SKILLED NURSING VISIT NOTE
(according to POC)

Patient: SELL, RON		**Admit Date:** 06-25-2025	**DOB:** 04/29/1967	**Sex:** M	**PAN #** 2
Nurse: HEIDI L VANDERHEIDE, ADMINISTRATOR	**Type of Visit:** SN and Supervisory		**Visit Date & Time:** 07/09/2025	2:10 pm	- 2:28 pm

HOMEBOUND REASONS

- ☐ Requires assistance for most to all ADL
- ☐ Medical restrictions
- ☐ Dependent upon supportive device(s)
- ☐ Unsafe to leave home unassisted
- ☐ Taxing effort to leave home
- ☐ SOB on exertion
- ☐ Patient is Bedridden
- ☐ Other

Comments

Patient is not home bound is able to leave home without taxing effort

Patient Identification

- ☒ patient stated his/her name
- ☐ patient stated his/her address
- ☒ patient stated his/her dob
- ☐ caregiver stated patient name (if patient unresponsive)
- ☐ patient is known to me
- ☐ Other

VITAL SIGNS

Temperature (Fahrenheit)	97.7	Temporal	**Pulse** (beats per minute)	75	Radial	Regular	**Respirations** (breaths per minute)	18	Regular

Note:

Blood Pressure	**Right**	114 / 74	**Left**	/	**Weight** (pounds)	

☒ Patient denies pain

Pain Location

Medication last taken

Pain Description

Pain Intensity (scale of 0 to 10)

Pain acceptable level (scale of 0 to 10)

Pain Duration

Number of Falls Since Last Visit

CODING 0. None 1. One 2. Two or more		
	0	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.
	0	**B. Injury (except major)**: Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	0	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Infections

Has the patient had infections since the last visit?

- [X] **No**
- [ ] **Yes**

Date of latest infection:

Infection Description/Details :

CARDIOVASCULAR

[ ] **Within Normal Limits** **Heart Sounds** [X] Regular [ ] Irregular [ ] Murmur **Chest Pain** [X] **No Chest Pain**

Location [ ] Substernal [ ] Left Shoulder/Hand **Other**

Edema: [ ] Sacral [ ] Pedal [ ] Pitting Pitting Severity: [ ] Non-Pitting [ ] Claudication

Duration **Intensity** (scale of 0 to 10)

Type [ ] Dull [ ] Aching [ ] Sharp [ ] Anginal [ ] Radiating

Aggravating/Relieving Factors

Location

Cardiovascular Note: No new signs of worsening Peripheral Vascular Disease (PVD) observed. Patient denies chest pain, palpitations, or shortness of breath.

PULMONARY

[ ] **Within Normal Limits** **Lung Sounds:** [X] Clear [ ] Crackles [ ] Rales [ ] Wheezes [ ] Rhonchi [ ] Diminished [ ] Absent

Anterior: [ ] Right [ ] Left Posterior: [ ] Right Upper [X] Right Lower [X] Left Upper [X] Left Lower

Cough: [X] None [ ] Acute [ ] Chronic [ ] Dry [ ] Productive [ ] Unable to cough secretions [ ] Suction Needed [ ] Hemoptysis **Note**

Respiratory Status: [ ] SOB [ ] Dyspnea [ ] Orthopnea **Oxygen** **LPM** [ ] PRN [ ] Continuous **Pulse Oximetry** **%**

Pulmonary Note: Lungs clear to auscultation bilaterally, normal respiratory effort. No adventitious breath sounds (crackles, wheezes, rhonchi) noted. No use of accessory muscles observed. Oral mucosa moist, no cyanosis noted. Patient denies shortness of breath, cough, or sputum production.

