviewed as documented in EMR

Major Rehabilitation Goals: Mod I for mobility, ADL and transfers.
Rehabilitation Precautions: Fall

RECORDS REVIEW

I personally reviewed records including acute care hospital, skilled nursing facility, and therapy records. Summarization of the acute care course can be found inthe hospital course/HPI section. Discussed case with the primary medical team and/or leadership

DIAGNOSIS (ICD10)

S72141D: Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing J449: ChronicObstructive Pulmonary Disease, Unspecified I10: Essential (Primary) Hypertension M6281: Muscle Weakness (Generalized) Z741: Need For Assistance With Personal Care

MIPS

** Document e-signed by Paul Ilkanich, MD on Aug 11, 2025 1:26 PM PDT**

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Date: Aug 20, 2025
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Allergies :	Lisinopril, PHENobarbital, tiZANIdine, Cymbalta				
Diagnoses :	No Medical Diagnosis Found				

Author:_api_claimocity [e-SIGNED]

Skin & Wound Evaluation V7.0

Resident: Brown, Mildred (10047) | **Effective Date:** 08/12/2025 09:16 | **Location:** 500-B 523 0
Initial Admission: 07/30/2025 | **Admission:** 07/30/2025 | **Date of Birth:** 01/31/1934
Score: NA | **Category:** NA | **Physician:** Doodnauth, Davanand

A. Describe

1. Type:
- ○ 1. Abrasion
- ○ 2. Abscess
- ○ 3. Arterial
- ○ 4. Blister
- ○ 5. Bruise
- ○ 6. Burn
- ○ 7. Cancer Lesion
- ○ 8. Diabetic
- ○ 9. Hematoma
- ○ 10. Hidradenitis Suppurativa
- ○ 11. Laceration
- ○ 12. Moisture Associated Skin Damage (MASD)
- ○ 13. Mole
- ○ 14. Open Lesion
- ◉ 15. Pressure
- ○ 16. Pressure - Kennedy Terminal Ulcer
- ○ 17. Pressure - Medical Device Related Pressure Injury
- ○ 18. Rash
- ○ 19. Skin Tear
- ○ 20. Surgical
- ○ 21. Venous
- ○ 22. Other

15a. Stage:
- ○ 1. Stage 1: Non-blanchable erythema of intact skin
- ○ 2. Stage 2: Partial-thickness skin loss with exposed dermis
- ○ 3. Stage 3: Full-thickness skin loss
- ○ 4. Stage 4: Full-thickness skin and tissue loss
- ○ 5. Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration
- ○ 6. Mucosal Membrane: found on mucous membrane
- ◉ 7. Unstageable: Obscured full-thickness skin and tissue loss

15a7a. Due To:
- ◉ 1. Slough and/or eschar
- ○ 2. Non-removable device/dressing

22. Location

Right Heel

23. Acquired:
- ○ 1. In-House Acquired
- ◉ 2. Present on Admission

24. How long has the wound been present? (wound age when first assessed, after that it is auto calculated):
- ○ 1. New
- ○ 2. Exact Date
- ○ 3. 1 week
- ○ 4. 2 weeks
- ○ 5. 1 month
- ○ 6. 1-3 months
- ○ 7. 3-6 months
- ○ 8. 6-9 months

- 9. 9-12 months
- 10. 1-2 years
- 11. Over 2 years
- 12. Unknown

24a. Exact Date:

25. Staged by

- 1. N/A
- 2. In-house nursing
- 3. Home Health
- 4. Hospice
- 5. Health Care Provider
- 6. Wound Care Clinic
- 7. Other

B. Wound Measurements

1. Area: 0.5 cm2
2. Length: 1.1 cm
3. Width: 0.7 cm
4. Depth: Not Applicable
5. Undermining: Not Applicable
6. Tunneling: Not Applicable

C. Wound Bed

1. ☐ Epithelial
2. ☐ Granulation
3. ☐ Slough
4. ☑ Eschar

4a. % Eschar

- 1. 100% of wound filled
- 2. 90% of wound filled
- 3. 80% of wound filled
- 4. 70% of wound filled
- 5. 60% of wound filled
- 6. 50% of wound filled
- 7. 40% of wound filled
- 8. 30% of wound filled
- 9. 20% of wound filled
- 10. 10% of wound filled
- 11. 0% of wound filled

