



1 Bruce M. Brusavich, State Bar No. 93578
 2 Terry S. Schneier, State Bar No. 118322
 3 **AGNEWBRUSAVICH**
 4 A Professional Corporation
 5 20355 Hawthorne Boulevard
 6 Second Floor
 7 Torrance, California 90503
 8 (310) 793-1400

FILED
 ALAMEDA COUNTY

JUN 29 2017

CLERK OF THE SUPERIOR COURT
 By Stephanie J. ... Deputy

6 Andrew N. Chang
 7 ESNER, CHANG & BOYER
 8 Southern California Office
 9 234 East Colorado Boulevard
 10 Suite 750
 11 Pasadena, CA 91101
 12 (626) 535-9860121

10 Attorneys for Plaintiff

12 SUPERIOR COURT OF THE STATE OF CALIFORNIA
 13 FOR THE COUNTY OF ALAMEDA

AGNEW BRUSAVICH
 LAWYERS
 20355 HAWTHORNE BOULEVARD · TORRANCE, CALIFORNIA 90503-2401
 TELEPHONE: (310) 793-1400 FACSIMILE: (310) 793-1489 E-MAIL: ob@agnewbrusavich.com

15 LATASHA NAILAH SPEARS WINKFIELD;
 16 MARVIN WINKFIELD; SANDRA CHATMAN;
 17 and JAHl McMATH, a minor, by and
 18 through her Guardian ad Litem, LATASHA
 19 NAILAH SPEARS WINKFIELD,

18 Plaintiffs,

20 vs.

21 FREDERICK S. ROSEN, M.D.; UCSF BENIOFF
 22 CHILDREN'S HOSPITAL OAKLAND
 23 (formerly Children's Hospital & Research
 24 Center at Oakland); MILTON McMATH, a
 25 nominal defendant, and DOES 1
 26 THROUGH 100,

24 Defendants.

CASE NO. RG 15760730 **FAX FILE**

ASSIGNED FOR ALL PURPOSES TO:
 JUDGE STEPHEN PULIDO - DEPT. "16"

**DECLARATION OF SHARLEEN
 BANGURA, R.N.**

[Filed Concurrently with Plaintiffs' Opposition to Motion for Summary Judgment and Separate Statement of Disputed and Undisputed Material Facts in Opposition to Motion for Summary Judgment

Date Action Filed: 03/03/15

I, Sharleen Bangura, R.N., declare:

1. I am a registered nurse in the State of New Jersey, and in that capacity I have regularly provided nursing care to Jahi McMath in her apartment for the last

AGNEW BRUSAVICH
LAWYERS
20355 HAWTHORNE BOULEVARD, TORRANCE, CALIFORNIA 90503-2401
TELEPHONE: (310) 793-1400 FACSIMILE: (310) 793-1499 E-MAIL: ob@agnewbrusavich.com

1 three years. I have personal knowledge of the facts stated here, and if called as
2 a witness I could and would testify competently to them.

3 2. In addition to her parents, Jahi is cared for by nurses who work in three
4 shifts, 24/7. I have been her nurse on the day shift since she was discharged from
5 St. Peter's Medical Center in early 2014.

6 3. Jahi's nursing care is contemporaneously documented on "Nurse Shift
7 Note & Time Record" forms. The Nurse's Shift Note & Time Record dated 9/9/14
8 attached as Exhibit 1 documented the following: "Pt. Noted to be on her menstrual
9 cycle as evidenced by a large amount of bright red blood in her diaper."

10 4. I have observed that Jahi is more alert on some days than she is on other
11 days. On her alert days, if I ask her to squeeze my hand, she does so. If I ask her to
12 move different parts of her body, she will move that part. When I put on meditation
13 music for her to listen to, I watch as her heart rate goes down. Her heart rate
14 increases when she is listening to music that I know she enjoys, like Bobby Brown,
15 who is one of her favorites. Attached to this declaration as Exhibit 2 are true and
16 correct copies of Nurse's Shift Notes & Time Records that I authored between
17 February 18, 2016 and August 7, 2016. In each of these notes, I noted times that I
18 observed Jahi's movements in response to commands from family members.

19 I declare under penalty of perjury under the laws of the States of New Jersey
20 and California that the foregoing is true and correct.

21 Executed this 27 day of June, 2017 at Somerset, New Jersey.

22
23 
24 Sharleen Bangura, R.N., Declarant
25
26
27
28

EXHIBIT 1

CLINICAL NOTES

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other



Client: [Handwritten Name]

Mon Tue Wed Thu Fri Sat Sun

WEEKEND ON GUARD

Temp

Pulse

Resp

BP

PAIN LEVEL 0 1 2 3 4 5 6 7 8 9 10

[Extremely faint handwritten notes, likely bleed-through from the reverse side of the page]

EXHIBIT 2

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jani McMath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 2/21/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
2/18	M T W Th F Sa Su	7am	3pm	8HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

L. Delors
Client Signature
MEDICAID ID#: _____ (State of PA Only)

Sharon Benzina
Employee Signature/Title
Date

Temp: <u>97'</u>	Pulse: <u>81</u>	RP/AP	Resp: <u>2</u>	O2 Sat: <u>100%</u>	B/P: <u>138/101</u>	Sitting/Lying/Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1 cal @ 40ml/hr</u>					
Respiratory Status: <u>Vent dependent (Bronchi)</u>	Bowel Status: <u>Incontinent (+) BS x 4 Quads</u>					
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent (Strict I&O)</u>					
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SPRx2, HOB up, Dolphin Bed, Bil profo boots & hand rolls</u>					
Cardiac Status: <u>HR Regular (+) Peripheral pulses (Cap refill) (Brush)</u>	Communication needs: <u>Non-Verbal</u>					
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:					
Skin Integrity: <u>Warm, Dry, intact Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked					
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Other: <u>O2 Aspiration/Reflux/Fall Precaution</u>					
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10						
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>						
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No						
If no, intervention/follow-up <u>N/A</u>						

SHIFT NOTES: 7am Received report from night nurse. JM in bed positioned on her back eyes closed. Bil profo boots intact. Skin warm, dry, intact. Resp. unlabeled 12hpm. Bronchi that clears c/sk. Shiley H.O.D.T. Trach Patent, intact, Midline, cuff inflated & secured by velcro ties to 1st finger breath & attached to the LTVL150 vent c/humidified heater. Vent setting as ordered. Continuous Pulse OX monitoring in place. Alarms set & functioning audibly. #20FR Regular Patent & intact. Jevity 1 cal infusing @ 40ml/hr tolerating well. 8am Meds given per MAR. Arginine N/A eye ointment applied. 9am oral care. 9:15am PROM on all extremities. 9:45am ABT Vest x 20mins. 10:20am Bed bath/diaper change void only 10:50am Peg site cleaned. Site pink & dry. dressed & groomed repositioned to left side. 12pm - Meds/Flush given per MAR. eye ointment applied. 2pm - Meds given c/flush. 2:45pm - Diaper change void c/ Meds soft PM. per care given. Repositioned to right side. 3pm - VSS, NAB, Sx/pd nasal Trach as needed. JM

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: Tolerated all aspects of care. ↑ Move-
 ① 39ml of fluid replacement needed. Maint to rooms. Commands. Report
 ② Maintained SAT 92-96 on RA given to evening nurse. SB
 ③ Tolerated feeding.
 ④ Personal care met. ⑤ No injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
 COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Johi McMath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 2/21/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
2/17	M T W Th F Sa Su	6:30 am	4pm	9 1/2 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L Spear
Client Signature

MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Charleen Bangma RN 2/17/16
Employee Signature/Title Date

Temp: <u>98</u>	Pulse: <u>83</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>122/82</u>	Sitting <input checked="" type="checkbox"/> Lying <input checked="" type="checkbox"/> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jeuity 1 cal @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (HYGAS CTA)</u>	Bowel Status: <u>Incontinent (BS active)</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR N/A, HOB ↑, ODP in bed</u> <u>Bk proto boots & hand rolls</u>				
Cardiac Status: <u>HR Regular Cap refill</u> <u>Brush</u>	Communication needs: <u>Non-verbal</u>				
Edema: <u>none</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Other: <u>O2/Aspiration/Reflex Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 6:30am Received report from night nurse. Jim in bed positioned on her back. Bk eyes closed covered. N/A soaked gauze. Shiley HOBCT Trach Patent, intact, midline. cuff inflated & secured by velcro ties & attached to the LTVLSSO vent & humidified heater. Vent setting verified. Pulse Di in place. Probe on (2) middle finger. Alarms set & functioning. Audibly: lungs CTA Resp unlabored 12bpm. Abdomen soft non-tender. #2 DFR peg tube Patent & intact. Jeuity 1 cal infusing @ 40ml/hr. BS active. 7:00am PRN on all extremities. 8am Meds given per MAR. Arginine N/A mom aware. Eye ointment applied. 9am ABT vest x2 mins. 9:30 oral care. Sxn p/d Trach. 11am Partial bed bath given diaper change void csm soft. Trach care. Peg site cleaned sit pink & dry. dressed & groomed. Repositioned to left side. 12pm Meds/Flush given per MAR. eye ointment applied. 2pm Meds given & flush. 2:30pm Diaper change void only. Peri care given. Repositioned to right side. 4pm eye ointment applied. VSS, NAD, Sxn p/d/nasal/Trach as needed.

- PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT
- ① Retained 557ml of fluid. Intolerated all aspects of care. Jim responds
 - ② maintained SAT ↑ 92% on RA to mom's commands by moving head/foot
 - ③ Feeding tolerated ④ Personal finger when asked. Report given to
 - Care met ⑤ NO Injury evening nurse. SB

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
 COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
 HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD

2/15/16



Client's Name: Johi McNath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 2/21/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
2/15	(M) T W Th F Sa Su	7am	11am	16hrs

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L Spears
Client Signature
MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Shaleen Bangma RN 2/15/16
Employee Signature/Title Date

Temp: <u>97.7</u>	Pulse: <u>88</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>120/95</u>	Sitting <input checked="" type="checkbox"/> Lying <input checked="" type="checkbox"/> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>No Jewelry / Cal & 4oml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CTA)</u>	Bowel Status: <u>Incontinent (H) BS Active</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SRM, HORN, DOPPIN Bed</u> <u>Blk Proto boots & hand rails</u>				
Cardiac Status: <u>HR Regular</u> <u>Cap refill brisk</u>	Communication needs: <u>Non-verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	Other: <u>O2 Aspiration / Reflux / Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>(0)</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 7am Received report from night nurse. Jm in bed positioned on her back. eyes closed. Blk Proto boots on. Skin warm, dry, intact. Resp unlabored 12bpm. lungs CTA. Shiley H/D DCT Trach patent, intact midline. cuff inflated & secured by Velcro ties to 1 finger breadth & attached to the LULLO Vent humidified heater vent setting as ordered. AC/17, PEEP 15, TV/Su/Fi/O2/RA. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. #20FR Peg tube patent & intact. Jevity 1cal infusing @ 4oml/hr tolerating well. Abdomen soft non-tender. BS Active.

8am Meds given per MAR. eye ointment applied. 9am Oral Care. Meds given & Flush. 9:30am ABT vest x 20mins. 10am PBDM on all extremities. 11am Diaper Change. 11:30am Peri Care given. Repositioned to left side. NB Bath per Mom. Peg site Naoned (site pink & dry) dressing applied. 12pm Meds/Flush given per MAR. eye ointment applied. 2pm Meds given & Flush. 2:30pm Diaper Change. 3pm Peri Care given. Repositioned to right side. 4pm eye ointment applied. 5:30pm Diaper Change.

- PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT
- ① 190ml of fluid replacement given.
 - ② Maintained SAT 92% on RA cease of Resp.
 - ③ Tolerated feeding.
 - ④ Personal Care Met
 - ⑤ All Safety Precaution Maintained No injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO

COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)

DME Respiratory Therapist Other:

CLINICAL NOTES

02/15/16
2 of 2



- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

Client's Name: Jahi McMath

Client#: 619-27

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	2	15	16						

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

Void 12pm. Peri Care given. Repositioned onto back. Bk prolo boots on feet. 1pm - Meds/Flush given per MAR. 6:30pm - PROM on all extremities. 7pm - Vent Circuits Changed. Pt sat on back-up vent while circuits changed. Tolerated well. No S/S of distress or discomfort. 8pm - Meds given per MAR. eye ointment applied. 9pm - ABI vest x 20 mins. 9:30pm - oral care. 10pm - Diaper change. Void 2:30am soft BM. Peri Care given. Repositioned to left side. 11pm - VSS, NAD, SM on nasal/Trach as needed. Jm tolerated all aspects of care. Jm moved head/fingers to her mother's commands throughout shift. Report given to night nurse. SB

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW JRN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:

Continue C.P.O.C.

CARE PLAN UPDATE: YES NO HHA present? YES NO
 Patient participated in Care Plan Update? YES NO HHA SUPERVISION: YES NO

Signature/Title: Shroven Bannu RN Date: 2/15/16

1 of 2
2/12/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahi McNath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 2/14/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
2/12	M T W Th F Sa Su	7am	8pm	13hrs

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

[Signature]
Client Signature
MEDICAID ID#: _____ (State of PA Only)

Shaleen Bhangwa RN 2/12/16
Employee Signature/Title Date

Temp: <u>96.5</u>	Pulse: <u>78</u> RP/AP	Resp: <u>2</u>	O2 Sat: <u>100%</u>	B/P: <u>124/93</u> Sitting / (Lying) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1cal @ 40ml/hr</u>			
Respiratory Status: <u>Vent dependent</u>	Bowel Status: <u>Incontinent (BS active)</u>			
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>			
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SP1 x 2, 4081, Dolphin Bed</u> <u>Oil Prabs boots & hand falls</u>			
Cardiac Status: <u>HR Regular</u> <u>Cap refill brisk</u>	Communication needs: <u>non-verbal</u>			
Edema: <u>none</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:			
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked			
Neurological: <u>ABX</u> <input type="checkbox"/> Seizures x _____	Other: <u>O2/Aspiration/Reflux Fall Precaution</u>			
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) (0) 1 2 3 4 5 6 7 8 9 10				
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>				
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, intervention/follow-up <u>N/A</u>				

SHIFT NOTES: 7am Received report from night nurse. Jm in bed positioned on back. Oil eyes closed covered. Nas soaked gauze. Trach patent, intact, medline, cuff inflated & secured by velcro ties & attached to the CIVILSO Venti-humidified header. Vent setting verified. Pulse ox in place. Probe on D Big toe. Alarms set & functioning audibly. Lungs CTA. Resp unlabored 12bpm. Abdomen soft non tender #20FR Reg tube patent & intact site pink & dry. Jevity 1cal infusing @ 40ml/hr. No Residual. BS Active. 7:30 PRN on all extremities. 8am Meds given Per MAR. Arginine N/A eye ointment applied. 9am Meds given & flush. ABX Vest x 20 mins. 10:30am Partial Bed bath given diaper change void only 88m. Reg site cleaned, dressed & groomed. Repositioned to right side. 11:00 oral care. 12pm Med/Flush given Per MAR. eye ointment applied. 2pm Meds given & flush. 2:30pm diaper change void & med soft BM. Peri Care given. Repositioned to left side. 4pm eye ointment applied. 6pm Meds/Flush given Per MAR

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

- ① maintained S & O @ ur @ 80ml
- ② maintained of SAT ↑ 92% on RA
- ③ Tolerated feeding
- ④ Personal care met.
- ⑤ NO Injury

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

2/12/16

Client's Name: Jahi McMath

Client#: 619-27

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	2	14	16						

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6pm - Meds/Flush given per MAR. (6:30pm - Diaper Change Liquid (102.8ml)
 7pm - Med Soft Pm. Peri care given. Repositioned onto back. Blk Puffs knots
 on feet. Trach Care Provided. 7:45 Evening Meds given per MAR. eye
 ointment applied. 8pm - VS, NAD, Sn pr NAD. Trach as needed. Jim
 Moved, fingers/Head to her mother commands. Jim tolerated all
 aspects of care. Report given to mom. SB

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:
Continue C.P.O.C.

