BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308
Attending: Clifford Ehmke **Reg Date:** 12/25/16
Reason: PSYCHOSIS NOS

Allergies

No Known Allergies Allergy (Verified 01/14/17 16:02)

Active Prescriptions

Paliperidone SUSTENNA* [Invega Sustenna*] 234 mg IM Q30D #1 syringe 02/10/17 [Rx]

Diagnoses

CANNABIS USE, UNSPECIFIED, UNCOMPLICATED (12/25/16)
NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED (12/25/16)
SCHIZOAFFECTIVE DISORDER, UNSPECIFIED (12/25/16)
UNSP PSYCHOSIS NOT DUE TO A SUBSTANCE OR KNOWN PHYSIOL COND (12/25/16)
BIPOLAR DISORDER, UNSPECIFIED (12/25/16)
POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED (12/25/16)
PERSONALITY DISORDER, UNSPECIFIED (12/25/16)
TRANSSEXUALISM (12/25/16)
INSOMNIA, UNSPECIFIED (12/25/16)
ESSENTIAL (PRIMARY) HYPERTENSION (12/25/16)
UNEMPLOYMENT, UNSPECIFIED (12/25/16)
PROBLEM RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES, UNSP (12/25/16)
FAMILY HX OF ISCHEM HEART DIS AND OTH DIS OF THE CIRC SYS (12/25/16)

Medications Given

Discontinued Medications

Acetaminophen (Tylenol Tab*) 650 mg PO Q4H PRN
    PRN Reason: PAIN or TEMP > 101 F
    Last Admin: 02/07/17 17:07 Dose: 650 mg
Al Hydrox/Mg Hydrox/Simethicone (Maalox Plus*) 30 ml PO Q4H PRN
    PRN Reason: INDIGESTION
    Last Admin: 01/29/17 14:38 Dose: 30 ml
Chlorpromazine HCl (Thorazine Inj*) Confirm Administered Dose 100 mg .ROUTE .STK-MED ONE
    Stop: 01/01/17 07:18
    Last Admin: 01/01/17 07:28 Dose: 100 mg
Chlorpromazine HCl (Thorazine Tab*) Confirm Administered Dose 100 mg .ROUTE .STK-MED ONE
    Stop: 01/01/17 07:19
    Last Admin: 01/01/17 07:28 Dose: Not Given
Device (Nicotine Mouth Piece*) 1 each INH .CARTRIDGE SCH
Device (Nicotine Mouth Piece*) Confirm Administered Dose 1 each .ROUTE .STK-MED ONE

Continued on Page 2

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Medications Given - Continued

Stop: 12/25/16 09:54
Last Admin: 12/25/16 09:57 Dose: 1 each
Diphenhydramine HCl (Benadryl Po*) Confirm Administered Dose 50 mg .ROUTE .STK-MED ONE
Stop: 01/22/17 23:28
Last Admin: 01/22/17 23:28 Dose: 50 mg
Haloperidol (Haldol Tab*) Confirm Administered Dose 5 mg .ROUTE .STK-MED ONE
Stop: 01/22/17 23:28
Last Admin: 01/22/17 23:28 Dose: 5 mg
Multivitamins (Theragran Tab*) 1 tab PO DAILY SCH
Last Admin: 02/10/17 08:42 Dose: 1 tab
Nicotine (Nicotine Inhaler*) 10 mg INH Q2H PRN
PRN Reason: CRAVING
Last Admin: 02/10/17 08:42 Dose: 10 mg
Nicotine (Nicotine Patch 21 Mg/24 Hr*) 1 patch TRANSDERM DAILY SCH
Last Admin: 02/08/17 08:06 Dose: Not Given
Nicotine (Nicotine Inhaler*) Confirm Administered Dose 10 mg .ROUTE .STK-MED ONE
Stop: 01/12/17 11:13
Last Admin: 01/12/17 11:40 Dose: Not Given
Nicotine Polacrilex (Nicotine Gum*) 2 mg PO Q2H PRN
PRN Reason: CRAVING
Paliperidone (Invega Tab*) 6 mg PO BEDTIME SCH
Last Admin: 02/06/17 20:35 Dose: 6 mg
Paliperidone Palmitate (Invega Sustenna*) 234 mg IM ONCE ONE
Stop: 02/07/17 11:01
Last Admin: 02/07/17 13:32 Dose: 234 mg
Paliperidone Palmitate (Invega Sustenna*) 156 mg IM ONCE ONE
Stop: 02/10/17 09:01
Last Admin: 02/10/17 08:04 Dose: 156 mg
Pharmacy Profile Note (Nicotine Patch Removal Note*) 1 note PATCH OFF 2100 SCH
Last Admin: 02/07/17 20:32 Dose: Not Given
Risperidone (Risperdal-M Tab *) 1 mg PO DAILY SCH
Last Admin: 01/05/17 08:03 Dose: Not Given
Spironolactone (Aldactone Tab*) 50 mg PO DAILY SCH
Last Admin: 02/08/17 08:06 Dose: Not Given
Ziprasidone (Geodon (Generic) *) 40 mg PO DAILY SCH
Last Admin: 01/09/17 10:00 Dose: 40 mg
Ziprasidone (Geodon Im Inj*) 10 mg IM DAILY PRN
PRN Reason: AGITATION
Ziprasidone (Geodon Cap*) 80 mg PO DAILY SCH
Last Admin: 01/17/17 10:36 Dose: 80 mg
Ziprasidone (Geodon Im Inj*) 20 mg IM DAILY PRN
PRN Reason: AGITATION
Ziprasidone (Geodon Cap*) 80 mg PO DAILY SCH
Last Admin: 01/19/17 10:02 Dose: 80 mg
Ziprasidone (Geodon (Generic) *) 40 mg PO DAILY SCH
Last Admin: 01/19/17 10:02 Dose: 40 mg
Ziprasidone (Geodon Im Inj*) 30 mg IM DAILY PRN
PRN Reason: AGITATION
Ziprasidone (Geodon (Generic) *) 40 mg PO BEDTIME SCH
Last Admin: 01/24/17 20:43 Dose: 40 mg
Ziprasidone (Geodon Cap*) 80 mg PO BEDTIME SCH
Last Admin: 01/24/17 20:43 Dose: 80 mg

Continued on Page 3

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Medications Given - Continued

Ziprasidone (Geodon Im Inj*) 30 mg IM BEDTIME PRN
PRN Reason: AGITATION
Ziprasidone (Geodon Im Inj*) 30 mg IM BEDTIME PRN
PRN Reason: AGITATION
Ziprasidone (Geodon Im Inj*) 30 mg IM BEDTIME PRN
PRN Reason: AGITATION

Nursing Notes

02/10/17 11:20 Nursing Note by Aether,Shannon Esme

Discharge Note: Patient discharged home, a Medicaid taxi was provided for transportation. Patient escorted to main entrance of the hospital by MHT. Patient alert and oriented upon discharge, calm, cooperative and in behavioral control. Received Invega Sustenna this morning. Patient verbalized readiness for discharge, denying further need to remain in the hospital for safety. Patient specifically able to deny suicidal ideation or planning, she denied homicidal ideation or planning. Denied AH and denied delusional thinking. Patient reviewed her discharge instructions and plan, verbalizing understanding and agreement. Patient denied questions and has written copy of her discharge plan.

Initialized on 02/10/17 11:20 - END OF NOTE

02/10/17 05:36 Nursing Note by Schaffhouser,Patricia
Pt slept 4.5 hours as evidenced by all routine safety checks. She remained safe and in no distress . Staff will continue to monitor for safety and change in status.

Initialized on 02/10/17 05:36 - END OF NOTE

02/09/17 21:50 Nursing Note by Fritsche,Amanda

1500-2300:

Anne Rose presents as euthymic with a congruent affect. Pt reports she feels ready for discharge. Pt reports she is worried about her house. Pt was visible in the milieu interacting with peers and staff. Pt reported using the comfort room "really helps." Pt was present for dinner and About Me group. Pt was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 02/09/17 21:50 - END OF NOTE

02/09/17 14:20 Nursing Note by Cottrell,John
7-3 shift: This client remains essentially unchanged. Alert and oriented, denies all symptoms of psychosis and says he does not need medication.
No impulsive behavior, no outbursts or anger expressed. Says he would like to receive his Invega Sustena as early as possible tomorrow so he can leave as early as possible. In fair control.

Initialized on 02/09/17 14:20 - END OF NOTE

02/09/17 13:40 Social Worker by Bliss,Alison

Continued on Page 4

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Nursing Notes - Continued

Met with patient regarding discharge planning. Patient is agreeable to follow up with TCMH. Discussed transportation with medicaid taxi which patient has never utilized before, this writer will include information in discharge packet about this resource for the future.
Writer explained the HHUNY Case Manager Program to patient as well as the Case Management Program offered through her Insurance Carrier, Beacon Health Options. Patient refuses to sign ROIs for either case management program stating she does not require this service and feels she can manage on her own and with a therapist at TCMH.

Introduced patient to Hannah with Care Transitions to discuss that program.

Initialized on 02/09/17 13:40 - END OF NOTE

02/09/17 05:30 Nursing Note by Schaffhouser,Patricia
Pt remained safe as evidenced by all routine 30 minute visual checks. She slept about 6.0 hours, and when she awoke she was in good spirits and excited about a discharge soon. Will continue to monitor for safety and mental status.

Initialized on 02/09/17 05:30 - END OF NOTE

02/08/17 21:54 Nursing Note by Kondrk,Anissa
3-11pm
Pt presents this shift as euthymic with congruent affect. Pt has been visible in the milieu and social with peers. Pt was willing to have a short 1:1 and stated that she was feeling okay and looking forward to discharge. Pt was meal and group compliant. Pt has been calm and cooperative. Pt has been safe on all checks, will continue to monitor for safety and changes in mental status.

Initialized on 02/08/17 21:54 - END OF NOTE

02/08/17 12:13 Nursing Note by Cottrell,John
7-3 shift: This client remains essentially unchanged. She is demonstrating no untoward effects from the injection she received yesterday. Client presents with euphoric mood and congruent affect, socializing well with select peers. She is alert and oriented, denies all symptoms of psychosis and the need for medication. Patient is looking forward to leaving Friday.

Initialized on 02/08/17 12:13 - END OF NOTE

02/08/17 05:33 Nursing Note by Niver,Brandy L

11p-7a Shift-Pt appeared to sleep throughout most of shift, currently awake listening to radio in day room, slept 5hrs. Pt has been safe on all checks, will continue to monitor for changes in mental status.

Initialized on 02/08/17 05:33 - END OF NOTE

02/07/17 21:16 Nursing Note by Campbell,Ryan

Shift 3 pm - 11 pm

Continued on Page 5

Pt. presents as euthymic with congruent affect. Pt. is pleasant upon approach and is social with peers and staff. Pt. declined 1:1 stating she was ready to sleep. Pt. is cooperative with staff and offers no complaints of treatment this shift. Pt. relates "I'm looking forward to being discharged on Thursday or Friday." Pt. is in behavioral control. Will continue to monitor for safety and thought content.

Initialized on 02/07/17 21:16 - END OF NOTE

02/07/17 16:11 Social Worker by Bliss,Alison
This writer met with patient to discuss discharge planning. It was dec'd in treatment team that we would not take patient to court for retention. If patient goes to GBHC this would have to be done. Therefore the plan is to discharge patient later this week if she is agreeable to follow up and takes IM Invega prior to discharge. Patient states she is willing to go to TCMH for outpatient f/u. She would also like to go down to DSS to apply for temporary assistance regarding home bills and late mortgage.

Initialized on 02/07/17 16:11 - END OF NOTE

02/07/17 12:59 Nursing Note by Lanzara,Victoria

Anne has presented with a euthymic mood this shift. She did express irritability with an angry verbal outburst when discussing long-acting IM medication, stating "I do not require an antipsychotic!" She also discussed her housing stating, "I'm worried I'm going to lose my house. I'm behind on mortgage payments". Eye contact was intense at times. She stated that PRN Tylenol has been effective in managing right leg pain. She has attended some groups. She is looking forward to possible discharge this Friday. She has utilized the comfort room this shift. Will continue to monitor.

Initialized on 02/07/17 12:59 - END OF NOTE

02/07/17 05:43 Nursing Note by Hamilton,Angela

11p-7a: Pt appeared to be asleep on all 30 minute visual checks from 1100 till approximately 0215. Pt then sat quietly in the day room writing. No change in mental status noted this shift. Pt slept for 3.5 hours and is laying down at this time. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 02/07/17 05:43 - END OF NOTE

02/06/17 21:51 Nursing Note by Fritsche,Amanda

1500-2300:

Anne presents as euthymic with a congruent affect. Pt currently denies as psychotic symptoms. Pt reports she feels ready for discharge. Pt reports she feel frustrated about the "inconsistency" with the comfort room sign in sheet. Pt is visible in the milieu, reading and socializing with peers. At times pt is seen pacing the hallways. Pt did not attend groups. Pt was present for dinner. Pt was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 02/06/17 21:51 - END OF NOTE

Continued on Page 6

02/06/17 13:01 Nursing Note by Aether,Shannon Esme

Patient calm, cooperative and in behavioral control. Makes good eye contact and is able to make her needs known effectively. Patient continues to verbalize readiness for discharge, and denies further need to remain in the hospital for safety. Patient verbalizes that he feels it would be safer for him to be at home than in the inpatient setting. Patient reports willingness to attend outpatient treatment at TCMHC.
Patient ate both meals today. He has been present in the milieu and appropriate with peers. Used comfort room appropriately during the time he signed up for. Safe on all visual checks. Will continue to monitor.
Shannon Aether, RN.

Initialized on 02/06/17 13:01 - END OF NOTE

02/06/17 05:44 Nursing Note by Ferraro,Neely

2300-0700
Patient appeared to be asleep on most 30 minute checks throughout the night. Pt. slept for 4 hours and is awake at this time. Pt. was safe on all checks; will continue to monitor for safety and mental status.

Initialized on 02/06/17 05:44 - END OF NOTE

02/05/17 20:07 Nursing Note by Sava,Erica
1500-2300

Pt presents mostly euthymic with congruent affect. Pt became annoyed that people were not following comfort room schedule. Pt was able to quickly calm down and suggested a solution. Pt also became annoyed that she was still on the unit. Pt states the doctor keeping her here should be locked up. Pt apologized for getting annoyed and recognized the staff present were not responsible for her staying here. Pt positive for meal. Pt negative for group. Pt visible in milieu. Pt in behavioral control. Pt safe on all checks. Will continue to monitor for safety and changes in mental status.

Initialized on 02/05/17 20:07 - END OF NOTE

02/05/17 13:14 Nursing Note by Aether,Shannon Esme

Addendum entered by Aether,Shannon Esme, RN 02/05/17 14:39:

Patient overheard writer tell another patient that this unit is 'safe'. Patient reacted with apparent anger directed at writer, speaking forcefully that this is "not a safe place". Patient also asserted, "I've been attacked by staff three times through no fault of my own!" Patient re-directed as his speech content could make other patients feel uncomfortable and potentially un-safe; patient able to remain in control-- he asked for/was given nicotine replacement. Will continue to monitor. Shannon Aether, RN.

Original Note:

Patient in behavioral control throughout the day. Present for both meals and napped in between. Attended

Continued on Page 7

community meeting. Exhibits good eye contact and is able to make her needs known effectively. Patient continues to deny need for inpatient psychiatric treatment, expressing delusions that Dr. Ehmke is specifically targeting her and keeping her against his will without justification. Patient asserts, "I have a real life outside of here!" Patient is able to discuss her feelings with self control and containment, but she does appear attached to her convictions. She has been appropriate with peers, and generally pleasant with staff members. Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 02/05/17 13:14 - END OF NOTE

02/05/17 05:34 Nursing Note by Smalser,Carrie

2300-0700
Pt appeared asleep on most 15 minute visual checks. Pt appeared to sleep 5.5 hours and remains asleep. Pt safe on all checks. Will continue to monitor for changes to behavior, mood and mental status.