NEUROMUSCULAR

[ ] **Within Normal Limits**

Mental Status: [ ] Disoriented [ ] Agitated [ ] Forgetful [ ] Depressed

Alert & Oriented to [X] Person [X] Place [X] Time

Grip Strength: [X] Equal [ ] Unequal **Grasp Left:** **Right:**

[ ] Headache

Impairment [ ] Visual [ ] Speech [ ] Hearing

Mark Applicable [ ] syncope [ ] Vertigo [ ] Ataxia

Pupils [X] PERRLA [ ] Unequal

Falls : Denies falls

Neuromuscular Note: A&Ox3, normal affect, agitated. Acute behavior changes noted. Patient is responding to outside stimuli. Seems to be agitated with roommate in the home.

GASTROINTESTINAL

[ ] **Within Normal Limits**

Bowel Sounds: [X] Normal [ ] Abnormal [ ] Hypoactive [ ] Hyperactive

Bowel Sounds Note:

Abdominal Pain: [X] None [ ] Continuous [ ] Intermittent [ ] Non-tender [ ] Diffuse [ ] Localized

Abdominal Note:

Appetite: [X] Good [ ] Fair [ ] Poor

Diet Note: [ ] NPO

☐ Continuous ☐ Intermittent

Tube Feeding Note:

Bowel Movements: ☐ Normal ☐ Distention ☐ Flatulence ☐ Diarrhea ☐ Constipation ☐ Incontinence ☐ Impaction

Last BM 7/8/2025 **Enema**

Mark Applicable: ☐ Colostomy ☐ Ileostomy

Gastrointestinal Note: Patient has hernia

GENITOURINARY

☐ **Within Normal Limits**

Urine Frequency: **Urine Color:** **Urine Odor:**

Symptoms: ☒ Incontinence ☐ Urgency ☐ Hesitancy ☐ Dysuria ☐ Nocturia ☐ Oliguria ☐ Retention

Urinary Catheter: Type: **Size:** **Last Changed on:** **Irrigation:** **Bulb Inflated:**

Genitourinary Note: Patient is occasionally incontinent of bowl and bladder.

ENDOCRINE

☐ **Within Normal Limits**

Blood Sugar: Glucometer Reading ☐ Fasting ☐ Postprandial

Frequency of Testing ☐ Daily ☐ More than once a day ☐ AC&HS ☐ None

Hypo/Hyperglycemia Frequency

Diabetes Controlled with ☐ Insulin ☐ Oral Hypoglycemics ☐ Diet

Monitored / Administered by: ☐ Self ☐ Family ☐ HH Staff ☐ Other

Patient aware of Signs and Symptoms ☒ Yes ☐ No

Endocrine Note: Denies s/sx of hypo/hyperglycemia.

SKIN

☐ **Normal (Warm/Dry/Intact)**

Color ☒ Pink ☐ Pale ☐ Flushed

Temperature ☒ Warm ☐ Cool

Turgor ☒ Good ☐ Fair ☐ Poor

Condition ☒ Moist ☐ Dry/Rash/Itchy

Skin Note: Inspected bilateral amputation stumps: [detail findings, e.g., clean, dry, intact, no redness/swelling].

WOUND CARE

☒ No signs and symptoms of infection noted by nurse at this time

☐ Signs and symptoms of infection noted:

☐ Doctor Notified

WOUNDS INFORMATION

Type of Wound: Diabetic

Location: left foot ulcer

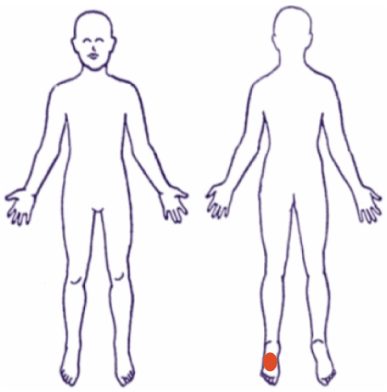
Length/Width/Depth: in cm

Sq. cm (LxW):

Tissue Thickness:

Drainage Type:

Drainage Amount:



Undermining: //

Wound Bed Color:

Tunnelling/Location: //

Odor: None

Edema: ☐ None ☐ Present

Wound Edge:

Wound Bed Tissue: ☐ Bloody ☐ Sloughing ☐ Necrotic ☐ Eschar ☐ Granular ☐ Weeping ☐ Healthy ☐ Other:

Surrounding Tissue: ☐ Normal for ethnic group ☐ Pale ☐ Red ☐ Edema ☐ Blanched ☐ Purple ☐ Cool ☐ Shiny ☐ Black ☐ Warm ☐ Other:

Notes: No break through drainage. dressing intact.