CARE PLAN UPDATE: YES NO
 Patient participated in Care Plan Update? YES NO
 HHA present? YES NO
 HHA SUPERVISION: YES NO

Signature/Title: Shaleen Bangura RN Date: 2/12/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: John McMath
 Client Services Manager: Lamar Fisher

Client #: 619-27
 Week Ending Sunday: 3/27/16
 Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
3/23	M T W Th F Sa Su	6 ³⁰ am	4pm	9 1/2 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

[Signature]
 Client Signature
 MEDICAID ID#: _____ (State of PA Only)

Shaloon Banguna RN 3/23/16
 Employee Signature/Title Date

Temp: <u>97'</u>	Pulse: <u>75</u> RP/AP	Resp: <u>2</u>	O2 Sat: <u>100%</u>	B/P: <u>113/80</u>	Sitting (Lying) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>No Jevity 1 cal @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CTA)</u>	Bowel Status: <u>Incontinent (BS Active)</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR, x2 Hoist, Dolphin Bed, BL Puffo boots & hand rolls</u>				
Cardiac Status: <u>HR Regular</u>	Communication needs: <u>Non-verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>warm, dry, intact</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked				
<u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABS</u> <input type="checkbox"/> Seizures x	Other: <u>0 @ Aspiration/Reflex/Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 6³⁰am Report received from night nurse. Jim in bed lying on her back. Eyes closed. Shiley 4.0 Trach Patent & intact & attached to the LTV 150 Vent. Vent setting verified. Continuous pulse ox monitoring in place. Probe on (R) middle finger. Alarms set & functioning audibly. Resp unlabored T&Bm. Lungs CTA. #20FR Peg tube Patent & intact Jevity 1 cal infusing @ 40ml/hr. BS Active. Abdomen soft non-tender.
8am Meds given per MAR. eye ointment applied. 9am Oral Care. Meds given & flush.
9³⁰am ABS vert x2 abdoms. 10am PRN on all extremities. 10³⁰am Bed bath/diaper changed. Peg site cleaned (site pink & dry) Trach care dressed & groomed. Repositioned to left side. 12pm Meds/flush given per MAR. eye ointment applied. 2pm Meds given & flush. 2³⁰pm Diaper change void x1 Med soft BM Per Care given. Repositioned to right side. 4pm eye ointment applied. VSS, NAD, Sun Palmall Trach as needed. Jim tolerated all aspects of care ↑ movement throughout the shift. Report given to evening nurse — SB

- PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT
- Maintained I & D (+) or (-) Scomu
 - Maintained SAT 100% on RA
 - Tolerated feeding
 - Personal Care needs met.
 - All safety Precaution maintained NO injury

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
 COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
 HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahi McMath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 3/20/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
3/14	(M) T W Th F Sa Su	4pm	11pm	7 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L. Spears
Client Signature

MEDICAID ID#: _____ (State of PA Only)

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Shaloon Bengua RN 3/14/16
Employee Signature/Title Date

Temp: <u>97.4</u>	Pulse: <u>75</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>121/91</u>	Sitting <input type="checkbox"/> Lying <input checked="" type="checkbox"/> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1cal @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CTA)</u>	Bowel Status: <u>Incontinent</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SPRAX2, HOBT, Dolphin bed</u> <u>BL PRAB boots & hand rolls</u>				
Cardiac Status: <u>HR Regular</u> <u>Cap refill brisk</u>	Communication needs: <u>Non-Verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes & pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABI</u> <input type="checkbox"/> Seizures x	Other: <u>O2 Aspiration/Reflux fall precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other: <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up: <u>N/A</u>					

SHIFT NOTES: 4pm - Received report from Day nurse. Jm in bed positioned on her right side. Eyes closed covered & Nss soaked gauze. Resp unlabored 12bpm lungs CTA. Shiley 4.0 DCT Trach, Patent, intact, midline. Cuff inflated & secured by Velcro ties & attached to the LTV150 Vent & humidified heater. Vent setting as ordered AC12, PEEP15, TV150, FiO2/RA. Continuous Pulse Ox Monitoring in place. Alarms set & functioning audibly. #20FR Peg tube Patent & intact Jevity 1cal infusing @ 40ml/hr. Abdomen soft non-tender. 6pm - Meds/Flush given per MAR. 6:30pm - Diaper change void only 0Bm. Peri care given. Repositioned onto Douch. BL PRAB boots on feet. 7pm - PROM on all extremities. 8pm - Oral Care. Meds given per MAR. eye ointment applied. 9pm - ABI vest x20mins. 10:30pm - Diaper change void only 0Bm. Peri care given. Trach Care. Repositioned to left side. 11pm - VSS, NAD, Sxn Polynasal/Trach as

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: Needed Jm tolerated all aspects of Care. Jm moved head & left fingers to Mother's Command. Report given to Night Nurse.

① maintained J & O (+) or (-) Sx on RA
 ② maintained SAT 192% on RA
 ③ Tolerated feeding.
 ④ Personal Care met ⑤ NO injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
 COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A
 HHA Present: Yes No N/A
 Care Plan Update: Yes No
 Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jani McMath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 3/13/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
3/11	M T W Th F Sa Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

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L. Spartz
Client Signature

MEDICAID ID#: _____ (State of PA Only)

Shaleen Bangura RN 3/11/16
Employee Signature/Title Date

Temp: <u>97</u>	Pulse: <u>76</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>130/103</u> Sitting (<u>Lying</u>) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>Non Jevity / Cal 40ml/HR</u>			
Respiratory Status: <u>Vent dependent (Lungs)</u>	Bowel Status: <u>Incontinent</u>			
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>			
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR + X2 HOBT, Dolphin bed</u> <u>Bill proto books & hand rolls</u>			
Cardiac Status: <u>HR Regular</u> <u>Cap refill BRUSH</u>	Communication needs: <u>Non-Verbal</u>			
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:			
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked			
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Other: <u>04 Aspiration/Reflux/Fall Precaution</u>			
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10				
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>				
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, intervention/follow-up <u>N/A</u>				

SHIFT NOTES: 7am - Received report from night nurse. Jim in bed positioned on her back. Eyes closed. General appearance normal. Shiley 4.0 DET Patent & intact & attached to the JULISO Vent & humidified heater. Vent setting verified. Continuous pulse oximetry in place. Alarms set & functioning audibly. #20PR Reg tube Patent & intact Jevity lead infusing @ 40ml/HR. Abdomen soft non-tender. 8am Meds given per MAR. Arginine N/A. Eye ointment applied. 9am Meds given. Oral care given. 9:30am ABT. Vent X2 Omins. 10am Diaper change void only. 11pm Per care given. Trach care provided repositioned to left side. No bath. Per Mom. 12pm Meds/Flush given per MAR. Eye ointment applied. 1pm PRN on right side. 2pm Meds given & flush. 2:30pm Diaper change void & LG soft. 3pm Per care given. Repositioned to right side. 3pm USS, NAD, SIM pol. Nasal Trach as needed. Jim tolerated all aspects of care. Jim moved fingers (2) hand to Mom's command.

- PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT**
- 1) maintained SPO_2 @ 90-95% Report given to evening nurse
 - 2) maintained SAT \uparrow 92% on RA
 - 3) Tolerated feeding
 - 4) Personal Care needs met
 - 5) All safety precautions maintained No injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE TIME RECORD



Client's Name: Jahi McMath

Client #: 619-27

Client Services Manager: Lamar Fisher

Week Ending Sunday: 3/6/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
3/4	M T W Th F Sa Su	7am	11pm	16 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statement documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

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[Signature]
Client Signature
MEDICAID ID#: _____ (State of PA Only)

Employee Signature/Title: Charleen Banguer RN Date: 3/4/16

Temp: <u>97</u>	Pulse: <u>81</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>124/81</u>	Sitting <input checked="" type="checkbox"/> (Lying) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>Npo Jevity local @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CIA)</u>	Bowel Status: <u>Treatment</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SpO2, HOB, Dolphin bed</u>				
Cardiac Status: <u>HR Regular</u>	Communication needs: <u>Non-Verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, intact</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked				
Mucous Membranes: <u>Pink & moist</u>	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	Other: <u>O2 Aspiration/Reflux Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up: <u>N/A</u>					