Initialized on 02/05/17 05:34 - END OF NOTE

02/04/17 20:34 Nursing Note by Sava,Erica
1500-2300

Anne present euthymic with congruent affect. Pt visible in milieu. Pt less visibly responsive to internal stimuli. Pt states she feels good today. Pt talks about mom being supportive. Pt states "I could not have done it without her." Pt positive for meal and group. Pt likes using the comfort room and computer to check emails. Pt worried about house and her pipes freezing. Pt believes she does not need to be here and that it was a misunderstanding. Pt talks about a time that she bought shoes online and got two different sizes. Pt believes that the mafia might have tampered with the mail or that someone at amazon was targeting her. Pt remains in behavioral control. Pt safe on all checks. Will continue to monitor for safety and changes in mental status.

Initialized on 02/04/17 20:34 - END OF NOTE

02/04/17 13:31 Nursing Note by Cosgrove,Kelly Anne
Dayshift Note: Anne appears euthymic predominantly this shift, as well is social with select peers and staff. She has been seen in the milieu throughout this shift and was observed attending cinema therapy group. She reported "feeling better that I was able to access the computer". She reports she left good and is feeling "okay". Speech is less pressured and tangential but rapid at times, Pt. was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 02/04/17 13:31 - END OF NOTE

02/04/17 05:52 Nursing Note by Roy,Matthew

Client laid in bed with eyes closed ~ 3.5 hours during the shift. Client is currently sleeping in assigned bed. Client was safe on all visual safety checks. Client will continue to be monitored.

Initialized on 02/04/17 05:52 - END OF NOTE

Continued on Page 8

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Nursing Notes - Continued

02/03/17 22:27 Nursing Note by Lewis,Shana
1900-2300 Pt. presents this shift as labile, with flat affect. Pt. continues to voice frustration with being admitted on this unit, and brightens on talk of videos online she has posted about movies. Pt. med and meal compliant, but does not feel she needs medication. Safe on all 30 minute checks, will continue to monitor for safety and status change.

Initialized on 02/03/17 22:27 - END OF NOTE

02/03/17 17:23 Social Worker by Bliss,Alison
Patient approached this writer this morning to check in. This writer asked her if she heard she is able to have computer privileges and the patient responded with rapid speech that she does not have her passwords and needs access to her smart phone and a fax machine. She became more agitated as she spoke about her anger at this writer for signing off on treatment plan indicating patient will be going to state hospital. She expressed feelings of frustration with her hospitalization and with Dr. Ehmke and then erased Dr. Ehmke's name from the whiteboard which lists him as her doctor. This writer disengaged in conversation as patient was not able to speak calmly or respectfully and patient walked away de-escalating soon after.

Later in the day patient calmly approached this writer asking if I would let Dr. Ehmke know that we have had some conversation related to her housing and mail. She would like Dr. Ehmke to know that this is evidence that she is engaging in discharge planning. This writer let her know that I would.

Initialized on 02/03/17 17:23 - END OF NOTE

02/03/17 15:14 Nursing Note by Barton,Nathaniel

0700-1500: The Pt presents as labile. At times she has been euthymic and pleasant in conversation. At other times the Pt has been very irritable, saying "fuck you...shut the fuck up," and giving the finger to this writer repeatedly after receiving minimal feedback about her behavior. The Pt relates great frustration with her hospitalization and with her MD. Pt has been safe on all checks; will continue to monitor for any changes in mood and behavior.

Initialized on 02/03/17 15:14 - END OF NOTE

02/03/17 05:06 Nursing Note by Brown,Michele

2300-0700

Patient had appeared to have rested comfortably at long intervals through most of the shift. Patient currently awake and alert Continues to speak of hackers and being persecuted for her intelligence and her transgender status. She took her medication as ordered "under protest", further stated that Invega is slightly better than the Geodon. Medicated with Tylenol for c/o foot pain, has been doing stretching exercises as well. Has remained safe on all checks.

Initialized on 02/03/17 05:06 - END OF NOTE

02/02/17 20:51 Nursing Note by Powers,Kate

1500-2300

Continued on Page 9

Anne Rose presents this shift as generally euthymic with congruent affect. Pt. declines concerns and questions at this time. Pt. has been visible in the milieu. Pt. is social and appropriate with peers and staff. Pt. is less intrusive than in the past and appears more organized. Pt. does not appear to be responding to internal stimuli. Pt. is positive for meals and groups. Pt. is able to make needs known. Pt. has remained calm, cooperative, and in behavioral control. Will continue to monitor for changes in mental status and safety.

Initialized on 02/02/17 20:51 - END OF NOTE

02/02/17 14:19 Nursing Note by Barton,Nathaniel

0700-1500: Pt presents as flat but pleasant during conversation. She relates frustration with this hospitalization and voices a strong desire for d/c. She has been relatively seclusive today, spending periods of time laying in bed. She voices no other needs or concerns and has been safe on all checks. Will continue to monitor for any changes in mood and behavior.

Initialized on 02/02/17 14:19 - END OF NOTE

02/02/17 13:18 Recreation Therapist Note by Stevenson,Kylee K

Patient has been more pleasant with this writer than when first admitted. Patient continues to decline to attend programming during the day but has engaged in some evening programming per notes. Patient is socially interactive with peers and is mostly visible in the milieu. Patient has been more compliant and cooperative with staff. Will continue to follow up with patient and encourage involvement in programming.

Initialized on 02/02/17 13:18 - END OF NOTE

02/02/17 10:26 Social Worker by Bliss,Alison

Addendum entered by Bliss,Alison 02/02/17 13:14:

Terri called this writer back to give update that they do not have a discharge tomorrow thus there is not yet an opening for patient to transfer. Terri anticipates that there will a discharge on Monday or Tuesday and so we hope to transfer patient on Tuesday. Terri will give this writer a call to update on Monday.

Original Note:

Rec'd phone call from Terri at GBHC 773-4132. There is a possible discharge happening tomorrow so patient could be admitted tomorrow afternoon at 1 or 2 pm. Terri needs updated nursing notes and doctors progress notes faxed over. She will let this writer know by noon if they can definitely take patient tomorrow.

Writer faxed updated doctor progress notes and nursing notes to GBHC.

Initialized on 02/02/17 10:26 - END OF NOTE

02/02/17 05:35 Nursing Note by Schaffhouser,Patricia
Pt remained safe as evidenced by all routine 30 minute checks. She was pleasant and in good spirits and retired, sleeping for 4.5 hours. Will continue to monitor for safety and change in mental status.

Continued on Page 10

Initialized on 02/02/17 05:35 - END OF NOTE

02/01/17 23:37 Nursing Note by Burns,Haley
1900-2300
Pt presents as dysphoric with a congruent affect. She is cooperative and calm during 1:1, kindly expressing "my appreciation for the care the nursing staff has given me today". She repeatedly refers to "my beloved Lenore" during 1:1 conversation, and expressed concern that "this hospital is the reason I am not able to see her or function in society on my own right now. At least this Invega isn't going to kill me like the Geodon, but I am still taking it against my will". She was medication compliant and took her HS meds without incident. Patient was also meal compliant and attended group this evening showing active participation and relevant ideas to the topic. Patient remained in behavioral control during the shift and was safe on all checks.

Initialized on 02/01/17 23:37 - END OF NOTE

02/01/17 14:18 Nursing Note by Aether,Shannon Esme

Patient visible in the milieu throughout most of the day, napping briefly in between meals. Patient appears slightly disheveled and malodorous: Patient continues to state that she does not trust the water in Ithaca and so refuses to shower here. Patient states that she washes her clothes in the sink; she did ask for/was given deodorant.
Patient continues to deny rationale for on-going hospitalization, expressing delusional beliefs regarding her treating psychiatrist. Patient reviewed and signed her treatment plan update, but did state it was "stupid". Patient expressed anger and irritability when discussing her inpatient hospitalization. She does apologize for these remarks and overall has remained in behavioral control.
Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 02/01/17 14:18 - END OF NOTE

02/01/17 05:13 Nursing Note by Roy,Matthew

2300-0700
Patient appeared to sleep ~ 4.5 hours. Patient is currently awake in milieu with another patient. Patient was safe on all visual safety checks. Patient will continue to be monitored.

Initialized on 02/01/17 05:13 - END OF NOTE

01/31/17 22:44 Nursing Note by Baker,Kristin
1500 - 2300

Pt presents as dysphoric with congruent affect. Pt is pleasant in interaction. Pt is present in the milieu and social with select peers and staff. Pt continues to express that she does not need to be here. Pt is meal compliant. Pt took PO HS med without protest. Pt offered no complaints. Safe on all checks. Will continue to monitor for thought content and behavior.

Initialized on 01/31/17 22:44 - END OF NOTE

01/31/17 14:05 Nursing Note by Aether,Shannon Esme

Continued on Page 11

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Nursing Notes - Continued

Patient calm and in control. Present in milieu throughout the day. Able to make her needs known. Noted to be smiling brightly during interactions this morning. Patient ate both meals. Attended community meeting only, denies need to attend other groups. Patient expressed anger when discussing on-going psychiatric admission and treatment, displaying paranoid thought processes. Patient denies lethality towards himself or others and asserts the only reason he is in the hospital is because of the cold weather and the fact that he is homeless. Patient spent time expressing himself in an angry monologue, but did apologize right before walking away from writer. Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 01/31/17 14:05 - END OF NOTE

01/31/17 13:50 Social Worker by Bliss,Alison
Phone call to Terri at GBHC 773-4132. Patient is next on the list for admission. There is one possible discharge for later this week. Terri will be in touch with this writer as soon as she has a confirmed discharge so that we can begin the transfer for patient.

Initialized on 01/31/17 13:50 - END OF NOTE

01/31/17 06:18 Nursing Note by Hamilton,Angela

11p-7a: Pt appeared to be asleep on all 30 minute visual checks throughout the night. No change in mental status noted this shift. Pt slept for 4.5 hours and is laying down at this time. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/31/17 06:18 - END OF NOTE

01/30/17 21:01 Nursing Note by Campbell,Ryan

Shift 3 pm - 11 pm

Pt. presents as having an improved mood. Pt. is insightful during evening group and is helpful to peers during free time. Pt. is social with peers and staff - Pt. is somewhat tangential during conversation but is mostly well focused. Pt. has a markedly irritable/angry mood at the mention of treatment. When Pt. becomes irritable she is easily redirected. Pt. often makes statements that she is being targeted by "hackers" and consequently has had several cellular devices rendered useless. Pt. is in behavioral control. Will continue to monitor for safety and thought content.

Initialized on 01/30/17 21:01 - END OF NOTE

01/30/17 12:00 Social Worker by Bliss,Alison
This writer met with patient to check in. She states that she spoke to a neighbor over the weekend about her mail. Per her neighbor her mail has been overflowing from her mailbox so she would like to be able to either get her mail forwarded to the neighbor or held at the post office. The neighbor is Bob Mendel. The forwarding address for mail would be: RFM Communications 1670 Trumansburg Road Ithaca, NY 14880. This writer will see what can be done about the mail situation and follow up with patient. Patient is not willing to sign any ROIs at this time and does not think anyone will be willing to bring her mail to the unit for her. Throughout this meeting the patient was tangential at times in her speech, expressing delusional ideas about the FBI and stating that "Dr. Ehmke is a psychopath who is illegally keeping me here."

Continued on Page 12

Initialized on 01/30/17 12:00 - END OF NOTE

01/30/17 11:26 Nursing Note by Aether,Shannon Esme

Patient in behavioral control. Ate breakfast. Exhibits good eye contact and is able to make her needs known effectively. Patient continues to deny need for on-going hospitalization. Patient denies AH, "I haven't had those since 2003 when I used PCP." Patient denies suicidal ideation or planning. Denies urges to harm others physically but continues to report wanting to "hurt Dr. Ehmke in court", asserting that "Dr. Ehmke is delusional". Patient states that he does not need to be transferred to a state hospital and expresses his perception that this is counter move by Dr. Ehmke to address his wish to sue him after he is discharged. Patient appears disheveled and slightly malodorous. Writer offered to help him with laundry but he refuses to wash his clothes in the Ithaca water, identifying/naming toxins in the water system. Patient did find a new shirt in the donated clothing bin.
Has not attended group programming. Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 01/30/17 11:26 - END OF NOTE

01/30/17 05:39 Nursing Note by Ferraro,Neely

2300-0700
Patient appeared to be asleep on some 30 minute checks throughout the night. Pt. slept for 4 hours and is awake at this time. Pt. was safe on all checks; will continue to monitor for safety and changes in mental status.

Initialized on 01/30/17 05:39 - END OF NOTE

01/29/17 21:02 Nursing Note by Powers,Kate

1500-2300

Anne presents this shift as dysphoric with flat affect. Pt. has remained mostly seclusive to room, minimal interactions with peers and staff this shift. Pt. denies concerns and questions at this time. Pt. has not had any noted verbal outbursts this shift. Pt. does not appear to be responding to internal stimuli. Pt. is positive for meals but has not attended group programming. Pt. has remained in appropriate and in behavioral control. Will continue to monitor for changes in mental status and safety.

Initialized on 01/29/17 21:02 - END OF NOTE

01/29/17 09:49 Nursing Note by Aether,Shannon Esme

Patient in behavioral control with periods of irritability. He expresses dissatisfaction with on going admission and being "medicated" against his will. Patient denies legitimate court paperwork stating treatment over objection. Patient denies rationale for hospitalization, stating that he is not a danger to himself or others. However, patient does assert that although he does not want to hurt anyone physically, he does plan "to rake Dr. Ehmke over the coals" in court, stating that he wants "to punish" him with a lawsuit after he leaves the inpatient setting. Patient continues to state Dr. Ehmke does not have a valid medical license and is illegally providing medical treatment. Patient does not allow interactive conversation regarding this topic,

Continued on Page 13

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Nursing Notes - Continued

closing communication in a tangential, hyperverbal monologue, finally ending conversation by stating, "I was brought to the hospital by an ambulance, not a police car" while waving his arms.
Patient ate breakfast this morning. Appropriate with peers. He is malodorous and disheveled. Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 01/29/17 09:49 - END OF NOTE

01/29/17 05:15 Nursing Note by Ferraro,Neely

2300-0700
Patient was awake in the milieu at the start of shift. Pt. went to her room at midnight and appeared to be asleep on all 30 minute checks throughout the night. Pt. was safe on all checks. Pt. appeared to sleep for 5 hours and is asleep at this time. Will continue to monitor for safety and changes in mental status.

Initialized on 01/29/17 05:15 - END OF NOTE

01/28/17 23:15 Nursing Note by Baker,Kristin
1500 - 2300

Pt presents as dysphoric with congruent affect. Pt is present in the milieu and social with select peers and staff. Pt is pleasant upon approach and able to engage in appropriate conversation. Pt is meal and group compliant. During 1900 group, pt shared about her relationship with her significant other, but reports not seeing this person in two years. Pt took her HS PO Invega without protest. Safe on all checks and in behavioral control. Will continue to monitor for mood and behavior.

Initialized on 01/28/17 23:15 - END OF NOTE

01/28/17 12:59 Nursing Note by Pudney,Kelsey

0700-1500 shift:

Pt presents as dysphoric with an irritable edge. Pt has been mostly seclusive to herself. Pt has not attended group programming, and is positive for meals. Pt is endorsing depression and anxiety, stating "this place makes me depressed." Pt continues to express belief that it is unnecessary for him to be here. Pt has been safe on all visual checks. Will continue to monitor for safety and changes in mental status.

