Frankfort Regional
Healthcare at Home

2041 Creative Drive, Suite 250
Lexington, KY 40505
Phone: (859) 269-2587
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Attention: **From:** Marla Cain

Fax: (859) 399-6697 **Date:** 10/28/2025 4:24 PM EST

Phone: **Pages:** 61 (including cover)

Re: Nurses notes and wnd care / measurements (last 4)

Comments:

As requested via phone call from Todd McGrath, please let me know if you need anything else. Thank you, Marla,

Frankfort Regional Healthcare at Home

10/28/2025 04:21:20 PM
Printed By: CAIN, MARLA

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/23/2025 **Visit Number:** 7 **Visit Type:** SN11 - SN VISIT

General: NICKENS, KHALILAH B. LEX00023560901

Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:
10/23/2025	7	SN11 - SN VISIT	LEX	X

Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:
376214	RACHEL DAUGHERTY RN	AM	0.00	0	0	0

Time:

TRAVEL TIME	DRIVE START TIME	10/23/2025 03:54 PM	DRIVE END TIME	10/23/2025 04:12 PM
IN-HOME TIME	BEGAN	10/23/2025 04:12 PM	INCOMPLETE	10/23/2025 04:57 PM
DOCUMENTATION TIME	RESUMED	10/23/2025 07:09 PM	COMPLETED	10/23/2025 07:21 PM

Total In-Home Time:	0.74	Hours
Total Drive Time:	0.31	Hours
Total Doc Time:	0.21	Hours
Total Time:	0.95	Hours

Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrument Problems
Temperature	97.2	10/23/2025 04:22 PM	FOREHEAD	N
Pulse	87	10/23/2025 04:22 PM	RADIAL	N
Pulse Characteristics:			*WNL	
Respirations	18	10/23/2025 04:22 PM		N
Respiration Characteristics:			WNL	
Blood Pressure	138 / 78	10/23/2025 04:22 PM	LYING ARM - RT	N
Oxygen Saturation Level (%)	94	10/23/2025 04:23 PM		N
Oxygen Saturation Characteristics:			ON ROOM AIR	
Pain	0	10/23/2025 04:22 PM		N

Assessment

PATIENT IDENTIFIERS

INDICATE TWO PATIENT IDENTIFERS USED FOR THIS VISIT:

PATIENT NAME
DATE OF BIRTH
VISUAL RECOGNITION

HEAD/NECK

INDICATE HEAD AND NECK ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NO PROBLEMS IDENTIFIED

EYES/EARS/NOSE/THROAT

INDICATE EYES/EARS/NOSE/THROAT FINDINGS:

PERRL

PAIN

DOES THE PATIENT REPORT OR EXHIBIT PAIN?

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
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Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/23/2025 **Visit Number:** 7 **Visit Type:** SN11 - SN VISIT

Assessment

NO - PATIENT IS A 0 ON A 0-10 PAIN SCALE AND/OR EXHIBITS A 0 ON STANDARDIZED PAIN SCALES

INTEGUMENTARY - ICC

INDICATE INTEGUMENTARY (HEAD TO TOE ASSESSMENT) FINDINGS INCLUDING OBSERVING FOR NEW PRESSURE ULCERS AND CHECKING BETWEEN THE TOES:

WOUND(S)

DOES THE PATIENT HAVE IV ACCESS?

NO

CARDIOVASCULAR

INDICATE CARDIOVASCULAR FINDINGS:

WNL

STABLE WITH CURRENT MEDICATION REGIMEN/INTERVENTIONS

RESPIRATORY

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

WNL

DOES THE PATIENT UTILIZE SUPPLEMENTAL OXYGEN – EITHER CONTINUOUSLY, INTERMITTENTLY OR PRN?

NO

GENITOURINARY

INDICATE GENITOURINARY FINDING(S):

INDWELLING/SUPRAPUBIC CATHETER

INDICATE INDWELLING/SUPRAPUBIC CATHETER FINDINGS (MARK ALL THAT APPLY):

WNL

INDICATE SIZE AND TYPE OF CATHETER

20 FRENCH 30 ML

INDICATE INSERTION / LAST CHANGED DATE:

10/23/2025

GASTROINTESTINAL

INDICATE GASTROINTESTINAL ASSESSMENT FINDING(S): (MARK ALL THAT APPLY)

WNL

NUTRITIONAL

INDICATE NUTRITIONAL STATUS SINCE LAST VISIT:

NO CHANGE

COGNITIVE/BEHAVIORAL

WAS BEHAVIORAL STATUS ASSESSED?

YES

INDICATE BEHAVIORAL ASSESSMENT FINDINGS:

NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

NEUROLOGIC

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

ALERT
ORIENTED TO PERSON
ORIENTED TO TIME
ORIENTED TO PLACE
ABLE TO FOLLOW SIMPLE COMMANDS
FORGETFUL

INDICATE ABNORMAL NEUROLOGIC FINDINGS:

NO CHANGE-PATIENT AT BASELINE

Visit Note Report

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Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/23/2025 **Visit Number:** 7 **Visit Type:** SN11 - SN VISIT

Assessment

OTHER (SPECIFY)

INDICATE OTHER ABNORMAL NEUROLOGIC FINDINGS:
SPINA. BIFIDA

ENDOCRINE/HEMATOPOIETIC

INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT FINDINGS:
NO ENDOCRINE/HEMATOPOIETIC FINDINGS

IS THE CLIENT TAKING AN ANTICOAGULANT?
NO

FUNCTIONAL

INDICATE MUSCULOSKELETAL STATUS:
OTHER - SPECIFY

INDICATE OTHER MUSCULOSKELETAL FINDINGS (PLEASE INDICATE TYPE, ANATOMICAL LOCATION, AND DESCRIPTION):
SPINAL BIFIDA, DOES NOT AMBULATE

SUPERVISORY FUNCTIONS

WERE SUPERVISORY FUNCTIONS PERFORMED THIS VISIT?
NO

INDICATE REASON SUPERVISORY FUNCTIONS NOT PERFORMED:
NOT APPLICABLE

CARE COORDINATION

INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES INVOLVED IN THIS CASE:
NO

ANY CHANGES TO THE PLAN OF CARE OR TREATMENT WERE COMMUNICATED TO THE PATIENT AND/OR PATIENT REPRESENTATIVE AND/OR CAREGIVER?
N/A

Wound Assessment

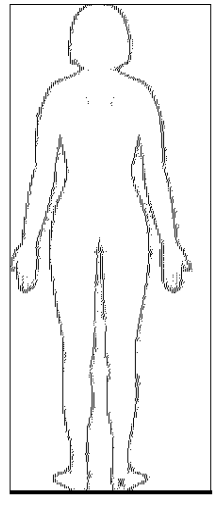
Historical wounds are retained as inactive and wound numbers continuously increment for subsequent episodes and admissions.

Anatomical Figures

Anatomical View

Wound # / Location / Type / Source

Question	Answer
FEMALE POSTERIOR	
#12 - HEEL, RT, UNSPECIFIED - HCHB	
Onset Date: 03/20/2025	
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	21
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1.8 X 1.5 X 0.2
SURFACE AREA (SQ CM)	2.7
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	75-100%
EDGES	DISTINCT
SHAPE	ROUND
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SMALL
ODOR	NONE
EPITHELIALIZATION	75-<100%



Visit Note Report

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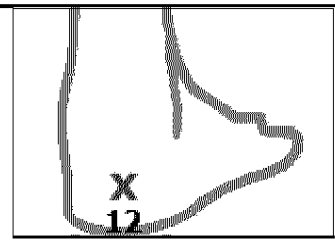
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/23/2025 **Visit Number:** 7 **Visit Type:** SN11 - SN VISIT

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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO LEFT GREAT TOE AND RIGHT HEEL AS FOLLOWS: CLEANSED WITH VASHE, APPLIED HYDROFERA BLUE READY, COVERED WITH DRY GAUZE, SECURED WITH TAPE USING CLEAN TECHNIQUE. CHANGE DRESSING EVERY OTHER DAY AND PRN FOR SOILING/DISLODGEMENT. * PATIENT TOLERATED WELL WITH NO COMPLIANTS DURING PROCEDURE



Wound Images
N/A

Narrative

PLEASE DOCUMENT SPECIFIC SKILL PROVIDED, PATIENTS RESPONSE TO TREATMENT AND SUMMARY OF PATIENTS PROGRESS TOWARD GOALS:

PATIENT LAYING IN BED UPON THIS NURSE'S ARRIVAL. PATIENT REPORTED SHE HAD JUST GOTTEN BACK FROM THE SENIOR CENTER AND HAD A GREAT DAY TODAY. PATIENT DENIES PAIN AND REPORTS NO FALLS. WOUND CARE COMPLETED TO RIGHT HEEL WITHOUT ISSUES, COMPLICATIONS, OR SIGNS AND SYMPTOMS OF INFECTION. AREA MEASURESED SMALLER THAN LAST WEEK FROM 2 X 2X 0.2 CMTO 1.8 X 1.5 X .2 CM. PATIENT GOES TO PODIATRY USUALLY ONCE A MONTH TO HAVE WOUND LOOKED AT. PATIENT VERY PLEASED WITH PROGRESS. PATIENT'S SUPRAPUBIC CATHETER CHANGED TODAY WITHOUT ISSUES, OLD CATHETER REMOVED AFTER BALLOON WAS DEFLATED. 30 MLS RETURNED FROM BALLOON, NEW S/P CATHETER 20 FRENCH 30 MLS CATHETER WAS INSERTED WITHOUT ISSUES OR COMPLICATIONS AND 75 MLS OF URINE RETURNED. PATIENT TOLERATED PROCEDURE WELL. PATIENT LIVES WITH SISTERS WHO ARE MAIN CAREGIVERS. PATIENT INSTRUCTED TO CALL OFFICE WITH ANY ISSUES BETWEEN NOW AND NEXT SCHEDULED VISIT.PATIENT REPORTED "I WILL"

Patient Goals

Patient Goal

TO GET STRONGER, FEEL BETTER, WOUND TO HEAL

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/23/2025 **Visit Number:** 7 **Visit Type:** SN11 - SN VISIT

Interventions Provided

1. ASSESS AND EVALUATE CO-MORBID CONDITIONS

DETAILS/COMMENTS: ASSESSED AND EVALUATED THAT CO-MORBID CONDITIONS AND SYMPTOMS RELATED TO CO-MORBID CONDITIONS ARE CURRENTLY CONTROLLED.

REVIEWED AND INSTRUCTED ON RECENT EXACERBATION OF CO-MORBID CONDITIONS

2. INSTRUCT PATIENT/CAREGIVER ON PATHOPHYSIOLOGY/UNDERLYING CAUSES OF HYPERTENSION

DETAILS/COMMENTS: INSTRUCTED TO UTILIZE HYPERTENSION ZONE TOOL TO RECONGIZE AND REPORT SIGNS AND SYMPTOMS OF A CHANGE IN CONDITION.

EDUCATED ON CAUSES OF HYPERTENSION

3. INSTRUCT PATIENT/CAREGIVER ON SIGNS / SYMPTOMS OF HYPERTENSION

DETAILS/COMMENTS: INSTRUCTED ON SIGNS / SYMPTOMS OF HYPERTENSION SUCH AS NOSE BLEEDS, DIZZINESS, WEAKNESS, HEADACHE, EAR NOISE AND BUZZING, BLURRED VISION AND/OR ALTERED LEVEL OF CONSCIOUSNESS.

4. INSERT/CHANGE CATHETER

DETAILS/COMMENTS: REMOVED OLD CATHETER

CLEANSED PERINEAL AREA UTILIZING CLEAN TECHNIQUE, 20 FRENCH CATHETER INSERTED WITH 30 ML BULB, INFLATED WITH 30 ML OF WATER AND SECURED CATHETER

RETURNED 50 ML URINE, SECURED TUBING AND ENSURED PROPER BAG PLACEMENT

5. PROVIDE/INSTRUCT PATIENT/CAREGIVER ON WOUND CARE

DETAILS/COMMENTS: INSTRUCTED ON WOUND CARE TO RIGHT HEEL

6. PROVIDE INSTRUCTION RELATED TO PATIENT'S RISK FOR FALLS AND SAFETY TO PREVENT FALLS

DETAILS/COMMENTS: INSTRUCTED ON REMOVING HAZARDS IN THE HOME

INSTRUCTED TO KEEP A PHONE CLOSE BY AT ALL TIMES

INSTRUCTED THAT IF GRAB BARS ARE INSTALLED, BE SURE THEY ARE ATTACHED INTO STUDS IN THE WALL FOR SAFETY.

7. EVALUATE PATIENT'S RESPONSE TO PHARMACOLOGICAL AND NON-PHARMACOLOGICAL PAIN REGIMEN INCLUDING PATIENT'S RESPONSE TO THE PAIN SCALE.

DETAILS/COMMENTS: ASSESSED THAT PAIN MEDICATIONS ARE BEING TAKEN AS PRESCRIBED

ASSESSED THAT BOTH A PHARMACOLOGICAL AND NONPHARMACOLOGICAL PAIN REGIMEN ARE BEING UTILIZED

ASSESSED THAT USE OF PAIN MEDICATIONS WITH ACTIVITIES/WOUND CARE IS COORDINATED.

8. INSTRUCT PATIENT/CAREGIVER ON THE USE OF MEDICATIONS TO TREAT DISEASE PROCESSES

DETAILS/COMMENTS: INSTRUCTED ON MEDICATION REGIMEN INCLUDING CORRECT MEDICATION, DOSAGE, FREQUENCY, TIMES

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/23/2025 **Visit Number:** 7 **Visit Type:** SN11 - SN VISIT

Goals Met

1. CHANGES TO CO-MORBID CONDITIONS WILL BE IDENTIFIED AND REPORTED TO THE PROVIDER
2. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF THE PATHOPHYSIOLOGY/UNDERLYING CAUSES OF HYPERTENSION
3. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF THE SIGNS AND SYMPTOMS OF HYPERTENSION
4. PATIENT TOLERATED CATHETER INSERTION WITH RETURN OF URINE
5. PATIENT VERBALIZES TOLERANCE TO WOUND CARE. PATIENT / CAREGIVER VERBALIZES / RETURNS DEMONSTRATION OF WOUND CARE
6. PATIENT / CAREGIVER VERBALIZE/DEMONSTRATE APPROPRIATE METHODS TO REDUCE FALL RISK.
7. INCREASED PAIN OR INEFFECTIVE PAIN CONTROL MEASURES ARE IDENTIFIED AND PROMPTLY REPORTED TO THE PROVIDER.
8. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF THE USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.