SHIFT NOTES: 7am Report received from night nurse. Jmin bed positioned on her back
Blk eyes closed & covered. NSS soaked gauze. Mucous membranes pink & moist. Resp
unlabored 12bpm. lungs CIA. Shiley 4.0 D/T Trach patent, intact, midline, cuff inflated &
Secured by Velcro ties to 1 finger breadth & attached to the ITU/ISO vent humidified
heater. Vent setting as ordered. Aclz Peep 15, TV 500, Fio2 1RA. Continuous pulse ox.
Monitoring in place. Alarms set & functioning audibly. #20FR Peg tube Patent & intact
Jevity local infusing @ 40ml/hr. Abdomen soft non-tender. Skin warm, dry, intact.
8am Meds given per MAR. Arginine N/A mom aware. eye ointment applied. 9am oral
Care. Meds given & flush. 9:30am ABT Vest x 20mins tolerated well. 10am - PRN
on all extremities. 10:30am Bed bath given. diaper change void only @ Pm.
Peg site cleaned & dressed & groomed. Repositioned to left side. 12pm - Meds/
Flush given per MAR. eye ointment applied. 2pm - Meds given per MAR. 2:30p -

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: diaper change void @ Med soft 1 Pm. Peri
① maintained I & O (+/-) 500ml Care given Repositioned to right side.
② maintained SAT 92% on RA
③ Tolerated feeding ④ Personal Care Needs met.
⑤ All Safety Precautions maintained No Injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
 COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
 HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

CLINICAL NOTES

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

2 of 2
3/4/16



Client's Name: Jahi Melkath

Client#: 619-27

Week ending Sunday	Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	3	4	16	16					3/4	

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

4pm - eye ointment applied. 6pm - Meds/Flush given Per MAR. 6:30pm - Diaper Change void & Med soft BM Peri Care given. Trach Care provided. Repositioned onto back. Bil Proto boots on feet. 7pm - PROM on all extremities. 8pm - Meds given Per MAR. eye ointment applied. 9pm - ABI vest x20mins. 10pm - oral care - Diaper Change void only & BM Peri Care given. Reposition to left side. 11pm - VSS, NAD, Sn p/nasal Trach as needed. JM tolerated all aspects of care. JM moved fingers on both hands to mother's commands. Report given to night nurse. SB

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:

Continue C.P.O.c.

CARE PLAN UPDATE: YES NO HHA present? YES NO

Patient participated in Care Plan Update? YES NO HHA SUPERVISION: YES NO

Signature/Title: Sharon Bengina RN Date: 3/4/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Johi McMath
 Client Services Manager: Diana Moncayo

Client #: 619-27
 Week Ending Sunday: 4/24/16
 Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
4/21	M T W TH F Sa Su	7am	3pm	8hrs

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

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Shaleen Banguer RN 4/21/16
 Employee Signature/Title Date

Client Signature: _____
 MEDICAID ID#: _____ (State of PA Only)

Temp: <u>98</u>	Pulse: <u>80</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u> B/P: <u>123/92</u> Sitting <u>(Lying)</u> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>No Fevity 1 cal @ 40 ml/hr</u>		
Respiratory Status: <u>Vent dependent (lungs CIA)</u>	Bowel Status: <u>Incontinent (BS active)</u>		
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent (Strict I & O)</u>		
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR+2, HO3, 100% in bed</u> <u>Blk Protoboots & hand rolls</u>		
Cardiac Status: <u>HR Regular</u> <u>Cap refill brisk</u>	Communication needs: <u>Non-Verbal</u>		
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:		
Skin Integrity: <u>Warm, Dry, Intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked		
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	Other: <u>Od Aspiration/Reflex/fall Precautions</u>		
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10			
Recurrent <input type="checkbox"/> New (location) <u>N/A</u>		Exacerbating Factors: <u>N/A</u>	
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u>		Effective <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, intervention/follow-up <u>N/A</u>			

SHIFT NOTES: 7am Received report from night nurse. Jim in bed positioned on her back. Blk eyes closed. General appearance normal. Blk Protoboots on feet. Trach Patent & intact. Attached to the HILLUS vent & humidified heater. Vent setting verified. Continuous pulse oximetry monitoring in place. Alarms set & functioning audibly. Lungs CIA. Resp unlabored labored. Abdomen soft non-tender (H) BS x 4 Qads #2 OFE Regular Patent & intact. Fevity 1 cal infusing @ 40 ml/hr. 8am - Meds given per MAR. Eye ointment applied. 9am oral care. Meds given & flush. 9:30am ABT. Vest x 20 min. 10am PRN x 4 extremities. 10:30am Bed bath given. Diaper change. W/d only. Q Bn. Reg site cleaned. Trach care. Dressed & groomed. Repositioned to left side. 12pm - Med/Flush given per MAR. eye ointment applied. 2pm - Meds given & flush. 2:30pm - Diaper change. W/d only. Q Bn. Peri care given. Repositioned to right side. 3pm - VSS NAB, Sin pol/Nasal/Trach as needed. Tolerated all aspects of care. Jim moved head & hands to mom's side. Commands Report given to evening nurse.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT

1) maintained I & O 0 or 0 500ml
 2) maintained SAT 92 on RA
 3) Tolerated feeding. (H) Personal Care needs met.
 4) All Safety Precautions maintained NO injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO

COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other.

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jani McNorth

Client #: 619-27

Client Services Manager: Diana Moncayo

Week Ending Sunday: 4/10/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
4/4	(M) T W Th F Sa Su	4pm	11pm	7 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L Spears
Client Signature
MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Muneen Bangura RN 4/4/16
Employee Signature/Title Date

Temp: <u>97.3</u>	Pulse: <u>80</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>149/108</u>	Sitting / <u>(C)</u> Lying / Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NO Fevity local @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CTA)</u>	Bowel Status: <u>Incontinent (BS active)</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> APRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR-X2, HOB-1, Dolphin bed</u> <u>BL prof boots & hand rolls</u>				
Cardiac Status: <u>HR Regular</u> <u>Cap refill brisk</u>	Communication needs: <u>Non-Verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	Other: <u>O2/Aspiration/Reflux/Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) 0 1 2 3 4 5 6 7 8 9 10	Exacerbating Factors: <u>N/A</u>				
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u>	Effective <input type="checkbox"/> Yes <input type="checkbox"/> No				
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u>					
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 4pm - Received report from Day nurse. Jim in bed positioned on her right side. eyes closed covered TNSs soaked gauze. Resp unlabored 12bpm, lungs CTA. Shiley 4.0 D/T Trach Patent, intact, Midline, cuff inflated & secured by velcro ties to 1 finger breath & attached to the LULLSO Vent humidified header. Vent setting as ordered A/C12, PEEP 5, TV 500, FIO2/RA. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. #2 of FR peatube Patent & intact. Fevity local infusing @ 40ml/hr. Abdomen soft non-tender. Skin warm, dry, intact. 6pm - Diaper change void = 594ml @ 8pm Peri Care given. Repositioned onto back. BL prof boots on feet. Meds/Flush given per MAR. 6:45pm - PRDM x2 Omns. 10:30pm Diaper change void 2 Med soft BM. Peri Care given. Repositioned to left side. 11pm - USS, NAD, Skin palpable Trach as needed. Jim tolerate all aspects of care. Jim moved head & hands to mom command.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: Report given to night nurse.

- Maintained T & D (+ or -) stool
 - Maintained SAT 100% on RA
 - Delayed feeding.
 - Personal care met
 - All Safety Precautions maintained NO Injury
- HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
- COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other.

CLINICAL NOTES

5/13/16
2 of 2



- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

Client's Name: Jahi McMath

Client#: 619-27

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	5	15					13		

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

4:20pm Clindamycin 150mg started for trach infection NO adverse reactions. 6pm Meds/Flush given per MAR. 6:30pm Diaper Change Void=640ml 0Bm Peri Care given Repositioned onto back B/L Prfto boots on feet. 7pm ABM on all extremities. 8pm Meds given per MAR Eye ointment applied. 9pm ABI vest x20mins. 10:30pm Diaper Change Void=206ml 0Bm Peri Care given Repositioned to left side. 11pm V/S, NAD, SxN p/nasal Trach as needed. Jm tolerated all aspects of care. Jm moved her head w/ fingers, 1/2 hand when asked. Report given to night nurse. SB

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. OPT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS: _____

PLAN FOR NEXT SHIFT/VISIT:

Continue c.p.o.c.