Initialized on 01/28/17 12:59 - END OF NOTE

01/28/17 05:16 Nursing Note by Ferraro,Neely

2300-0700
Patient appeared to be asleep on some 30 minute checks throughout the night. Pt. was safe on all checks. Pt. appeared to sleep for 3 hours and is awake at this time. Will continue to monitor for safety and changes in mental status.

Initialized on 01/28/17 05:16 - END OF NOTE

Continued on Page 14

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center | Loc:BEHAVIORAL SERVICES UNIT | Bed:202-01
60 F 05/01/1956 | Med Rec Num:M000597460 | Visit:A00082793308

Nursing Notes - Continued

01/27/17 21:15 Nursing Note by Campbell,Ryan

Shift 3 pm - 11 pm

Pt. is often tangential during conversation - much less so than the past few days. Pt. is in behavioral control. Pt. is meal and group compliant - insightful during groups. Pt. has small angry outbursts at the mention of treatment or medication stating, and at times shouting, "the medication is wrong." Pt. also shares that she is and has been "In a trap for the past 2 years." Pt. is social with peers and staff. Pt. is safe on all checks. Will continue to monitor for safety and thought content.

Initialized on 01/27/17 21:15 - END OF NOTE

01/27/17 10:37 Nursing Note by Youngs,Matthew R

Patient is hyperverbal/disruptive with an irritable edge. Patient does not believe that he should be here and stated "I have been kidnapped, I am being held here against my will". Patient endorses depression and anxiety stating "I am sick of this place". Patient denies SI, HI or any auditory or visual hallucinations at this time. Patient is meal, group compliant and continues to be monitored for safety and any changes in his mental status.

Initialized on 01/27/17 10:37 - END OF NOTE

01/27/17 05:43 Nursing Note by Hamilton,Angela

11p-7a: Pt appeared to be asleep on all 30 minute visual checks from 0030 thru 0330. No change in mental status noted this shift. Pt slept for 3 hours and walking around milieu at this time. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/27/17 05:43 - END OF NOTE

01/26/17 21:50 Nursing Note by Campbell,Ryan

Shift 3 pm - 11 pm

Pt. presents as hyperverbal with an irritable edge - often tangential during conversation. Pt. approached T/W to review notes relating to claimed past employment and housing stating that "I'm being imprisoned because of so called delusions and feelings of paranoia - which I don't have." Pt. relates that changes in medication are allowing Pt. to have improved mood and quality of sleep but assured T/W that all prescribed medications "are bad" as she is not in need of Psychiatric treatment. Pt. attended groups and is meal compliant. Pt. is social with staff and peers. Will continue to monitor for safety and thought content.

Initialized on 01/26/17 21:50 - END OF NOTE

01/26/17 12:16 Spiritual Care Note by Szajman,Tziona E

Received request from Anne to see Rev Tim Dean. Visited with Anne today and explained Rev Dean was

Continued on Page 15

away fro the next week. Anne said she needed specific information on weddings that only Rev Dean could provide. I said I would leave Rev Dean a note he would receive upon his return and that if Anne left the hospital before they could meet, Anne was welcome to call the Spiritual Care office late next week. Anne continued talking for another 10-15 minutes. Will revisit upon request.

Initialized on 01/26/17 12:16 - END OF NOTE

01/26/17 11:05 Nursing Note by Aether,Shannon Esme

Patient visible in the milieu this morning. Ate breakfast. Pleasant upon approach and interactive with her peers. Patient makes good eye contact and is able to make her needs known effectively. Patient continues to deny need for inpatient psychiatric admission. Patient speaks in a hyperverbal, tangential style, not allowing staff to offer feedback. She asserts that she is "a major league computer programmer" and indicates that this role led to current hospitalization. Patient asserts that she has also been unjustly misrepresented in porn through computer manipulation, stating that amateurs are also capable of this technology now.
Patient has not attended group programming, saying there is no need. Patient states that as far as psychiatric treatment, he only needs to meet with Dr. Kevin Field as an outpatient; however, patient states he does not have money to pay for services right now. In the next sentence, patient states that he is waiting to receive 10,000 dollars from his brother who lives in California. Patient states that he does not feel safe checking his bank account to see if the money has already been deposited, since he does not trust computers, stating that they have all been hacked.
Patient spoke with positive feeling about a woman he states he has been close to for a long time, stating that he hopes she can visit him today.
Safe on all visual checks.

Initialized on 01/26/17 11:05 - END OF NOTE

01/26/17 05:48 Nursing Note by Sidle,Matthew G

Addendum entered by Sidle,Matthew G 01/26/17 05:49:

Pt on 30 min visual checks, not 15.

Original Note:

11p-7a: Pt appeared to be asleep on most 15 minute visual checks throughout the night. No change in mental status noted this shift. Pt slept for 4.5 hours and is awake at this time. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/26/17 05:48 - END OF NOTE

01/25/17 17:37 Nursing Note by Ayers,Rachel

Patient seen eating all meals today but, continues to rant over medications and attending physician concerns. She quiets down once she has verbalized her concerns. In the afternoon becomes upset due to couch being used by another patient. She continues to be very vocal through out the shift with this writer. Presently. requesting two pillows to sleep and patient has request met.

Continued on Page 16

Initialized on 01/25/17 17:37 - END OF NOTE

01/25/17 11:28 Social Worker by Bliss,Alison
Phone call to Terri at GBHC. Terri states that patient is appropriate for their unit and has been placed on the waitlist. She is currently number 5 on the list and they expect this number to go down soon as they have a few admissions this week.

Initialized on 01/25/17 11:28 - END OF NOTE

01/25/17 05:30 Nursing Note by Brown,Michele

Patient had appeared to have rested comfortably at long intervals throughout the night. Approached the nurses station c/o feeling groggy d/t Geodon. She states she is getting too much sleep (7 hours) as she only normally sleeps for 4 hours a night. Patient alert, oriented, calm and cooperative.

Initialized on 01/25/17 05:30 - END OF NOTE

01/24/17 18:12 Nursing Note by Aether,Shannon Esme

Patient has been calm, cooperative and in behavioral control this evening. Patient ate dinner. Makes good eye contact and is able to make her needs known effectively. Patient does continue to state that Geodon is an unnecessary medication; when patient was asked what medication might be helpful, patient denied need for any type of antipsychotic medicine. Patient asserts that he prefers using 50% marijuana and 50% "CBD" or "CBN".
Patient explained the purposes of CBD and CBN in depthly to writer, in a monologue style with pressured speech. Pacing the halls at this time. Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 01/24/17 18:12 - END OF NOTE

01/24/17 15:23 Social Worker by Bliss,Alison
This writer met with patient to check in. Patient was the most calm and cooperative during this meeting that writer has observed since she has been on the unit. We were able to discuss her housing and some of her supports. Patient states that she has lived at her home, which is a converted barn, since 1994. She believes her power has been shut off since she has not been there in over a month but states she can have it turned back on. She stated that she left her home b/c of hacking but she feels it may be safe to return now. She also states that her brother was supposed to transfer her some money which would help to get her affairs in order (brother lives in California) and that she spoke with "her beloved" Lenora Quvus who may come to visit the patient on Thursday as she lives locally. The patient declined to sign any ROIs at this time.

Patient was also able to speak coherently about past psychiatrist history and discussed previous hospitalizations as well as her previous education at University of Texas Austin and work at Cornell University.

When this writer attempted to reflect back that the patient seems to be doing better, she stated that it is the Geodon that is making her worse and proceeded to states that Dr. Ehmke was a "phoney doctor" and that she was going to sue him. She also expressed contempt towards Dr. Kevin Field stating that he has made false statements about her mental health. Patient showed this writer many printed and hand written documents and discussed paranoid thoughts about her hospitalization and delusional beliefs. Patient became

Continued on Page 17

angry at one point in the conversation when discussing the Geodon and raised her voice but was able to remain in behavioral control and be verbally deescalated. The patient also insisted on lifting up her shirt to show this writer her back tattoo despite this writer asking her to refrain from doing so. At the end of our meeting the patient thanked this writer for my time.

Initialized on 01/24/17 15:23 - END OF NOTE

01/24/17 10:44 Nursing Note by Aether,Shannon Esme

Patient present in the milieu this morning. Ate breakfast. Completed a.m. ADLs. Patient makes good eye contact and is able to make his needs known effectively. Patient asked writer to sit with him and review his own paperwork; patient expressed wanting to convey that he is completely sane and his current admission is the result of false, "libelous" circumstances. Patient asserted that Dr. Ehmke is both "a fraud" and "a TV doctor", stating that he is not qualified to practice psychiatry. Patient asserts that he has been the "victim of identify fraud" related to his role as a data software engineer who works with the US govt. to combat international and national hacking. Patient denies need to take Geodon; patient states that Dr. Ehmke told him people are saying he is doing better, "But I'm actually doing much worse; it's not like me to have angry outbursts like this." Patient states his angry outbursts are directly related to Geodon medication treatment. (Patient has not had angry outbursts today so far.)
Patient does not appear to have insight regarding admission circumstances, need for on-going hospitalization or possibility of further treatment at the state hospital if his symptoms do not improve. Patient rejects feedback that supports need for inpatient treatment, going back to initial transport to the hospital on the day of admissio, "I was brought to the hospital by an ambulance, check the record. They say I was brought by the police..."
Safe on all visual checks. Will continue to monitor. Shannon Aether, RN.

Initialized on 01/24/17 10:44 - END OF NOTE

01/24/17 06:12 Nursing Note by Brown,Michele

Patient approached the nurses station to request I document her c/o itchy right eye. Internal sclera red with clear fluid. Denied any crust when she awoke, no edema.

Initialized on 01/24/17 06:12 - END OF NOTE

01/24/17 06:03 Nursing Note by Sidle,Matthew G

11p-7a: Pt appeared to be asleep on most 30 minute visual checks throughout the night. No change in mental status noted this shift. Pt slept for 5 hours and is awake at this time. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/24/17 06:03 - END OF NOTE

01/23/17 22:26 Nursing Note by Hanna-Martinez,Tahlia

3-11pm

Anne presents as euthymic with congruent affect. Denies SI, HI, depression, anxiety. Pleasant upon approach. Did not attend programming. Ate 100% dinner. Visible in the milieu, socially interactive with

Continued on Page 18

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Nursing Notes - Continued

peers, and staff. Apologized to staff for outburst last night. In behavioral control. Safe on all checks. Will continue to monitor for safety, and changes in mental status.

Initialized on 01/23/17 22:26 - END OF NOTE

01/23/17 13:32 Nursing Note by Lister,Barbara

0700-1500 Nursing Note:
Pt was aggitated and hyperverbal at start of shift and fixated on side effects of geodon. As the shift progressed, pt was more calm and less verbal. Pt slept some. She shaved today. She states she is not a threat to herself or others. Pt took court ordered medication and declined going to any groups. She has been safe on all checks and in behavioral control. She will continue to be monitored for safety and for any changes to her thoughts, mood, affect, and behavior.

Initialized on 01/23/17 13:32 - END OF NOTE

01/23/17 06:31 Nursing Note by Brown,Michele

2300-0700

Patient became agitated and disruptive with peers at the beginning of the shift in the milieu. Stated she would like to return to the milieu and it was requested she instead retire to her room for the night. Patient initially stated fear of sleeping in her room because it does not have a lock on the door. Patient remained agitated and talking to herself seemingly in two different voices.

MD updated, orders obtained and patient medicated with Benadryl 50mg and Haldol 5mg PO at 2328.

Patient had appeared to have fallen asleep and remained resting comfortably at long intervals from 0030-0600. Patient awoke and remains angry regarding her "illegal" stay in the hospital.

Initialized on 01/23/17 06:31 - END OF NOTE

01/23/17 05:44 Nursing Note by Ferraro,Neely

2300-0700
Patient became agitated in the milieu at start of shift. Pt. went to her room and appeared to be asleep at 0030 and was asleep on all 30 minute checks. Pt. was safe on all checks. Pt. slept for 5 hours and is awake at this time. Will continue to monitor for safety and mental status.

Initialized on 01/23/17 05:44 - END OF NOTE

01/22/17 22:34 Nursing Note by Parseghian,Roberta E

Anne was visible the entire shift but minimally social. She attended groups and ate dinner and snack. She continues to complain about her care. Denying that she ever went to court. Gathering papers to sue the hospital. Frequently verbally attacks staff. She accepted HS medication after verbally berating medication nurse,. Safe on all safety checks. Will continue to be monitored.

Initialized on 01/22/17 22:34 - END OF NOTE

Continued on Page 19

01/22/17 10:11 Nursing Note by Schaffhouser,Patricia
Pt. spent 1:1 conversation time with writer to again rail at the unit, the doctor and her continued assertion that she is here illegally, and not mentally ill. She is focused on potential side effects of geodon, and is trying to get ample fluids. She continues to be hyperverbal, and at times pressured. She remained in behavioral control.

Initialized on 01/22/17 10:11 - END OF NOTE

01/22/17 06:17 Nursing Note by Barton,Nathaniel

05:00- Pt approached the RN station and quickly became argumentative and verbally abusive, cursing at staff multiple times for encouraging the Pt to cooperate with her doctor. After swearing and giving this writer the finger repeatedly the Pt sat quietly in the milieu. Will continue to monitor for any changes in mood and behavior.

Initialized on 01/22/17 06:17 - END OF NOTE

01/22/17 05:53 Nursing Note by Ferraro,Neely

2300-0700
Patient appeared to be asleep on most 30 minute checks throughout the night. Pt. was safe on all checks. Pt. appeared to sleep for 4.5 hours in the milieu and is awake at this time. Will continue to monitor for safety and changes in mental status.

Initialized on 01/22/17 05:53 - END OF NOTE

01/21/17 22:09 Nursing Note by Parseghian,Roberta E

Anne was visible and social with select peers the entire shift. She continues to threaten suing the doctor and staff because of being forced to take medications "That are poisoning me and changing my behavior." She rants about "debugging the network."She ate dinner and snack. She sat through groups with minimal participation.She gave staff copies of hotel receipts for her chart "to prove I was not evicted." She accepted HS medication after accusing RN of "poisoning me". She was safe on all safety checks. Will continue to be monitored.

Initialized on 01/21/17 22:09 - END OF NOTE

01/21/17 14:00 Nursing Note by Parseghian,Roberta E

Anne was visible the entire shift. She was minimally social with peers and when speaking with staff the content of her conversation was paranoid, delusional at times. She spoke of music videos being infiltrated. She gave staff three photos and stated "I want these put in my chart."She reports "these are pictures to prove I have a home. I am not homeless. I was not evicted. I am just behind in two payments. That is where I work and I live." Pt reports it is a converted chicken barn which she has been turning into a music studio. She ate breakfast and lunch. Safe on all safety checks. Will continue to be monitored.

Continued on Page 20

Initialized on 01/21/17 14:00 - END OF NOTE

01/21/17 06:12 Nursing Note by Hamilton,Angela

11p-7a:
Pt appeared to sleep on the couch in the milieu for 5 hours. Pt continues to express her angry over events that took place earlier in the day. No change in mental status noted this shift. Pt Slept for 5 hours and is sitting in the milieu at this time. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/21/17 06:12 - END OF NOTE

01/20/17 21:34 Nursing Note by Fritsche,Amanda

Addendum entered by Fritsche,Amanda, RN 01/20/17 22:14:

At 2145, writer notified all patients that they have 15 minutes to take their medications. Pt started to scream "I am not taking fucking geodon." Pt continued to swear and yell. Pt got into a staff's face. Security was called, milieu was cleared. Pt agreed to take her medication PO. Will continue to monitor.