Goals Not Met

1. FALL RISK IS PROMPTLY IDENTIFIED TO IMPLEMENT INTERVENTIONS QUICKLY.
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL
2. PATIENT / CAREGIVER ADMINISTERS MEDICATIONS AS PRESCRIBED AS EVIDENCED BY NO ADVERSE EFFECTS OR MEDICATION ERROR.
EXCEPTION CODE: NOT APPLICABLE TO CLIENT'S POC

Agent Signature:

RACHEL DAUGHERTY RN 10/23/2025 07:21 PM
(Electronically Signed)

Client Signature:

Frankfort Regional Healthcare at Home

10/28/2025 04:20:59 PM
Printed By: CAIN, MARLA

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

General: NICKENS, KHALILAH B. LEX00023560901

Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:
10/16/2025	6	RN10 - RN VISIT + SUP	LEX	X

Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:
376214	RACHEL DAUGHERTY RN	AM	0.00	0	0	0

Time:

TRAVEL TIME	DRIVE START TIME	10/16/2025 03:36 PM	DRIVE END TIME	10/16/2025 04:04 PM
IN-HOME TIME	BEGAN	10/16/2025 04:04 PM	INCOMPLETE	10/16/2025 04:39 PM
DOCUMENTATION TIME	RESUMED	10/19/2025 03:54 PM	COMPLETED	10/19/2025 04:01 PM

Total In-Home Time:	0.58	Hours
Total Drive Time:	0.47	Hours
Total Doc Time:	0.12	Hours
Total Time:	0.71	Hours

Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrument Problems
Temperature	99	10/16/2025 04:30 PM	FOREHEAD	N
Pulse	84	10/16/2025 04:30 PM	RADIAL	N
Pulse Characteristics:			*WNL	
Respirations	18	10/16/2025 04:30 PM		N
Respiration Characteristics:			WNL	
Blood Pressure	128 / 72	10/16/2025 04:30 PM	SITTING ARM - LT	N
Oxygen Saturation Level (%)	95	10/16/2025 04:37 PM		N
Oxygen Saturation Characteristics:			ON ROOM AIR	
Pain	0	10/16/2025 04:37 PM		N

Assessment

PATIENT IDENTIFIERS

INDICATE TWO PATIENT IDENTIFERS USED FOR THIS VISIT:

PATIENT NAME
DATE OF BIRTH
VISUAL RECOGNITION

HEAD/NECK

INDICATE HEAD AND NECK ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NO PROBLEMS IDENTIFIED

EYES/EARS/NOSE/THROAT

INDICATE EYES/EARS/NOSE/THROAT FINDINGS:

PERRL

PAIN

DOES THE PATIENT REPORT OR EXHIBIT PAIN?

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

Assessment

NO - PATIENT IS A 0 ON A 0-10 PAIN SCALE AND/OR EXHIBITS A 0 ON STANDARDIZED PAIN SCALES

INTEGUMENTARY - ICC

INDICATE INTEGUMENTARY (HEAD TO TOE ASSESSMENT) FINDINGS INCLUDING OBSERVING FOR NEW PRESSURE ULCERS AND CHECKING BETWEEN THE TOES:

WOUND(S)

DOES THE PATIENT HAVE IV ACCESS?

NO

CARDIOVASCULAR

INDICATE CARDIOVASCULAR FINDINGS:

WNL
STABLE WITH CURRENT MEDICATION REGIMEN/INTERVENTIONS

RESPIRATORY

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

WNL

DOES THE PATIENT UTILIZE SUPPLEMENTAL OXYGEN – EITHER CONTINUOUSLY, INTERMITTENTLY OR PRN?

NO

GENITOURINARY

INDICATE GENITOURINARY FINDING(S):

INDWELLING/SUPRAPUBIC CATHETER

INDICATE INDWELLING/SUPRAPUBIC CATHETER FINDINGS (MARK ALL THAT APPLY):

WNL

INDICATE SIZE AND TYPE OF CATHETER

20 FRENCH, S/P

INDICATE INSERTION / LAST CHANGED DATE:

9/25/2025

GASTROINTESTINAL

INDICATE GASTROINTESTINAL ASSESSMENT FINDING(S): (MARK ALL THAT APPLY)

WNL

NUTRITIONAL

INDICATE NUTRITIONAL ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

PATIENT TAKES 3 OR MORE PRESCRIBED OR OVER THE COUNTER DRUGS PER DAY - 1 PT
PATIENT NOT ALWAYS PHYSICALLY ABLE TO SHOP, COOK, AND/OR FEED SELF - 2 PTS

TOTAL NUTRITION ASSESSMENT SCORE:

3

BASED ON THE SCORE, THE NUTRITIONAL RISK LEVEL IS:

PATIENT IS AT A MODERATE NUTRITIONAL RISK

COGNITIVE/BEHAVIORAL

WAS BEHAVIORAL STATUS ASSESSED?

YES

INDICATE BEHAVIORAL ASSESSMENT FINDINGS:

NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

NEUROLOGIC

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

ALERT
ORIENTED TO PERSON
ORIENTED TO TIME

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
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Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

Assessment

ORIENTED TO PLACE
ABLE TO FOLLOW SIMPLE COMMANDS
FORGETFUL

INDICATE ABNORMAL NEUROLOGIC FINDINGS:
PARALYSIS

INDICATE THE TYPE OF PARALYSIS
PARAPLEGIA

ENDOCRINE/HEMATOPOIETIC

INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT FINDINGS:
NO ENDOCRINE/HEMATOPOIETIC FINDINGS

IS THE CLIENT TAKING AN ANTICOAGULANT?
NO

FUNCTIONAL

INDICATE MUSCULOSKELETAL STATUS:
OTHER - SPECIFY

INDICATE OTHER MUSCULOSKELETAL FINDINGS (PLEASE INDICATE TYPE, ANATOMICAL LOCATION, AND DESCRIPTION):
SPINAL BIFIDA

SUPERVISORY FUNCTIONS

INDICATE DISCIPLINE OF EMPLOYEE BEING EVALUATED:
LICENSED VOCATIONAL NURSE

INDICATE NAME OF LVN BEING EVALUATED IF APPLICABLE:
KASEY ATHA, LPN
KIM WAINSCOTT, LPN

IS THE CLIENT SATISFIED WITH THE CURRENT CARE BEING PROVIDED BY THE LVN?
YES

DOES THE LVN NOTIFY THE CLIENT OR CAREGIVER, IN TIMELY FASHION, OF CHANGES IN THE PLAN OF CARE, SCHEDULE / TIME CHANGES?
YES

DOES THE LVN RESPECT THE CLIENT'S RIGHTS RELATED TO PRIVACY, DIGNITY, CONFIDENTIALITY, PERSONAL BELONGINGS AND PROPERTY?
YES

INDICATE CHANGES IN PLAN/GOAL/UPDATE, IF APPLICABLE:
N/A

CARE COORDINATION

INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES INVOLVED IN THIS CASE:
NO

ANY CHANGES TO THE PLAN OF CARE OR TREATMENT WERE COMMUNICATED TO THE PATIENT AND/OR PATIENT REPRESENTATIVE AND/OR CAREGIVER?
N/A

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
FEMALE ANTERIOR	
#10 - GREAT TOE, LT, UNSPECIFIED [INACTIVATED 10/16/2025] - HCHB	
Onset Date: 09/28/2023	
CHANGE IN STATUS	INACTIVATE WOUND - COMPLETELY EPITHELIALIZED

Visit Note Report

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Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

WOUND ASSESSED	YES
TOTAL WAT SCORE	N/A
WOUND CARE PROVIDED	

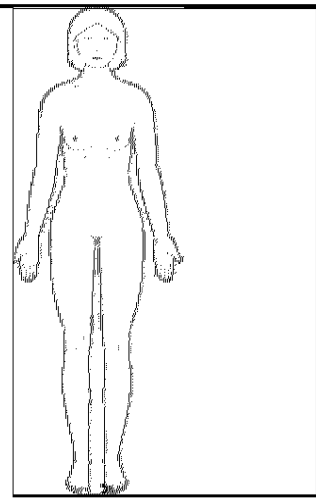
Wound Images
N/A

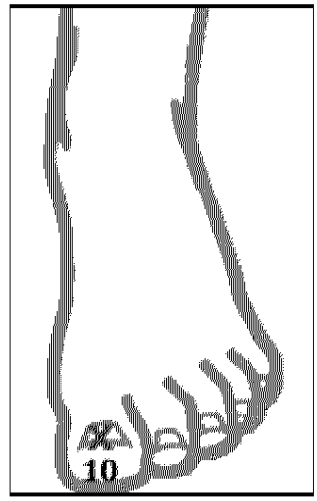
FEMALE POSTERIOR

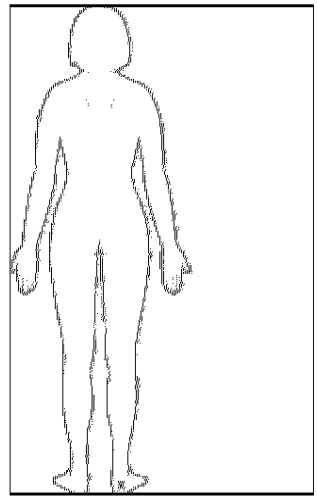
#12 - HEEL, RT, UNSPECIFIED - HCHB

Onset Date: 03/20/2025

CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	21
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1.5 X 1 X 0.2
SURFACE AREA (SQ CM)	1.5
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	75-100%
EDGES	DISTINCT
SHAPE	ROUND
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SMALL
ODOR	NONE
EPITHELIALIZATION	75-<100%
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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO LEFT GREAT TOE AND RIGHT HEEL AS FOLLOWS: CLEANSED WITH VASHE, APPLIED HYDROFERA BLUE READY, COVERED WITH DRY GAUZE, SECURED WITH TAPE USING CLEAN TECHNIQUE. CHANGE DRESSING EVERY OTHER DAY AND PRN FOR SOILING/DISLODGEMENT. * PATIENT TOLERATED WELL WITH NO COMPLIANTS DURING PROCEDURE





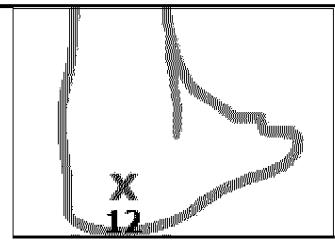


Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

Wound Images
N/A



Narrative

PLEASE DOCUMENT SPECIFIC SKILL PROVIDED, PATIENTS RESPONSE TO TREATMENT AND SUMMARY OF PATIENTS PROGRESS TOWARD GOALS:

UPON THIS NURSE'S ARRIVAL, PATIENT WAS SITTING IN WHEELCHAIR REPORTING SHE HAD JUST GOTTEN BACK FROM THE SENIOR CITIZENS CENTER. PATIENT DENIES PAIN TODAY. PATIENT'S CATHETER IS NOT DUE TO BE CHANGED UNTIL 10-25. WOUND CARE COMPLETED TODAY TO RIGHT HEEL WITHOUT COMPLICATIONS OR ANY SIGNS AND SYMPTOMS OF INFECTION. PICTURES AND MEASUREMENTS OBTAINED. WOUND TO LEFT GREAT TOE IS BEING INACTIVATED DUE TO HEALED. PATIENT REPORTS SHE WENT TO HER PODIATRIST YESTERDAY. PER PATIENT, SHE RECEIVED A GOOD REPORT AND WOUNDS ARE HEALING FINE. PATIENT'S SISTER IS DOING WOUND CARE ON DAYS SKILLED NURSE IS NOT IN HOME. PATIENT LIVES WITH HER 2 SISTERS. PATIENT INSTRUCTED TO CALL HOME HEALTH WITH ANY ISSUES OR COMPLICATIONS BETWEEN NOW AND NEXT VISIT.

Patient Goals

Patient Goal

TO GET STRONGER, FEEL BETTER, WOUND TO HEAL

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

Interventions Provided

1. INSTRUCT PATIENT / CAREGIVER TO COORDINATE ADMINISTRATION OF PAIN MEDICATION AND ACTIVITIES.

DETAILS/COMMENTS: INSTRUCTED TO COORDINATE ADMINISTRATION OF PAIN MEDICATION AND ACTIVITIES TO ALLOW TIME FOR ANALGESIC EFFECT

INSTRUCTED HOW TO UTILIZE THE ZONE TOOL TO RECOGNIZE SPECIFIC SIGNS, SYMPTOMS THAT NECESSITATE CALLING A NURSE, PROVIDER OR 911.

2. IDENTIFY EFFECTIVENESS OF PHARMACOLOGIC PAIN CONTROL REGIMEN AND CONTACT PROVIDER IF NEW/CHANGED REGIMEN IS REQUIRED.

DETAILS/COMMENTS: EDUCATED ON HOW PAIN CONTROL MEDICATION REGIMEN IS EFFECTIVE AS PRESCRIBED

3. INSTRUCT ON SPECIAL PRECAUTIONS FOR ALL HIGH-RISK MEDICATIONS (SUCH AS HYPOGLYCEMICS, ANTICOAGULANTS, ETC.) AND HOW AND WHEN TO REPORT PROBLEMS THAT MAY OCCUR

DETAILS/COMMENTS: INSTRUCTED ON HOW AND WHEN TO REPORT PROBLEMS THAT MAY OCCUR DUE TO HIGH-RISK MEDICATIONS

4. INSTRUCT PATIENT / CAREGIVER IN SCORING PAIN LEVEL TO ALLOW DETERMINATION OF IMPROVEMENT OR DECLINE OF PAIN MANAGEMENT.

DETAILS/COMMENTS: INSTRUCTED IN SCORING PAIN LEVEL TO ALLOW DETERMINATION OF IMPROVEMENT OF PAIN

EDUCATED ON HOW SCORING PAIN LEVEL HELPS RATE THE LEVEL OF PAIN SO IT CAN BE COMMUNICATED TO THE PROVIDER, OTHER HEALTH PROFESSIONALS, OR OTHER CAREGIVERS

5. INSTRUCT PATIENT / CAREGIVER THAT PAIN IS BEST CONTROLLED BEFORE IT REACHES AN UNMANAGEABLE LEVEL.

DETAILS/COMMENTS: INSTRUCTED THAT PAIN IS BEST CONTROLLED BEFORE IT REACHES AN UNMANAGEABLE LEVEL. MEDICATION SHOULD BE GIVEN PRIOR TO OR AS SOON AS POSSIBLE AFTER ONSET OF PAIN BEFORE IT BECOMES MORE INTENSE

INSTRUCTED HOW TO UTILIZE THE ZONE TOOL TO RECOGNIZE SPECIFIC SIGNS, SYMPTOMS THAT NECESSITATE CALLING A NURSE, PROVIDER OR 911.

6. EVALUATE PATIENT'S RESPONSE TO PHARMACOLOGICAL AND NON-PHARMACOLOGICAL PAIN REGIMEN INCLUDING PATIENT'S RESPONSE TO THE PAIN SCALE.

DETAILS/COMMENTS: ASSESSED THAT PAIN MEDICATIONS ARE BEING TAKEN AS PRESCRIBED

ASSESSED THAT BOTH A PHARMACOLOGICAL AND NONPHARMACOLOGICAL PAIN REGIMEN ARE BEING UTILIZED

7. INSTRUCT ON APPROPRIATE PAIN MANAGEMENT TECHNIQUES

DETAILS/COMMENTS: INSTRUCTED TO "CALL US FIRST" AND WHEN TO CALL 911

INSTRUCTED TO TAKE MEDICATIONS AS PRESCRIBED WHILE PAIN IS STILL TOLERABLE

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/16/2025 **Visit Number:** 6 **Visit Type:** RN10 - RN VISIT + SUP

Goals Met

1. PATIENT VERBALIZES / DEMONSTRATES ADEQUATE PAIN CONTROL AND INCREASED ABILITY TO COMPLETE ACTIVITIES WITHOUT COMPLAINTS OF PAIN.

2. PATIENT VERBALIZES DECREASED PAIN LEVEL AS A RESULT OF PHARMACOLOGIC PAIN CONTROL REGIMEN.

3. PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF SPECIAL PRECAUTIONS TO BE TAKEN FOR ALL HIGH-RISK MEDICATIONS

4. PATIENT/CAREGIVER WILL VERBALIZE UNDERSTANDING OF HOW AND WHEN TO REPORT PROBLEMS THAT MAY OCCUR DUE TO HIGH-RISK MEDICATIONS

5. PATIENT / CAREGIVER VERBALIZES KNOWLEDGE OF PAIN SCORING RELATED TO ACCURATELY DETERMINING THE IMPROVEMENT OR DECLINE OF PAIN MANAGEMENT.