CARE PLAN UPDATE: YES NO HHA present? YES NO

Patient participated in Care Plan Update? YES NO HHA SUPERVISION: YES NO

Signature/Title: Shameen Bangma RN Date: 5/13/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahi No Math

Client #: 619-27

Client Services Manager: Diana Montoya

Week Ending Sunday: 5/22/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
5/20	M T W Th (F) Sa Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

[Signature]
Client Signature
MEDICAID ID#: _____ (State of PA Only)

Shaoen Bengua RN 5/20/16
Employee Signature/Title Date

Temp: <u>98</u>	Pulse: <u>91</u> RP/AP	Resp: <u>17</u>	O2 Sat: <u>100%</u>	B/P: <u>131/97</u>	Sitting <input checked="" type="checkbox"/> Lying <input checked="" type="checkbox"/> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Fairly / oral 840ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CIA)</u>	Bowel Status: <u>Incontinent (BS Active)</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent (Strict I&O)</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SKIN 2, HOB, DOLPHIN BED</u>				
Cardiac Status: <u>HR Regular</u>	Communication needs: <u>Non-Verbal</u>				
Cap refill: <u>British</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Edema: <u>None</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked				
Skin Integrity: <u>Coarm dry, intact</u>	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Mucous membranes: <u>pink & moist</u>	Other: <u>Aspiration/Reflux/Fall Precaution</u>				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10				
Recurrent <input type="checkbox"/> New (location): <u>N/A</u>	Exacerbating Factors: <u>N/A</u>				
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u>	Effective <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 7am Received report from night nurse. Jim in bed positioned on her back. Eye closed. General appearance normal. All PRNs boots on feet. Shiley Trach Patent & intact & attached to the LTVL. So Vent & humidified heater. Vent setting verified. Continuous pulse ox monitoring in place. Alarms set & functioning. Audibility. Lungs CIA. Resp unlabored 12bpm. Abdomen soft non-tender. BS Active #20FR. Reg tube Patent & intact. Fairly / oral infusing @ 40ml/hr. 8am Oral Care. Meds given per MAR. eye ointment applied. 8:30am ABT (clindamycin) given & flush. 9am Meds given 9:30am ABT vent x 20ml. 10:30am Bed bath. Wd & lg soft. 8m Reg site cleaned. Trach care dressed & groomed. Repositioned to right side. 12pm Meds/Flush given per MAR. 2pm PRN X4 extremities. Meds given. 3:45pm Diaper Change. Wd & Mod soft. 8m Peri Care given. Repositioned to left side. 3pm VSS/NAD. Sxnd nasal trach as needed. JM tolerated all

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

① Maintained I&O (+) or (-) SROM	Aspects of Care. JM moved fingers & hand when requested by mom. Report given to mom.
② Maintained ABT @ 92% on RA	
③ Tolerated feeding	
④ Personal Care met	
⑤ No injury.	

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahi McMath

Client #: 60427

Client Services Manager: Diana Monaco

Week Ending Sunday: 5/29/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
0525	M T (W) Th F Sa Su	6:30 am	3pm	8 1/2 hrs

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Client Signature: [Signature]
MEDICAID ID#: _____ (State of PA Only)

Employee Signature/Title: Shaloon Bengina RN
Date: 5/25/16

Temp: <u>98</u>	Pulse: <u>85</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>127/87</u>	Sitting <input checked="" type="checkbox"/> Lying <input checked="" type="checkbox"/> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NO Feedy 1 cal @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs CIA)</u>	Bowel Status: <u>Incontinent</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR, HOB, DDPain bed</u> <u>Bk Prob looks & handrails</u>				
Cardiac Status: <u>HR Regular</u> <u>Cap refill brisk</u>	Communication needs: <u>Non-Verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Other: <u>CD Aspiration/Reflux Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 7am Received report from night nurse. JM in bed positioned on her back. eye closed Bk Prob looks on feet. Shiley Trach patent intact & attached to the LTVL50 vent & humidified water. Vent setting verified. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. lungs CIA. Resp unlabeled 12bpm. #20FR peg tube patent & intact Feedy 1 cal @ 40ml/hr. BS active Abdomen soft non-tender. 8am Meds given per MAR. eye ointment applied 9am oral care. Meds given. 9:30am ABT vest x abdomen. 10am PROM legs only 10:30am bed bath given. Void only 08m. Peg site cleaned. Trach care. Dresser & groomed Repositioned to right side. 11am Meds/Flush given per MAR eye ointment applied. 2pm Meds given & flush. 2:30pm Diaper change Void & Med soft 8m. per care given. Repositioned to left side. 3pm VSS, NAD. Skin palpated all trach as needed. JM tolerated all aspects of care. JM moved head & right hand. to mom's request. Report given to evening nurse. — 8B

- PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:
- Maintained T & O @ or @ 50ml
 - Maintained SAT @ 92% on RA
 - Tolerated feeding.
 - Personal Care needs met.
 - NO injury

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahi Memath

Client #: 619-27

Client Services Manager: Diana Morayo

Week Ending Sunday: 5/29/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
5/29	M T W Th F Sa Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

J. Adams
Client Signature
MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Shaloon Bengura RN 5/29/16
Employee Signature/Title Date

Temp: <u>98.2</u>	Pulse: <u>77</u> RP / AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>104/75</u>	Sitting / Lying / Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1 Cal @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (lungs SA)</u>	Bowel Status: <u>Incontinent</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR 2, HOB 1, Dolphin bed</u> <u>Blk Prato boots & hand rolls</u>				
Cardiac Status: <u>HR Regular</u> <u>Cap refill BTK.</u>	Communication needs: <u>Non-verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	Other: <u>O2 / Aspiration / Reflow / Fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 7am Received report from night nurse. Jim in bed positioned on her back eye closed Blk Prato boots on feet. Hand rolls in place. Shirley Trach Patent, intact & secured by Velcro ties to 1 finger breath & attached to the BIVUSD Vent. humidified heater. Vent setting verified. Continuous Pulse ox monitoring in place. Alarms set & functioning audibly. lungs CTA. Resp unlabored 12bpm RR 20RR Reg tube patent & intact Jevity 1 Cal infusing @ 40ml/hr (P) BSx4 Qods. Abdomen soft non-tender. 8am Meds given per MAR eye ointment applied. 9am Oral Care. Meds given. 9am ABT test x doming. 10am PRN x4 extremities 10am Bed Bath given void & Med soft Pom. Reg site cleaned. Trach care. dressed & groomed Repositioned to right side. 12pm - Meds/Flush given per MAR. Eye ointment applied. 2pm - Meds given. 2:30pm - Diaper Change void only 4pm peri care given. Repositioned to left side. 3pm VSS NAD.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

- 1 Maintained J & O
- 2 Maintained SAT @ 92% on RA
- 3 Initiated feeding.
- 4 Personal Care mdt
- 5 NO injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO

COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable) DME Respiratory Therapist Other:

CLINICAL NOTES

5/30/16
2 of 2



- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

Client's Name: Jahi McMath

Client#: 619-27

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	6	15	16						

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6:30pm - Diaper Change void = 434ml OBM peri care given. Repositioned onto back. BL pads boots on feet. 7:30pm PROM on all extremities. 8pm - Oral Care. Meds given per MAR eye ointment applied. 9pm - ABS vest x20mins. 10:30pm Diaper Change void = 236ml Med Soft OBM peri care given. Repositioned to right side. 11pm - VSS, NAD, Sx on nasal/traeh as needed. Im titrated all aspects of care. Im moved head & hands left & right to Grandmother request. Report given to ~~the~~ night nurse. 83

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

[This section is crossed out with a diagonal line.]

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:
Continue C.P.A.C.