Original Note:

1500-2300:

Anne presents as euthymic with a congruent. Pt is pleasant upon approach. Pt reports she wants discharge. Additionally, pt reports she is willing to take her geodon at 2200. Pt is visible in the milieu throughout shift. Pt is social and interactive with peers and staff. Pt had no outburst this shift. Pt was present for dinner but not anger management. Pt was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 01/20/17 21:34 - END OF NOTE

01/20/17 15:47 Nursing Note by Purrier,Kerrie Anne

Nursing Notes- 11:09- 3pm
Patient safe on all checks. Anne slept briefly out in the unit. Continues to be visible out on unit.

Initialized on 01/20/17 15:47 - END OF NOTE

01/20/17 11:08 Nursing Note by Purrier,Kerrie Anne

Nursing Notes 0700-11:09
Patient received at the change of shift visible oou. Patient declined to shower despite being given a basin to " cleanse vital areas of the body." Patient asserts that the " water in the hospital is contaminated; I get mine at the water fountain on the unit." Patient attended groups with minimal interruption until the end of the session,where she was discouraged against persecutory accusations about the medical staff. Anne retorted that "I am not back talking the doctors I am criticizing them." Anne assisted with facial shaving after breakfast. Patient declined the morning medications, but was receptive to complying to night Geodon.

Continued on Page 21

Outspoken with peers to the point where the conversation had to be redirected to a more savoury and appropriate arena. Meal compliant. Continue to monitor for changing.

Initialized on 01/20/17 11:08 - END OF NOTE

01/20/17 05:43 Nursing Note by Hamilton,Angela

11p-7a:
Pt layed on couch in milieu either talking with peers, reading her books or writing on all 30 minute visual checks throughout the night. No change in mental status noted this shift. Pt Slept for 1 hours and is sitting on couch in milieu at this time Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/20/17 05:43 - END OF NOTE

01/19/17 23:00 Nursing Note by Hanna-Martinez,Tahlia

3-11pm

Anne presents as euthymic with congruent affect. At times he presents as agitated when speaking of hospitalization and MD Ehmke. Pt states that he wishes to sue Dr.Ehmke. He denies SI, HI, depression, anxiety. He states that he feels agitated from medication and has been having nightmares, nursing staff informed. He went to group and participated well. He ate meal. Socially interactive with peers and staff. Pleasant upon approach. Safe on all checks. Will continue to monitor for safety and changes in mental status.

Initialized on 01/19/17 23:00 - END OF NOTE

01/19/17 10:21 Student Nurse by Wright,Courtney

Addendum entered by Wright,Courtney 01/19/17 12:20:

While serving lunch at 1215 pt stated to "go to hell" when offering a cookie, and proceeded to state "all nurses can go to hell" continuing ranting statements the entire way through the line and to the table.

Original Note:

Addendum entered by Wright,Courtney 01/19/17 11:25:

Pt perseverating on being computer hacked, being held at the hospital illegally, his MD is a fraud, and he is not treatment over objection. Primary 1 to 1 (John) gave pt medication information on Geodon, per pt request.

Original Note:

Pt had outburst of yelling during group, and left group upset with staff at 1015. Pt still continues to think that she has been kidnapped and is being held here. Also states that "there is no such thing" as treatment over objection. Pt is currently sitting in the milieu tapping her hands on the chair silently.

Continued on Page 22

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Nursing Notes - Continued

Initialized on 01/19/17 10:21 - END OF NOTE

01/19/17 04:50 Nursing Note by Burns,Haley

Patient presented to nursing station at 0451 requesting that a note be added to her medical record regarding "the increase in nightmares I've had since the increase in Geodon". Patient began yelling stating "this is the third nightmare I've had already, and I want it to be known that you do not have proper treatment over objection paperwork and I am getting worse on this shit. I am going to kill that fucking Ehmke in court. This lawsuit will be in my favor". Patient stated "I am restless and losing my patience and will lose it if I have to keep taking this shit". Patient began slapping the doorway into the nursing station but was able to be redirected into the milieu where she still presented as hyperverbal with an irritable edge, but expressed that she would calm down and acknowledged that her behavior is inappropriate and apologized for her actions. She later came back to the window the "clear that air about killing Dr. Ehmke, what I meant was I am going to kill the court case and walk out of here after I win it. I have no intention of hurting him". She was informed that she could discuss her concerns with her psychiatrist tomorrow and was observed sitting in the milieu calmly and in behavioral control.

Initialized on 01/19/17 04:50 - END OF NOTE

01/18/17 21:13 Nursing Note by Fritsche,Amanda

1500-2300:

Anne slept from 1500 to 1930. Pt reports she is sleeping so much due to her new geodon dose. Pt reports she is "coping" with the medication change. Pt reports she wants her medication changed to HS to help with her sleep cycle. Pt had no outburst this shift. Pt was pleasant upon approach. Pt was visible in the milieu after 1930. Pt was interactive with peers. Pt was not present for dinner or groups. Pt state she would eat later in the shift. Pt was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 01/18/17 21:13 - END OF NOTE

01/18/17 13:44 Nursing Note by Barton,Nathaniel

0700-1500: The Pt presented as labile for the first half of the shift. She related multiple complaints about her hospitalization, especially with taking her medication. The Pt has stated that she feels her doctor is delusional for saying that Geodon will help her psychotic symptoms improve. She relates that she has the CYP2D6*4 heterozygous allele, and that this condition predisposes her to heightened side effects from taking Geodon. She stated that the Geodon will "knock me out," and "will make me very irritable with staff." Since eating lunch she has been laying in bed. Pt has been safe on all checks; will continue to monitor for any changes in mood and behavior.

Initialized on 01/18/17 13:44 - END OF NOTE

01/18/17 05:12 Nursing Note by Brown,Michele

Addendum entered by Brown,Michele, RN 01/18/17 05:32:

Patient remains angry and stating she will refuse the Geodon by mouth. Describes the nightmare as follows

Continued on Page 23

in summary:

Watching a movie in a theater, very vivid. There were robots and a servant robot servicing a "Lord" robot. The "Lord" robot told the servant that he is obsolete and all of the robots were disassembled and put into bodies of worms and than into ice where they were writhing in pain. The patient (in her dream) than looked at her watch and stated, "Hm, it's 1130 and I have not contacted my beloved yet" and woke up.

Patient questioning the difference in effect from PO/IM as well as the expected dose.

Original Note:

2300-0700

Patient up all shift. Voicing frustration about being kidnapped and being medicated with Geodon which is causing side effects including insomnia and nightmares. Patient states she will not take the Geodon by mouth any more and "they will have to get violent" and give it via injection. Agitated when speaking about the current conditions and treatments of this hospital. Has remained in behavioral control.

Initialized on 01/18/17 05:12 - END OF NOTE

01/17/17 21:59 Nursing Note by Fritsche,Amanda

1500-2300:

Anne presents with an irritable edge towards the beginning of the shift. By the end of the shift pt was pleasant and calm. Pt continues to be fixated on her geodon dose making her feel agitated and "not herself." Additionally, pt continues to request a new doctor. Pt reports she wants to "sue this place for 10 billion dollars." Pt is requesting to be discharge so she can continue to "code for the government." Pt was visible in the milieu, interacting with peers and staff. Pt was present for dinner but not groups. Pt was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 01/17/17 21:59 - END OF NOTE

01/17/17 15:21 Social Worker by Bliss,Alison
Phone call with Teri at GBHC 773-4132. Confirmed that state hospital referral and legals were rec'd. Referral still needs to be reviewed by Dr. Rahman. Currently they have 6 people on their wait-list but this will go down to 3 on Thursday. Teri will give this writer a call back after referral is reviewed and a decision is made.

Phone call to Sue at EPC 737-4905. Voicemail left inquiring on patient's referral.

Initialized on 01/17/17 15:21 - END OF NOTE

01/17/17 12:22 Student Nurse by Wright,Courtney

Addendum entered by Wright,Courtney 01/17/17 12:37:

Pt observed talking to self in the milieu

Continued on Page 24

Original Note:

7-3 Shift: pt sociable with peers. Agitated when offered morning medication. Pt says geodon makes her angry and is killing her. Continues to state that she is being held at the hospital illegally, and talks about computers being hacked. Pt sat in the milieu all morning and is currently in her room lying down.

Initialized on 01/17/17 12:22 - END OF NOTE

01/17/17 05:40 Nursing Note by Schaffhouser,Patricia
Pt remained in the milieu throughout the night shift, sleeping only briefly, about 1.5 hours. She remains fixed on the conspiracy with government interventions, and also her illegal incarceration. She is quite pleasant with selected staff, and irritable with others. Will continue to monitor.

Initialized on 01/17/17 05:40 - END OF NOTE

01/16/17 21:19 Nursing Note by Myers,Erin

1500-2300
Pt appears as dysphoric. Pt appeared to be asleep from 1500-1700. Pt complained of staff and his meds. Pt mentioned concerns for his home property. Pt was positive for meals and attend groups. When asked to talk to this writer pt denied wanting to talk at these time and would tell staff when she was ready to talk. Pt was visible in the milieu and conversed politely with peers. Patient safe on all checks, will continue to monitor for changes to mood and behavior.

Initialized on 01/16/17 21:19 - END OF NOTE

01/16/17 12:02 Student Nurse by Wright,Courtney
7-3 Shift: Pt continues to be verbally abusive and aggressive when taking meds. Remains in denial about the fact that she is a pt and has treatment over objection, continues to assert that she has been kidnapped and is here illegally. Talking to self in the milieu, sociable with select peers. Pressured speech when talking to peers and staff. Seems focused on others rather than focusing on own issues. Continues to take geodon only, refusing all other meds. Did not attend am groups.

Initialized on 01/16/17 12:02 - END OF NOTE

01/16/17 11:00 Social Worker by Lee,Rebecca
Faxed pt's clinicals and demographics to EPC and GBHC for referral to LTC.

Initialized on 01/16/17 11:00 - END OF NOTE

01/16/17 06:34 Nursing Note by Niver,Brandy L

11p-7a Shift-Pt awake throughout most of shift, continues with multiple complaints i.e "this unit is in violation of the fire code. It is past the regulatory 15 days for the 9.39, I don't know this Dr. Lowry, I should be released, I am not crazy nor do I need to be here," Pt also stated that she feels someone has stolen her digital image and created a porn movie that is circulating the internet that she did not approve of. Pt able to

Continued on Page 25

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Nursing Notes - Continued

remain in behavioral control throughout shift, slept maybe 1.5hrs total, currently awake reading in the milieu, will continue to monitor for changes in mental status.

Initialized on 01/16/17 06:34 - END OF NOTE

01/15/17 20:58 Nursing Note by Miller,Rachel
0700-1500
Pt presents as dysphoric. Pt was in her room for a majority of the shift, but came out and has been social this evening. during 1:1 pt talked about how staff is saying that shes homeless but is not, and owns a house that is nearby and that she is unable to go back to the home because someone told her that she was homeless. Pt ate dinner, and took medication. Pt has been safe on all checks, will continue to monitor for safety and thought content.

Initialized on 01/15/17 20:58 - END OF NOTE

01/15/17 11:49 Nursing Note by Dickens,Julie

0700-1500 Patient presents dysphoric with an irritable edge this shift. Patient presents with pressured speech and demonstrates ideas of grandeur and persecution as evidenced by patient's soliloquy regarding court papers being false, "I have 30 years of data management experience and once my gender was marked wrong on the sticker's it can't just be corrected, but no one believes me and I own my own home, I don't rent. I own a $170,000 home with $100,000 worth of equity. That's why I'm here." Patient accepted copy of Court Order for Treatment Over Objections and after much encouragement took only Geodon 80 mg PO, refusing other odered medications. Client is visible in milieu most of shift and is minimally social with select peers. Patient offers numerous complaints to all staff and required redirection from nurses station several times during shift. Patient ate meals and is safe on all checks.

Initialized on 01/15/17 11:49 - END OF NOTE

01/15/17 05:27 Nursing Note by Roy,Matthew

2300-0700
Patient remained awake in milieu for entire shift. Patient was very talkative. Patient frequently made statements such as the 'Air Force put PCP in my pot,' "This place has fire code violations and isn't fit for human habitation," "that immigrant b**ch took the couch away - there was nothing wrong with the couch. Bring the couch back in." Patient would often raise voice while making these statements, and at one point pounded his fist loudly on a book while speaking on these subjects. Patient was able to be redirected. The patient seemed concerned about the side effects of Geodon, a med that the patient claims she was forced to take. The patient also expresses anger about being in the hospital for longer than 2 weeks. Patient was safe on all visual safety checks. Patient will continue to be monitored for safety.

Initialized on 01/15/17 05:27 - END OF NOTE

01/14/17 19:51 Nursing Note by Carlisle,John
1500-2300
Patient presents as flat with agitated affect. Patient is seclusive to self for majority of shift, only coming out of her room to get food and drink. Patient positive for meals, negative for groups. Patient declined having a one-on-one interview. Patient made allusions to delusions of persecution, also seen apparently responding to

Continued on Page 26

internal stimuli.
Patient safe on all checks, will continue to monitor for changes to mood and behavior.

Initialized on 01/14/17 19:51 - END OF NOTE

01/14/17 14:28 Nursing Note by Cosgrove,Kelly Anne
Dayshift Note: Patient was labile and irritable this morning, she was verbally abusive towards staff during the morning community meeting and was asked to leave group due to her disruptive behaviors. She complied with staff's directives. During medication pass she refused to present to the medication window however after talking with t/w during 1:1 session she complied with oral Geodon and was more cooperative. Her thought content is delusional and makes persecutory delusions known with reference to FBI. Pt has been observed in the milieu and social with her peers at times. Pt. has attended all meals and is somewhat cooperative with groups as she attended group cinema therapy. Pt has been safe on all visual checks, will continue to monitor for safety and changes in mental status.

Initialized on 01/14/17 14:28 - END OF NOTE

01/14/17 05:56 Nursing Note by Schaffhouser,Patricia
Anne remained awake through out this shift. She sat in the milieu, reading and occaisionall talking and singing to herself. She continues to discuss the "blackhats" who have hacked her identity, and insists that the FBI will cone and straighten it out. Will continue to monitor for safety and changes in mental status with routine 30 minute visual checks.

Initialized on 01/14/17 05:56 - END OF NOTE

01/13/17 20:58 Nursing Note by Kondrk,Anissa
3-11pm
Pt has been visible in the milieu and social with select peers. Pt was meal compliant. Pt attended groups and was appropriate. Pt denies SI. Pt endorses anxiety and depression and stated "I've had a terrible day". Pt talked at length about receiving treatment over objection. Pt was seen talking to herself in the milieu. Pt has remained in behavioral control. Pt has been safe on all checks, will continue to monitor for safety and changes in mental status.

Initialized on 01/13/17 20:58 - END OF NOTE

01/13/17 16:23 Social Worker by Bliss,Alison
Phone call with Laura Bevacqua, attorney at MHLS. She attempted to meet with patient earlier in the week to discuss a state hospital referral. She reports patient did not believe she was who she said she was and was unable to engage in a productive or coherent conversation, given this and her knowledge of the case she is giving clearance for a state hospital referral.

Initialized on 01/13/17 16:23 - END OF NOTE

01/13/17 15:33 Recreation Therapist Note by Stevenson,Kylee K

Continued on Page 27

Patient continues to not attend programming since her admission and has been refusing to accept individualized treatment options offered. Patient is mostly visible sitting in the milieu during the day and has been observed to talk and gesture to herself. Patient will seek out this writer throughout the day to talk about music but will become instantly agitated when discussing her treatment. Patient will become defensive and dismissive and state she is "smarter" than the staff. Will continue to meet with patient and follow up.