6. PATIENT VERBALIZES ADEQUATE PAIN CONTROL AS A RESULT OF PAIN CONTROL REACHED PRIOR TO REACHING AN UNMANAGEABLE LEVEL.

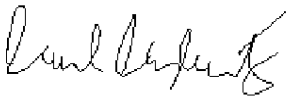
7. INCREASED PAIN OR INEFFECTIVE PAIN CONTROL MEASURES ARE IDENTIFIED AND PROMPTLY REPORTED TO THE PROVIDER.

8. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF PHARMACOLOGIC AND NON PHARMACOLOGIC PAIN CONTROL TECHNIQUES

Goals Not Met

1. PATIENT TOLERATED CATHETER INSERTION WITH RETURN OF URINE
EXCEPTION CODE: NOT APPLICABLE TO CURRENT VISIT

Agent Signature:



RACHEL DAUGHERTY RN 10/19/2025 04:01 PM
(Electronically Signed)

Client Signature:

Frankfort Regional Healthcare at Home

10/28/2025 04:20:25 PM
Printed By: CAIN, MARLA

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/09/2025 **Visit Number:** 5 **Visit Type:** SN11 - SN VISIT

General: NICKENS, KHALILAH B. LEX00023560901

Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:
10/09/2025	5	SN11 - SN VISIT	LEX	X

Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:
377755	KIMBERLY WAINSCOTT LPN	AM	0.00	0	0	0

Time:

TRAVEL TIME	DRIVE START TIME	10/09/2025 02:08 PM	DRIVE END TIME	10/09/2025 02:19 PM
IN-HOME TIME	BEGAN	10/09/2025 02:19 PM	COMPLETED	10/09/2025 02:56 PM

Total In-Home Time:	0.61	Hours
Total Drive Time:	0.19	Hours
Total Time:	0.61	Hours

Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrument Problems
Temperature	98.4	10/09/2025 02:27 PM	FOREHEAD	N
Pulse	80	10/09/2025 02:27 PM	RADIAL	N
Pulse Characteristics:			*WNL	
Respirations	16	10/09/2025 02:27 PM		N
Respiration Characteristics:			WNL	
Blood Pressure	122 / 70	10/09/2025 02:27 PM	SITTING ARM - LT	N
Pain	0	10/09/2025 02:27 PM		N

Assessment

PATIENT IDENTIFIERS

INDICATE TWO PATIENT IDENTIFERS USED FOR THIS VISIT:

PATIENT NAME
DATE OF BIRTH

HEAD/NECK

INDICATE HEAD AND NECK ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NO PROBLEMS IDENTIFIED

EYES/EARS/NOSE/THROAT

INDICATE EYES/EARS/NOSE/THROAT FINDINGS:

PERRL

PAIN

DOES THE PATIENT REPORT OR EXHIBIT PAIN?

NO - PATIENT IS A 0 ON A 0-10 PAIN SCALE AND/OR EXHIBITS A 0 ON STANDARDIZED PAIN SCALES

INTEGUMENTARY - ICC

INDICATE INTEGUMENTARY (HEAD TO TOE ASSESSMENT) FINDINGS INCLUDING OBSERVING FOR NEW PRESSURE ULCERS AND CHECKING BETWEEN THE TOES:

WOUND(S)

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/09/2025 **Visit Number:** 5 **Visit Type:** SN11 - SN VISIT

Assessment

DOES THE PATIENT HAVE IV ACCESS?
NO

CARDIOVASCULAR

INDICATE CARDIOVASCULAR FINDINGS:
EDEMA

INDICATE LOCATION OF EDEMA:
LOWER RIGHT
LOWER LEFT

INDICATE CHARACTERISTICS OF EDEMA (LOWER RIGHT):
TRACE

INDICATE CHARACTERISTICS OF EDEMA (LOWER LEFT):
TRACE

RESPIRATORY

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)
WNL

DOES THE PATIENT UTILIZE SUPPLEMENTAL OXYGEN – EITHER CONTINUOUSLY, INTERMITTENTLY OR PRN?
NO

GENITOURINARY

INDICATE GENITOURINARY FINDING(S):
INDWELLING/SUPRAPUBIC CATHETER

INDICATE INDWELLING/SUPRAPUBIC CATHETER FINDINGS (MARK ALL THAT APPLY):
WNL

INDICATE SIZE AND TYPE OF CATHETER
20FR/ 30ML

INDICATE INSERTION / LAST CHANGED DATE:
9/25/2025

GASTROINTESTINAL

INDICATE GASTROINTESTINAL ASSESSMENT FINDING(S): (MARK ALL THAT APPLY)
WNL

NUTRITIONAL

INDICATE NUTRITIONAL STATUS SINCE LAST VISIT:
NO CHANGE

COGNITIVE/BEHAVIORAL

WAS BEHAVIORAL STATUS ASSESSED?
YES

INDICATE BEHAVIORAL ASSESSMENT FINDINGS:
NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

NEUROLOGIC

INDICATE CLIENT'S MENTAL STATUS: (MARK ALL THAT APPLY)
ALERT
ORIENTED TO PERSON
ORIENTED TO PLACE
ABLE TO FOLLOW MULTI-STEP COMMANDS

INDICATE ABNORMAL NEUROLOGIC FINDINGS:
NO CHANGE-PATIENT AT BASELINE

ENDOCRINE/HEMATOPOIETIC

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/09/2025 **Visit Number:** 5 **Visit Type:** SN11 - SN VISIT

Assessment

INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT FINDINGS:
NO ENDOCRINE/HEMATOPOIETIC FINDINGS

IS THE CLIENT TAKING AN ANTICOAGULANT?
NO

FUNCTIONAL

INDICATE MUSCULOSKELETAL STATUS:
DECREASED STRENGTH

IN WHAT EXTREMITIES DOES DECREASED STRENGTH EXIST (MARK ALL THAT APPLY):
LOWER BILAT

SUPERVISORY FUNCTIONS

WERE SUPERVISORY FUNCTIONS PERFORMED THIS VISIT?
NO

INDICATE REASON SUPERVISORY FUNCTIONS NOT PERFORMED:
NOT APPLICABLE

CARE COORDINATION

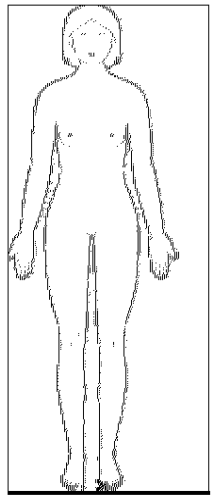
INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES INVOLVED IN THIS CASE:
NO

ANY CHANGES TO THE PLAN OF CARE OR TREATMENT WERE COMMUNICATED TO THE PATIENT AND/OR PATIENT REPRESENTATIVE AND/OR CAREGIVER?
N/A

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

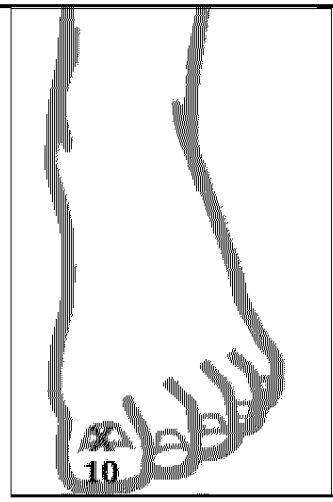
Question	Answer
FEMALE ANTERIOR	
#10 - GREAT TOE, LT, UNSPECIFIED [INACTIVATED 10/16/2025] - HCHB	
Onset Date: 09/28/2023	
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	N/A
MEASUREMENTS TAKEN	NO
REASON MEASUREMENTS NOT TAKEN	UNABLE
DEPTH DESCRIPTION	NON-BLAN
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	INTACT
EDGES	INDIST
SHAPE	ROUND
EXUDATE TYPE	NONE
EXUDATE AMOUNT	NONE
ODOR	NONE
EPITHELIALIZATION	100%
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

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

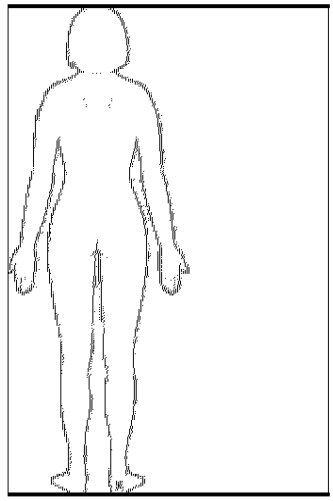
Visit Date: 10/09/2025 **Visit Number:** 5 **Visit Type:** SN11 - SN VISIT

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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	WOUND CARE TO LEFT GREAT TOE AND RIGHT HEEL AS FOLLOWS: CLEANSED WITH VASHE, APPLIED HYDROFERA BLUE READY, COVERED WITH DRY GAUZE, SECURED WITH TAPE USING CLEAN TECHNIQUE. CHANGE DRESSING EVERY OTHER DAY AND PRN FOR SOILING/DISLODGEMENT. SKIN INTACT TO LEFT GREAT TOE



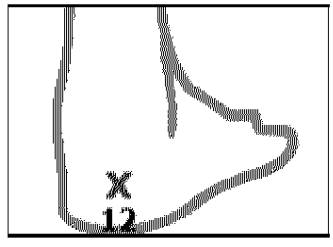
Wound Images
N/A

FEMALE POSTERIOR



#12 - HEEL, RT, UNSPECIFIED - HCHB
Onset Date: 03/20/2025

CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	27
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1.5 X 2.1 X 0.2
SURFACE AREA (SQ CM)	3.15
DEPTH DESCRIPTION	FULL THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	75-100%
EDGES	DISTINCT
SHAPE	ROUND
EXUDATE TYPE	SEROUS
EXUDATE AMOUNT	MOD
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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO



Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/09/2025 **Visit Number:** 5 **Visit Type:** SN11 - SN VISIT

DRAIN PRESENT	NO		
WOUND CARE PROVIDED	SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO LEFT GREAT TOE AND RIGHT HEEL AS FOLLOWS: CLEANSED WITH VASHE, APPLIED HYDROFERA BLUE READY, COVERED WITH DRY GAUZE, SECURED WITH TAPE USING CLEAN TECHNIQUE. CHANGE DRESSING EVERY OTHER DAY AND PRN FOR SOILING/DISLODGEMENT. * RIGHT HEEL WOUND WITH FULLY GRANULATED WOUND BED, EDGES INTACT AND WELL DEFINED. MODERATE AMOUNT SEROUS EXUDATE NOTED. PATIENT TOLERATED WOUND CARE WITHOUT COMPLAINTS OF PAIN. NO SIGNS OF INFECTION.		

Wound Images
N/A

Narrative

PLEASE DOCUMENT SPECIFIC SKILL PROVIDED, PATIENTS RESPONSE TO TREATMENT AND SUMMARY OF PATIENTS PROGRESS TOWARD GOALS:

PATIENT SITTING UP IN BED WATCHING AMERICAN IDELL ON HER TABLET ON SN ARRIVAL. PATIENT IS ALERT AND ORIENTED X2. VITAL SIGNS STABLE, AFEBRILE. NO RESPIRATORY SYMPTOMS NOTED, LUNGS CLEAR. ABDOMEN SOFT NONDISTENDED NONTENDER WITH BOWEL SOUNDS PRESENT X4 QUADS. DENIES NAUSEA VOMITING DIARRHEA. SUPRAPUBIC CATHETER PATENT WITH CLEAR YELLOW URINE DRAINING TO BEDSIDE DRAINAGE. PATIENT DENIES ABDOMINAL PAIN. WOUND CARE COMPLETED TO RIGHT HEEL AS ORDERED. WOUND BED FULLY GRANULATED, EDGES WELL DEFINED AND INTACT, MODERATE SEROUS EXUDATE NOTED. OLD DRESSING REMOVED WOUND CLEANSED WITH NORMAL SALINE, PATTED DRY, HYDROFERA BLUE APPLIED COVERED WITH GAUZE AND WRAPPED WITH KERLIX. PATIENT TOLERATED WOUND CARE WELL WITHOUT COMPLAINTS OF PAIN. HEEL LIFT BOOT IN PLACE FOR OFFLOADING AND PRESSURE RELIEF.

INSTRUCTED ON SIGNS / SYMPTOMS OF INFECTION TO WOUND INCLUDING INCREASED DRAINAGE, REDNESS, INCREASED PAIN, ODOR, FEVER, INCREASED EDEMA

INSTRUCTED HOW TO UTILIZE THE ZONE TOOL TO RECOGNIZE SPECIFIC SIGNS, SYMPTOMS THAT NECESSITATE CALLING A NURSE, PROVIDER OR 911.

Patient Goals

Patient Goal

TO GET STRONGER, FEEL BETTER, WOUND TO HEAL

Interventions Provided

1. PROVIDE/INSTRUCT PATIENT/CAREGIVER ON WOUND CARE

DETAILS/COMMENTS: INSTRUCTED ON WOUND CARE OF RIGHT HEEL

INSTRUCTED ON SIGNS / SYMPTOMS OF INFECTION TO WOUND INCLUDING INCREASED DRAINAGE, REDNESS, INCREASED PAIN, ODOR, FEVER, INCREASED EDEMA

INSTRUCTED HOW TO UTILIZE THE ZONE TOOL TO RECOGNIZE SPECIFIC SIGNS, SYMPTOMS THAT NECESSITATE CALLING A NURSE, PROVIDER OR 911.

Goals Met

1. PATIENT VERBALIZES TOLERANCE TO WOUND CARE. PATIENT / CAREGIVER VERBALIZES / RETURNS DEMONSTRATION OF WOUND CARE

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/09/2025 **Visit Number:** 5 **Visit Type:** SN11 - SN VISIT

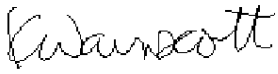
Goals Not Met

1. PATIENT TOLERATED CATHETER INSERTION WITH RETURN OF URINE
EXCEPTION CODE: NOT APPLICABLE TO CURRENT VISIT

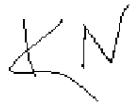
Supplies Delivered

2 - MEDIPORE RETENTION TAPE, 3 INCH X 10 YARD - 1 ROLL (3M) - ROLL
30 - GAUZE 4X4 12 PLY STERILE - 1 PACK OF 2 (MCKESSON) - PACK
14 - CONFORMING STRETCH GAUZE STERILE, 3IN X 4.1 YDS - 1 ROLL (MCKESSON) - ROLL

Agent Signature:



Client Signature:



KIMBERLY WAINSCOTT LPN 10/09/2025 02:56 PM
(Electronically Signed)

Last Modification Date: 10/9/2025 4:46 PM **Last Modified By:** SQL-SVC-JAMS-PRD-RWX

LATE ENTRY

SUPPLIES DELIVERED/USED EDITED BY SQL-SVC-JAMS-PRD-RWX ON Oct 9 2025 4:46PM

Frankfort Regional Healthcare at Home

10/28/2025 04:19:11 PM
Printed By: CAIN, MARLA

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/02/2025 **Visit Number:** 4 **Visit Type:** SN11 - SN VISIT

General: NICKENS, KHALILAH B. LEX00023560901

Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:
10/02/2025	4	SN11 - SN VISIT	LEX	X

Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:
377765	KASEY ATHA LPN	AM	0.00	45768	45814	46

Time:

TRAVEL TIME	DRIVE START TIME	10/02/2025 09:04 AM	DRIVE END TIME	10/02/2025 10:04 AM
IN-HOME TIME	BEGAN	10/02/2025 10:04 AM	COMPLETED	10/02/2025 10:43 AM

Total In-Home Time:	0.66	Hours
Total Drive Time:	1.00	Hours
Total Time:	0.66	Hours

Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrument Problems
Temperature	97.6	10/02/2025 10:35 AM	TEMPORAL	N
Pulse	93	10/02/2025 10:35 AM	APICAL	N
Pulse Characteristics:			*WNL	
Respirations	18	10/02/2025 10:35 AM		N
Respiration Characteristics:			WNL	
Blood Pressure	120 / 83	10/02/2025 10:35 AM	LYING ARM - LT	N

Assessment

PATIENT IDENTIFIERS

INDICATE TWO PATIENT IDENTIFERS USED FOR THIS VISIT:

PATIENT NAME
DATE OF BIRTH

HEAD/NECK

INDICATE HEAD AND NECK ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NO PROBLEMS IDENTIFIED

EYES/EARS/NOSE/THROAT

INDICATE EYES/EARS/NOSE/THROAT FINDINGS:

PERRL

PAIN

DOES THE PATIENT REPORT OR EXHIBIT PAIN?