CARE PLAN UPDATE: YES NO
 Patient participated in Care Plan Update? YES NO
 HHA present? YES NO
 HHA SUPERVISION: YES NO

Signature/Title: Sharon Benzina RN Date: 5/30/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahn Mellath

Client #: 61927

Client Services Manager: Diana Moncayo

Week Ending Sunday: 6/5/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
6/3	M T W Th F Sa Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L. Spear

Client Signature

MEL ICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Sharon Bengua RN 6/3/16
Employee Signature/Title Date

Temp: <u>98.1</u>	Pulse: <u>89</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>120/79</u> Sitting (Lying) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>No Jevity, Cal @ 40ml/hr</u>			
Respiratory Status: <u>Vent dependant (scattered rhonchi)</u>	Bowel Status: <u>Incontinent</u>			
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>			
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SP, X2, HOB, Dolphin bed</u>			
Cardiac Status: <u>HR Regular</u>	Communication needs: <u>Non-Verbal</u>			
Cap refill: <u>Brisk</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:			
Edema: <u>None</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked			
Skin Integrity: <u>Warm, Dry, intact</u>	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked			
Mucous membranes: <u>pink & moist</u>	Other: <u>O2 Aspiration Reflex Fall Precaution</u>			
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10			
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u>	Exacerbating Factors: <u>N/A</u>			
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other: <u>N/A</u>	Effective <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, intervention/follow-up: <u>N/A</u>				

SHIFT NOTES: 7am Received report from night nurse Jim in bed positioned on the right side, eyes closed. Shiley Trach patent, intact & attached to the LTVLSD Vent & humidified heater. Vent setting verified. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. Scattered rhonchi hears c 8m. Resp unlabored 12bpm #2 DER peg tube patent & intact Jevity cal @ 40ml/hr BS active. Abdomen soft non-tender. 8am Meds given per MAR. Eye ointment applied. 9am Meds given. 10am ABT vest x 20mins 10:30am bed bath given void = 362ml DBM. Peg site cleaned site pink & dry. Trach care, dressed & groomed Repositioned onto back. Bk Probs boots on feet. 11:30am Oral Care. 12pm Meds/Flush given per MAR. eye ointment applied. 2pm Meds given & flush. PRN x 4 extrimitts. 2:45pm Diaper change void = 382ml 3pm peri care given. Repositioned to left side. 3pm VSS, NAD, SKN POL

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT:

- maintained I & O (+) or (-) 800ml
- Maintained SAT 92% on RA
- Tolerated feeding.
- Personal Care met.
- No injury.

Nasal Trach as needed. Jim tolerated all aspect of care. Report given to evening nurse.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? Review orders for reporting parameters YES NO

COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)

DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A
HHA Present: Yes No N/A

Care Plan Update: Yes No
Client Participated in Care Plan Update Yes No

CLINICAL NOTES

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

6/4/16
2 of 2



Client's Name: Jani Math

Client#: 619-27

Week ending Sunday	Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	6	5	16							

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6:30pm - Diaper Change void = 386 ml 08pm Peri Care given. Repositioned onto back. Bk. Proso boots on feet. 7pm - PROM on all extremities
 8pm - Meds given per MAR. eye ointment applied. Oral Care. 9pm ABT Vest x2 Admins 10:30pm Diaper Change. Void = 146 ml Med 8:30pm. Peri Care given. Repositioned to right side. 11pm - VSs, NAD, 8x4 pol/nasal Trach as needed. JM tolerated all aspects of care. JM moved hands & fingers on left & right hand to grandmother's commands. Report given to night nurse. 88

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS: _____

PLAN FOR NEXT SHIFT/VISIT:
Continue c.p.o.c.

CARE PLAN UPDATE: YES NO
 Patient participated in Care Plan Update? YES NO
 HHA present? YES NO
 HHA SUPERVISION: YES NO
 Signature/Title: Sharon Bengua RN Date: 6/4/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jani Melath

Client #: 619-27

Client Services Manager: Diana Moncayo

Week Ending Sunday: 6/12/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
6/12	M T W Th F Sa Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L. Spears
Client Signature

MEDICAID ID#: _____ (State of PA Only)

I certify that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Amaleen Bengura RN 6/12/16
Employee Signature/Title Date

Temp: <u>97</u>	Pulse: <u>81</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>119%</u> B/P: <u>83/62</u> Sitting <u>(Lying)</u> / Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>No Jevity Cal @ 40ml/hr</u>		
Respiratory Status: <u>Vent dependent (lungs CTA)</u>	Bowel Status: <u>Incontinent</u>		
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>		
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SK x 2, HOB up, DOLMIN bed, BK Profo boots & hand rolls</u>		
Cardiac Status: <u>HR Regular</u>	Communication needs: <u>Non-Verbal</u>		
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:		
Skin Integrity: <u>Warm, Dry, Intact</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked		
<u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked		
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Other: <u>O2 / Aspiration / Reflux / Fall Precaution</u>		
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10			
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>			
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, intervention/follow-up <u>N/A</u>			

SHIFT NOTES: 7am - Received report from night nurse. Jm in bed positioned on her back. BK Profo boots & hand rolls in place. eyes closed. Shiley Trach patent, intact & attached to the (TUVIS) vent & humidified heater. Vent setting verified. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. Lungs CTA. Resp unlabored labpm. #20 Fr peg tube patent & intact. Jevity Cal @ 40ml/hr. BS active. Abdomen soft non-tender. 8am Meds give per MAR. eye ointment applied. 9am oral care. Meds given. 9:30am ABT. Vent x adm. 10am PROM on all extremities. 10:30am bed bath given. Diaper change void = 260 ml DBM. Peg site cleaned. site pink & dry. Trach care. dressed & groomed repositioned to right side. 12pm Meds / Flush given per MAR. eye ointment applied. 2pm - Meds given. 2:30pm Diaper change void = 103 ml DBM peri care given. Repositioned to left side. 3pm - VSS

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: NAD Sx on pt nasal / Trach as needed. Jm tolerated all aspects of care. Report given to Evening nurse.

① Maintained I & O (+) or (-) 500ml
② Maintained SAT 92% on RA
③ Tolerated feeding.
④ Personal Care met. ⑤ No injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO

COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable) DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A
HHA Present: Yes No N/A
Care Plan Update: Yes No
Client Participated in Care Plan Update Yes No

CLINICAL NOTES

2 of 2
6/13/16



- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

Client's Name: Jani McMath

Client#: 6927

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	6	19	16						

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6pm-Meds/Flush given per MAR. 6:30pm-Diaper Change Void=792 ml
 lg soft pm peri care given. Repositioned onto back. Blk Profo boots
 on feet. 7pm-PRN on all extremities. 8pm-Meds given. eye ointment
 applied. 9pm-ART vest x2mins. 10:30pm-Oral Care. Diaper
 Change. Void=212 ml. 11pm-ORAL care given. Repositioned to left side.
 11pm-DSS/NAD, SxN polnase/Trach as needed. Jm tolerated all
 aspects of care. Jm moved hands & fingers to mom's request.
 Report given to night nurse. SB

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:
Continue to P.O.C.

CARE PLAN UPDATE: YES NO
 Patient participated in Care Plan Update? YES NO

HHA present? YES NO
 HHA SUPERVISION: YES NO

Signature/Title: Sharon Bangwa RN. Date: 6/13/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jani McMath

Client #: 619-27

Client Services Manager: Diana Morcayo

Week Ending Sunday: 7/3/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
7/3	M T W Th F Sa (Su)	7am	3pm	8hrs

My signature certifies that I received service on the date as listed and that the times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

[Signature]
Client Signature
MEDICAID ID#: _____ (State of PA Only)

Sharon Bonomo RN 7/3/16
Employee Signature/Title Date

Temp: <u>97°</u>	Pulse: <u>88</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>105%</u> B/P: <u>132/99</u> Sitting <input checked="" type="checkbox"/> Lying <input type="checkbox"/> Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1 cal @ 40ml/hr</u>		
Respiratory Status: <u>Vent dependent (lungs CTA)</u>	Bowel Status: <u>Incontinent</u>		
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>		
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SR+xa, HOB+, Dolphin bed</u> <u>Blk Profo Mats & hand rolls</u>		
Cardiac Status: <u>HR Regular</u> <u>Cap refill Basia</u>	Communication needs: <u>Non-Verbal</u>		
Edema: <u>(2) knee</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:		
Skin Integrity: <u>warm, dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked		
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	Other: <u>O2/Aspiration/Reflux/Fall Precaution</u>		
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>(0)</u> 1 2 3 4 5 6 7 8 9 10			
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>			
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, intervention/follow-up <u>N/A</u>			

SHIFT NOTES: 7am Received report from night nurse. Jm in bed positioned on her back. Blk Profo Mats & hand rolls in place. eyes closed. Shirley Trach Patent, intact, & attached to the LTV150 vent. humidified heater. Vent setting verified. Continuous pulse & monitoring in place. Alarms set & functioning audibly. lungs CTA. Resp unlabored 12bpm. #20R2 per tube Patent & intact. Jevity 1cal infusing @ 40ml/hr. BS active. Abdomen soft non-tender. 8am Oral Care. Meds given. 9am Meds given 9:45am ABT vent xadmins. 10am PRN arms only. 11am Bed bath given. diaper change w/did = 168ml. Reg site cleaned. Trach Care. Cressed & groom. Repositioned to right side. 12pm Meds/Flush given per MAR. eye ointment applied. 2pm Meds given 2:45pm - Diaper change w/did = 85ml Med Bm. Peri Care given. Repositioned to left side. 3pm - VS, NAD, Sn pol/nasal Trach as needed. Jm tolerated all aspects of care. Jm moved finger & hand to man Request. Report

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: given to man.

