**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **5/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 98.7 F, HR- 66 bpm, RR -16 per min BS 144 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 142/70 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to diabetes mellitus. Knowledge deficit regarding measures to control diabetes mellitus and the medication Metformin 500 mg. 1 tablet by mouth daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN taught patient/PCG regarding signs and symptoms of Type 2 diabetes mellitus. Diabetes mellitus is more commonly known simply as diabetes. It's when your pancreas doesn't produce enough insulin to control the amount of glucose, or sugar, in your blood. The symptoms are excessive thirst, excessive intake of fluids, fatigue, increased urination, dry hot skin, itching, weakness. SN taught Patient/PCG regarding measures important in management of diabetes mellitus such as: follow prescribed diet, monitor blood sugars regularly, see physician, dentist, and eye doctor regularly, weight weekly.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **4/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 98.3 F, HR- 85 bpm, RR -16 per min BS 167 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 145/83 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to acute diastolic congestive heart failure. Knowledge deficit regarding measures to control acute diastolic congestive heart failure and the medication Furosemide 20 mg. 1 tablet by mouth once daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed patient/PCG regarding Congestive Heart Failure (CHF). Congestive Heart Failure (CHF), which is when the heart is unable to pump blood through the body for normal daily activities. Some signs or symptoms could be swelling of the feet and ankles and lower legs, intolerance to exertion or normal past activities, increased frequency of urination, rapid breathing, sensation of shortness of breath, difficulty breathing when lying down, weakness or fatigue, restlessness, anxiety, loss of appetite, nausea or vomiting, abnormal weight gain. Instructed patient to maintain daily activity plan prescribed by the doctor, alternate exercise, or activity with rest periods, avoid fatigue. If doctor prescribed fluid limitations, follow specific instructions: control fluid intake to prevent retention of body fluids, which prevents extra workload on the heart. Demonstrated to patient how to weight patient using as minimal clothing as possible to be done at approximately the same time of the day using the same weighing scale. Demonstrated to patients how to measure urine and fluids taken in and to record it. Instructed patient to notify PMD whenever there is an increase in weight of more than 5 lbs. a week.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **4/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 98.8 F, HR- 68 bpm, RR -16 per min BS 141 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 131/82 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to hypertensive heart and chronic kidney disease. Knowledge deficit regarding measures to control hypertensive heart and chronic kidney disease and the medication Labetalol 200 mg. 1 tablet by mouth daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed Patient/PCG regarding hypertensive heart and chronic kidney disease. Hypertensive kidney disease is a medical condition referring to damage to the kidney due to chronic high blood pressure. Your kidneys play a key role in keeping your blood pressure in a healthy range. Diseased kidneys are less able to help regulate blood pressure. As a result, blood pressure increases. If you have CKD, high blood pressure makes it more likely that your kidney disease will get worse, and you will have heart problems. Elevated BP leads to damage of blood vessels within the kidney. SN also instructed regarding medication Labetalol 200 mg. Lowering high blood pressure helps prevent kidney problems. SN advised patient/PCG to take medication Labetalol 200 mg. 1 tablet by mouth daily as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **4/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 98.5 F, HR- 96 bpm, RR -16 per min BS 163 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 137/66 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to chronic kidney disease. Knowledge deficit regarding measures to control chronic kidney disease and the medication Kerendia. Kerendia is an FDA approved tablet taken once a day by adults who have chronic kidney disease from Type 2 diabetes. Kerendia is used to slow down kidney damage, and to reduce the risk of kidney failure, cardiovascular death, heart attack and being hospitalized for heart failure.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed regarding chronic kidney disease. Chronic kidney disease (CKD) means your kidneys are damaged and can't filter blood the way they should. The disease is called “chronic” because the damage to your kidneys happens slowly over a long period of time. This damage can cause waste to build up in your body. CKD can also cause other health problems. Often, though, chronic kidney disease has no cure. Treatment usually consists of measures to help control signs and symptoms, reduce complications, and slow progression of the disease. If your kidneys become severely damaged, you may need treatment for end-stage kidney disease.