NO - PATIENT IS A 0 ON A 0-10 PAIN SCALE AND/OR EXHIBITS A 0 ON STANDARDIZED PAIN SCALES

INTEGUMENTARY - ICC

INDICATE INTEGUMENTARY (HEAD TO TOE ASSESSMENT) FINDINGS INCLUDING OBSERVING FOR NEW PRESSURE ULCERS AND CHECKING BETWEEN THE TOES:

WOUND(S)

DOES THE PATIENT HAVE IV ACCESS?

NO

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/02/2025 **Visit Number:** 4 **Visit Type:** SN11 - SN VISIT

Assessment

CARDIOVASCULAR

INDICATE CARDIOVASCULAR FINDINGS:
STABLE WITH CURRENT MEDICATION REGIMEN/INTERVENTIONS

RESPIRATORY

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)
WNL

DOES THE PATIENT UTILIZE SUPPLEMENTAL OXYGEN – EITHER CONTINUOUSLY, INTERMITTENTLY OR PRN?
NO

GENITOURINARY

INDICATE GENITOURINARY FINDING(S):
INDWELLING/SUPRAPUBIC CATHETER

INDICATE INDWELLING/SUPRAPUBIC CATHETER FINDINGS (MARK ALL THAT APPLY):
SEDIMENT IN URINE

INDICATE SIZE AND TYPE OF CATHETER
UNKNOWN

INDICATE INSERTION / LAST CHANGED DATE:
9/25/2025

GASTROINTESTINAL

INDICATE GASTROINTESTINAL ASSESSMENT FINDING(S): (MARK ALL THAT APPLY)
WNL

NUTRITIONAL

INDICATE NUTRITIONAL STATUS SINCE LAST VISIT:
NO CHANGE

COGNITIVE/BEHAVIORAL

WAS BEHAVIORAL STATUS ASSESSED?
NO

INDICATE REASON BEHAVIORAL STATUS NOT ASSESSED:
NOT APPLICABLE

NEUROLOGIC

INDICATE CLIENT'S MENTAL STATUS: (MARK ALL THAT APPLY)
ALERT
ORIENTED TO PERSON
ABLE TO FOLLOW SIMPLE COMMANDS
FORGETFUL

INDICATE ABNORMAL NEUROLOGIC FINDINGS:
PARALYSIS

INDICATE THE TYPE OF PARALYSIS
PARAPLEGIA

ENDOCRINE/HEMATOPOIETIC

INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT FINDINGS:
NO ENDOCRINE/HEMATOPOIETIC FINDINGS

IS THE CLIENT TAKING AN ANTICOAGULANT?
NO

FUNCTIONAL

INDICATE MUSCULOSKELETAL STATUS:
OTHER - SPECIFY

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/02/2025 **Visit Number:** 4 **Visit Type:** SN11 - SN VISIT

Assessment

INDICATE OTHER MUSCULOSKELETAL FINDINGS (PLEASE INDICATE TYPE, ANATOMICAL LOCATION, AND DESCRIPTION):
SPINA BIFIDA

SUPERVISORY FUNCTIONS

WERE SUPERVISORY FUNCTIONS PERFORMED THIS VISIT?
NO

INDICATE REASON SUPERVISORY FUNCTIONS NOT PERFORMED:
NOT APPLICABLE

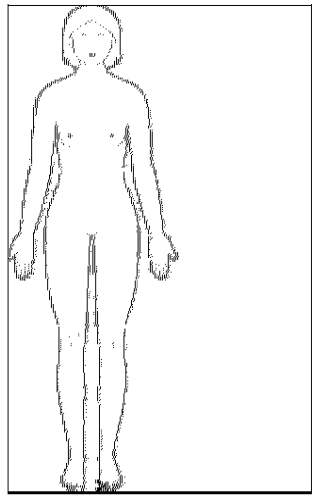
CARE COORDINATION

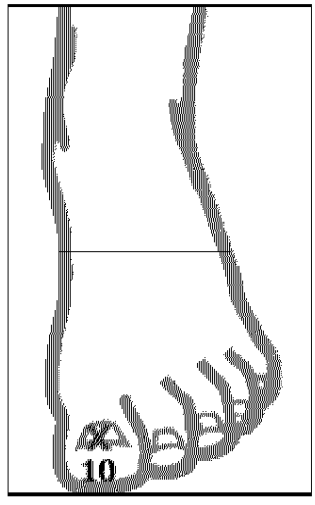
INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES INVOLVED IN THIS CASE:
NOT APPLICABLE

ANY CHANGES TO THE PLAN OF CARE OR TREATMENT WERE COMMUNICATED TO THE PATIENT AND/OR PATIENT REPRESENTATIVE AND/OR CAREGIVER?
N/A

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
FEMALE ANTERIOR	
#10 - GREAT TOE, LT, UNSPECIFIED [INACTIVATED 10/16/2025] - HCHB	
Onset Date: 09/28/2023	
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	N/A
MEASUREMENTS TAKEN	NO
REASON MEASUREMENTS NOT TAKEN	UNABLE
DEPTH DESCRIPTION	NON-BLAN
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	INTACT
EDGES	INDIST
SHAPE	ROUND
EXUDATE TYPE	NONE
EXUDATE AMOUNT	NONE
ODOR	NONE
EPITHELIALIZATION	100%
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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO

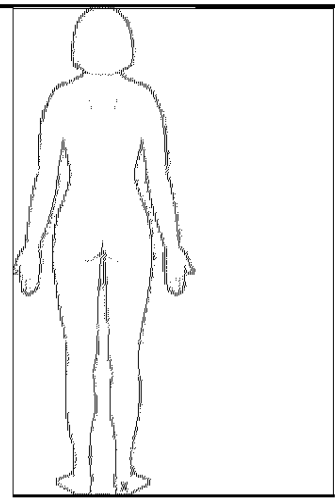
Visit Note Report

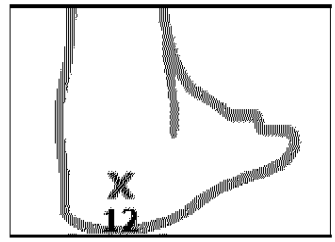
Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/02/2025 **Visit Number:** 4 **Visit Type:** SN11 - SN VISIT

DRAIN PRESENT	NO
WOUND CARE PROVIDED	WOUND CARE TO LEFT GREAT TOE AND RIGHT HEEL AS FOLLOWS: CLEANSED WITH VASHE, APPLIED HYDROFERA BLUE READY, COVERED WITH DRY GAUZE, SECURED WITH TAPE USING CLEAN TECHNIQUE. CHANGE DRESSING EVERY OTHER DAY AND PRN FOR SOILING/DISLODGEMENT. HEALED

Wound Images
N/A





FEMALE POSTERIOR

#12 - HEEL, RT, UNSPECIFIED - HCHB
Onset Date: 03/20/2025

CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	27
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	0.5 X 0.7 X 0.2
SURFACE AREA (SQ CM)	0.35
DEPTH DESCRIPTION	FULL THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	<75 & > 25%
EDGES	NOT ATTACH
SHAPE	ROUND
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	SMALL
ODOR	NONE
EPITHELIALIZATION	50-<75%
NECROTIC TISSUE TYPE	WHITE
NECROTIC TISSUE AMOUNT	<25%
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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/02/2025 **Visit Number:** 4 **Visit Type:** SN11 - SN VISIT

WOUND CARE PROVIDED	SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO LEFT GREAT TOE AND RIGHT HEEL AS FOLLOWS: CLEANSED WITH VASHE, APPLIED HYDROFERA BLUE READY, COVERED WITH DRY GAUZE, SECURED WITH TAPE USING CLEAN TECHNIQUE. CHANGE DRESSING EVERY OTHER DAY AND PRN FOR SOILING/DISLODGEMENT. * PERFORMED WOUND TX PER MD ORDER, NO PAIN BY PT, SHE HAS FU WOUND CLINIC IN TWO WEEKS		

Wound Images
N/A

Narrative

PLEASE DOCUMENT SPECIFIC SKILL PROVIDED, PATIENTS RESPONSE TO TREATMENT AND SUMMARY OF PATIENTS PROGRESS TOWARD GOALS:

PTS CG CAME FROM WORK TO ASSIST NURSE IN, PT LYING IN BED WITH NO PAIN VERBALIZED. CG CLEANED BM UP FROM PT, CATH DRAINING WITH AMBER COLOR URINE. PHYSICAL ASSESSMENT PERFORMED WITH NO IMMEDIATE FINDINGS OF CONCERN. WOUND TX PERFORMED WITHOUT DIFFICULTY OR PAIN.

NURSE INSTRUCTED ON WOUND CARE OF LEFT GREAT TOE AND RIGHT HEEL SITE/AREA
INSTRUCTED ON SIGNS / SYMPTOMS OF INFECTION TO WOUND INCLUDING COLOR CHANGES, TEMPERATURE, ODOROUS.
INSTRUCTED HOW TO UTILIZE THE ZONE TOOL TO RECOGNIZE SPECIFIC SIGNS, SYMPTOMS THAT NECESSITATE CALLING A NURSE, PROVIDER OR 911.
APPT SCHEDULED FOR OCT 14TH WOUND CARE.

Patient Goals

Patient Goal

TO GET STRONGER, FEEL BETTER, WOUND TO HEAL

Interventions Provided

1. PROVIDE/INSTRUCT PATIENT/CAREGIVER ON WOUND CARE

DETAILS/COMMENTS: INSTRUCTED ON WOUND CARE OF LEFT GREAT TOE SITE/AREA

INSTRUCTED ON SIGNS / SYMPTOMS OF INFECTION TO WOUND INCLUDING COLOR CHANGES, TEMPERATURE, ODOROUS.

INSTRUCTED HOW TO UTILIZE THE ZONE TOOL TO RECOGNIZE SPECIFIC SIGNS, SYMPTOMS THAT NECESSITATE CALLING A NURSE, PROVIDER OR 911.

2. INSTRUCT PATIENT/CAREGIVER ON PATHOPHYSIOLOGY RELATED TO SKIN BREAKDOWN

DETAILS/COMMENTS: INSTRUCTED ON THE SIGNS / SYMPTOMS OF SKIN BREAKDOWN

INSTRUCTED ON IMPORTANCE OF APPROPRIATE MEASURES TO PREVENT SKIN INJURY/BREAKDOWN INCLUDING ROUTINE INSPECTION OF SKIN

INSTRUCTED THAT IF RESTRICTED TO BED TO IMPLEMENT A TURNING SCHEDULE WHICH RESTRICTS TIME IN ONE POSITION FOR 2 HOURS OR LESS

INSTRUCTED TO KEEP SKIN CLEAN AND DRY ESPECIALLY OVER BONY PROMINENCES, TWICE DAILY OR AS INDICATED BY INCONTINENCE OR SWEATING

Visit Note Report

Client: NICKENS, KHALILAH B **MR No:** LEX00023560901 **Legacy MR No:**
Client DOB: 8/13/1988
Insured ID: 8YP2KA9VX18 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/02/2025 **Visit Number:** 4 **Visit Type:** SN11 - SN VISIT

Goals Met

1. PATIENT VERBALIZES TOLERANCE TO WOUND CARE. PATIENT / CAREGIVER VERBALIZES / RETURNS DEMONSTRATION OF WOUND CARE

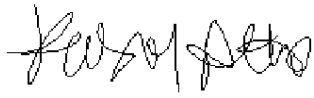
2. PATIENT / CAREGIVER VERBALIZES UNDERSTANDING OF THE PATHOPHYSIOLOGY / UNDERLYING CAUSES OF SKIN BREAKDOWN

Supplies Delivered

1 - CATHETER FOLEY STATLOCK / STABILIZATION DEVICE - 1 EACH (MCKESSON) - EACH
1 - CATHETER STATLOCK - 1 EACH (BARD) - EACH

Agent Signature:

Client Signature:



KASEY ATHA LPN 10/02/2025 10:43 AM
(Electronically Signed)

Last Modification Date: 10/2/2025 11:46 AM **Last Modified By:** SQL-SVC-JAMS-PRD-RWX

LATE ENTRY

SUPPLIES DELIVERED/USED EDITED BY SQL-SVC-JAMS-PRD-RWX ON Oct 2 2025 11:46AM

Frankfort Regional Healthcare at Home

10/24/2025 03:24:42 PM
Printed By: CAIN, MARLA

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

General: TUCKER, MILLARD H. LEX00071796201

Visit Date:	Visit Number:	Visit Type:	Branch Code:	Billable:
10/20/2025	11	RN10 - RN VISIT + SUP	LEX	X

Agent ID:	Agent Name:	Mileage Payment Method:	Trip Fees:	Mileage Start:	Mileage End:	Mileage:
376214	RACHEL DAUGHERTY RN	AM	0.00	0	0	0

Time:

TRAVEL TIME	DRIVE START TIME	10/20/2025 12:51 PM	DRIVE END TIME	10/20/2025 12:51 PM
IN-HOME TIME	BEGAN	10/20/2025 12:51 PM	COMPLETED	10/20/2025 01:40 PM

Total In-Home Time:	0.81	Hours
Total Drive Time:	0.00	Hours
Total Time:	0.81	Hours

Vital Signs

Vital Signs	Reading	Time Recorded	Details	Instrument Problems
Temperature	97.6	10/20/2025 01:16 PM	FOREHEAD	N
Pulse	72	10/20/2025 01:16 PM	RADIAL	N
Pulse Characteristics:			*WNL	
Respirations	18	10/20/2025 01:16 PM		N
Respiration Characteristics:			WNL	
Blood Pressure	92 / 62	10/20/2025 01:16 PM	SITTING ARM - RT	N
Fasting Blood Sugar	118	10/20/2025 01:17 PM		N
Random Blood Sugar	183	10/20/2025 01:17 PM		N
Oxygen Saturation Level (%)	98	10/20/2025 01:18 PM		N
Oxygen Saturation Characteristics:			ON ROOM AIR	
Pain	6	10/20/2025 01:17 PM		N

Assessment

PATIENT IDENTIFIERS

INDICATE TWO PATIENT IDENTIFERS USED FOR THIS VISIT:

PATIENT NAME
DATE OF BIRTH
VISUAL RECOGNITION

HEAD/NECK

INDICATE HEAD AND NECK ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

NECK PAIN

INDICATE FREQUENCY OF NECK PAIN:

ON AND OFF

EYES/EARS/NOSE/THROAT

INDICATE EYES/EARS/NOSE/THROAT FINDINGS:

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

Assessment

PERRL

PAIN

DOES THE PATIENT REPORT OR EXHIBIT PAIN?