Initialized on 01/13/17 15:33 - END OF NOTE

01/13/17 11:17 Nursing Note by Pudney,Kelsey

0700-1500 shift:

Pt was verbally abusive towards staff, stating that staff are not real doctors and nurses, and we do not have a legitimate court order to force medications on him, security was called due to pt escalating. When security arrived pt lowered voice and took medications. Pt has been visible in the milieu and social with select peers. Pt has not attended group programming and is positive for meals. Pt has been safe on all visual checks, will continue to monitor for safety and changes in mental status.

Initialized on 01/13/17 11:17 - END OF NOTE

01/13/17 05:41 Nursing Note by Schaffhouser,Patricia
Anne remained awake most of this shift, and was noted sleeping for 1 hour only in the milieu, which she referred to as "her nice nap". She occasionally approached the nurses station with requests, and was generally pleasant, although there was one outburst when she was upset that she was unable to find her underwear, which she had wrapped in a package and was apparently put in her "cubby" during safeties. She did talk and sing quietly to herself in the milieu when alone, as has been her habit. Will continue to monitor for safety and mental status.

Initialized on 01/13/17 05:41 - END OF NOTE

01/12/17 21:22 Nursing Note by Parseghian,Roberta E

Anne was visible and social most of the shift. She attended groups with good participation. She ate dinner and snack. She was social with peers and exhibited patience and gentleness towards newly admitted peer who unknowingly was irritating the other peers. She continues to doubt Dr Ehmke's credentials. She stated "Dr Gerson and Dr. Lowry think I am okay it is only Ehmke who thinks I need Geodon." He was critical of nurses "who agree with the doctor and force me to take medication. They could refuse to give it to me and stand up for a guy. They are just afraid to lose their job." She was safe on all 30 min safety checks. Will continue to be monitored.

Initialized on 01/12/17 21:22 - END OF NOTE

01/12/17 15:23 Social Worker by Bliss,Alison
Late entry: On 01/11/17 This writer confirmed with Dr. Ehmke that he spoke to patient about a referral for the state hospital.
This writer then spoke with Laura from Mental Hygiene Legal Services who will attempt to meet with patient and then will let this writer know if she will give clearance for a state hospital referral.

Initialized on 01/12/17 15:23 - END OF NOTE

Continued on Page 28

01/12/17 11:12 Nursing Note by Cottrell,John
7-3 Shift: Pt verbally abusive and agitated when taking am medications. Sociable with peers, smiling at times. Has been sitting in the milieu since breakfast. Has not attended group.

Initialized on 01/12/17 11:12 - END OF NOTE

01/12/17 06:10 Nursing Note by Sidle,Matthew G

11p-7a: Pt was awake on all 30 minute visual checks throughout the night. No change in mental status noted this shift. Pt did not sleep and is awake at this time reading in the milieu. Pt safe on all checks, will continue to monitor for safety and mental status.

Initialized on 01/12/17 06:10 - END OF NOTE

01/11/17 22:16 Nursing Note by Hanna-Martinez,Tahlia

3-11pm

Anne presents as euthymic with congruent affect. She had one irritable outburst towards staff regarding medication. She declined 1:1. She spent the majority of the shift sleeping in bed. She got up for dinner and ate 100%. She was pleasant upon approach. She did not attend group. Safe on all checks. Will continue to monitor for safety and changes in mental status.

Initialized on 01/11/17 22:16 - END OF NOTE

01/11/17 13:36 Nursing Note by Lister,Barbara

0700-1500 Nursing Note:
Pt declined 1:1. Pt was hyperverbal when asked to take medications. After lots of resistance, pt took geodon 80mg PO. Pt had periods of irritation with staff throughout shift and was seen talking to self at times. Pt was visible in milieu, did not attend groups, napped in the afternoon, and has been safe on all checks. Pt will continue to be monitored for safety and for any changes to her thought, mood, affect, and behavior.

Initialized on 01/11/17 13:36 - END OF NOTE

01/11/17 07:59 Nursing Note by Niver,Brandy L

11p-7a Shift-Pt awake throughout most of shift, sitting in milieu quietly talking to self or reading, pleasant upon approach, observed to be asleep for roughly 2.5hrs in the milieu. Pt has been safe on all checks, will continue to monitor for changes in mental status.

Initialized on 01/11/17 07:59 - END OF NOTE

01/11/17 01:01 Nursing Note by Vanpetten,Jacqueline

Continued on Page 29

Pt. in bed majority of the shift, out of bed for meals. Pt. states" I'm mad Geodon has been increase, i have plenty of energy because of Geodon and i don't like it." Pt. wants to leave. Pt. ate 100% dinner. Pt. seclusive to self, no interaction with peers. Continue to monitor pt safety,mood,thought process.

Initialized on 01/11/17 01:01 - END OF NOTE

01/10/17 13:21 Student Nurse by Wright,Courtney
7-3 Shift: Pt was angry this am that Geodone dose was increased to 80mtg. Pt was verbally abusive when offered morning meds, but ultimately took med. Pt has been socializing with peers most of the day but has been seen talking and having conversations with herself in the milieu. Pt reported at 1325 that the 80mg Geodone is "making me feel agitated and panicky". Pt did not attend groups.

Initialized on 01/10/17 13:21 - END OF NOTE

01/10/17 05:58 Nursing Note by Brown,Michele

2300-0700

Patient has appeared to be resting comfortably at long intervals from 0030-0515. Remained safe on all checks. Patient is currently sitting quietly in milieu.

Initialized on 01/10/17 05:58 - END OF NOTE

01/09/17 22:25 Nursing Note by Hanna-Martinez,Tahlia

3-11pm

Anne presents as less irritable today than previously observed in previous shifts. She is more pleasant, calm, and cooperative. No emotional outbursts this shift. She denies 1:1, stating "I don't feel depressed or anything, all I feel is disgust, that I am forced to be confined here." She continues to believe that she was wrongfully hospitalized, and that there is no reason for her to be here. She was visible in the milieu and was socially interactive with peers and staff. Euthymic with congruent affect. Brightens upon approach. She ate 100% dinner and snack. She attended relaxation group. Safe on all checks. Will continue to monitor for safety and changes in mental status.

Initialized on 01/09/17 22:25 - END OF NOTE

01/09/17 13:07 Student Nurse by Wright,Courtney
7-3 Shift: Pt took p.o med (Geodon) with minimal resistance. Refused remaining meds. Less irritable this am. Pt continues to state that there is "no such thing as treatment over objection" and continues to accuse staff of kidnapping her and keeping her here against her will. Socializing more with peers. Has not been observed talking to herself today, speech can be pressured and rambling at times.

Initialized on 01/09/17 13:07 - END OF NOTE

Continued on Page 30

01/09/17 05:39 Nursing Note by Ferraro,Neely

2300-0700
Patient appeared to be asleep on most 15 minute visual checks throughout the night. Pt. was safe on all checks. Pt. slept for 5 hours and is asleep in the milieu at this time. Will continue to monitor for safety and changes in mental status.

Initialized on 01/09/17 05:39 - END OF NOTE

01/08/17 10:44 Nursing Note by Cottrell,John
7-3 shift: This client remains unchanged. He is selectively sociable with peers, actively talks to himself, including hand gestures, when sitting in the milieu and alone in his room. Patient insight remains poor. He denies having any mental issues, says he is not a patient in this hospital, says " you are kidnapping me. You are going to jail for twenty years!". Client became extremely agitated when told he must take his medication. He was verbally abusive and making multiple threats to jail me . "The Supreme Court did not say treatment over objection! This is illegal".

Initialized on 01/08/17 10:44 - END OF NOTE

01/08/17 05:27 Nursing Note by Smalser,Carrie

2300-0700
Pt appeared asleep on most 15 minute visual checks. Pt appeared to sleep 6 hours and remains asleep. Pt safe on all checks. Will continue to monitor for changes to behavior, mood and mental status.

Initialized on 01/08/17 05:27 - END OF NOTE

01/07/17 22:47 Nursing Note by Parseghian,Roberta E

Anne was visible most of the shift sitting in the milieu or walking in the halls. She was minimally social. At times she rested in her bed and could be heard grumbling,complaining and cursing in her room. She ate dinner and snack and was rude to staff when informed she was not allowed to leave food in her room. She attended groups and participated and was medication compliant. Safe on all safety checks. Will continue to be monitored.

Initialized on 01/07/17 22:47 - END OF NOTE

01/07/17 10:26 Nursing Note by Schaffhouser,Patricia
Anne continues to express her insistance that her "incarceration" here is illegal, and that she is going to sue. When in her room, or sitting alone, she continues to talk and gesture. She sat in on groups today, but offered little, but rather observed. She remains safe on the unit, and staff continues to monitor for mental status change and safety.

Initialized on 01/07/17 10:26 - END OF NOTE

01/07/17 06:02 Nursing Note by Niver,Brandy L

Continued on Page 31

11p-7a Shift-Pt awake throughout most of shift, pleasant and polite in conversation, conversing with staff and peers appropriately, appears to be sleeping in bed at this time, slept roughly 1hr this shift. Pt has been safe on all checks, will continue to monitor for changes in mental status.

Initialized on 01/07/17 06:02 - END OF NOTE

01/06/17 21:05 Nursing Note by Taylor,Steven
1500-2300 Anne continues to present as paranoid and was noted to be talking to self. Pt continues to relate that the staff are not real health care providers and that Dr Ehmke is a fake Dr. Pt was noted to be talking to select peers and was seclusive to self at other times. Pt was meal compliant and was safe on all visual checks, will continue to monitor.

Initialized on 01/06/17 21:05 - END OF NOTE

01/06/17 17:08 Social Worker by Bliss,Alison
2PC was initiated and completed today. It is in patient's chart.

Initialized on 01/06/17 17:08 - END OF NOTE

01/06/17 13:26 Nursing Note by Lister,Barbara

0700-1500 Nursing Note:
Pt declined 1:1. Pt was irritable at start of shift. Pt was visible in milieu, socialized with peers but suspicious about staff and their credentials. Pt took her medications by mouth this morning. Pt spent mid morning and afternoon in bed and in her room seen talking to herself. She has been safe on all checks. She will continue to be monitored for safety and for any changes to her mood, thoughts, affect, and behavior.

Initialized on 01/06/17 13:26 - END OF NOTE

01/06/17 13:08 Recreation Therapist Note by Stevenson,Kylee K

Patient has continued to decline programming since admission and is typically observed sitting in the milieu during these times. Patient continues to present with an irritable edge, stating to this writer that "the hospital is being run by terrorists" and continues to be fixated on the unit not being "up to code." Patients mood brightens when talking about music and once being in a band. Patient continues to be observed talking and gesturing to herself. Will continue to encourage patient to engage in treatment, milieu activities and positive interactions with others.

Initialized on 01/06/17 13:08 - END OF NOTE

01/06/17 05:42 Nursing Note by Myers,Erin

2300-0700
Pt slept throughout the shift, 5.0 hours as evidenced by all checks. Only getting up once around 0300-0345 and was in behavioral control at that time. Will continue to monitor for safety and mental status with all routine 15 minute visual checks.

Continued on Page 32

Initialized on 01/06/17 05:42 - END OF NOTE

01/05/17 22:57 Nursing Note by Baker,Kristin
1500 - 2300

Pt presents as dysphoric with an irritable edge. Pt received evening Geodon (see medication note). Pt continues to express paranoid/persecutory delusions concerning treatment and unit policies. Pt is present in the milieu at times and social with select peers. Pt is meal complaint. Pt is observed to be periodically talking to herself in her room. Safe on all checks. Will continue to monitor for thought content and behavior.

Initialized on 01/05/17 22:57 - END OF NOTE

01/05/17 17:40 Social Worker by Bliss,Alison
This writer rec'd the Treatment Over Objection order signed by Judge Cassidy from Attorney Tom Smith.

I then attempted to serve patient this paperwork alongside two RN staff members. Patient rejected this order and stated that staff, the court, and judge are not "real" and the order is "illegal." Patient ripped up the court order and gave it back to this writer while continuing to express paranoid delusions. Patient proceeded to leave her room and security had to be called after she walked into the milieu vocalizing paranoid delusions about staff while refusing to take her mediation. Please see nursing note on medication for resolution of this event.

Initialized on 01/05/17 17:40 - END OF NOTE

01/05/17 16:36 Nursing Note by Baker,Kristin

Addendum entered by Baker,Kristin, RN 01/05/17 17:10:

Pt was initially offered POs at 15:45 and ultimately took the medication at 1600.

Original Note:

Medication Note:

Pt was offered her ordered dose of 40 mg of PO Geodon in her room by two RNs. Pt replied with a monologue based in paranoid/persecutory delusions while . Pt voiced complaints of: disbelief concerning the medication being not as stated; the staff not being "real" RNS, Doctors, and Social Workers; and illegal court proceedings. Pt continued to refuse PO meds while taking them in her hand and walking to the milieu. Security was called and the milieu was cleared while IM medication was drawn up. Pt eventually took PO medication with staff encouragement. Pt was then asked to take time and space in her room to ensure the safety of the unit.

Initialized on 01/05/17 16:36 - END OF NOTE

01/05/17 12:15 Nursing Note by Lister,Barbara

0700-1500 Nursing Note:
Pt presents as agitated, irritable, and paranoid this shift. Pt denies that she is a patient here, stating we are all imposters, and that the medications ordered are not for her. Pt was seclusive to her room most of shift

Continued on Page 33

and seen talking to herself. She is social with select peers. She refused her medications. Pt has been safe on all checks. She will continue to be monitored for safety and for any changes to her mood, thoughts, affect, and behavior.

Initialized on 01/05/17 12:15 - END OF NOTE

01/04/17 14:25 Nursing Note by Lister,Barbara

Pt states that she has been assaulted by Lynn S., another patient on the unit, in the community. She states that she was verbally threatened by patient stating she was going to bring her "AK" and had the middle finger stuck up at her. Charge nurse made aware.

Initialized on 01/04/17 14:25 - END OF NOTE

01/04/17 13:36 Nursing Note by Lister,Barbara

0700-1500 Nursing Note:
When asked to do 1:1, pt refused then continued to talk for about 20 minutes in a hyperverbal fashion. She was talking about cyberware, Walmart and the phones they sell being hacked, her businesses and websites, the fire hazards in the hospital and how it should be shut down, and not getting a court hearing (one was scheduled 1/3/17, she declined to go). She states that depression is "not bad" and that she came here for PTSD and not having a place to live. She states she is not a danger to herself and others and that she should be discharged.
She declined to take medications today, ate meals, was seen talking out loud in her room by herself, did not attend groups, and declined to sign her treatment plan. She has been safe on all checks and in behavioral control. She will continue to be monitored for safety and for any changes to her mood, thoughts, affect, and behavior.

Initialized on 01/04/17 13:36 - END OF NOTE

01/04/17 05:42 Nursing Note by Morse,Chris
Sleep-Pt has slept from 2315-0515. No change in mental status noted. Pt remains safe on all 15 min. safety checks. Will continue to monitor

Initialized on 01/04/17 05:42 - END OF NOTE

01/03/17 20:25 Nursing Note by Hewitt,Anne
15:00 to 23:00- Pt appears euthymic with congruent affect. Pt observed socializing with peers in the milieu at the start of shift. Pt observed walking around the unit or laying down in her bed. Pt didn't attend evening groups. Pt denied having a one on one tonight and said "I would just like to relax". Pt observed dancing to music when the radio was playing. Pt safe on all checks and in behavioral control.

Initialized on 01/03/17 20:25 - END OF NOTE

01/03/17 13:35 Nursing Note by Cottrell,John
7-3 shift: This client is essentially unchanged. He refuses to take prescribed medications, has loud conversations with himself in the milieu and his bathroom. Patient refuses to discuss his thoughts and

Continued on Page 34

feelings, becoming irritated and suspicious of posed questions. He denies that he is a patient and is oppositional to any information given him. Patient is hyperverbal when something superficial or non health related is mentioned . Client is tangential with many references made regarding technology.