- Maintained I & O @ +/- 85ml
- Maintained SAT 92% on RA.
- Tolerated feeding.
- Personal care met.
- All Safety Precautions maintained. No injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
 COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

CLINICAL NOTES

2 of 2
7/4/16



- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____

Client's Name: Jahi McMath

Client#: 619-27

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	7	10	16						

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6:30pm - Diaper Change void = 484ml OAM peri care given. Repositioned onto back. Blk Profo boots on feet. 7pm - PROM on arms only. 8pm - oral care. Nads given. 9pm - ABI best x adminis
 10:30pm - Diaper Change void = 104ml OAM Peri Care given. Repositioned to right side. 11pm - VSS, NAD, Sx n p/nasal / Trach as needed. Jm tolerated all aspects of care. Report given to night nurse.

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW LIRN/LPN HHA Client Serv. Mgr. N/A

COMMENTS:

PLAN FOR NEXT SHIFT/VISIT:
Continue C.P.O.c.

CARE PLAN UPDATE: YES NO HHA present? YES NO
 Patient participated in Care Plan Update? YES NO HHA SUPERVISION: YES NO

Signature/Title: Sharon Benguer RN Date: 7/4/16

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jahi McMath

Client #: 619-27

Client Services Manager: Diana Moncayo

Week Ending Sunday: 8/7/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
8/1	(M) T W Th F Sa Su	3pm	11pm	8hrs

My signature certifies that I received service on the date as listed and that times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

L. Sperry
Client Signature
MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Shaloon Bengua BN
Employee Signature/Title Date

Temp: <u>97.5</u>	Pulse: <u>80</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>158/123</u> Sitting (Lying) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>Npo Jeivity 1cal @ 40ml HR</u>			
Respiratory Status: <u>vent dependent (Lungs CIA)</u>	Bowel Status: <u>Incontinent (BS active)</u>			
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>			
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SRM x2, HOBR, Dolphin Be</u>			
Cardiac Status: <u>HR Regular</u> <u>Cap refill B/B</u>	Communication needs: <u>Non-Verbal</u>			
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:			
Skin Integrity: <u>Warm, Dry, Intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked			
Neurological: <u>ABS</u> <input type="checkbox"/> Seizures x	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked			
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10	Other: <u>Od/Aspiration/Reflux/all Percutic</u>			
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u>	Exacerbating Factors: <u>N/A</u>			
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u>	Effective <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, Intervention/follow-up <u>N/A</u>				

SHIFT NOTES: 3pm - Received report from Day Nurse. Jim in bed positioned on her left side eyes closed covered CNSS soaked gauze. Resp unchanged 12rpm Lungs CIA. Sabley Trach Patent, intact, midline. Cuff inflated & secured by velcro ties to 1 finger breadth & attached to the LTVLSD vent & humidified heater vent setting as ordered AC/12, PEEP/5, TV/50, FiO2/RA. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. #20 FR pcp tube Patent & intact Jeivity 1cal infusing @ 40ml/hr. Abdomen soft non-tender. Skin warm dry, intact. 4pm eye ointment applied. 6pm Diaper change void: 368 ml. B/B Peri Care given. Repositioned onto back. Bk Prato boots in place. Meds/Flus given. 7pm PAIN 8pm Meds given Per MAR. eye ointment applied. 9pm ABS rest x2 admin. 10pm Diaper change void: 206 ml Med Bm peri Care given. Repositioned to right side. 11pm VSS, NAD, SRM p/ Nasal/ Trach

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: as needed. Jim tolerated all aspects

- Maintained I & O @ 50ml of care. Jim moved finger & hands to
- Maintained SAT 100% on RA Mom's commands. Report given to nurse.
- Tolerated feeding.
- Personal Care Met.
- NO injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Johi McMath

Client #: 619-27

Client Services Manager: Diana Morayo

Week Ending Sunday: 8/7/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
8/2	M <u>0</u> W Th F Sa Su	7am	4pm	9hrs

My signature certifies that I received service on the date as listed and that times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

I. Spiera
Client Signature
MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Shaleen Bangwa RN 8/2/16
Employee Signature/Title Date

Temp: <u>97.1</u>	Pulse: <u>79</u> RP/AP	Resp: <u>2</u>	O2 Sat: <u>100%</u>	B/P: <u>102</u> Sitting (Lying) Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1 Cal @ 40ml/hr</u>			
Respiratory Status: <u>Vent dependent (lungs OK)</u>	Bowel Status: <u>Incontinent</u>			
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>			
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SPR x2 HOBT, Doppler brach</u>			
Cardiac Status: <u>HR Regular Cap refill BTK</u>	Communication needs: <u>Non-verbal</u>			
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:			
Skin Integrity: <u>Warm, Dry, intact Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked			
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked			
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>0</u> 1 2 3 4 5 6 7 8 9 10	Other: <u>Od/Aspiration/Reflex/Fall Accidents</u>			
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u>	Exacerbating Factors: <u>N/A</u>			
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other <u>N/A</u>	Effective <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, Intervention/follow-up <u>N/A</u>				

SHIFT NOTES: 7am Received report from night nurse. Jim in bed positioned on her back, eyes closed. Respirations 12 bpm. Lungs clear. Shiley Trach Patent, intact & secured by Velcro ties to 1 finger breadth & attached to the LTV HSO vent humidified heater. Vent setting verified. Continuous pulse oximetry in place. Alarms set & functioning audibly. #20FR Peg tube Patent & intact. Jevity 1 Cal infusing @ 40ml/hr. Abdomen soft non-tender. BS active. 8am oral care. Meds given. eye ointment applied. 9am Meds given. 9:30am ABT. 10am PRN. 10:30am Bed bath given. Diaper change void = 267 ml med pm. Peg site cleaned. Trach care. dressed & groomed. Repositioned to right side. 12pm Meds/Flush given per MAR. eye ointment applied. 2pm Meds given. 2:30pm Diaper change void = 389 ml Med pm Per Care given. Repositioned to left side. 4pm eye ointment applied. VSS.

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT

<u>1</u> Maintained T & O @ 97.1	<u>1</u> tolerated all aspects of care. Jim move head & hands to Mom's request.
<u>2</u> Maintained SAT @ 98.9 on RA	<u>2</u> Report given to nurse. — SB
<u>3</u> Tolerated feeding.	
<u>4</u> Personal Care Met.	
<u>5</u> No injury.	

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other.