5. Evidence of Infection

- [x] 1. Fever
- [x] 2. Increased drainage
- [ ] 3. Increased pain
- [ ] 4. Malaise
- [ ] 5. Redness/inflammation
- [ ] 6. Streaking
- [ ] 7. Warmth
- [x] 8. None
- [ ] 9. Not applicable

6. Other

- [ ] 1. Bleeding
- [ ] 2. Bone
- [ ] 3. Fibrin
- [ ] 4. Gangrene
- [ ] 5. Hematoma
- [ ] 6. Hypergranulated
- [ ] 7. Intact blister
- [ ] 8. Islands of epithelium
- [ ] 9. Pink or red
- [ ] 10. Ruptured blister
- [ ] 11. Scab
- [ ] 12. Sutured
- [x] 13. None
- [ ] 14. Not applicable
- [ ] 15. Other

D. Exudate

1. Amount

- (•) 1. None
- ( ) 2. Light
- ( ) 3. Moderate
- ( ) 4. Heavy

2. Type

- (•) 1. None
- ( ) 2. Serous
- ( ) 3. Sanguineous/Bloody
- ( ) 4. Serosanguineous
- ( ) 5. Purulent
- ( ) 6. Seropurulent

3. Odor noted after cleansing

- (•) 1. None
- ( ) 2. Faint
- ( ) 3. Moderate
- ( ) 4. Strong

E. Periwound

1. Edges:

- [ ] 1. Attached: Edge appears flush with wound bed or as a sloping edge
- [ ] 2. Non-Attached: Edge appears as a cliff
- [ ] 3. Rolled Edge (Epibole): Edge appears curled under
- [ ] 4. Epithelialization: New, pink to purple, shiny skin tissue

2. Surrounding Tissue:

- [x] 1. Blanching (whitening of external tissue)
- [x] 2. Blister
- [x] 3. Calloused – Fibrotic or Hyper-keratotic
- [x] 4. Dark reddish brown
- [x] 5. Denuded – loss of epidermis caused by exposure to urine, feces, body fluids, wound exudate or friction.
- [x] 6. Discoloration - black/blue
- [x] 7. Dry/Flaky
- [x] 8. Eczematous
- [x] 9. Erythema: Redness of the skin - may be intense bright red to dark red or purple
- [x] 10. Excoriated: Superficial loss of tissue
- [x] 11. Fragile: Skin that is at risk for breakdown
- [x] 12. Intact: Unbroken skin
- [x] 13. Macerated: Wet, white, waterlogged tissue
- [x] 14. Normal in color
- [x] 15. Scarring
- [x] 16. Other

3. Induration
   - (●) 1. None present
   - ( ) 2. Induration, < 2cm around wound
   - ( ) 3. Induration 2-4 cm extending < 50% around wound
   - ( ) 4. Induration 2-4 cm extending > 50% around wound
   - ( ) 5. Induration > 4 cm in any area around wound
4. Edema
   - (●) 1. No swelling or edema
   - ( ) 2. Non-pitting edema extends < 4cm around wound
   - ( ) 3. Non-pitting edema extends > 4 cm around wound
   - ( ) 4. Pitting edema extends < 4 cm around wound
   - ( ) 5. Crepitus and/or pitting edema extends > 4 cm around wound
5. Periwound Temperature:
   - ( ) 1. Cool
   - ( ) 2. Normal
   - ( ) 3. Warm
   - ( ) 4. Hot (localized heat)

F. Wound Pain

1. [x] Cognitively Impaired

8. Pain:

0	1	2	3	4	5	6	7	8	9	10

9. Pain Frequency:
   - (●) 1. None
   - ( ) 2. Intermittent
   - ( ) 3. At Dressing
   - ( ) 4. Continuous
10. Notes on Pain:

n/a

G. Orders

1. Goal of Care:
   - ( ) 1. Healable
   - (●) 2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration

- (●) 3. Monitor/Manage: Wound healing not achievable due to untreatable underlying condition

