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:** Skilled Nursing **Visit Date & Time:** 07/05/2025 6:26 am - 6:51 am

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)	Pulse (beats per minute)	Respirations (breaths per minute)

Note:

Blood Pressure **Right** / **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, alert. Speech coherent. No acute behavioral concerns noted during visit. Noted increased mental clarity compared to previous visits. No tremors or involuntary movements observed. Sensation to light touch and sharp/dull intact in upper extremities. Sensation in residual limbs [describe, e.g., absent distally, intact proximally].

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 7/3/2025 **Enema**

Mark Applicable: ☐ Colostomy ☐ Ileostomy

Gastrointestinal Note:

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

Patient aware of Signs and Symptoms ☐ Yes ☐ No

Endocrine Note:

Diabetes Controlled with ☐ Insulin ☐ Oral Hypoglycemics ☐ Diet

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

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

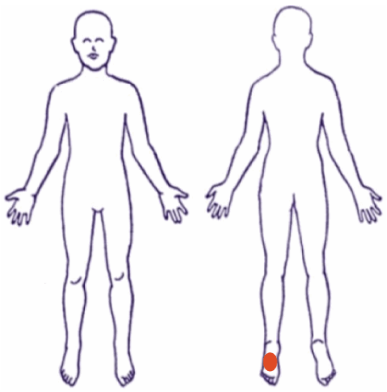
☐ Signs and symptoms of infection noted:

☐ 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:

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:

Negative Pressure Wound Therapy: ☐

MEDICATIONS

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

Med Note: Medications administered as per orders.

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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:

Patient/Caregiver Response:

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 making positive progress towards the goal of managing acute and complex medical conditions at a stable level, as evidenced by consistent monitoring and medication adherence. He denied any new acute symptoms or concerns at this visit. His increased mental clarity and reported continence are significant positive outcomes, likely related to his improved compliance with the Quetiapine regimen.

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 7/4/2025

Next Physician Visit 7/8/2025

Plan:

GENERAL NOTES

Ronald Sell exhibits a complex, unstable medical status requiring skilled nursing interventions for medication management, wound care, and ongoing assessment. His bilateral lower extremity amputations significantly impact functional independence, necessitating daily aide services. Active Schizophrenia remains a significant challenge impacting adherence and overall health outcomes, though patient is currently adhering to his medication regimen, which has resulted in increased mental clarity. He is at high risk for rehospitalization (M1033) as evidenced by frequent recent acute care utilization. The critical lack of informal caregiver support necessitates comprehensive home health involvement. Patient denies pain at this visit, which is managed by rest and medication. Patient is currently NOT HOMEBOUND. Nutritional risk due to Prediabetes and chronic wounds is being addressed, with groceries delivered. Neuromuscular assessment confirms significant mobility limitations due to amputations, but independent bed mobility is a positive finding. Patient reports no incontinence.

Patient/Patient Representative Signature Ron Sell Date 07/05/2025

RON SELL