YES - PATIENT REPORTS OR EXHIBITS PAIN

INDICATE SUBJECTIVE OR OBJECTIVE PAIN ASSESSMENT:

SUBJECTIVE PAIN ASSESSMENT

INDICATE WHEN THE CLIENT'S REPORTED PAIN OCCURS:

DURING THE DAY AND NIGHT

INDICATE CLIENT'S CURRENT PAIN SCALE RATING:

6

INDICATE CLIENT'S PAIN SCALE RATING FOR BEST/LEAST INTENSITY OF PAIN:

2

INDICATE CLIENT'S PAIN SCALE RATING FOR WORST/MOST INTENSITY OF PAIN:

8

INDICATE LOCATION OF PAIN (MARK ALL THAT APPLY)

RIGHT LOWER EXTREMITY
OTHER - SPECIFY

INDICATE LOCATION OF PAIN IN RIGHT LOWER EXTREMITY (MARK ALL THAT APPLY):

LOWER LEG
FOOT

INDICATE OTHER LOCATION OF PAIN:

NECK PAIN

INDICATE QUALITY OF PAIN: (MARK ALL THAT APPLY)

ACHING
SHARP
SORE

INDICATE WHAT RELIEVES PAIN (MARK ALL THAT APPLY):

MEDICATIONS
OXYGEN
POSITIONING
REST/SLEEP

INDICATE ADDITIONAL DETAILS THAT DESCRIBE THE CLIENT'S PAIN AND RESPONSE TO TREATMENT (I.E. SPECIFIC PAIN MEDS GIVEN TO THE PATIENT AND PATIENT'S RESPONSE TO PAIN TREATMENT, ETC.)

PATIENT REPORTS PAIN A 6/10 IN NECK AND RIGHT FOOT, TAKES GABAPENTIN AND TYLENOL

INTEGUMENTARY - ICC

INDICATE INTEGUMENTARY (HEAD TO TOE ASSESSMENT) FINDINGS INCLUDING OBSERVING FOR NEW PRESSURE ULCERS AND CHECKING BETWEEN THE TOES:

WOUND(S)

DOES THE PATIENT HAVE IV ACCESS?

NO

CARDIOVASCULAR

INDICATE CARDIOVASCULAR FINDINGS:

WNL
STABLE WITH CURRENT MEDICATION REGIMEN/INTERVENTIONS

RESPIRATORY

INDICATE RESPIRATORY ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)

WNL

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

Assessment

DOES THE PATIENT UTILIZE SUPPLEMENTAL OXYGEN – EITHER CONTINUOUSLY, INTERMITTENTLY OR PRN?
NO

GENITOURINARY

INDICATE GENITOURINARY FINDING(S):
WNL

GASTROINTESTINAL

INDICATE GASTROINTESTINAL ASSESSMENT FINDING(S): (MARK ALL THAT APPLY)
OSTOMY FOR BOWEL ELIMINATION

INDICATE BRAND AND SIZE OF APPLIANCE
UNKNOWN

NUTRITIONAL

INDICATE NUTRITIONAL ASSESSMENT FINDINGS: (MARK ALL THAT APPLY)
PATIENT TAKES 3 OR MORE PRESCRIBED OR OVER THE COUNTER DRUGS PER DAY - 1 PT

TOTAL NUTRITION ASSESSMENT SCORE:
1

BASED ON THE SCORE, THE NUTRITIONAL RISK LEVEL IS:
GOOD

COGNITIVE/BEHAVIORAL

WAS BEHAVIORAL STATUS ASSESSED?
YES

INDICATE BEHAVIORAL ASSESSMENT FINDINGS:
NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

NEUROLOGIC

INDICATE CLIENT'S MENTAL STATUS: (MARK ALL THAT APPLY)
ALERT
ORIENTED TO PERSON
ORIENTED TO TIME
ORIENTED TO PLACE
ABLE TO FOLLOW SIMPLE COMMANDS
FORGETFUL

INDICATE ABNORMAL NEUROLOGIC FINDINGS:
NUMBNESS

ENDOCRINE/HEMATOPOIETIC

INDICATE ENDOCRINE/HEMATOPOIETIC ASSESSMENT FINDINGS:
DIABETES

SPECIFY TYPE
DIABETES TYPE II

IS THE CLIENT TAKING INSULIN?
YES

WHEN WERE THE PATIENTS BLOOD SUGAR LEVELS LAST CHECKED AND WHAT ARE THE USUAL READINGS?:
DEXCOM
100-316

CAN THE PATIENT DRAW UP INJECTABLE MEDICATION (I.E., INSULIN, B12, CALCIMAR) ?
YES

IS THE CLIENT TAKING AN ANTICOAGULANT?
NO

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

Assessment

FUNCTIONAL

INDICATE MUSCULOSKELETAL STATUS:
AMPUTATION

IN WHAT EXTREMITIES DO AMPUTATIONS EXIST (MARK ALL THAT APPLY):
LOWER LEFT

SUPERVISORY FUNCTIONS

INDICATE DISCIPLINE OF EMPLOYEE BEING EVALUATED:
LICENSED VOCATIONAL NURSE

INDICATE NAME OF LVN BEING EVALUATED IF APPLICABLE:
KASEY ATHA, LPN AND KIM WAINSCOTT, LPN

IS THE CLIENT SATISFIED WITH THE CURRENT CARE BEING PROVIDED BY THE LVN?
YES

DOES THE LVN NOTIFY THE CLIENT OR CAREGIVER, IN TIMELY FASHION, OF CHANGES IN THE PLAN OF CARE, SCHEDULE / TIME CHANGES?
YES

DOES THE LVN RESPECT THE CLIENT'S RIGHTS RELATED TO PRIVACY, DIGNITY, CONFIDENTIALITY, PERSONAL BELONGINGS AND PROPERTY?
YES

INDICATE CHANGES IN PLAN/GOAL/UPDATE, IF APPLICABLE:
N/A

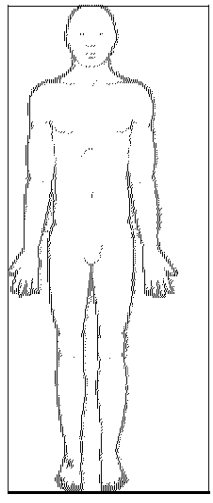
CARE COORDINATION

INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES INVOLVED IN THIS CASE:
NO

ANY CHANGES TO THE PLAN OF CARE OR TREATMENT WERE COMMUNICATED TO THE PATIENT AND/OR PATIENT REPRESENTATIVE AND/OR CAREGIVER?
N/A

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

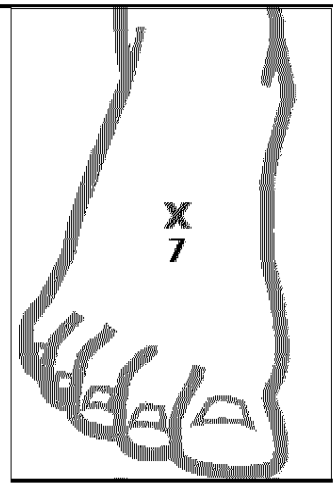
Question	Answer
MALE ANTERIOR	
#7 - MID DORSUM, RT, TRAUMASUPERFIC [INACTIVATED 09/18/2025], [REACTIVATED 09/25/2025] - HCHB	
Onset Date: 06/25/2025	
CHANGE IN STATUS	NONE
WOUND ASSESSED	YES
TOTAL WAT SCORE	34
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	2.5 X 2 X 0
SURFACE AREA (SQ CM)	5
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	NONE
EDGES	INDIST
SHAPE	ROUND
EXUDATE TYPE	SEROSANG
EXUDATE AMOUNT	MOD
ODOR	NONE

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

EPITHELIALIZATION	<25%
NECROTIC TISSUE TYPE	YELLOW
NECROTIC TISSUE AMOUNT	75-<100%
TOTAL NECROTIC TISSUE SLOUGH	76-100%
TOTAL NECROTIC TISSUE ESCHAR	76-100%
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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO
WOUND CARE PROVIDED	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. TOLERATED WELL WITH ONLY COMPLIANTS OF TENDERNESS



Wound Images
N/A

Narrative

PLEASE DOCUMENT SPECIFIC SKILL PROVIDED, PATIENTS RESPONSE TO TREATMENT AND SUMMARY OF PATIENTS PROGRESS TOWARD GOALS:

PATIENT IN MOTORIZED SCOOTER

Patient Goals

Patient Goal

TO GET MY WOUNDS HEALED AND WALK

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

Interventions Provided

1. ASSESS AND EVALUATE CO-MORBID CONDITIONS

DETAILS/COMMENTS: ASSESSED AND EVALUATED THAT CO-MORBID CONDITIONS AND SYMPTOMS RELATED TO CO-MORBID CONDITIONS ARE CURRENTLY CONTROLLED.

REVIEWED AND INSTRUCTED ON RECENT EXACERBATION OF CO-MORBID CONDITIONS

2. PROVIDE/INSTRUCT PATIENT/CAREGIVER ON WOUND CARE

DETAILS/COMMENTS: INSTRUCTED ON WOUND CARE TO TOP OF RIGHT FOOT

3. EVALUATE PATIENT'S RESPONSE TO PHARMACOLOGICAL AND NON-PHARMACOLOGICAL PAIN REGIMEN INCLUDING PATIENT'S RESPONSE TO THE PAIN SCALE.

DETAILS/COMMENTS: ASSESSED THAT PAIN MEDICATIONS ARE BEING TAKEN AS PRESCRIBED

ASSESSED THAT BOTH A PHARMACOLOGICAL AND NONPHARMACOLOGICAL PAIN REGIMEN ARE BEING UTILIZED

ASSESSED THAT USE OF PAIN MEDICATIONS WITH ACTIVITIES/WOUND CARE IS COORDINATED.

4. REVIEW MEDICAL HISTORY WITH PATIENT/CAREGIVER TO IDENTIFY REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS.

DETAILS/COMMENTS: REVIEWED MEDICAL HISTORY WITH PATIENT/CAREGIVER TO IDENTIFY REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS.

5. REVIEW MEDICATIONS FOR POTENTIAL CONTRAINDICATIONS OR SIDE EFFECTS THAT MAY BE CONTRIBUTING TO DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS.

DETAILS/COMMENTS: REVIEWED MEDICATIONS FOR POTENTIAL CONTRADICTIONS OR SIDE EFFECTS THAT MAY BE CONTRIBUITING TO DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS.

Goals Met

1. CHANGES TO CO-MORBID CONDITIONS WILL BE IDENTIFIED AND REPORTED TO THE PROVIDER

2. PATIENT VERBALIZES TOLERANCE TO WOUND CARE. PATIENT / CAREGIVER VERBALIZES / RETURNS DEMONSTRATION OF WOUND CARE

3. INCREASED PAIN OR INEFFECTIVE PAIN CONTROL MEASURES ARE IDENTIFIED AND PROMPTLY REPORTED TO THE PROVIDER.

4. PATIENT AND/OR CAREGIVER CAN VERBALIZE RISKS OR REASONS CONTRIBUTING TO DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS AND STRATEGIES TO MITIGATE THE DECLINE.

5. ALL IDENTIFIED MEDICATIONS THAT MAY BE CONTRIBUTING TO A DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS ISSUES HAVE BEEN REPORTED TO THE PHYSICIAN

Goals Not Met

1. PATIENT / CAREGIVER VERBALIZE / DEMONSTRATE APPROPRIATE TECHNIQUE FOR OBTAINING SPECIMEN FOR URINE TESTING.
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

2. PATIENT / CAREGIVER ADMINISTERS MEDICATIONS AS PRESCRIBED AS EVIDENCED BY NO ADVERSE EFFECTS OR MEDICATION ERROR.
EXCEPTION CODE: NOT APPLICABLE TO CLIENT'S POC

3. ALL MEDICATIONS HAVE BEEN REVIEWED TO IDENTIFY ANY POTENTIAL CONTRAINDICATIONS OR SIDE EFFECTS THAT MAY BE CONTRIBUTING TO EXHAUSTION
EXCEPTION CODE: ADDITIONAL TIME REQUIRED TO MEET INTERVENTION/GOAL

Visit Note Report

Client: TUCKER, MILLARD H **MR No:** LEX00071796201 **Legacy MR No:**
Client DOB: 3/24/1957
Insured ID: 9JU0H97XU10 **Primary Payor:** PALMETTO MEDICARE PDGM

Visit Date: 10/20/2025 **Visit Number:** 11 **Visit Type:** RN10 - RN VISIT + SUP

Agent Signature:

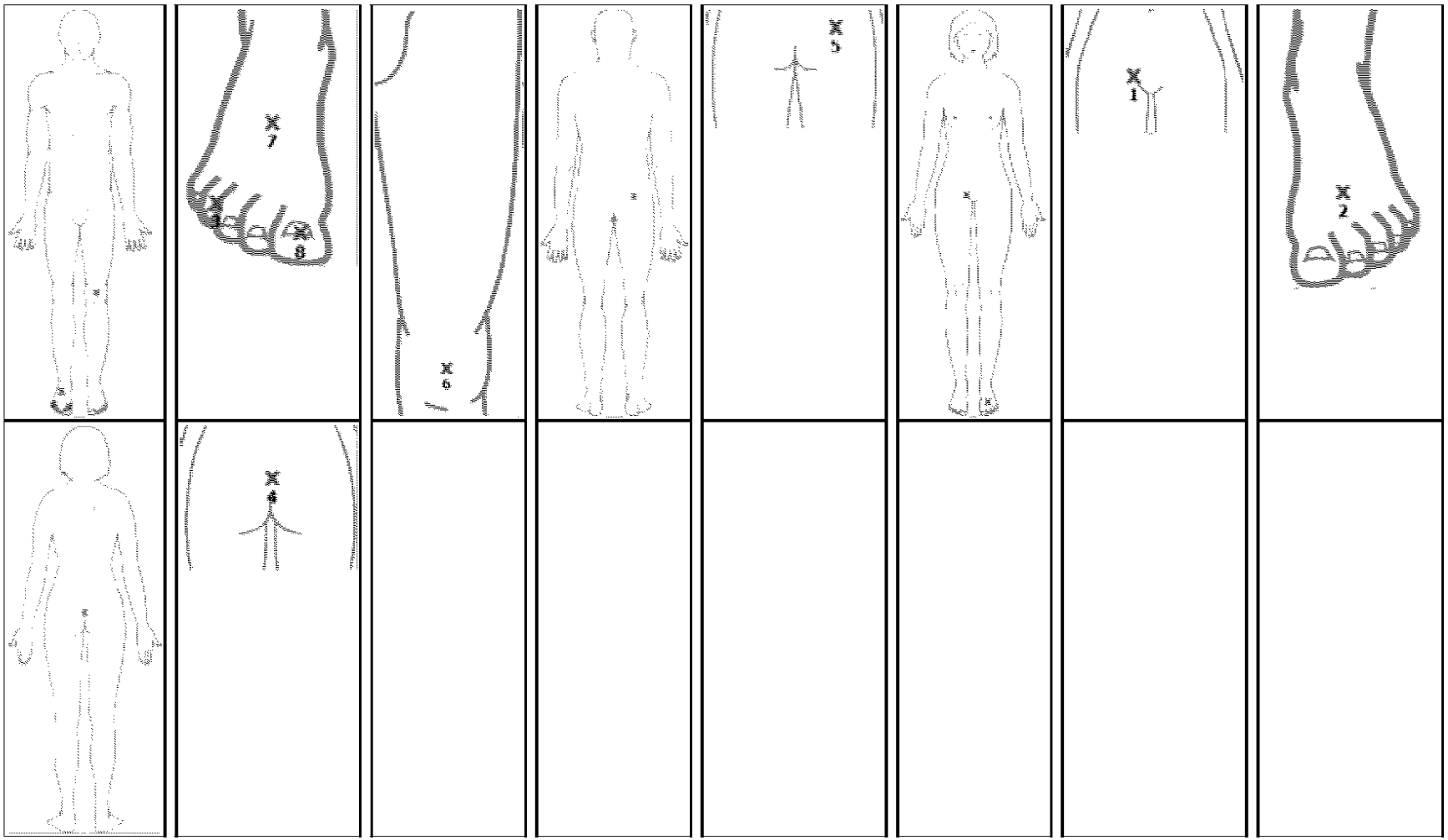
RACHEL DAUGHERTY RN 10/20/2025 01:40 PM
(Electronically Signed)