Negative Pressure Wound Therapy: ☐

MEDICATIONS

☐ Medication List Reviewed and Updated ☐ Allergy Updated
☐ Missed Doses

Med Note: Medications administered as per orders. No missed doses.

Medication Changes ☒ Unchanged ☐ New/Changed

IV Therapy: ☒ NA **Route** ☐ PICC Line ☐ Peripheral ☐ Implanted Port **Site**

Dressing Change ☐ Self ☐ Family ☐ HH Staff ☐ Other

Line Flush ☐ Self ☐ Family ☐ HH Staff ☐ Other ☐ Saline ☐ Heparin

IV Therapy Note:

Orders and Interventions

Skilled Nursing

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Vital signs within parameters

Patient/Caregiver Response: Vital signs are currently within individually established parameters.
Order: Parameters To Notify Physician: Temperature > 101 < 96 Respirations > 14 < 22 Blood Pressure Systolic > 160 < 90 Blood Pressure Diastolic > 100 < 50 Pulse Rate > 120 < 50 Pulse Ox < 88 Pain Levels > 7
Goal:: Vitals signs will stay within parameters within 2 weeks
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:
Order: Skilled nursing Frequency and Duration Two Times daily

Goal:: Patient's acute and complex medical conditions will be managed and maintained at a stable level, as evidenced by effective medication administration and monitoring, and absence of acute complications requiring changes to the prescribed twice-daily skilled nursing visits throughout the certification period.
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:
Order: Skilled Nursing to Assess and Eval once per cert period

Goal:: Patient's medical status and functional progress will be thoroughly assessed to determine continued skilled home health need and to update the plan of care for the next certification period.
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Provided direct medication administration for all prescribed medications as ordered.

Patient/Caregiver Response: Verbalizes s/sx to report to SN and MD.
Order: Observe and Assess Medications Safety

Goal:: Patient will remain compliant with medication safety during certification period
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:
Order: Instructions/Teaching Medication Safety

Goal:: Patient/Caregiver will verbalize understanding of medication safety techniques within cert period
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Daily assessment of wound/stump for signs of infection (redness, swelling, warmth, pain, drainage, odor).
Patient/Caregiver Response: Patient verbalized s/sx of infection.
Order: Instructions/Teaching Infection control/precaution
Goal:: Patient/Caregiver will verbalize understanding of Infection Control and precautions within cert period
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:
Patient/Caregiver Response:
Order: Instructions/Teaching Ambulation safety, fall precautions
Goal:: Patient/Caregiver will verbalize understanding of Ambulation safety and fall precuations within
Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Instruct patient on the importance of daily visual inspection of all skin surfaces, especially residual limbs, heels, and other pressure points, given his reduced sensation.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects.
Order: Regularly assess sensation in remaining extremities and residual limbs (e.g., light touch, sharp/dull, temperature discrimination) to identify areas of deficit.
Goal:: Patient will maintain intact skin integrity on remaining extremities and residual limbs, free from new breakdown or signs of injury, throughout the certification period.
Body System: Sensory

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Monitor surrounding skin for maceration, redness, or further breakdown.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects.
Order: Assess wound characteristics at each visit (size, depth, drainage, odor, tissue type) and document progress.
Goal:: Patient's left foot ulcer will show signs of healing (e.g., decreased size, improved granulation tissue) by 2 weeks, and absence of new skin breakdown.
Body System: Sensory