Initialized on 01/03/17 13:35 - END OF NOTE

01/03/17 12:38 Social Worker by Bliss,Alison
This writer spoke to MHLS attorney Laura who was on the unit meeting with patient. Laura states she attempted to meet with patient again today as court is at 2 PM per patient's request and TOO. Patient is refusing to meet and speak with Laura and does not believe that she is her attorney.

This writer met with patient to ask her if she would like to go to court today and let her know that an officer from TCSD was here to transport her. The patient states that court was not real and she was never served paperwork, when this writer reminded patient that I attempted to serve her the paperwork last week but she refused she stated that the paperwork was phoney. The patient then states she wanted to meet with the officer to talk to him about code violations on the unit, the patient walked toward the door in an attempt to speak to the officer and this writer let her know that the officer could not enter the unit and he was not here to review fire code. The patient was irritated with this writer and then walked away.

Initialized on 01/03/17 12:38 - END OF NOTE

01/03/17 05:40 Nursing Note by Schaffhouser,Patricia
Pt remained in the milieu , talking to herself, occasionally tapping or pounding on the table. She did go to bed and slept for 3.5 hours as evidenced by checks. Will continue to monitor for safety and mental status with all routine 15 minute visual checks.

Initialized on 01/03/17 05:40 - END OF NOTE

01/02/17 21:34 Nursing Note by Fritsche,Amanda

1500-2300:

Anne declined a formal 1:1. Pt reports she is "doing well" and needs no "help." Pt wants discharge because there is "nothing wrong with her." Pt has been observed reacting to internal stimuli, talking to herself in the milieu and in her room. Pt was seclusive to self. Pt was present for dinner but not groups. Pt was safe on all checks and remained in behavioral control. Will continue to monitor.

Initialized on 01/02/17 21:34 - END OF NOTE

01/02/17 13:30 Nursing Note by Morlu,Zlanweah
0700-1500:
Anne Rose has had no changes this shift. Pt. declined all services pertaining to her tx;vitals, meds, meeting with 1:1, and groups. Pt. has been observed reacting to internal stimuli;talking loudly to self in the milieu and when she's alone in her room. Pt. was meals compliant, visible in the milieu, and minimally social with peers. Pt. was safe on all checks, will continue to be monitored for safety and changes in mental status.

Initialized on 01/02/17 13:30 - END OF NOTE

Continued on Page 35

01/02/17 11:04 Social Worker by Lee,Rebecca
This writer spoke to the desk Sargent at the TCSD to confirm they will provide transportation for pt tomorrow. Pt has court scheduled at 2:00, and another pt is scheduled at 1:00. The sherriff's dept has stated at this time that they will transport both pt at the same time. This writer asked that the TCSD be here by 12:15 to ensure we arrive at court with enough time so pt can meet with the MHLS attorney prior to her scheduled appearance. The Sargent endorsed that this is workable for them and stated they will plan to be here by then.

Initialized on 01/02/17 11:04 - END OF NOTE

01/02/17 06:17 Nursing Note by Roy,Matthew

2300-0700
Patient has laid in bed with eyes closed from 2300-0345, was in the milieu from 0345-0430, and laid in bed with eyes closed from 0430-present. Patient was safe on all visual safety checks. Patient will continue to be monitored.

Initialized on 01/02/17 06:17 - END OF NOTE

01/01/17 17:22 Nursing Note by Parseghian,Roberta E

Anne was tearful at the beginning of the shift and expressed anger at staff because of the IM injection administered earlier in the shift. She reported feeling "like I was raped". She stated "I was in my room. I would of been fine. They didn't need to do that."She spent most of the shift so far seclusive to herself in her room. She did come to the dayroom and ate dinner.She did not participate in afternoon group. Requests nicotine replacement almost every two hours.Presently lying in bed resting.

Initialized on 01/01/17 17:22 - END OF NOTE

01/01/17 12:27 Nursing Note by Cottrell,John
nursing note: Patient, a while after receiving prn IM, continue to have dysphoric mood with an irritable affect. She presented in much better control, however, voice volume was lower and was slightly less disorganized. Patient continues to say she has been kidnapped and says she is not a patient.

Initialized on 01/01/17 12:27 - END OF NOTE

01/01/17 07:38 Nursing Note by Cottrell,John
nursing note: Client presented as extremely agitated, screaming, accusing staff of kidnapping him along with other paranoid ideation. He was non-responsive to redirection, was behaving in an out of control manner that caused fear and agitation on the part of peers. He refused p.o. medication, stating we are trying to poison him. Thorazine 100mg IM given per order for out of control, extremely agitated behavior that was a major disruption to the care of other patients and causing agitation on the part of peers. Security was called to assist in the administration of medication given the agitated and unpredictable behavior of the patient. Verbal de-escalation and redirection were ineffective given his psychotic state.

Continued on Page 36

Initialized on 01/01/17 07:38 - END OF NOTE

01/01/17 06:30 (created 01/01/17 07:50) Nursing Note by Niver,Brandy L

11p-7a Shift-Pt awake throughout most of shift, appeared to be asleep by 0515, slept roughly 1.25hrs. Pt, while awake, observed talking to self, smacking self in face, insulting self while standing in front of the mirror. Pt has been tenuously in control throughout shift, is argumentative with staff, shushing staff when redirection attempts are made, dismissive of staff and staff directives. Pt able to retire to room at times, remains in minimal behavioral control, will continue to monitor for changes in mental status.

Initialized on 01/01/17 07:50 - END OF NOTE

12/31/16 20:09 Nursing Note by Parseghian,Roberta E

Anne was visible most of the shift. She ate dinner and sat through groups.She was minimally social and in behavioral control. Around 2000 she was verbally assaulted by a male peer(LS) who then lunged at her with intent to harm but was intercepted by John C. MHT. Anne reports minimal contact with the peer and denies injury. She remains in the mileu at this time.

Initialized on 12/31/16 20:09 - END OF NOTE

12/31/16 14:51 Nursing Note by Morlu,Zlanweah
0700-1500:
Anne Rose declined to have a 1:1 with t/w claiming "I am preoccupied (talking to self)." Pt was dysphoric with flat and restricted affect. Pt. was visible in the milieu. Pt. was seclusive to self. Pt. has been reacting to internal stimuli majority of the shift. At one point during the shift, pt. was yelling very loudly in her room "I don't need to be here and I am being held here against my well.I want to go out and smoke and do what I want to do." Pt then went into the day room where she continued to talk very loudly and refused for staff to close the door, security was called to do a walk though. Pt. was offered a refill on her nicotine inhaler which appeared to help pt. calm down. There was no other incident with pt. behavior the remainder the shift. Pt. was safe on all checks, will continue to be monitored for safety and changes in mental status.

Initialized on 12/31/16 14:51 - END OF NOTE

12/31/16 05:44 Nursing Note by Schaffhouser,Patricia
Pt was awake much of this shift, sleeping only about 1.5 hours. During the course of this shift, she at times ranted about her incarceration, being kidnapped and suffering from Stockholm Syndrome. She constantly complained about this facility being a fire hazard, and that she will sue staff, and damns us to hell. At nearly 0600 he began to yell and threaten another patient. Staff responded, separated both patient for 1:1 intervention. He is somewhat calmer.

Initialized on 12/31/16 05:44 - END OF NOTE

Continued on Page 37

12/31/16 02:14 Nursing Note by Brown,Michele

Patient was initially awake and alert at the beginning of the shift. Irritable and talking to herself, agitated at times when asked how she was--replied only not well loudly and asked t/w if I wanted to see the illegal papers keeping her here. Remained in behavioral control. Appeared to fall asleep in her bed since approximately 0130. Safe on all checks.

Initialized on 12/31/16 02:14 - END OF NOTE

12/30/16 19:54 Nursing Note by Vanpetten,Jacqueline

Pt. declined 1:1,and groups. Pt. visible in the milieu talking to herself. Pt. smiling,pleasant,and calm. Pt. ate 100% dinner/snack. Pt. singing with peer LS. Pt. states" My nails are long and sturdy to play my guitar." Pt. remained in behavioral control. Continue to monitor pt safety,mood,thought process.

Initialized on 12/30/16 19:54 - END OF NOTE

12/30/16 15:24 Recreation Therapist Note by Coats,Maureen

Pt. has declined programming that has been offered by this writer since admission. Pt. is observed to be in the milieu but is not interacting with staff or peers. Pt. is observed to be talking to herself loudly with hand gestures. Con't to provide encouragement for appropriate staff interactions and positive involvement in unit groups and activities.

Initialized on 12/30/16 15:24 - END OF NOTE

12/30/16 14:04 Social Worker by Bliss,Alison
This writer attempted to meet with patient to serve her the Order to Show Cause and the Treatment Over Objection paperwork. Patient states "this is not real, it's phoney, I am not a danger to myself and I should be immediately released." This writer attempted to tell patient about court which will be on Tuesday 01/03/16 at 2:00 PM, patient interrupted this writer multiple times and questioned the names and credentials of people listed on the paperwork stating "He is not a real doctor, this is ridiculous." Patient then handed paperwork back to this writer and states she will not accept it. This writer put patient's copy of legal paperwork in her chart in case she does want it in the future.

Initialized on 12/30/16 14:04 - END OF NOTE

12/30/16 13:11 Nursing Note by Washington,Shay
0700-1500
Patient presents this shift as dsyphoric with an irritable affect. Pt has been visible in the milieu talking to herself throughout the shift. Pt was unable to complete 1:1. Pt stated to this writer, "This place is not up to fire code, shut up I don't want to here another word from you." Pt is not medication compliant. Pt is not group compliant. Pt is meal compliant. Pt was safe on all checks. Will continue to monitor for safety and thought content.

Initialized on 12/30/16 13:11 - END OF NOTE

12/30/16 08:23 Nursing Note by Powers,Joni Lynn

Continued on Page 38

Patient approached the medication window to request replacement nicotine cartridge. When offered scheduled morning medications, patient responding by gesturing two thumbs down and stating "I question the sanity of anyone who would offer me that medication."

Initialized on 12/30/16 08:23 - END OF NOTE

12/30/16 05:37 Nursing Note by Schaffhouser,Patricia
Anne remained in the milieu throughout the night shift, sleeping for only about three hours as evidenced by all 15 minute visual checks. She approached at intervals for refills on her nicotine replacement unit. She was noted singing and talking to herself for long periods during the shift. Will continue to monitor for safety and mental status with usual routine 15 minute visual checks.

Initialized on 12/30/16 05:37 - END OF NOTE

12/29/16 19:42 Nursing Note by Sava,Erica
1500-2300

Patient presents euthymic with congruent affect. Patient reports she is not a danger to herself or others and therefore does not understand why she is on the unit. Patient positive for meal. Patient positive for anger management but negative for evening group. Patient is visible in the milieu talking to self. Patient is hyperverbal. Patient reports she foes not understand why she is on the unit. Patient does not believe this unit is the Behavioral Services Unit. Patient talks about a cyber war. Patient stated "I know people in high places, and hopefully the FBI will be here soon." Patient states she is not safe on unit because the doctors are frauds and the unit is a fire hazard. Patient states "water is toxic so I will not bath myself in it." Patient states her credit cards were mysteriously turned off which is why she is unable to stay at hotels. Patient also reports someone made a call to the hotel she was staying at stating she had a gun. Patient states this was not true. Patient remains in behavioral control. Patient safe on all checks. Will continue to monitor for safety and changes in mental status.

Initialized on 12/29/16 19:42 - END OF NOTE

12/29/16 13:28 Social Worker by Bliss,Alison
TOO paperwork was completed by Dr. Ehmke and Dr. Lowry. This was faxed by this writer to Harris-Beach Attorneys as well as Mental Hygiene Legal Services.

Phone call with Tom Smith, attorney for CMC at Harris-Beach. This writer requested that the court hearing occur at the hospital rather than at the court house due to concerns for patient's ability to remain in behavioral control and flight risk. He will speak with the court and MHLS and let this writer know as court had been scheduled at the courthouse for tomorrow 12/30 at 2:30 PM.

This writer spoke with Laura from MHLS while she was on the unit. Laura has consented to move the hearing to next week, previously scheduled court date for tomorrow has been canceled. Laura will meet with patient on the unit to discuss court further.

Initialized on 12/29/16 13:28 - END OF NOTE

12/29/16 12:40 Nursing Note by Saddlemire,Shane

Continued on Page 39

Anne has been visible in the milieu throughout the shift. She continues to be overheard talking to herself. She presents as irritable, expressing that she believes her stay here to be illegal and unjustified. She has declined all medications. She has been present for meals and requesting nicotine replacement. She continues to speak in a grandiose manner, often stating how intelligent she is and and good at most tasks. She has not been attending unit programming.

Initialized on 12/29/16 12:40 - END OF NOTE

12/29/16 05:54 Nursing Note by Brown,Michele

Patient was initially awake at the beginning of the shift. Appeared to fall asleep on a couch in the milieu from 0030-0245. She has since awoken and continues to talk to herself, seemingly responding to internal stimuli. Conversation at times becomes intense and argumentative. Patient approached the nurses station around 0300 demanding to be moved to another area d/t the numerous code infractions, siting illegal activity including keeping someone against their will. Patient remains sitting in the milieu at this time.

Initialized on 12/29/16 05:54 - END OF NOTE

12/28/16 20:21 Nursing Note by Saddlemire,Shane

Addendum entered by Saddlemire,Shane, RN 12/28/16 20:55:

Anne has been observed talking to herself throughout the shift, as if responding to internal stimuli.

Original Note:

Anne has been visible in the milieu throughout the shift. She has mostly been keeping to herself, except to let staff know her general distaste for being admitted on the unit. She reports not needing any medication and that she plans on not taking any while she is here. She believes that staff here are not really who they say they are and do not possess accurate credentials. She has an overall irritable edge and remains hyperverbal and tangential in conversation, often expressing how incredibly intelligent she is. She has remained in control of her behavior and has been making her needs known.

Initialized on 12/28/16 20:21 - END OF NOTE

12/28/16 11:59 Recreation Therapist Note by Stevenson,Kylee K

This writer has made several attempts to engage patient in a meaningful conversation and to talk about leisure interests. Patient is fixated on being discharged and is irritable during our interactions making it difficult to engage in a conversation. Patient did speak about her passion for music and playing guitar during recreation group but other information has been difficult to obtain d/t patient being unwilling/unable to interact with this writer. Continue to follow up with patient to establish rapport and encourage involvement in treatment.

Initialized on 12/28/16 11:59 - END OF NOTE

12/28/16 10:28 Nursing Note by Cottrell,John

Continued on Page 40

7-3 shift: Client is dysphoric with an irritable affect. He is demanding at times, denies being a patient, speech can be pressured or rambling. Patient is refusing medications prescribed and does not attend group sessions. When asked about his thoughts and symptoms of psychosis, he becomes irritable and defensive and his voice volume raises. While he denies psychosis, he was noted talking to himself and spontaneously laughing while sitting alone in the milieu. Refusing vital signs. Complains that her chart stickers designate her as a male.

Initialized on 12/28/16 10:28 - END OF NOTE

12/28/16 09:02 Social Worker by Bliss,Alison
Late entry: Copy of patient's request for a court hearing was faxed to Harris-Beach Attorneys on 12/27 as well as copy of clinical record. This writer then followed up with an email to Thomas Smith at Harris-Beach to alert him to materials sent and court request.

