PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)

I. FACILITY INFORMATION *(To be completed by the licensee/designee)*

1. NAME OF FACILITY			2. TELEPHONE
STERLING SENIOR COMMUNITY Board and Care			(714) 357-1377
3. ADDRESS	**CITY**		**ZIP CODE**
15442 Columbia Lane	Huntington Beach	CA	92647

4. LICENSEE'S NAME	5. TELEPHONE	6. FACILITY LICENSE NUMBER
	( )	

II. RESIDENT/PATIENT INFORMATION *(To be completed by the resident/resident's responsible person)*

1. NAME	2. BIRTH DATE	3. AGE
HO CAO	2/1/1943	80 Y.O.

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(To be completed by resident/resident's legal representative)

I hereby authorize release of medical information in this report to the facility named above.

1. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE

2. ADDRESS	3. DATE

IV. PATIENT'S DIAGNOSIS *(To be completed by the physician)*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered.
(Please attach separate pages if needed.)

1. DATE OF EXAM	2. SEX	3. HEIGHT	4. WEIGHT	5. BLOOD PRESSURE
7/25/23	M	62 INCHES	127 lbs	124/66

6. TUBERCULOSIS (TB) TEST

a. Date TB Test Given	b. Date TB Test Read	c. Type of TB Test	d. Please Check if TB Test is:
> 7/14/23 > 7/21/23	> 7/17/23 > 7/24/23	Mantoux	☒ Negative ☐ Positive

e. Results: mm 0 f. Action Taken (if positive): N/A

g. Chest X-ray Results: N/A

h. Please Check One of the Following:

☐ Active TB Disease ☐ Latent TB Infection ☒ No Evidence of TB Infection or Disease

7. PRIMARY DIAGNOSIS: Acute stroke due to ischemic / acute lacunar stroke

a. Treatment/medication (type and dosage)/equipment:

1) on PT/OT/ST services

2) clopidogrel Bisulfate Oral tablet 75mg - 1 tablet by mouth daily

3) Rosuvastatin calcium 40mg - 1 table t by mouth at bedtime

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☒ No

c. If not, what type of medical supervision is needed?

=== NEEDS ASSISTANCE WITH ADL's AND MEDICATION ADMINISTRATION===

8. SECONDARY DIAGNOSIS(ES): Dysarthria following stroke

a. Treatment/medication (type and dosage)/equipment:

1) on ST services

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☒ No

c. If not, what type of medical supervision is needed?

=== NEEDS ASSISTANCE WITH ADL's AND MEDICATION ADMINISTRATION===

9. CHECK IF APPLICABLE TO 7 OR 8 ABOVE: 1) Vascular dementia

☐ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☒ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgement and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

10. CONTAGIOUS/INFECTIOUS DISEASE: None

a. Treatment/medication (type and dosage)/equipment:

N/A

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No

c. If not, what type of medical supervision is needed?

N/A

11. ALLERGIES: Levastatin; nsaids

a. Treatment/medication (type and dosage)/equipment:

none

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☐ No N/A

c. If not, what type of medical supervision is needed? N/A

12. OTHER CONDITIONS: GERD; CKD stag 3; Essential Hypertension; Diverticulosis of colon; DM 2 c' microalbuminuria

a. Treatment/medication (type and dosage)/equipment:
1) lisinopril 20mg - ½ tablet by mouth daily
2) amlodipine 5mg - 1 tablet by mouth daily

b. Can patient manage own treatment/medication/equipment? ☐ Yes ☒ No

c. If not, what type of medical supervision is needed?

=== NEEDS ASSISTANCE WITH ADL's AND MEDICATION ADMINISTRATION===

13. PHYSICAL HEALTH STATUS	YES	NO	ASSISTIVE DEVICE (If applicable)	EXPLAIN
a. Auditory Impairment		✓		
b. Visual Impairment		✓		
c. Wears Dentures		✓		
d. Wears Prosthesis		✓		
e. Special Diet	✓		controlled carbohydrates; puree texture nectar/mildly thick consistency	
f. Substance Abuse Problem		✓		
g. Use of Alcohol		✓		
h. Use of Cigarettes		✓		
i. Bowel Impairment	✓		} Incontinent of Bladder c' Bowel	
j. Bladder Impairment	✓			
k. Motor Impairment/Paralysis		✓		
l. Requires Continuous Bed Care		✓		
m. History of Skin Condition or Breakdown		✓		

14. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented	✓		è episodes
b. Inappropriate Behavior		✓	
c. Aggressive Behavior		✓	
d. Wandering Behavior		✓	
e. Sundowning Behavior		✓	
f. Able to Folb w Instructions	✓		
g. Depressed		✓	
h. Suicidal/Self-Abuse		✓	
i. Able to Communicate Needs	✓		
j. At Risk if Allowed Direct Access to Personal Grooming and Hygiene Items		✓	
k. Able to Leave Facility Unassisted		✓	

15. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self		✓	
b. Able to Dress/Groom Self		✓	needs moderate assistance è upper body è. total Dependence è lower body
c. Able to Feed Self		✓	needs minimum assistance
d. Able to Care for Own Toileting Needs		✓	Total Dependent
e. Able to Manage Own Cash Resources		✓	

16. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications		✓	
b. Able to Administer Own Injections		✓	
c. Able to Perform Own Glucose Testing		✓	
d. Able to Administer Own PRN Medications		✓	
e. Able to Administer Own Oxygen		N/A	
f. Able to Store Own Medications		✓	

17. AMBULATORY STATUS:

a. 1. This person is able to independently transfer to and from bed: ☐ Yes ☒ No

Total Dependent c transfers

2. For purposes of a fire clearance, this person is considered:
☐ Ambulatory ☐ Nonambulatory ☒ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and/or a person who depend upon mechanical aids such as crutches, walkers, and wheelchairs.
Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

b. If resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☒ Both Physical and Mental Condition

c. If a resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☒ Illness: Resident had acute Lacunar stroke

☐ Recovery from Surgery: _____

☐ Other: _____

NOTE: An illness or recovery is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____ (number of days)

2. _____ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)

3. If illness or recovery is permanent, please explain: Acute Lacunar Stroke

e. Is resident receiving hospice care?

☑ No ☐ Yes If yes, specify the terminal illness: _____

18. PHYSICAL HEALTH STATUS: ☐ Good ☑ Fair ☐ Poor

19. COMMENTS:

=== Please see MD's D/C Summary for list of medications ===

NOTE: OK TO USE BEDRAILS FOR BED MOBILITY

20. PHYSICIAN'S NAME AND ADDRESS (PRINT)

DR. MARK PELLEGRINO - 17542 E. 17th Street, Tustin, CA 92780

21. TELEPHONE	**22. LENGTH OF TIME RESIDENT HAS BEEN YOUR PATIENT**
(714) 734-5500	
23. PHYSICIAN'S SIGNATURE	**24. DATE** 7/25/2