H. Treatment

1. Dressing appearance:
   - [x] 1. Intact
   - [ ] 2. Missing
   - [ ] 3. Dry
   - [ ] 4. Saturated
   - [ ] 5. Leaking
   - [ ] 6. None
2. Cleansing Solution
   - [ ] 1. Acetic Acid
   - [ ] 2. Cetrimide
   - [ ] 3. Chlorhexidine
   - [ ] 4. Hydrogen peroxide
   - [x] 5. Normal Saline
   - [ ] 6. Povidone Iodine
   - [ ] 7. Soap & Water
   - [ ] 8. Sodium hypochlorite
   - [ ] 9. Sterile Water
   - [ ] 10. Water
   - [ ] 11. Generic wound cleanser
   - [ ] 12. Other
   - [ ] 13. None
3. Debridement
   - (●) 1. Autolytic
   - (●) 2. Biologic
   - (●) 3. Enzymatic
   - (●) 4. Mechanical
   - (●) 5. Polyacrylate
   - (●) 6. Sharp
   - (●) 7. Surgical-outpatient
   - (●) 8. None
4. Primary Dressing:
   - [ ] 1. Antimicrobial
   - [ ] 2. Antifungal
   - [ ] 3. Biologic
   - [ ] 4. Calcium Alginate
   - [ ] 5. Charcoal
   - [ ] 6. Clear Acrylic
   - [ ] 7. Composite Dressing
   - [ ] 8. Film/Membrane
   - [ ] 9. Foam
   - [ ] 10. Hydrocolloid
   - [ ] 11. Hydrogel
   - [ ] 12. Hydrophilic Fiber
   - [ ] 13. Hypertonic
   - [ ] 14. Negative Pressure Wound Therapy
   - [ ] 15. Non-Adherent Synthetic
   - [ ] 16. Pain controlling
   - [x] 17. Other
   - [ ] 18. No dressing applied

17a. Other, specify

Skin prep

5. Secondary Dressing:

- [x] 1. Composite
- [x] 2. Compression wrap
- [x] 3. Dry
- [x] 4. Film/Membrane
- [x] 5. Foam
- [x] 6. Hydrocolloid
- [x] 7. Silicone
- [x] 8. Other
- [x] 9. No secondary dressing

6. Modalities

- [x] 1. Electrical stimulation
- [x] 2. Electromagnetic therapy
- [x] 3. Ultrasound mist
- [x] 4. Other
- [x] 5. None

7. Additional Care

- [x] 1. Air Flow Pad
- [x] 2. Compression
- [x] 3. Cushion
- [x] 4. Customized shoe wear
- [x] 5. Foam Mattress
- [x] 6. Foot cradle
- [x] 7. Heel Suspension/Protection device
- [x] 8. Incontinence management
- [x] 9. Mattress with Pump
- [x] 10. Mobility aid(s) provided
- [x] 11. Molsture barrier
- [x] 12. Moisture Control
- [x] 13. Nutrition/Dietary supplementation
- [x] 14. Padded rails/chair
- [x] 15. Positioning Wedge
- [x] 16. Repositioning device(s)
- [x] 17. Turning/repositioning program
- [x] 18. Other
- [x] 19. None

I. Progress

1. Progress:

- (x) 1. New
- ( ) 2. Improving
- ( ) 3. Stable
- ( ) 4. Stalled
- ( ) 5. Deteriorating
- ( ) 6. Monitoring
- ( ) 7. Resolved

2. Infection

- ( ) 1. MD/Provider diagnosed infection
- ( ) 2. Suspected Infection
- (x) 3. None

3. Notes:

Skin & Wound Evaluation V7.0

Resident: Brown, Mildred (10047)

n/a

4. Education:

n/a

Notifications:

5. ☑ Practitioner Notified

5a. Enter name of practitioner notified:

Dr. Doodnauth

6. ☑ Resident/Responsible Party Notified:

6a. Enter name of resident/responsible party notified:

Brenda

7. ☑ Dietician Notified

7a. Enter the name of dietician notified:

Haven Kitchens

8. ☑ Therapy (PT, OT, ST) Notified

Signed By	Signed Date
Andreala Clark, LPN, Unit Coordinator [e-SIGNED]	08/14/2025