Client Signature:

Wound Record Report

10/24/2025 03:25:48 PM

Client:	TUCKER, MILLARD H.	**SOC Date:**	11/19/2024
MR No:	LEX00071796201	**Episode Start Date:**	09/15/2025
Legacy MR No:		**Episode End Date:**	11/13/2025
DOB	03/24/1957		



Wound Summary:

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Anatomical View

Wound # - Location - Type - Source	Onset Date	Active	Visit Date	LxWxD(CM)	SA (SQ CM)	EXU TPE	EXU AMT	S/S INF
FEMALE ANTERIOR								
#1 - INGUINAL, RT, SURG INC [INACTIVATED 05/19/2025], [REACTIVATED 11/19/2024] - HCHB	07/04/2024	N	05/19/2025	NA*	NA*	NA*	NA*	NA*
#2 - DIST DORSUM, LT, SURG INC [INACTIVATED 09/25/2025] - HCHB	06/26/2024	N	09/25/2025	NA*	NA*	NA*	NA*	NA*
MALE ANTERIOR								
#3 - ANT - 4TH TOE, RT, DIAB ULCER [INACTIVATED 08/29/2025] - HCHB	01/22/2025	N	08/29/2025	NA*	NA*	NA*	NA*	NA*
#6 - PATELLAR, LT, TRAUMASUPERFIC [INACTIVATED 07/14/2025] - HCHB	06/25/2025	N	07/14/2025	NA*	NA*	NA*	NA*	NA*
#7 - MID DORSUM, RT, TRAUMASUPERFIC [INACTIVATED 09/18/2025], [REACTIVATED 09/25/2025] - HCHB	06/25/2025	Y	10/23/2025	2.8 X 1.8 X 0	5.04	SEROUS	MOD	NO
#8 - GREAT TOE, RT, SKIN TEAR [INACTIVATED 08/04/2025] - HCHB	07/05/2025	N	08/04/2025	NA*	NA*	NA*	NA*	NA*
FEMALE POSTERIOR								
#4 - ANT - COCCYX, PU STAGE I [INACTIVATED 04/22/2025] - HCHB	01/22/2025	N	04/22/2025	NA*	NA*	NA*	NA*	NA*
MALE POSTERIOR								
#5 - UP BUTTOCK, RT, PU STAGE IV [INACTIVATED 07/16/2025] - HCHB	05/02/2025	N	07/16/2025	NA*	NA*	NA*	NA*	NA*

NA* = Not Assessed

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

Assessment Question Set - Effective 07/28/2013 12:00 AM - Current

#1 - INGUINAL, RT - HCHB [INACTIVATED 05/19/2025], [REACTIVATED 11/19/2024]

Onset Date: 07/04/2024

Wound Record Report

Client: TUCKER. MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	11/19/2024 3:30 PM Baseline
AGENT	HULETTE. LESLIE RN
CHANGE IN STATUS	INACTIVATED - COMPLETELY EPITHELIALIZED, REACTIVATED - NEW ORDER
STAGE HISTORY	
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	28
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	28 X 9 X 0.1
SURFACE AREA (SQ CM)	252
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	<75 & > 25%
EDGES	INDIST
SHAPE	IRREG
EXUDATE TYPE	SEROUS
EXUDATE AMOUNT	MOD
ODOR	FAINT
EPITHELIALIZATION	50-<75%
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

Effective Date	Care Provided
11/19/2024 3:30 PM	CLEANSED WITH NORMAL SALINE, APPLIED PROMAGRAN. COVERED WITH FOAM BORDER. PT TOLERATED WITHOUT COMPLICATIONS OR COMPLAINTS

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
05/08/2025 1:04 PM	05/08/2025		SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS, DIET, EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING DM, HTN, COPD, AFIB, PVD AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT OF MANAGEMENT OF HYPERTENSION. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT STAGE 4 PRESSURE ULCER ON RIGHT GLUTEAL)CARE TO AS FOLLOWS: CLEANSE WITH NS, PAT DRY, APPLY AQUACEL AG AND COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO SURGICAL SITE IN RIGHT GROIN AS FOLLOWS: CLEANSE WITH NS, COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO 4TH RIGHT TOE AS FOLLOWS: CLEANSE WITH NS, PAINT WITH BETADINE, LEAVE OPEN TO AIR. USING CLEAN TECHNIQUE. APPLY 3 X WEEK. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION	RESUMPTION OF CARE	Y	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			CONTROL MEASURES. PHYSICAL THERAPIST TO ASSESS/EVALUATE FOR PHYSICAL THERAPY NEEDS AND DEVELOP A PHYSICAL THERAPY PLAN OF CARE				
03/18/2025 11:55 AM	03/21/2025	05/08/2025	SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING WOUND CARE AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR UNINTENTIONAL WEIGHT LOSS WITH PATIENT AND/OR CAREGIVER AND IDENTIFY STRATEGIES TO REDUCE FURTHER UNINTENTIONAL WEIGHTLOSS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS. DIET. EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY. NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT PRESSURE ULCER CARE TO COCCYX AS FOLLOWS: CLEANSE WITH NORMAL SALINE OR MILD SOAP AND WATER. APPLY SKIN BARRIER CREAM AND LEAVE OPEN TO AIR USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED DAILY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO AS FOLLOWS: CLEANSE WITH NS, PAT DRY, APPLY PRISMA, COVER WITH FOAM BORDERED GAUZE USING CLEAN/ASEPTIC TECHNIQUE. CHANGE DRESSING EVERY MONDAY, WED, FRIDAY AND PRN FOR SOILING/DISLODGEMENT. SN TO PERFORM WOUND CARE TO RIGHT 4TH TOE ABRASION AS FOLLOWS: CLEANSE WITH NORMAL SALINE. PAT DRY, PAINT WITH BETADINE, LEAVE OTA DAILY AND PRN. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY. IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.	485 ORDERS	N	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			PHYSICAL THERAPIST TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. PHYSICAL THERAPY WILL ESTABLISH OR UPGRADE A HOME EXERCISE PROGRAM PHYSICAL THERAPY TO MONITOR AND PROVIDE TECHNIQUES TO ASSIST WITH REDUCING PATIENT'S PAIN AS CLINICALLY APPROPRIATE. PHYSICAL THERAPY TO PROVIDE PROSTHETIC TRAINING TO INCLUDE: RESIDUAL LIMB CONDITIONING (SHRINKING & SHAPING), RANGE OF MOTION, MUSCLE STRENGTHENING, AND GAIT TRAINING WITH/WITHOUT A PROSTHESIS OR ASSISTIVE DEVICE.				
03/18/2025 11:55 AM	03/18/2025	03/21/2025	CLEANSE WITH NS. PAT DRY. APPLY PRISMA. COVER WITH FOAM BORDERED GAUZE USING CLEAN/ASEPTIC TECHNIQUE. CHANGE DRESSING EVERY MONDAY, WED, FRIDAY AND PRN FOR SOILING/DISLODGEMENT.	PHYSICIAN ORDER	N	N	N
01/22/2025 11:12 AM	01/22/2025	03/18/2025	STAGE 1 PRESSURE ULCER TO COCCYX. CLEANSE WITH WOUND CLEANSER. PAT DRY WITH GAUZE. APPLY BARRIER CREAM. LEAVE OPEN TO AIR.	PHYSICIAN ORDER	N	N	N

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
11/19/2024 2:43 PM	11/22/2024	01/22/2025	SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HTN, DM, WOUND CARE, AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY. NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO RIGHT GROIN AS FOLLOWS: CLEANSE WITH NORMAL SALINE. APPLY PROMAGRAN. COVER WITH FOAM. USING CLEAN/ASEPTIC TECHNIQUE. CHANGE DRESSING 3 TIMES WEEKLY AND PRN FOR SOILING/DISLODGEMENT. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. PHYSICAL THERAPIST TO ASSESS/EVALUATE FOR PHYSICAL THERAPY NEEDS AND DEVELOP A PHYSICAL THERAPY PLAN OF CARE OCCUPATIONAL THERAPIST TO EVALUATE FOR OT SERVICES AND DEVELOP PLAN OF CARE FOR PROVIDER SIGNATURE. SKILLED NURSE TO INITIATE SOC ON 11/18/24 RELATED TO PATIENT NOT ANSWERING PHONE OR DOOR. VORB TONYA LEECH, RN/AMY COMER, APRN	485 ORDERS	N	N	N
07/04/2024 10:57 AM	07/04/2024	11/22/2024		485 ORDERS	N	N	N

Wound Images
N/A

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

#2 - DIST DORSUM, LT, SURG INC - HCHB [INACTIVATED 09/25/2025]

Onset Date: 06/26/2024

Wound Details	09/25/2025 1:21 PM Baseline
AGENT	POPP, CARA RN
CHANGE IN STATUS	INACTIVATED - ACTIVATED IN ERROR
STAGE HISTORY	
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	N/A

Wound Care Provided

Effective Date	Care Provided
09/25/2025 1:21 PM	

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
07/04/2024 10:57 AM	07/04/2024			485 ORDERS	Y	N	N

Wound Images
N/A

#3 - ANT - 4TH TOE, RT - HCHB [INACTIVATED 08/29/2025]

Onset Date: 01/22/2025

Wound Details	01/22/2025 11:56 AM Baseline
AGENT	MUTOMBO, KUMWIMBA LPN
CHANGE IN STATUS	NONE
STAGE HISTORY	
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	14
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	0.5 X 0.5 X 0
SURFACE AREA (SQ CM)	0.25
DEPTH DESCRIPTION	NON-BLAN
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	INTACT
EDGES	DISTINCT
SHAPE	ROUND
EXUDATE TYPE	NONE
EXUDATE AMOUNT	NONE
ODOR	NONE

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	01/22/2025 11:56 AM Baseline
EPITHELIALIZATION	100%
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

Effective Date	Care Provided
01/22/2025 11:56 AM	PRESSURE ULCER TO RIGHT 4TH TOE. CLEANSED WITH WOUND CLEANSER. PATTED DRY WITH GAUZE. APPLIED BETADINE. COVERED WITH FOAM DRESSING. PATIENT TOLERATED TREATMENT WELL

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
07/16/2025 10:22 AM	07/23/2025		SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HEART FAILURE, COPD, DM AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS, DIET, EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO PROVIDE INSTRUCTIONS RELATED TO MANAGEMENT OF CONGESTIVE HEART FAILURE INCLUDING BUT NOT LIMITED TO DEFINITION, RISKS FACTORS, AND MEASURES TO PREVENT EXACERBATION, SIGNS/SYMPTOMS AND POTENTIAL COMPLICATIONS. SKILLED NURSE TO OBSERVE AND ASSESS RESPIRATORY SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED RESPIRATORY STATUS	485 ORDERS	Y	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			RELATED TO COPD INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND PERMITTED ACTIVITIES. MAY PERFORM O2 SATURATION LEVEL PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF GASTROINTESTINAL STATUS AND TO INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT RELATED TO ALTERED GASTROINTESTINAL STATUS RELATED TO COLOSTOMY INCLUDING PATHOPHYSIOLOGY, NUTRITIONAL REQUIREMENTS, AND MEDICATION REGIMEN. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO DIABETIC ULCER RIGHT FOOT AND 4TH TOE, SKI. TEAR RIGHT GREAT TOE AS FOLLOWS: CLEANSE ALL WITH NS, APPLY AQUACEL AG TO TOP OF FOOT, COVER WITH MEPILEX, PAINT RIGHT 4TH TOE WITH BETADINE, LEAVE OPEN TO AIR. APPLY XEROFORM TOMRIGHT GREAT TOE AND WRAPMWITH GAUZE. USING CLEAN TECHNIQUE. CHANGE DRESSING 3 X WEEKLY AND PRN FOR SOILING/DISLODGEMENT. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.				
05/16/2025 12:53 PM	05/19/2025	07/23/2025	SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HTN, DM AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS FALLS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY POSSIBLE TRENDS AND EDUCATIONAL OPPORTUNITES TO REDUCE FALL RISK. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS, DIET, EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL	485 ORDERS	N	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT OF MANAGEMENT OF HYPERTENSION. SKILLED NURSE TO INSTRUCT PATIENT ON COLOSTOMY MANAGEMENT INCLUDING APPLIANCE TYPE AND USAGE. STOMAL CARE, AND IRRIGATION. SKILLED NURSE MAY PERFORM COLOSTOMY APPLIANCE CHANGE AND STOMA CARE EACH VISIT AS NEEDED. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT PRESSURE ULCER CARE TO STAGE 4 PRESSURE ULCER ON RIGHT GLUTEAL FOLD AS FOLLOWS: CLEANSE WITH NS , APPLY AQUACEL AG TO WOUND BED AND COVER WITH FOAM BORDER DRESSING USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO INCISION SITE LOCATED RIGHT GROIN AS FOLLOWS: CLEANSE WITH NS, COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO DIABETIC ULCER ON RIGHT 4TH TOE AS FOLLOWS: CLEANSE WITH NS, PAINT WITH BETADINE. LEAVE OPEN TO AIR. USING CLEAN TECHNIQUE. CHANGE DRESSING 3 XWEEKLY AND PRN FOR SOILING/DISLODGEMENT. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. PHYSICAL THERAPIST TO ASSESS/EVALUATE FOR PHYSICAL THERAPY NEEDS AND DEVELOP A PHYSICAL THERAPY PLAN OF CARE				
05/08/2025 1:04 PM	05/08/2025	05/19/2025	SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS, DIET, EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS.	RESUMPTION OF CARE	N	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING DM. HTN, COPD, AFIB, PVD AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT OF MANAGEMENT OF HYPERTENSION. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY. NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT STAGE 4 PRESSURE ULCER ON RIGHT GLUTEAL)CARE TO AS FOLLOWS: CLEANSE WITH NS, PAT DRY, APPLY AQUACEL AG AND COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO SURGICAL SITE IN RIGHT GROIN AS FOLLOWS: CLEANSE WITH NS, COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO 4TH RIGHT TOE AS FOLLOWS: CLEANSE WITH NS, PAINT WITH BETADINE, LEAVE OPEN TO AIR. USING CLEAN TECHNIQUE. APPLY 3 X WEEK. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. PHYSICAL THERAPIST TO ASSESS/EVALUATE FOR PHYSICAL THERAPY NEEDS AND DEVELOP A PHYSICAL THERAPY PLAN OF CARE				
03/18/2025 11:55 AM	03/21/2025	05/08/2025	SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING WOUND CARE AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR UNINTENTIONAL WEIGHT LOSS WITH PATIENT AND/OR CAREGIVER AND IDENTIFY STRATEGIES TO REDUCE FURTHER UNINTENTIONAL WEIGHTLOSS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS.	485 ORDERS	N	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS. DIET. EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY. NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT PRESSURE ULCER CARE TO COCCYX AS FOLLOWS: CLEANSE WITH NORMAL SALINE OR MILD SOAP AND WATER. APPLY SKIN BARRIER CREAM AND LEAVE OPEN TO AIR USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED DAILY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO AS FOLLOWS: CLEANSE WITH NS, PAT DRY, APPLY PRISMA, COVER WITH FOAM BORDERED GAUZE USING CLEAN/ASEPTIC TECHNIQUE. CHANGE DRESSING EVERY MONDAY, WED, FRIDAY AND PRN FOR SOILING/DISLODGEMENT. SN TO PERFORM WOUND CARE TO RIGHT 4TH TOE ABRASION AS FOLLOWS: CLEANSE WITH NORMAL SALINE. PAT DRY, PAINT WITH BETADINE, LEAVE OTA DAILY AND PRN. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY. IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. PHYSICAL THERAPIST TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. PHYSICAL THERAPY WILL ESTABLISH OR UPGRADE A HOME EXERCISE PROGRAM PHYSICAL THERAPY TO MONITOR AND PROVIDE TECHNIQUES TO ASSIST WITH REDUCING PATIENT'S PAIN AS CLINICALLY APPROPRIATE. PHYSICAL THERAPY TO PROVIDE PROSTHETIC TRAINING TO INCLUDE: RESIDUAL LIMB CONDITIONING (SHRINKING & SHAPING), RANGE OF MOTION, MUSCLE STRENGTHENING, AND GAIT TRAINING WITH/WITHOUT A PROSTHESIS OR ASSISTIVE DEVICE.				
03/05/2025 1:35 PM	03/05/2025	03/21/2025	CLEANSE ROGHT 4TH TOE WITH SALINE, PAT DRY. PAINT WITH BETADINE, LEAVE OTA.	PHYSICIAN ORDER	N	N	N