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **4/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 98.1 F, HR- 83 bpm, RR -16 per min BS 179 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 133/80 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered cardiovascular status due to Athscl heart disease of native coronary Artery w/o angina pectoris. Knowledge deficit regarding measures to control Athscl heart disease of native coronary Artery w/o angina pectoris and the medication Nitroglycerin 0.4 mg. Nitroglycerin sublingual tablets are used to treat episodes of chest pain in people who have coronary artery disease. SN advised patient/PCG to take medication Nitroglycerin 0.4 mg. sublingual 1 tablet sublingual as needed for chest pain every 5 minutes up to 3 tablets if chest pain persists call 911 as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN taught Patient/PCG about disease process regarding measures important in management of Athscl heart disease of native coronary Artery w/o angina pectoris. Atherosclerosis, sometimes called hardening of the arteries, can slowly narrow the arteries throughout your body. The patient was instructed the importance of no smoking or using tobacco products, the effect nicotine has on the cardiac system causing the heart to work faster, constricting blood vessels and decreasing the amount of oxygen delivered to the heart. The patient was recommended the benefits of exercise, increase in high-density lipoproteins, which lowers blood pressure, weight loss, improved cardiovascular status. SN instructed Patient/PCG regarding medication Prasugrel 10 mg. Prasugrel is used with aspirin by patients with heart disease (recent heart attack, unstable angina) who undergo a certain heart procedure. This medication helps to prevent other serious heart/blood vessel problems. This 'anti-platelet' effect helps to keep blood flowing smoothly in your body. SN advised patient/PCG to take medication Prasugrel 10 mg. 1 tablet by mouth daily as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **3/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 99.2 F, HR- 80 bpm, RR -16 per min BS 149 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 134/69 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to Other disorders of lung. Knowledge deficit regarding measures to control Other disorders of lung and the medication Anoro Ellipta 62.5-25 mcg. 1 puff by mouth 2 times daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed regarding medication Breo Ellipta 200-25 mcg. Breo Ellipta is a once-daily combination medicine used to treat asthma or COPD (chronic obstructive pulmonary disease), it helps improve breathing, reduce COPD flare-ups and help prevent and control asthma symptoms. This inhaler contains 2 medications: fluticasone and vilanterol. Fluticasone belongs to a class of drugs known as corticosteroids. It works by reducing the swelling of the airways in the lungs to make breathing easier. Vilanterol belongs to a class of drugs known as long-acting beta agonists. It works by relaxing the muscles around the airways so that they open, and you can breathe more easily. Side Effects headache, dry/irritated throat, hoarseness, runny nose, and coughing may occur as your body adjusts to the medication. If any of these effects last or get worse, tell your doctor or pharmacist promptly. SN instructed regarding medication Symbicort 160 mcg. -4.5 mcg. This product is used to control and prevent symptoms caused by asthma or ongoing lung disease (chronic obstructive pulmonary disease-COPD, which includes chronic bronchitis and emphysema). It contains 2 medications: budesonide and formoterol. Budesonide works by reducing the irritation and swelling of the airways. Formoterol works by opening airways in the lungs to make breathing easier. Both drugs work by relaxing the muscles around the airways in the lungs so they open to make breathing easier. SN advised patient/PCG to inhale Symbicort 160 mcg. - 4.5 mcg. 1 puff by mouth daily as ordered by MD. SN instructed regarding medication Advair Diskus 250-50 mcg. This product is used to control and prevent symptoms caused by asthma or ongoing lung disease (chronic obstructive pulmonary disease-COPD, which includes chronic bronchitis and emphysema). It contains 2 medications: fluticasone and salmeterol. Fluticasone belongs to a class of drugs known as corticosteroids. It works by reducing the irritation and swelling of the airways. Salmeterol belongs to the class of drugs known as long-acting beta agonists. It works by opening airways in the lungs to make breathing easier. Controlling symptoms of breathing problems can decrease time lost from work or school.