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Assess pain regularly using a consistent pain scale (0-10), noting location, intensity, quality, and aggravating/alleviating factors. Report uncontrolled pain or new types of pain (e.g., neuropathic/phantom limb pain) to the physician for medication adjustment.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects.
Order:
Goal:: Patient will report pain at a manageable level (e.g., = 3/10 on a consistent basis) that allows participation in care and rest.
Body System: Sensory

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Inspect all integumentary surfaces (especially residual limbs, heels, sacrum, and other bony prominences) daily for any new areas of redness, breakdown, blistering, or pressure injuries, given his mobility limitations and history of non-pressure chronic ulcers.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects.
Order: Observation and Assessment Wound Healing Status, Measure Wound to left foot Weekly

Goal:: The left foot ulcer will be significantly reduced in size or healed, and patient will demonstrate improved understanding and compliance with skin care regimen to prevent future breakdown by end of cert.
Body System: Integumentary

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:

Order: Perform wound care for the left foot ulcer 3 times weekly as ordered, utilizing sterile technique.

Goal:: The left foot ulcer will show signs of improvement (e.g., decreased size, increased granulation tissue, decreased exudate), and there will be no new skin breakdown on any integumentary surfaces.
Body System: Integumentary

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Educate patient on the importance of consistent wound care, dressing changes (if any are self-managed), and proper hand hygiene.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects.
Order: Observation and Assessment Wound for Signs and Symptoms of infection

Goal:: Wound(s) will be completely healed without complications within 2 weeks
Body System: Integumentary

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Educate patient on the direct adverse effects of tobacco use (1 pack per day) on respiratory health, including increased risk for COPD, lung cancer, and impaired healing.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects., Verbalize understanding
Order: Observation and Assessment Respiratory Status and pulse oximetry every visit or PRN if dyspneic

Goal:: Patient will have improved respiratory status and improved oxygenation as evidenced by normal breath sounds, respiratory rate and depth, absence of respiratory complaints and warm, dry skin with good color within
Body System: Respiratory

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Monitor for signs and symptoms of cardiac compromise (e.g., chest pain, shortness of breath, edema, palpitations, fatigue) or worsening Peripheral Vascular Disease (e.g., new pain in residual limbs, changes in skin color/temperature).
Patient/Caregiver Response: Patient denied any cardiac symptoms.
Order: Observation and Assessment Cardiovascular/Pulmonary Status

Goal:: Patient's cardiac status will return to and remain within normal limits for this patient without further progression of complications during certification period
Body System: Cardiac

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Assess for and report any changes in urinary patterns (e.g., frequency, urgency, volume, color, odor) or discomfort.
Patient/Caregiver Response: Hygiene is within normal limits. Patient continues to be cooperative with HHA.
Order: Instructions/Teaching Importance of good perineal hygiene

Goal:: Patient/Caregiver will verbalize understanding of the importance of good perineal hygiene within two weeks
Body System: Genitourinary

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Reinforce the importance of consistent foot care and daily skin checks for remaining extremities and residual limbs due to ongoing risk for ulcers, neuropathy, and PVD complications.
Patient/Caregiver Response: Patient denied experiencing any new or worsening adverse effects.
Order: Instructions/Teaching Skin/foot care and breakdown prevention.
Goal:: Patient/caregiver will be knowledgeable about skin/foot care and breakdown prevention within
Body System: Endocrine

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Educate patient on dietary recommendations for managing Prediabetes (e.g., balanced meals, consistent carbohydrate intake, limiting sugary drinks).
Patient/Caregiver Response: Verbalize understanding
Order: Instructions/Teaching Diabetic Disease process, progress and potential complications.
Goal:: Patient will verbalize understanding of the importance of managing Prediabetes conditions, including medication adherence, dietary recommendations, and symptom recognition, by end of cert
Body System: Endocrine