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
01/22/2025 11:12 AM	01/22/2025	03/05/2025	STAGE 1 PRESSURE ULCER TO COCCYX. CLEANSE WITH WOUND CLEANSER. PAT DRY WITH GAUZE. APPLY BARRIER CREAM. LEAVE OPEN TO AIR.	PHYSICIAN ORDER	N	N	N

Wound Images
N/A

#4 - ANT - COCCYX - HCHB [INACTIVATED 04/22/2025]

Onset Date: 01/22/2025

Wound Details	01/22/2025 11:56 AM Baseline
AGENT	MUTOMBO, KUMWIMBA LPN
CHANGE IN STATUS	NONE
STAGE HISTORY	PU STAGE I
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	14
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	2 X 1 X 0
SURFACE AREA (SQ CM)	2
DEPTH DESCRIPTION	NON-BLAN
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	INTACT
EDGES	DISTINCT
SHAPE	ELONG
EXUDATE TYPE	NONE
EXUDATE AMOUNT	NONE
ODOR	NONE
EPITHELIALIZATION	100%
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

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	01/22/2025 11:56 AM Baseline
STATE	ACUTE
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO

Wound Care Provided

Effective Date	Care Provided
01/22/2025 11:56 AM	STAGE 1 PRESSURE ULCER TO COCCYX. CLEANSED WITH WOUND CLEANSER. PATTED DRY WITH GAUZE. APPLIED BARRIER CREAM. LEAVE OPEN TO AIR. PATIENT TOLERATED TREATMENT WELL

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
03/18/2025 11:55 AM	03/21/2025		SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING WOUND CARE AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR UNINTENTIONAL WEIGHT LOSS WITH PATIENT AND/OR CAREGIVER AND IDENTIFY STRATEGIES TO REDUCE FURTHER UNINTENTIONAL WEIGHTLOSS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS, DIET, EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT PRESSURE ULCER CARE TO COCCYX AS FOLLOWS: CLEANSE WITH NORMAL SALINE OR MILD SOAP AND WATER. APPLY SKIN BARRIER CREAM AND LEAVE OPEN TO AIR USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED DAILY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO AS FOLLOWS: CLEANSE WITH NS, PAT DRY, APPLY PRISMA, COVER WITH FOAM BORDERED GAUZE USING CLEAN/ASEPTIC TECHNIQUE. CHANGE DRESSING EVERY MONDAY, WED, FRIDAY AND PRN FOR SOILING/DISLODGEMENT. SN TO PERFORM WOUND CARE TO RIGHT 4TH TOE ABRASION AS FOLLOWS: CLEANSE WITH NORMAL SALINE, PAT DRY, PAINT WITH BETADINE, LEAVE OTA DAILY AND PRN.	485 ORDERS	Y	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY, IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. PHYSICAL THERAPIST TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. PHYSICAL THERAPY WILL ESTABLISH OR UPGRADE A HOME EXERCISE PROGRAM PHYSICAL THERAPY TO MONITOR AND PROVIDE TECHNIQUES TO ASSIST WITH REDUCING PATIENT'S PAIN AS CLINICALLY APPROPRIATE. PHYSICAL THERAPY TO PROVIDE PROSTHETIC TRAINING TO INCLUDE: RESIDUAL LIMB CONDITIONING (SHRINKING & SHAPING), RANGE OF MOTION, MUSCLE STRENGTHENING, AND GAIT TRAINING WITH/WITHOUT A PROSTHESIS OR ASSISTIVE DEVICE.				
01/22/2025 11:12 AM	01/22/2025	03/21/2025	STAGE 1 PRESSURE ULCER TO COCCYX. CLEANSE WITH WOUND CLEANSER. PAT DRY WITH GAUZE. APPLY BARRIER CREAM. LEAVE OPEN TO AIR.	PHYSICIAN ORDER	N	N	N

Wound Images
N/A

#5 - UP BUTTOCK, RT - HCHB [INACTIVATED 07/16/2025]
Onset Date: 05/02/2025

Wound Details	05/08/2025 1:55 PM Baseline
AGENT	ALLEN, MARGIE RN
CHANGE IN STATUS	NONE
STAGE HISTORY	PU STAGE IV
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	29
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	2 X 2 X 2
SURFACE AREA (SQ CM)	4
DEPTH DESCRIPTION	FULL THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	<25%
EDGES	INDIST

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	05/08/2025 1:55 PM Baseline
SHAPE	ROUND
EXUDATE TYPE	SEROUS
EXUDATE AMOUNT	MOD
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?	YES
WAS PAIN SUBJECTIVELY ASSESSED?	YES
WOUND PAIN LEVEL, WHERE 0 = "NO PAIN" AND 10 = "WORST POSSIBLE PAIN"	5
PAIN FREQUENCY	DAILY
PAIN QUALITY	ACHING
PAIN INTERVENTIONS	MEDICATION, REST
RESPONSE TO PAIN INTERVENTIONS	FULL
STATE	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO

Wound Care Provided

Effective Date	Care Provided
05/08/2025 1:55 PM	CLEANED WITH NS, PATTED DRY, APPLIED AQUACEL AG AND COVERED WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. WOUND CARE PERABOVE. TOLERATED WELL

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
05/16/2025 12:53 PM	05/19/2025		SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HTN. DM AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS FALLS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY POSSIBLE TRENDS AND EDUCATIONAL OPPORTUNITES TO REDUCE FALL RISK.	485 ORDERS	Y	N	N

SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS.
SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT.
SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS. DIET. EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS.
SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS
SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES.
SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT OF MANAGEMENT OF HYPERTENSION.
SKILLED NURSE TO INSTRUCT PATIENT ON COLOSTOMY MANAGEMENT INCLUDING APPLIANCE TYPE AND USAGE. STOMAL CARE, AND IRRIGATION. SKILLED NURSE MAY PERFORM COLOSTOMY APPLIANCE CHANGE AND STOMA CARE EACH VISIT AS NEEDED.
SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY. NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION.
SKILLED NURSE TO PERFORM / INSTRUCT PRESSURE ULCER CARE TO STAGE 4 PRESSURE ULCER ON RIGHT GLUTEAL FOLD AS FOLLOWS: CLEANSE WITH NS , APPLY AQUACEL AG TO WOUND BED AND COVER WITH FOAM BORDER DRESSING USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT.
SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO INCISION SITE LOCATED RIGHT GROIN AS FOLLOWS: CLEANSE WITH NS. COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT.
SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO DIABETIC ULCER ON RIGHT 4TH TOE AS FOLLOWS: CLEANSE WITH NS, PAINT WITH BETADINE. LEAVE OPEN TO AIR. USING CLEAN TECHNIQUE. CHANGE DRESSING 3 XWEEKLY AND PRN FOR SOILING/DISLODGEMENT.
SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY. IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION.
SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE.
SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES.
SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES.
SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			PHYSICAL THERAPIST TO ASSESS/EVALUATE FOR PHYSICAL THERAPY NEEDS AND DEVELOP A PHYSICAL THERAPY PLAN OF CARE				
05/08/2025 1:04 PM	05/08/2025	05/19/2025	SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW POTENTIAL REASONS FOR DECLINE IN MENTAL, EMOTIONAL OR BEHAVIORAL STATUS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS, DIET, EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING DM, HTN, COPD, AFIB, PVD AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT OF MANAGEMENT OF HYPERTENSION. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT STAGE 4 PRESSURE ULCER ON RIGHT GLUTEAL)CARE TO AS FOLLOWS: CLEANSE WITH NS, PAT DRY, APPLY AQUACEL AG AND COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO SURGICAL SITE IN RIGHT GROIN AS FOLLOWS: CLEANSE WITH NS, COVER WITH MEPILEX BORDER USING CLEAN TECHNIQUE. WOUND CARE TO BE PERFORMED 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO 4TH RIGHT TOE AS FOLLOWS: CLEANSE WITH NS, PAINT WITH BETADINE, LEAVE OPEN TO AIR. USING CLEAN TECHNIQUE. APPLY 3 X WEEK. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY. IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION	RESUMPTION OF CARE	N	N	N

Client:	TUCKER, MILLARD H.	MR No:	LEX00071796201	Legacy MR No:		Episode Start Date:	09/15/2025

	CONTROL MEASURES. PHYSICAL THERAPIST TO ASSESS/EVALUATE FOR PHYSICAL THERAPY NEEDS AND DEVELOP A PHYSICAL THERAPY PLAN OF CARE

Wound Images
N/A

#6 - PATELLAR, LT - HCHB [INACTIVATED 07/14/2025]

Onset Date: 06/25/2025

Wound Details	06/25/2025 11:53 AM Baseline
AGENT	ALLEN, MARGIE RN
CHANGE IN STATUS	NONE
STAGE HISTORY	
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	19
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	1 X 2 X 0.1
SURFACE AREA (SQ CM)	2
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	INTACT
EDGES	INDIST
SHAPE	ROUND
EXUDATE TYPE	NONE
EXUDATE AMOUNT	NONE
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	BR RED
PERIPHERAL TISSUE EDEMA	NONE
PERIPHERAL TISSUE INDURATION	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO
STATE	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Care Provided

Effective Date	Care Provided
06/25/2025 11:53 AM	CLEANED WITH NS, APPLIED AQUACEL AG, COVERED WITH MEPLIX BORDER. CHANGE 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT WOUND CARE PER ABOVE. TOLERATED WELL

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
06/25/2025 11:09 AM	06/25/2025		WOUND CARE FOR NEW WOUNDS ON LEFT STUMP AND RIGHT FOOT : CLEAN WITH NS, APPLY AQUACEL AG, COVER WITH MEPLIX BORDER. CHANGE 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT	PHYSICIAN ORDER	Y	N	N

Wound Images
N/A

#7 - MID DORSUM, RT, TRAUMASUPERFIC - HCHB [INACTIVATED 09/18/2025], [REACTIVATED 09/25/2025]
Onset Date: 06/25/2025

Wound Details	10/23/2025 9:45 AM	10/20/2025 1:40 PM	10/16/2025 9:50 AM	10/13/2025 11:47 AM	10/09/2025 10:33 AM	10/06/2025 10:20 AM	10/02/2025 11:36 AM	09/29/2025 2:32 PM
AGENT	WAINSCOTT, KIMBERLY LPN	DAUGHERTY, RACHEL RN	WAINSCOTT, KIMBERLY LPN	WAINSCOTT, KIMBERLY LPN	WAINSCOTT, KIMBERLY LPN	WAINSCOTT, KIMBERLY LPN	ATHA, KASEY LPN	DAUGHERTY, RACHEL RN
CHANGE IN STATUS	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
STAGE HISTORY								
WAS WOUND ASSESSED	YES	YES	YES	YES	YES	YES	YES	YES
TOTAL WAT SCORE	33	34	34	24	N/A	31	N/A	30
MEASUREMENTS TAKEN	YES	YES	YES	YES	NO	YES	NO	YES
LENGTHxWIDTHxDEPTH(CM)	2.8 X 1.8 X 0	2.5 X 2 X 0	2.5 X 1.3 X 0	3 X 2 X 0.1		3.2 X 2.2 X 0.1		3 X 2 X 0.3
REASON MEASUREMENTS NOT TAKEN					NOT DUE		NOT DUE	
DEPTH DESCRIPTION	NECROTIC	PART THICK	NECROTIC	PART THICK	FULL THICK	FULL THICK	PART THICK	FULL THICK
SURFACE AREA (SQ CM)	5.04	5	3.25	6		7.04		6
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO	NO	NO	NO	NO	NO	NO	NO
GRANULATION TISSUE	<25%	NONE	<25%	NONE	<75 & > 25%	<75 & > 25%	<75 & > 25%	<75 & > 25%
EDGES	DISTINCT	INDIST	DISTINCT	DISTINCT	DISTINCT	DISTINCT	NOT ATTACH	INDIST
SHAPE	ROUND	ROUND	ROUND	IRREG	ELONG	IRREG	ELONG	ROUND
EXUDATE TYPE	SEROUS	SEROSANG	SEROUS	NONE	SEROUS	SEROUS	SEROSANG	SEROUS
EXUDATE AMOUNT	MOD	MOD	MOD	NONE	MOD	MOD	SMALL	SMALL
ODOR	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
EPITHELIALIZATION	<25%	<25%	<25%	<25%	25-<50%	<25%	50-<75%	50-<75%
NECROTIC TISSUE TYPE	YELLOW	YELLOW	YELLOW	NONE	YELLOW	YELLOW	YELLOW	YELLOW
NECROTIC TISSUE AMOUNT	NONE	75-<100%	NONE	NONE	NONE	NONE	<25%	25-<50%
TOTAL NECROTIC TISSUE SLOUGH	51-75%	76-100%	51-75%	0-25%	26-50%	0-25%	0-25%	26-50%
TOTAL NECROTIC TISSUE ESCHAR	0-25%	76-100%	0-25%	0-25%	0-25%	0-25%	0-25%	26-50%

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	09/25/2025 1:21 PM	09/18/2025 1:25 PM	06/25/2025 11:53 AM Baseline
AGENT	POPP, CARA RN	DAUGHERTY, RACHEL RN	ALLEN, MARGIE RN
CHANGE IN STATUS	INACTIVATED - COMPLETELY EPITHELIALIZED, REACTIVATED - INACTIVATED IN ERROR	INACTIVATED - COMPLETELY EPITHELIALIZED. REACTIVATED - INACTIVATED IN ERROR	NONE
STAGE HISTORY			
WAS WOUND ASSESSED	YES	YES	YES
TOTAL WAT SCORE	26	N/A	23
MEASUREMENTS TAKEN	YES		YES
LENGTHxWIDTHxDEPTH(CM)	1.5 X 1.5 X 0.2		1.5 X 1.5 X 0.3
REASON MEASUREMENTS NOT TAKEN			
DEPTH DESCRIPTION	PART THICK		PART THICK
SURFACE AREA (SQ CM)	2.25		2.25
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO		NO
GRANULATION TISSUE	75-100%		INTACT
EDGES	NOT ATTACH		INDIST
SHAPE	ROUND		ROUND
EXUDATE TYPE	SEROSANG		SEROUS
EXUDATE AMOUNT	MOD		SMALL
ODOR	NONE		NONE
EPITHELIALIZATION	<25%		<25%
NECROTIC TISSUE TYPE	NONE		NONE
NECROTIC TISSUE AMOUNT	NONE		NONE
TOTAL NECROTIC TISSUE SLOUGH	0-25%		0-25%
TOTAL NECROTIC TISSUE ESCHAR	0-25%		0-25%