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD

Client's Name: Johi McMath

Client #: 619-27



Client Services Manager: Diane Mancayo

Week Ending Sunday: 8/7/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
8/7	M T W (Th) F Sa Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that all times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

J. Sparto
Client Signature

MEDIC ID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Shaeen Bengner RN 8/4/16
Employee Signature/TITLE Date

Temp: <u>97.6</u>	Pulse: <u>78</u> RP/AP	Resp: <u>2</u>	O2 Sat: <u>100%</u>	B/P: <u>130/86</u>	Sitting <u>(Lying)</u> / Standing
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>NPO Jevity 1 cal @ 40ml/hr</u>				
Respiratory Status: <u>Vent dependent (Lungs CTA)</u>	Bowel Status: <u>Incontinent</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SP, 2, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100</u>				
Cardiac Status: <u>HR Regular</u> <u>Cap refill Bristle</u>	Communication needs: <u>Non-Verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, intact</u> <u>Mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked <input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Neurological: <u>ASST</u> <input type="checkbox"/> Seizures x	Other: <u>Od/Aspiration/Reflux/fall Precaution</u>				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>(0)</u> 1 2 3 4 5 6 7 8 9 10					
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u> Exacerbating Factors: <u>N/A</u>					
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other: <u>N/A</u> Effective <input type="checkbox"/> Yes <input type="checkbox"/> No					
If no, Intervention/follow-up: <u>N/A</u>					

SHIFT NOTES: 7am Received report from night nurse. Jim in bed positioned on her back. All PRN books & hand rolls in place. Eyes closed covered with NSS soaked gauze. Respiration 12bpm. Lungs CTA. Continuous pulse ox monitoring in place. Alarms set & functioning audibly. Shiley Trach Patent, intact, midline, cuff inflated & secured by Velcro ties to 1 finger breadth & attached to the L Tiller Vent & humidified heater. Vent setting verified. #20FR Reg tube Patent & intact. Jevity 1 Cal infusing @ 40ml/hr. BS active. Abdomen soft non-tender. 8am oral care. Meds given. eye ointment applied. 9am Meds given. 10am PRN on all extremities. No bath per Norm. 11am washed Pt hair. 12pm Meds/Flush given. eye ointment applied. 1pm Diaper change void = 252 ml 2pm Peri care given. Trach care provided. Repositioned to right side. 2pm Meds given. 3pm VSS, NAD, S/N p/Nasal Trach

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: as needed. Jim tolerated all aspects of care. Jim moved her head & hands to mom's commands. Report given to Nurse.

① T = 79.8 O = 252 Retaining 546 ml
② maintained SAT 92-96 on RA
③ Tolerated feeding. ④ Personal Care met. ⑤ No injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO

COORDINATED WITH/REPORTED TO: N/A Clin Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable)
 DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

NURSE'S SHIFT NOTE & TIME RECORD



Client's Name: Jani McMath

Client #: 619-27

Client Services Manager: Diana Monaco

Week Ending Sunday: 8/7/16
Month/Day/Year

DATE	DAY (circle day worked)	TIME STARTED	TIME FINISHED	TIME WORKED
8/6	M T W Th F (Sa) Su	7am	3pm	8 HRS

My signature certifies that I received service on the date as listed and that times and services performed are accurate. I understand that if payment for this service will be from Federal and State funds, any false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I also agree to the terms on the back of this form.

J. Spina
Client Signature

MEDICAID ID#: _____ (State of PA Only)

My signature certifies that I provided service to the client on the date and time listed above, and that the report of client status and care provided are accurate. I understand that I will be paid on the verified time on this time record and that my pay includes compensation for time spent for client care, documentation, and travel between cases. I also agree to the terms on the back of this form.

Sholom Bengua RN 8/6/16
Employee Signature/Title Date

Temp: <u>97.6</u>	Pulse: <u>82</u> RP/AP	Resp: <u>12</u>	O2 Sat: <u>100%</u>	B/P: <u>118/81</u>	Sitting <input checked="" type="checkbox"/> Lying <input checked="" type="checkbox"/> Standing <input type="checkbox"/>
Mental Status: <input type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other	Nutrition/Diet: <u>No Jevity / Cal 240ml/hr</u>				
Respiratory Status: <u>Vent dependent (Lungs SA)</u>	Bowel Status: <u>Incontinent</u>				
<input checked="" type="checkbox"/> Trach <input checked="" type="checkbox"/> Vent <input type="checkbox"/> CPAP <input checked="" type="checkbox"/> Alarms Set <input type="checkbox"/> N/A	Urinary Status: <u>Incontinent</u>				
Oxygen: <input type="checkbox"/> Continuous <input checked="" type="checkbox"/> PRN <input type="checkbox"/> N/A	Environment/Safety: <u>SRT x2, HOB, 20pin bed</u>				
Cardiac Status: <u>HR Regular Caprefill BRICK</u>	Communication needs: <u>NON-Verbal</u>				
Edema: <u>None</u>	Infection Control: <input checked="" type="checkbox"/> Standard Precautions <input type="checkbox"/> Other:				
Skin Integrity: <u>Warm, Dry, Intact, mucous membranes pink & moist</u>	<input checked="" type="checkbox"/> Equipment checked <input checked="" type="checkbox"/> Back up equipment checked				
Neurological: <u>ABT</u> <input type="checkbox"/> Seizures x _____	<input checked="" type="checkbox"/> Emergency equipment checked <input checked="" type="checkbox"/> Go Bag checked				
Pain Status: Client reports pain as a problem: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Intensity Level (Circle one) <u>(0)</u> 1 2 3 4 5 6 7 8 9 10	Other: <u>02/Aspiration/Reflux/Hall Pericardic</u>				
<input type="checkbox"/> Recurrent <input type="checkbox"/> New (location): <u>N/A</u>	Exacerbating Factors: <u>N/A</u>				
Treatment: <input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Other: <u>N/A</u>	Effective <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, intervention/follow-up <u>N/A</u>					

SHIFT NOTES: 7am Received report from night nurse. Jm in bed positioned on her back. Ph. Arto boots & hand rolls in place. Eyes closed. Sniley Trach patent & intact & attached to the CIVISO Vent. humidified heater. Vent setting verified. Continuous pulse ox monitoring in place. Alarms set & functioning. Audible lungs CIA. Reso unlabeled 12pm. #20FR Reg tube patent & intact Jevity 1 Cal infusing @ 40ml/hr. BS Active. Abdomen soft nontender. 8am Meds given eye ointment applied. 9am oral care. Meds given. 9:30am ABT vest x20mils 10am PRN x4 extremities 10:30am Bed bath given diaper change void = 192ml Sn PM per site cleaned. Trach care dressed & groomed. Repositioned to right side. 12pm Meds/Flush given. eye ointment applied. 2pm Meds given 2:30pm Diaper change void = 160ml Sn peri care given. Repositioned to left side. 3pm - VSS, NAD, Sn RM nasal. Trach as needed. Jm tolerate

PROGRESS TOWARD GOALS/OUTCOMES OF THIS SHIFT: All aspects of care. Report given to evening nurse.

- Maintained I & O @ or - 50ml
- Maintained SRT 192ml on RA
- Tolerated feeding.
- Personal Care Met.
- NO Injury.

HAS A CHANGE IN STATUS OCCURRED THAT REQUIRES REPORTING? (Review orders for reporting parameters) YES NO
COORDINATED WITH/REPORTED TO: N/A Cln Mgr RN/LPN Client Svc Mgr Physician (Addendum completed, if applicable) DME Respiratory Therapist Other:

HHA Supervision: Yes No N/A Care Plan Update: Yes No
HHA Present: Yes No N/A Client Participated in Care Plan Update Yes No

CLINICAL NOTES

2 of 2

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Medical Social Services
- Nursing
- Other _____



Client's Name: Jahi Mollath Client#: 619-27

Month	Day	Year	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week ending Sunday	8	7	16						8/7

Time Arrived: _____ Time Left: _____

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10

6pm - Meds/Flush given per Mar. 7pm - PACU 9pm - Meds given. Eye ointment applied. 9pm - ABT vest x2 admin. 9:45 pm Diaper Change

Udd = 264ml hbpm peri care given. Trach care provided. Reposition to right side. Wom - VSS, NAD, Smp on Nasal Trach as needed. Jm Moved head & hands to mom's commands. Jm tolerated all aspects of care. Report given to night nurse. _____ SB

OUTCOME FOR THIS SHIFT/VISIT (Progress toward goals, including client's response to pain intervention):

COORDINATED WITH/REPORTED TO: Physician Clinical Mgr. PT OT SP MSW RN/LPN HHA Client Serv. Mgr. N/A

COMMENTS: _____

PLAN FOR NEXT SHIFT/VISIT:

Continue C.P.O.c.

CARE PLAN UPDATE: YES NO HHA present? YES NO
 Patient participated in Care Plan Update? YES NO HHA SUPERVISION: YES NO

Signature/Title: Shalena Bangura RN Date: 8/7/16