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Monitor for therapeutic effects (e.g., improved mood, reduced agitation, pain control) and adverse effects (e.g., sedation, dizziness, ataxia, extrapyramidal symptoms, changes in alertness, constipation).
Patient/Caregiver Response: Patient has increased agitation. Educated about deep breathing , distraction techniques. Patient verbalized understanding.
Order: Instructions /Teaching Signs and symptoms of psychiatric exacerbation to observe and report to nurse or MD
Goal:: Monitor for signs of acute psychiatric exacerbation (e.g., increased agitation, withdrawal, disorganized thought, severe paranoia).
Body System: Neuro/Emotional/Behavioral Status

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention: Educate patient on the purpose, dose, frequency, and potential side effects of all neurological/psychiatric medications.
Patient/Caregiver Response: Patient is agitated stating he is not crazy and does not hear voices. Is compliant with medication but does not know if he want to continue to take psychiatric medication. education on importance of adherence to medication, speaking to MD for dose titration. Patient verbalized understanding.
Order: Assess mental status at each visit (orientation, affect, thought process, presence of hallucinations/delusions, level of cooperation).
Goal:: Patient will demonstrate improved medication adherence for his neurological/psychiatric conditions, reporting manageable pain levels by end of cert period
Body System: Neuro/Emotional/Behavioral Status

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:
Patient/Caregiver Response:
Order: Observation and Assessment Patient's need/use of assistive devices
Goal:: Patient will transfer/ambulate and use assistive devices safely within as evidenced by lack of falls and/or other problems and verbalization of increased stability with ambulation within
Body System: Musculoskeletal

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:

Order: Observation and Assessment Circulatory Status and management

Goal:: Patient will have proper residual limb hygiene and care.

Body System: Musculoskeletal

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:

Order: Observation and Assessment Parameters to Notify Physician

Goal:: Patient's condition will be monitored for deviations from expected baseline, and any significant changes or signs of worsening will be promptly and effectively communicated to the physician to ensure timely intervention and prevent acute care utilization.

Body System: General

Effective Date: 6/25/25 **Goal Status:** Progressing

Goal Met: ☐ **Discontinued:** ☐

Intervention:

Patient/Caregiver Response:

Order: Observation and Assessment Vitals Signs to monitor:

Respiratory Status
Gastrointestinal Status
CardioPulmonary Status
Integumentary Status
Pain Management
Endocrine Status
Neurological Status
Renal/Genitourinary Status

Goal:: Patient will be free of exacerbation from _____ within 60 days

Body System: General

PROGRESS TOWARDS GOALS

Patient is not progressing with education on importance of taking psychiatric medication appears to be at a stable level, as evidenced by consistent monitoring and medication adherence. He denied any new acute symptoms or concerns at this visit. Will continue to educate and monitor for acute changes, medication adherence.

PLAN / COORDINATION / CHECKLIST

Care Plan ☒ Patient/Caregiver consulted and in agreement with recommended changes ☐ Achieved Outcome

Care Coordination With ☐ Physician ☒ SN ☐ PT ☐ OT ☐ ST ☐ MSW ☐ Other

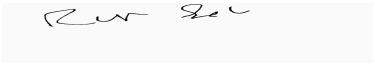
Next HH Nurse Visit 7/9/2025

Next Physician Visit 7/8/2025

Plan:

GENERAL NOTES

Patient was cooperative and participated in the Plan of Care. Patient expressed agreement with services and verbalized no questions/concerns at this time. Response to interventions was met with resistance today. Wound status is stable. Overall clinical status remains complex and requires ongoing skilled care. Continue to monitor closely for changes in condition and medication adherence. Noted positive change in mental clarity and continence, likely related to improved medication compliance. Educated patient on Practicing relaxation techniques (deep breathing, meditation, mindfulness, progressive muscle relaxation). Patient verbalized understanding.

Patient/Patient Representative Signature 

RON SELL

Date 07/09/2025

Signature of Nurse *Digitally Signed by* *HEIDI VANDERHEIDE, ADMINISTRATOR* Date 07/09/2025