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **3/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 99.4 F, HR- 99 bpm, RR -16 per min BS 167 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 131/81 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to paroxysmal atrial fibrillation. Knowledge deficit regarding measures to control paroxysmal atrial fibrillation and the medication Eliquis 1 tablet by mouth daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed Patient/PCG regarding paroxysmal atrial fibrillation. Atrial fibrillation is an irregular and often rapid heart rate that can increase your risk of strokes, heart failure and other heart-related complications. During atrial fibrillation, the heart's two upper chambers (the atria) beat chaotically and irregularly out of coordination with the two lower chambers (the ventricles) of the heart. Atrial fibrillation symptoms often include heart palpitations, shortness of breath and weakness. A major concern with atrial fibrillation is the potential to develop blood clots within the upper chambers of the heart. These blood clots forming in the heart may circulate to other organs and lead to blocked blood flow (ischemia). SN also instructed Patient/PCG regarding medication Warfarin Sodium 2 mg. Warfarin Sodium is used to treat blood clots and/or to prevent new clots from forming in your body. Preventing harmful blood clots helps to reduce the risk of a stroke or heart attack. Conditions that increase your risk of developing blood clots include a certain type of irregular heart rhythm (atrial fibrillation). SN instructed patient/PCG to take medication Warfarin Sodium 2 mg. by mouth 3 tablets daily as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **3/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 98.5 F, HR- 73 bpm, RR -16 per min BS 150 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 142/66 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to Hypothyroidism. Knowledge deficit regarding measures to control Hypothyroidism and the medication Levothyroxine 0.075 mg. 1 tablet by mouth daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed patient/PCG regarding Hypothyroidism. Hypothyroidism is when the thyroid gland does not produce enough thyroid hormones to meet the needs of the body. The thyroid is under active. Thyroid hormones regulate metabolism, or the way the body uses energy. If thyroxine levels are low, many of the body's functions slow down. Thyroid hormones affect multiple organ systems, so the symptoms of hypothyroidism are wide-ranging and diverse. Hypothyroidism develops slowly. Symptoms may go unnoticed for a long time, and they may be vague and general. SN also instructed Patient/PCG regarding medication Synthroid 88 mg. Synthroid or Levothyroxine is used to treat underactive thyroid (hypothyroidism). It replaces or provides more thyroid hormone, which is normally produced by the thyroid gland. SN advised patient/PCG to take medication Synthroid 88 mg. 1 tablet by mouth in the morning on empty stomach daily as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 1:32-2:17 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **1:32-2:17 22/02/2025 1:32-2:17** |
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**CLINICAL NOTE**

| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☒Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/**clear**  O2\_\_\_\_LPM/\_\_\_\_  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Neck, Joints**  Intensity: pain scale **2/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**21/02/2025**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled carbohydrate Low fat, Low cholesterol, NCS, Dash**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☒DM II | **Vital Signs**: T- 99.5 F, HR- 89 bpm, RR -16 per min BS 148 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 133/79 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to Mixed Hyperlipidemia. Knowledge deficit regarding measures to control Mixed Hyperlipidemia and the medication Atorvastatin Calcium 20 mg. 1 tablet by mouth daily as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. SN instructed patient/PCG regarding Mixed Hyperlipidemia. Mixed hyperlipidemia is a genetic disorder passed down through Family. The disorder contributes to heart disease and early heart attacks. Diabetes, hypothyroidism, obesity, and alcohol abuse can make the condition worse. Mixed hyperlipidemia is also known as familial combined hyperlipidemia. In fact, it's the most common inherited lipid disorder. SN instructed patient/PCG regarding Hyperlipidemia. Hyperlipidemia is a medical term for abnormally high levels of fats in the blood. The two major types of lipids found in the blood are triglycerides and cholesterol. Triglycerides are made when your body stores the extra calories it doesn’t need for energy. A diet high in refined sugar, fructose, and alcohol raises triglycerides. Cholesterol is produced naturally in your liver because every cell in your body uses it. Like triglycerides, cholesterol is also found in fatty foods like eggs, red meat, and cheese. Hyperlipidemia is more commonly known as high cholesterol. Although high cholesterol can be inherited, it’s more often the result of unhealthy lifestyle choices. SN also instructed Patient/PCG regarding the medication Pravastatin 20 mg. It is used along with a proper diet to help lower 'bad' cholesterol and fats (such as LDL, triglycerides) and raise 'good' cholesterol (HDL) in the blood. SN advised Patient/PCG to take medication Pravastatin 20 mg. 1 tablet by mouth daily as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☒Infection control measures  ☒Cane, walker Precautions☒ Universal Precautions ☒Other:911 protocols  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: 12:00-12:45 NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 022-001**  **PATIENT DATE TIME IN/OUT**  **12:00-12:45 22/02/2025 12:00-12:45** |
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