Initialized on 12/28/16 09:02 - END OF NOTE

12/28/16 05:43 Nursing Note by Schaffhouser,Patricia
Pt was awake for long intervals during this shift. She slept for about 3 hours, and spent much of the shift sitting in the milieu alone laughing and talking. She remained safe as evidenced by all routine 15 minute visual checks. Will continue to monitor for safety and change in mental status.

Initialized on 12/28/16 05:43 - END OF NOTE

12/27/16 20:43 Nursing Note by Powers,Kate

1500-2300

Bonze "Anne" presents this shift as euthymic with and irritable edge. Pt. stated "I want to leave, I shouldn't be here. I'm not a danger to myself or others." Pt. has been observed talking to what appears to be no one, and inspecting doors and walls for their "structural integrity." Pt. requested that staff "call the sheriff's department on my behalf." Pt. has been visible in the milieu and social with peers and staff. Pt. has been positive for meals but has not attended group programming this shift. Pt. has remained in behavioral control, will continue to monitor for changes in mental status and safety.

Initialized on 12/27/16 20:43 - END OF NOTE

12/27/16 19:48 Nursing Note by Hewitt,Anne
19:00- Pt approached writer in the nursing station and said that she is being held against her will. Pt is hyperverbal. Pt said that she is here on a 9.39 and that the physician's only have 48 hours to hold her. Writer explained that that is not true for a 9.39 but the patient would not listen. Pt kept asking to be discharged but writer said that would not be possible without a physician's order and that the physician's will discuss it tomorrow. Pt said, "I am not a harm to myself or anybody". Pt does not understand his hospitalization but continues to say that people are out to get him. Pt seen checking doors and furniture throughout the unit and say that they are not meeting legal standards. Will continue to monitor.

Initialized on 12/27/16 19:48 - END OF NOTE

Continued on Page 41

12/27/16 13:06 Social Worker by Bliss,Alison
This writer introduced myself to patient as I will be her social worker/discharge planner. Patient states she just spoke to a nurse about her legals and wants to be discharged immediately. Patient spoke about paranoid thoughts and delusions and was difficult to follow at times. She was somewhat irritable but became more cooperative when this writer brought up patient's therapist Dr. Kevin Field. She gave verbal permission for this writer to contact Dr. Field.

Voicemail left for Dr. Kevin Field (607) 535-4288

Initialized on 12/27/16 13:06 - END OF NOTE

12/27/16 12:44 Nursing Note by Lanzara,Victoria

Patient has been present in the milieu and is calm and interactive upon approach. She continues to remain focused on topics such as, "this facility is not up to code" and "this is not the real BSU". Her speech is pressured and tangential. She discussed contacting a lawyer from Mental Hygiene Legal Services and when asked if she would like to contact someone she stated, "there's no point now" and mentioned that she submitted a request for a court hearing. She also mentioned that "the phones are hacked". She denies intent/thoughts of harming self and others. She declined AM medications and having her vitals signs taken. Safe on all observational checks. Will continue to monitor.

Initialized on 12/27/16 12:44 - END OF NOTE

12/26/16 23:58 Nursing Note by Brown,Michele

Addendum entered by Brown,Michele, RN 12/27/16 05:40:

Patient remains awake and alert, sitting in milieu talking to herself. Requested nicotine inhaler and bandaids for her toes. States the socks without her shoes are causing irritations on her toes which is only worsened by her exposure to the city water which is poisoned. Calm and cooperative.

Original Note:

Addendum entered by Brown,Michele, RN 12/27/16 02:19:

Patient retired to her room and has appeared to be resting comfortably at long intervals since approximately 0030. Safe on all checks.

Original Note:

Patient currently up and socializing in the milieu with peers. Calm and cooperative. Noted to be speaking to herself at times.

Initialized on 12/26/16 23:58 - END OF NOTE

12/26/16 22:02 Nursing Note by Baker,Kristin
1500 - 2300

Continued on Page 42

Pt presents as disorganized with an irritable edge. Pt presents as having a paranoid thought process and pressured, tangential speech. Pt frequently appears at the nurses' with complaints that are not reality-based and is at times difficult to redirect. Pt reports the desire to be transferred to a medical floor due to her perception of the unit not being up to code: "None of the stuff here is the way it should be. The outlets shouldn't' be within a certain distance from the sinks. No one should even be here." Pt states, "I have asked to call the sheriff's office multiple times and I have not been able to call out myself because the federal hackers can get to anything. After confirming that this writer is an RN, pt showed t/w her calloused feet: "And look at this. This is not right I am being deprived of my shoes and now look what's happening. This floor is probably washed with city water and now I am being harmed." This writer offered the pt hospital slipper socks, which she immediately declined. Pt is noted to be pacing the unit throughout the shift. Pt is meal compliant. Pt did not attend groups this shift and had no scheduled meds. Safe on all checks. Will continue to monitor for thought content and behavior.

Initialized on 12/26/16 22:02 - END OF NOTE

12/26/16 13:45 Recreation Therapist Note by Stevenson,Kylee K

Attempted to meet with patient to introduce self and leisure services. Patient was initially polite when this writer introduced herself but then had an irritable edge when this writer asked to meet with patient as patient was only focused on meeting with the doctor and stated "I don't need to talk about recreation." Patient spoke briefly during our conversation about her job history but other information was difficult to assess. Patient has been observed to be talking and gesturing to herself in the milieu. Will attempt to meet with patient again.

Initialized on 12/26/16 13:45 - END OF NOTE

12/26/16 13:23 Nursing Note by Lanzara,Victoria

Patient has been present in the milieu and is interactive and calm upon approach. She has pressured and tangential speech and at times talks to herself. She declined her morning medications and she also declined to complete ADLs, stating "the Ithaca City water is poison". During this shift, she attempted to lift the cover off of the fire alarm, stating, "I was just testing some of the equipment in here". She denies intent/thoughts of harming self and others. Safe on all observational checks. Will continue to monitor.

Initialized on 12/26/16 13:23 - END OF NOTE

12/26/16 11:50 Social Worker by Owen,Kimberley
SW met with patient this morning in the milieu to complete psychosocial interview. She is a transitioned or transitioning male to female individual who reports coming to this hospital "for a psychiatric interview and to have a warm place to spend the night." Her tone is very entitled and accusatory. She was guarded but aggressive in her tone with writer. She is accusing her psychiatrist of not being a real psychiatrist, making suggestive remarks about the unit being unprofessional and her legal status being that she is being held here against her will. She states that she sees Kevin Field privately for therapy for about the last 3-4 years and that this has been a good relationship and she would welcome writer speaking to him about her although she becomes paranoid about the ROI and refuses to sign it. When asked if she give verbal permission she states, "yes". Otherwise the only information obtained from Anne Rose is that she owns and operates a software company since 1994 and a phone company. She also talks about being acquitted of criminal insanity in 1997 and being discharged by the Office of Mental Health in 2012 but does not provide any further information that makes sense to this writer. Anne Rose has put in a court request for a hearing. Dr. Rahman has been informed that this request is in. Writer will speak with Anne Rose one more time prior

Continued on Page 43

to forwarding the court request information to the attorney's. Psychosocial complete.

Initialized on 12/26/16 11:50 - END OF NOTE

12/26/16 05:02 Nursing Note by Brown,Michele

Patient initially appeared to be resting comfortably at long interval. Awoke and requesting nicotine inhaler around 0240. Patient calm and cooperative, will not wear ID band as it identifies her as male. Denied complaints. Remains awake, occasionally pacing around the unit, sometimes lying in her bed. Sometimes speaking to others about his extensive computer training and knowledge and other times speaking loudly to herself.

It was heard she said something along the lines of addressing the fact that there is "no security" here and speaking to herself about how there is a simple lock on the exit door.

Currently resting in her room.

Initialized on 12/26/16 05:02 - END OF NOTE

12/25/16 21:01 Nursing Note by Taylor,Steven
1100-2300 Bonze presents as alert and oriented to person only. Pt is noted to have pressured speech and disorganized in thought content as evident by pt talking at a very fast rate about not being on the mental health unit and how none of the staff on the unit are actually RN's when they are were identification badges stating they are. Pt was noted to tell Dr Rahman that he is not a Psychiatrist and was using profanity in a loud tone while doing so. Pt was noted to be seclusive to self and was seen and overheard talking to self about the, "Cyber war" that he is caught up in and on occasion interacting with invisible things. Pt has declined all medications offered and groups. Pt has been in behavioral control, was safe on all visual checks, will continue to monitor.

Initialized on 12/25/16 21:01 - END OF NOTE

12/25/16 05:56 Nursing Note by Brown,Michele

Patient received from Flex via stretcher, calm and cooperative. Speaks of government desire to kill her d/t knowledge she has regarding coding ~~and decoding cell phones.~~ Denies pain. Patient intermittently reports feeling anxious and agitated d/t not having her clothing at this time. Patient also reports all water obtained from the city is poisoned, but she is currently drinking coffee.

TRUE: DROUGHT and LOCAL Water Crisis of 2016 / TOMPKINS COUNTY

Initialized on 12/25/16 05:56 - END OF NOTE

12/25/16 05:06 Nursing Note by Hardy,Gregg

FALSE

ADMIT NOTE: 60YO M TO F TRANSGENDER PT HX: BIPOLAR D/O, MANIC W/ PSYCHOSIS, R/O SCHIZOPHRENIA, BORDERLINE PERS D/O, PTSD; BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR MHE. PT CALM/COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL

Continued on Page 44

DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN DUE TO HIS MENTAL ILLNESS. PT DENIES SI, HI,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "I'M ONE OF THE GOOD GUYS IN SOFTWARE AND BAD GUYS ARE TRYING TO KILL ME". PT ALSO STATES: "CROOKS IN THE FEDERAL GOVM'T ARE TRYING TO KILL ME". PT REMAINED HYPERVERBAL AND AGITATED THROUGHOUT EVAL. PT DENIED ANY CURRENT OUTPT MH TRTMT, OTHER THAN SESSIONS W/ DR KEVIN FIELDS - LAST ONE BEING APPROX 2MOS AGO. PT ALSO DENIES ANY CURRENT HOME MEDS. STATES ONLY CURRENT PROVIDER IS PCP - DR BREIMEN. PT VASCILLATES BTWN REQUESTING ADMIT AND STATING DESIRE TO BE D/C'd. PER PSYCHIATRIST, INVOL ADMIT DEEMED APPROP FOR THIS PT. LEGAL PAPERS SIGNED, S&R GIVEN, PT IN PAPER SCRUBS, TRANS TO UNIT VIA STRETCHER, ACCOMPANIED BY SECURITY W/O INCIDENT, ORIENTED TO UNIT AND RM, PT TRANSFERRED TO BED, CHARGE RN MICHELLE GREETED AND ASSUMED CARE OF PT AND WILL CONT TO MONITOR FOR SAFETY AND MENTAL STATUS.

TRUE

Initialized on 12/25/16 05:06 - END OF NOTE

12/25/16 05:00 (created 12/25/16 05:04) ED Nursing Note by Cunningham,Rebecca

Pt to the MHU via MHE. Pt stable.

Initialized on 12/25/16 05:04 - END OF NOTE

12/25/16 03:30 (created 12/25/16 05:04) ED Nursing Note by Cunningham,Rebecca

Pt is resting quietly. To monitor.

Initialized on 12/25/16 05:04 - END OF NOTE

12/25/16 02:30 (created 12/25/16 05:04) ED Nursing Note by Cunningham,Rebecca

MHE remains with pt. To monitor.

Initialized on 12/25/16 05:04 - END OF NOTE

12/25/16 01:35 (created 12/25/16 01:53) ED Nursing Note by Cunningham,Rebecca

Pt with loud outburst directed at MHE, angry that he was awakened for the evaluation. Security called, with pt eventually settling down and becoming cooperative with the evaluation.

Initialized on 12/25/16 01:53 - END OF NOTE

12/25/16 01:15 (created 12/25/16 01:57) ED Nursing Note by Cunningham,Rebecca
Pt is apparently sleeping at this time. To monitor.

Initialized on 12/25/16 01:57 - END OF NOTE

12/25/16 00:18 ED Nursing Note by Laue,Elizabeth

Continued on Page 45

PT CLEAR FOR MHE

Initialized on 12/25/16 00:18 - END OF NOTE

12/24/16 23:05 (created 12/25/16 00:35) ED Nursing Note by Cunningham,Rebecca

ED tech is in with pt at this time.

Initialized on 12/25/16 00:35 - END OF NOTE

12/24/16 22:50 (created 12/25/16 00:32) ED Nursing Note by Cunningham,Rebecca

Pt to room 6 via EMS, stating that he is here for a voluntary MHE. Pt states that he has PTSD, and is concerned, as he has " nowhere to go" and that he " doesn't want to freeze tonight". Pt denies SI/HI. Pt is transgender, states that he has had years of issues with gender dysphonia. Much reassurance provided. VSS. Pt cooperative. Procedure for MHE given to pt, pt understanding. ED tech made aware to convert room to safe room, have pt changed into paper scrubs, and obtain urine/labs.

Initialized on 12/25/16 00:32 - END OF NOTE

Orders

01/01/17 07:17
chlorproMAZINE INJ* [thoraZINE INJ*] 100 mg .ROUTE .STK-MED ONE

01/01/17 07:18
chlorproMAZINE TAB* [Thorazine TAB*] 100 mg .ROUTE .STK-MED ONE

01/05/17 15:00
Ziprasidone * [Geodon (generic) *] 40 mg PO DAILY
Ziprasidone IM INJ* [Geodon IM INJ*] 10 mg IM DAILY PRN

01/09/17 12:58
Ziprasidone IM INJ* [Geodon IM INJ*] 20 mg IM DAILY PRN

01/10/17 09:00
Ziprasidone CAP* [Geodon CAP*] 80 mg PO DAILY

01/11/17 13:53
Observation: q30 minutes QSHIFT
Physician Instructions:

01/12/17 11:12
Nicotine Inhaler* 10 mg .ROUTE .STK-MED ONE

01/18/17 09:00
Ziprasidone * [Geodon (generic) *] 40 mg PO DAILY

Continued on Page 46

Ziprasidone CAP* [Geodon CAP*] 80 mg PO DAILY

01/18/17 10:43
Ziprasidone IM INJ* [Geodon IM INJ*] 30 mg IM DAILY PRN

01/19/17 09:59
Ziprasidone IM INJ* [Geodon IM INJ*] 30 mg IM BEDTIME PRN

01/20/17 21:00
Ziprasidone * [Geodon (generic) *] 40 mg PO BEDTIME
Ziprasidone CAP* [Geodon CAP*] 80 mg PO BEDTIME
Ziprasidone IM INJ* [Geodon IM INJ*] 30 mg IM BEDTIME PRN

01/22/17 23:27
Haloperidol TAB* [Haldol TAB*] 5 mg .ROUTE .STK-MED ONE
diPHENhydraMINE PO* [Benadryl PO*] 50 mg .ROUTE .STK-MED ONE

01/25/17 10:51
Ziprasidone IM INJ* [Geodon IM INJ*] 30 mg IM BEDTIME PRN

01/25/17 21:00
Paliperidone TAB* [Invega TAB*] 6 mg PO BEDTIME

01/26/17
Pastoral Care Consult [Chaplain Consult - Patient Visit] Routine
Comment: Requests Tim Dean
Physician Instructions:

02/02/17 10:52
Patient Privileges QSHIFT
Physician Instructions: computer privileges per nursing limits

02/07/17 11:00
Paliperidone SUSTENNA* [Invega Sustenna*] 234 mg IM ONCE ONE

02/10/17
Discharge Patient From System Routine
Comment:
Actual Time of Discharge:: 11:10
Discharge Disposition: HOME

02/10/17 08:31
Discharge Routine
Comment:
Anticipated time of Discharge: 0900
Discharge Disposition:: HOME