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	10/23/2025 9:45 AM	10/20/2025 1:40 PM	10/16/2025 9:50 AM	10/13/2025 11:47 AM	10/09/2025 10:33 AM	10/06/2025 10:20 AM	10/02/2025 11:36 AM	09/29/2025 2:32 PM
EDGE / SURROUNDING TISSUE - MACERATION	ABSENT	ABSENT	PARTIAL	ABSENT	ABSENT	PARTIAL	ABSENT	PARTIAL
UNDERMINING	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
TUNNELING	NO	NO	NO	NO	NO	NO	NO	NO
SKIN COLOR SURROUNDING WOUND	NORM	NORM	BR RED	NORM	NORM	NORM	NORM	BR RED
PERIPHERAL TISSUE EDEMA	NONE	NONE	NONPIT <4CM	NONE	NONE	NONE	NONE	NONE
PERIPHERAL TISSUE INDURATION	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO	NO	NO	NO	NO	NO	NO	NO
STATE	CHRONIC	CHRONIC	CHRONIC	CHRONIC	CHRONIC	CHRONIC	CHRONIC	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO	NO	NO	NO	NO	NO	NO	NO
DEBRIDEMENT THIS VISIT	NO	NO	NO	NO	NO	NO	NO	NO
DRAIN PRESENT	NO	NO	NO	NO	NO	NO	NO	NO

Wound Care Provided

Effective Date	Care Provided
10/23/2025 9:45 AM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. WOUND BED CONTINUES TO HAVE 75% THICK YELLOW SLOUGH, WITH PINK EPITHELIAL TISSUE SURROUNDING. WOUND EDGES WELL DEFINED AND INTACT, MODERATE SEROUS EXUDATE. PERI WOUND PINK AND BLANCHABLE. TRACE EDEMA TO RIGHT FOOT. TOLERATED WOUND CARE WITHOUT COMPLAINTS OF PAIN
10/20/2025 1:40 PM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. TOLERATED WELL WITH ONLY COMPLIANTS OF TENDERNESS
10/16/2025 9:50 AM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. WOUND MEASURES SMALLER. CONTINUES TO HAVE ADHERENT YELLOW SLOUGH TO WOUND BED WITH APPROX 50% GRANULATION. PERI WOUND PINK AND BLANCHABLE, MODERATE SEROUS EXUDATE. TRACE EDEMA TO RLE
10/13/2025 11:47 AM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. WOUND FULLY COVERED WITH DRIED CRUST. NO DRAINAGE, NO ERYTHEMA. PATIENT REPORTS HAS LEFT DRESSING OFF FOR THE LAST COUPLE OF DAYS.
10/09/2025 10:33 AM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. WOUND CONTINUES TO HAVE ADHERENT YELLOW SLOUGH AT CENTER OF WOUND BED, VISIBLY SMALLER. NO SIGNS OF INFECTION. TOLERATED WOUND CARE WITHOUT COMPLAINTS OF PAIN
10/06/2025 10:20 AM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. WOUND BED WITH YELLOW ADHERENT SLOUGH 25%, 75% PINK GRANULAR TISSUE, MODERATE SEROUS EXUDATE
10/02/2025 11:36 AM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. CLEANSED WITH NS, APPLIED CA ALGINATE WITH SILVER, COVERED WITH GAUZE AND TAPE, PT NEEDS MORE BORDERED GAUZE. PT TOLERATED WELL NO C/O PAIN.
09/29/2025 2:32 PM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. PATIENT TOLERATED WOUND CARE WITHOUT COMPLICATIONS OR ISSUES
09/25/2025 1:21 PM	CLEANSED WITH NORMAL SALINE, APPLIED CALCIUM ALGINATE W/SILVER TO WOUND BED, COVERED WITH MEPILEX BORDER FOAM DRESSING. WOUND CARE COMPLETED. PT TOLERATED W/OUT C/O PAIN OR DISCOMFORT.
09/18/2025 1:25 PM	
06/25/2025 11:53 AM	CLEANED WITH NS, APPLIED AQUACEL AG. COVERED WITH MEPLIX BORDER. CHANGE 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT WOUND CARE PER ABOVE. TOLERATED WELL

Order Summary

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	09/25/2025 1:21 PM	09/18/2025 1:25 PM	06/25/2025 11:53 AM Baseline
EDGE / SURROUNDING TISSUE - MACERATION	ABSENT		ABSENT
UNDERMINING	NONE		NONE
TUNNELING	NO		NO
SKIN COLOR SURROUNDING WOUND	NORM		NORM
PERIPHERAL TISSUE EDEMA	NONE		NONE
PERIPHERAL TISSUE INDURATION	NONE		NONE
DOES PATIENT HAVE PAIN ASSOCIATED WITH THIS WOUND?	NO		NO
STATE	ACUTE		CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO		NO
DEBRIDEMENT THIS VISIT	NO		NO
DRAIN PRESENT	NO		NO

Wound Record Report

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
09/25/2025 12:51 PM	09/25/2025		SKILLED NURSE TO PERFORM/TEACH WOUND CARE TO R MID DORSUM OPEN ULCER. CLEANSE WITH NORMAL SALINE, APPLY CALCIUM ALGINATE W/SILVER TO WOUND BED, COVER WITH MEPILEX BORDER FOAM DRESSING USING CLEAN TECHNIQUE. CHANGE DRESSING 2X WEEKLY AND PRN SOILING/DISLODGEMENT. MAY USE EQUIVALENT PRODUCTS. V.O. DR. CROSS/JAMIE, AGENT/CARA POPP.RN.	PHYSICIAN ORDER	Y	N	N
09/08/2025 11:17 AM	09/08/2025	09/25/2025	FAXED ORDER FROM VA FOR WOUND CARE TO LEFT FOOT: CLEAN WITH NS. IODINE TO WOUND. WRAP LIGHTLY WITH ACE	PHYSICIAN ORDER	N	N	N
07/16/2025 10:22 AM	07/23/2025	09/08/2025	SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HEART FAILURE, COPD, DM AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS. DIET. EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO PROVIDE INSTRUCTIONS RELATED TO MANAGEMENT OF CONGESTIVE HEART FAILURE INCLUDING BUT NOT LIMITED TO DEFINITION, RISKS FACTORS, AND MEASURES TO PREVENT EXACERBATION, SIGNS/SYMPTOMS AND POTENTIAL COMPLICATIONS. SKILLED NURSE TO OBSERVE AND ASSESS RESPIRATORY SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED RESPIRATORY STATUS RELATED TO COPD INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND PERMITTED ACTIVITIES. MAY PERFORM O2 SATURATION LEVEL PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF GASTROINTESTINAL STATUS AND TO INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT RELATED TO ALTERED GASTROINTESTINAL STATUS RELATED TO COLOSTOMY INCLUDING PATHOPHYSIOLOGY, NUTRITIONAL REQUIREMENTS, AND MEDICATION REGIMEN. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY, NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO DIABETIC ULCER RIGHT FOOT AND 4TH TOE, SKI. TEAR RIGHT GREAT TOE AS FOLLOWS: CLEANSE ALL WITH NS, APPLY AQUACEL AG TO TOP OF FOOT, COVER WITH MEPILEX. PAINT RIGHT 4TH TOE WITH BETADINE, LEAVE OPEN TO AIR. APPLY XEROFORM TOMRIGHT GREAT TOE AND WRAPMWITH GAUZE. USING CLEAN TECHNIQUE. CHANGE DRESSING 3 X WEEKLY AND PRN FOR SOILING/DISLODGEMENT. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR	485 ORDERS	N	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY. IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.				
06/25/2025 11:09 AM	06/25/2025	07/23/2025	WOUND CARE FOR NEW WOUNDS ON LEFT STUMP AND RIGHT FOOT : CLEAN WITH NS, APPLY AQUACEL AG, COVER WITH MEPLIX BORDER. CHANGE 3 X WEEKLY AND PRN FOR SOILING OR DISLODGEMENT	PHYSICIAN ORDER	N	N	N

Wound Images
N/A

#8 - GREAT TOE, RT - HCHB [INACTIVATED 08/04/2025]
Onset Date: 07/05/2025

Wound Details	**07/07/2025 11:40 AM Baseline**
AGENT	ALLEN, MARGIE RN
CHANGE IN STATUS	NONE
STAGE HISTORY	
WAS WOUND ASSESSED	YES
TOTAL WAT SCORE	23
MEASUREMENTS TAKEN	YES
LENGTHxWIDTHxDEPTH(CM)	2 X 3 X 0.2
SURFACE AREA (SQ CM)	6
DEPTH DESCRIPTION	PART THICK
IS THIS A CLOSED SURGICAL WOUND OR SUSPECTED DEEP TISSUE INJURY?	NO
GRANULATION TISSUE	INTACT
EDGES	INDIST
SHAPE	ROUND
EXUDATE TYPE	BLOODY
EXUDATE AMOUNT	MOD
ODOR	NONE
EPITHELIALIZATION	<25%
NECROTIC TISSUE TYPE	NONE
NECROTIC TISSUE AMOUNT	NONE
TOTAL NECROTIC TISSUE SLOUGH	0-25%
TOTAL NECROTIC TISSUE ESCHAR	0-25%

Wound Record Report

Client: TUCKER. MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

Wound Details	07/07/2025 11:40 AM Baseline
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	CHRONIC
SIGNS AND SYMPTOMS OF INFECTION	NO
DEBRIDEMENT THIS VISIT	NO
DRAIN PRESENT	NO

Wound Care Provided

Effective Date	Care Provided
07/07/2025 11:40 AM	CLEANED WITH NS, APPLIED XEROFORM. WRAPPED WITH GAUZE , SECURED WITH KERLIX WOUND CARE PER ABOVE ,TOLERATED WELL

Order Summary

Date/Time	Effective From	Effective To	Order Text	Type	Current	Declined	Voided
07/16/2025 10:22 AM	07/23/2025		SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING HEART FAILURE, COPD, DM AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY SIGNIFICANT CHANGES IN CONDITION AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO REVIEW REASONS FOR PREVIOUS ER VISIT AND/OR HOSPITAL ADMISSIONS WITH PATIENT AND/OR CAREGIVER TO IDENTIFY OPPORTUNITIES FOR HEALTH IMPROVEMENT TO PREVENT FUTURE HOSPITALIZATIONS AND/OR ER VISITS. SKILLED NURSE TO REVIEW WITH PATIENT/CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S DIFFICULTY COMPLYING WITH MEDICAL INSTRUCTIONS (MEDICATIONS. DIET. EXERCISE) AND IDENTIFY STRATEGIES TO INCREASE PATIENTS ADHERENCE TO MEDICAL INSTRUCTIONS. SKILLED NURSE TO REPORT ANY IDENTIFIED MEDICATION ISSUES TO THE PHYSICIAN TO PREVENT RE-HOSPITALIZATIONS AND/OR ER VISITS SKILLED NURSE TO REVIEW WITH PATIENT AND/OR CAREGIVER POTENTIAL REASONS CONTRIBUTING TO THE PATIENT'S REPORTED EXHAUSTION (MENTAL OR PHYSICAL) TO IDENTIFY RELIEF MEASURES. SKILLED NURSE TO PROVIDE INSTRUCTIONS RELATED TO MANAGEMENT OF CONGESTIVE HEART FAILURE INCLUDING BUT NOT LIMITED TO DEFINITION, RISKS FACTORS. AND MEASURES TO PREVENT EXACERBATION, SIGNS/SYMPTOMS AND POTENTIAL COMPLICATIONS. SKILLED NURSE TO OBSERVE AND ASSESS RESPIRATORY SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED RESPIRATORY STATUS RELATED TO COPD INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND PERMITTED ACTIVITIES. MAY PERFORM O2 SATURATION LEVEL PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF GASTROINTESTINAL STATUS AND TO INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT RELATED TO ALTERED GASTROINTESTINAL	485 ORDERS	Y	N	N

Client: TUCKER, MILLARD H. **MR No:** LEX00071796201 **Legacy MR No:** **Episode Start Date:** 09/15/2025

			STATUS RELATED TO COLOSTOMY INCLUDING PATHOPHYSIOLOGY, NUTRITIONAL REQUIREMENTS, AND MEDICATION REGIMEN. SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY STATUS TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS AND REDUCE RISK FOR PRESSURE INJURY. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED SKIN INTEGRITY INCLUDING PATHOPHYSIOLOGY. NUTRITION AND MEDICATION REGIMEN. SKILLED NURSE TO REPORT SIGNIFICANT CHANGES IN STATUS TO PROVIDER FOR EARLY INTERVENTION. SKILLED NURSE TO PERFORM / INSTRUCT WOUND CARE TO DIABETIC ULCER RIGHT FOOT AND 4TH TOE, SKI. TEAR RIGHT GREAT TOE AS FOLLOWS: CLEANSE ALL WITH NS, APPLY AQUACEL AG TO TOP OF FOOT, COVER WITH MEPILEX. PAINT RIGHT 4TH TOE WITH BETADINE, LEAVE OPEN TO AIR. APPLY XEROFORM TOMRIGHT GREAT TOE AND WRAPMWITH GAUZE. USING CLEAN TECHNIQUE. CHANGE DRESSING 3 X WEEKLY AND PRN FOR SOILING/DISLODGEMENT. SKILLED NURSE TO PERFORM MULTIFACTOR FALL RISK ASSESSMENT AND IMPLEMENT INTERVENTIONS TO DECREASE RISK OF FALLS AND/OR RISK FOR HOSPITALIZATION DUE TO A HISTORY OF FALLS. SKILLED NURSE TO INSTRUCT ON HOME SAFETY. IMPACT OF POLYPHARMACY, ENVIRONMENTAL SAFETY, AND FALL PREVENTION. SKILLED NURSE FOR INSTRUCTIONS/REINFORCEMENT OF DIABETIC CARE TO INCLUDE DIET, SKIN CARE, ADMINISTRATION OF INSULIN ADMINISTRATION OF ANTIDIABETIC MEDICATION, BLOOD GLUCOSE TESTING AND DIABETIC FOOT CARE. SKILLED NURSE FOR OBSERVATION/ASSESSMENT OF PAIN, EFFECTIVENESS OF PAIN MANAGEMENT REGIMEN AND SKILLED TEACHING RELATED TO PAIN MANAGEMENT. NURSE TO INTERVENE TO MINIMIZE COMPLICATIONS IF PAIN LEVEL INCREASES. SKILLED NURSE TO INSTRUCT PATIENT / CAREGIVER REGARDING INFECTION CONTROL MEASURES. SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES.				
07/07/2025 11:04 AM	07/07/2025	07/23/2025	WOUND CARE TO SKIN TEAR ON RIGHT GREAT TOE, CLEAN WITH NS, APPLY XEROFORM, WRAP WITH GAUZE , SECURE WITH KERLIX	PHYSICIAN ORDER	N	N	N

Wound Images
N/A