02/10/17 09:00
Paliperidone SUSTENNA* [Invega Sustenna*] 156 mg IM ONCE ONE

12/24/16 23:25
Drug Screen UR ED/Pain Clinic Stat

Continued on Page 47

Comment:
Specimen: Has been collected
Urinalysis w/Refl Micro/Cult Stat
Specimen: Has been collected

12/24/16 23:40
Acetaminophen [CHEM] Stat
Comment:
Specimen: Has been collected
Alcohol [CHEM] Stat
Comment:
Specimen: Has been collected
CBC Auto Diff Stat
Comment:
Specimen: Has been collected
Comprehensive Metabolic Panel [CHEM] Stat
Comment:
Specimen: Has been collected
Salicylate [CHEM] Stat
Comment:
Specimen: Has been collected
TSH (Thyroid Stimulating Horm) [CHEM] Stat
Comment:
Specimen: Has been collected

12/25/16 05:35
Acetaminophen TAB* [Tylenol TAB*] 650 mg PO Q4H PRN
Al Hydrox/Mg Hydrox/Simet LIQ* [Maalox Plus*] 30 ml PO Q4H PRN
Mouth Piece, Nicotine* [Nicotine Mouth Piece*] 1 each INH .CARTRIDGE
Nicotine GUM* 2 mg PO Q2H PRN
Nicotine Inhaler* 10 mg INH Q2H PRN

12/25/16 09:00
Nicotine PATCH 21 MG/24 HR* 1 patch TRANSDERM DAILY
Spironolactone TAB* [Aldactone TAB*] 50 mg PO DAILY
Vitamin THERAPEUTIC TAB* [Theragran TAB*] 1 tab PO DAILY
risperiDONE-M * [Risperdal-M Tab *] 1 mg PO DAILY

12/25/16 09:53
Mouth Piece, Nicotine* [Nicotine Mouth Piece*] 1 each .ROUTE .STK-MED ONE

12/25/16 21:00
Nicotine Patch Removal NOTE* 1 note PATCH OFF 2100

Laboratory Information

	12/24/16 23:25	12/24/16 23:25	12/24/16 23:40
WBC			19.1 H

Continued on Page 48

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Laboratory Information - Continued

RBC			4.54
Hgb			14.2
Hct			42
MCV			93
MCH			31
MCHC			34
RDW			13
Plt Count			280
MPV			8
Neut % (Auto)			72.2
Lymph % (Auto)			17.7 L
Mono % (Auto)			7.2
Eos % (Auto)			1.7
Baso % (Auto)			1.2
Absolute Neuts (auto)			13.8 H
Absolute Lymphs (auto)			3.4
Absolute Monos (auto)			1.4 H
Absolute Eos (auto)			0.3
Absolute Basos (auto)			0.2
Absolute Nucleated RBC			0.01
Nucleated RBC %			0
Sodium			
Potassium			
Chloride			
Carbon Dioxide			
Anion Gap			
BUN			
Creatinine			
Est GFR (African Amer)			
Est GFR (Non-Af Amer)			
BUN/Creatinine Ratio			
Glucose			
Calcium			
Total Bilirubin			
AST			
ALT			
Alkaline Phosphatase			
Total Protein			
Albumin			
Globulin			
Albumin/Globulin Ratio			
TSH			
Urine Color	Yellow		
Urine Appearance	Clear		
Urine pH	5.0		
Ur Specific Gravity	1.012		
Urine Protein	Negative		
Urine Ketones	Negative		
Urine Blood	Negative		
Urine Nitrate	Negative		
Urine Bilirubin	Negative		

Continued on Page 49

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center   Loc:BEHAVIORAL SERVICES UNIT   Bed:202-01

60 F 05/01/1956   Med Rec Num:M000597460   Visit:A00082793308

Laboratory Information - Continued

Urine Urobilinogen	Negative		
Ur Leukocyte Esterase	Negative		
Urine Glucose	Negative		
Salicylates			
Urine Opiates Screen		None detected	
Acetaminophen			
Ur Barbiturates Screen		None detected	
Ur Phencyclidine Scrn		None detected	
Ur Amphetamines Screen		None detected	
U Benzodiazepines Scrn		None detected	
Urine Cocaine Screen		None detected	
U Cannabinoids Screen		None detected	
Serum Alcohol			

	12/24/16 23:40
WBC	
RBC	
Hgb	
Hct	
MCV	
MCH	
MCHC	
RDW	
Plt Count	
MPV	
Neut % (Auto)	
Lymph % (Auto)	
Mono % (Auto)	
Eos % (Auto)	
Baso % (Auto)	
Absolute Neuts (auto)	
Absolute Lymphs (auto)	
Absolute Monos (auto)	
Absolute Eos (auto)	
Absolute Basos (auto)	
Absolute Nucleated RBC	
Nucleated RBC %	
Sodium	136
Potassium	4.2
Chloride	102
Carbon Dioxide	28
Anion Gap	6
BUN	19
Creatinine	0.76
Est GFR (African Amer)	134.5
Est GFR (Non-Af Amer)	104.6
BUN/Creatinine Ratio	25.0 H
Glucose	93
Calcium	9.3
Total Bilirubin	0.30

Continued on Page 50

LEGAL RECORD COPY - DO NOT DESTROY

Laboratory Information - Continued

Test	Result
AST	20
ALT	29
Alkaline Phosphatase	98
Total Protein	7.0
Albumin	4.1
Globulin	2.9
Albumin/Globulin Ratio	1.4
TSH	1.95
Urine Color	
Urine Appearance	
Urine pH	
Ur Specific Gravity	
Urine Protein	
Urine Ketones	
Urine Blood	
Urine Nitrate	
Urine Bilirubin	
Urine Urobilinogen	
Ur Leukocyte Esterase	
Urine Glucose	
Salicylates	< 2.50
Urine Opiates Screen	
Acetaminophen	< 15
Ur Barbiturates Screen	
Ur Phencyclidine Scrn	
Ur Amphetamines Screen	
U Benzodiazepines Scrn	
Urine Cocaine Screen	
U Cannabinoids Screen	
Serum Alcohol	< 10

ED Visit information

Last Name: BLAYK
First Name: BONZE
Middle: ANNE ROSE
Birthdate: 05/01/1956
Age: 60
Sex: F
Language: ENGLISH

Status: Rm Ready
Priority: 2 - HIGH RISK
Condition: Improved
Arrival Date/Time: 12/24/16 22:47
Arrival Mode: BANGS AMBULANCE
Triaged At: 12/24/16 22:50
Time Seen by Provider: 12/24/16 22:51

Stated Complaint: MHE
Chief Complaint: EDMentalHealth

ED Location: Emergency Department
Area:
Station:
Group:
ED Provider: Shenker,David
ED Midlevel Provider:
ED Nurse:
Primary Care Provider:

Continued on Page 51

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

ED Visit information - Continued

Status/Phase	DtTm/Value	User/Action
Rm Ready	02/10/17 10:34:33	Priestley,Hannah J
Referrals (Outside Location)	Cayuga Ctr For Healthy Living	Edit
	02/10/17 10:15:14	Bliss,Alison
Referrals (Outside Location)	TOMPKINS CNTY MENTAL HLTH CTR	Edit
	02/09/17 14:23:21	Bliss,Alison
Referrals (Outside Location)	Cayuga Ctr For Healthy Living	Added
	02/09/17 14:23:08	Bliss,Alison
Referrals (Outside Location)	TOMPKINS CNTY MENTAL HLTH CTR	Edit
	02/09/17 14:22:55	Bliss,Alison
Referrals (Outside Location)	TOMPKINS CNTY MENTAL HLTH CTR	Added
Departed	12/25/16 04:49:50	Goldrick,Cynthia
Attending Provider	Mafuzur Rahman MD	New
Admitting Provider	Mafuzur Rahman MD	New
Prov in Room	12/24/16 22:51:49	Shenker,David
Ed Provider	David Shenker MD	New
MHU Evaluation	12/24/16 22:50	Cunningham,Rebecca
Chief Complaint	EDMentalHealth	New
Received	12/24/16 22:47:55	Goldrick,Cynthia
Stated Complaint	MHE	New

Procedures

GROUP PSYCHOTHERAPY (12/25/16)
INDIVIDUAL PSYCHOTHERAPY, COGNITIVE-BEHAVIORAL (12/25/16)
OTHER LOCAL DESTRUC SKIN (02/09/94)

Initial Vital Signs

Continued on Page 52

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Initial Vital Signs - Continued

	Temp	Pulse	Resp	BP	Pulse Ox
02/09/17 11:06			16		
02/08/17 09:41			16		
02/08/17 08:58			16		
02/07/17 12:57			16		
02/07/17 09:06			18		
02/06/17 12:54			16		
02/05/17 13:12			16		
02/04/17 11:57			16		
02/03/17 13:08			16		
02/02/17 11:10			16		
02/01/17 14:25			16		
01/31/17 13:48			16		
01/30/17 11:21			16		
01/29/17 09:46			16		
01/28/17 14:22			16		
01/26/17 10:57			16		
01/25/17 09:37			16		
01/24/17 10:36			16		
01/24/17 07:49	99.0 F	87	16	159/97	97
01/23/17 10:16			16		
01/23/17 01:28			16		
01/22/17 23:28			16		
01/22/17 13:15			16		
01/22/17 09:35			16		
01/21/17 13:32			16		
01/20/17 15:19			18		
01/19/17 09:21			16		
01/18/17 13:05			16		
01/18/17 11:45			16		
01/18/17 11:16			16		
01/18/17 08:00			16		
01/17/17 10:41			14		
01/16/17 10:12			16		
01/14/17 13:32			16		
01/13/17 08:46			16		
01/13/17 08:00			16		
01/12/17 11:26			16		
01/11/17 10:41			16		
01/10/17 11:48			16		
01/10/17 07:51			18		
01/09/17 11:08			16		
01/08/17 13:23			18		
01/06/17 10:20			16		
01/06/17 08:09			16		
01/05/17 10:17			16		
01/04/17 10:48			16		
01/03/17 10:37			16		
01/02/17 14:10			16		
01/01/17 10:33			16		
01/01/17 08:28			16		

Continued on Page 53

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01

60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Initial Vital Signs - Continued

01/01/17 07:28			16		
12/31/16 11:25			18		
12/30/16 14:26			16		
12/30/16 08:30			17		
12/29/16 10:10			16		
12/28/16 10:14			16		
12/27/16 12:42			20		
12/26/16 13:13			20		
12/26/16 10:39			16		
12/25/16 20:07			18		
12/25/16 05:50			16		
12/24/16 22:50	98.5 F	90	16	171/96	94

Last Documented Vital Signs

Continued on Page 54

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Last Documented Vital Signs - Continued

	Temp	Pulse	Resp	BP	Pulse Ox
02/09/17 11:06			16		
02/08/17 09:41			16		
02/08/17 08:58			16		
02/07/17 12:57			16		
02/07/17 09:06			18		
02/06/17 12:54			16		
02/05/17 13:12			16		
02/04/17 11:57			16		
02/03/17 13:08			16		
02/02/17 11:10			16		
02/01/17 14:25			16		
01/31/17 13:48			16		
01/30/17 11:21			16		
01/29/17 09:46			16		
01/28/17 14:22			16		
01/26/17 10:57			16		
01/25/17 09:37			16		
01/24/17 10:36			16		
01/24/17 07:49	99.0 F	87	16	159/97	97
01/23/17 10:16			16		
01/23/17 01:28			16		
01/22/17 23:28			16		
01/22/17 13:15			16		
01/22/17 09:35			16		
01/21/17 13:32			16		
01/20/17 15:19			18		
01/19/17 09:21			16		
01/18/17 13:05			16		
01/18/17 11:45			16		
01/18/17 11:16			16		
01/18/17 08:00			16		
01/17/17 10:41			14		
01/16/17 10:12			16		
01/14/17 13:32			16		
01/13/17 08:46			16		
01/13/17 08:00			16		
01/12/17 11:26			16		
01/11/17 10:41			16		
01/10/17 11:48			16		
01/10/17 07:51			18		
01/09/17 11:08			16		
01/08/17 13:23			18		
01/06/17 10:20			16		
01/06/17 08:09			16		
01/05/17 10:17			16		
01/04/17 10:48			16		
01/03/17 10:37			16		
01/02/17 14:10			16		
01/01/17 10:33			16		
01/01/17 08:28			16		

Continued on Page 55

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Last Documented Vital Signs - Continued

01/01/17 07:28			16		
12/31/16 11:25			18		
12/30/16 14:26			16		
12/30/16 08:30			17		
12/29/16 10:10			16		
12/28/16 10:14			16		
12/27/16 12:42			20		
12/26/16 13:13			20		
12/26/16 10:39			16		
12/25/16 20:07			18		
12/25/16 05:50			16		
12/24/16 22:50	98.5 F	90	16	171/96	94

Assessments and Treatments

ADLs: Meal Record Start: 12/25/16 05:12
Freq: Status: Discharge
Document 01/21/17 20:11 ROB0100 (Rec: 01/21/17 20:12 ROB0100 CMC-RDC2)
ADLs: Meal Record
General Information
Is Patient NPO? No
Does the Patient Require Assistance to Eat? No
Meal
Meal Dinner
Percent of Meal Consumed 100

Admission 01: General/Advance Directives Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Admission Data
Admission Data
Information Obtained From Patient
Swing Patient No
Patient Wearing Medication Patch No
Valuables Form Completed Yes
Valuables Placed in Safe Yes
Does Patient Have Own Meds with Them No
Patient Rights Booklet Given? Yes
Advance Directives
Advance Directives
Code Status Full Code
Code Status Requires Follow Up? N
Advance Directives Location No Advance Directives
Height/Weight
Height/Weight
Height 5 ft 7 in
Weight 150 lb
Actual/Estimated Weight Stated
Weight Comment -
Body Mass Index (BMI) 23.5

Admission 02: Infection/Isolation Assess Start: 12/25/16 05:12

Continued on Page 56

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)

Infectious Disease History
 Infectious Disease- History
  Traveled Outside the US in Last 30 Days — No
  Infectious Disease History — No
Infectious Disease - Active/Suspected
 Infectious Disease - Active/Suspected
  Active/Suspected Infectious Disease — No
Isolation and MRSA Assessment
 MRSA Assessment Status
  MRSA Assessment — No Update Needed
   Query Text:
   -No Update Needed: When isolation items have not changed since last documentation
   -Update Needed: Upon arrival or if isolation items have changed during stay
   -Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
 Isolation Assessment
  Reason for Isolation — None
  Type of Isolation — Standard Precautions
 Isolation Summary
  Does Patient Require Isolation — No

Admission 03: Vaccination Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)

Vaccine Status
 Vaccine Status
  Is Patient Able to Be Assessed for Vaccine Status — Yes
   Query Text:If no, document reason in comment below and click "Save."
Vaccinations
 Vaccination History
  Most Recent Tetanus Shot — Unsure
  Most Recent Varicella Vaccination — Unsure
Pneumococcal Vaccination Assessment
 Last Pneumococcal Vaccination
  Most Recent Pneumonia Vaccination — Unsure
 1. Pneumococcal Vaccine - Risk Assessment
  Patient Is — 5-64 Years of Age
  Patient is Age 5-64 and Has Any of the Following High Risk Conditions — None
 2. Pneumococcal Vaccine - Vaccination Status or Contraindications
  Pneumococcal Vaccine Contraindications — N/A (Vaccine Already Not Indicated Based on Age/Risk Assessment)
 3. Pneumococcal Vaccine - Indication
  Pneumococcal Vaccine — Not Indicated
Influenza Vaccination Assessment

Continued on Page 57

Assessments and Treatments - Continued

Last Influenza Vaccination
Most Recent Influenza Vaccination — Unsure
1. Influenza Vaccine (September 1st-March 31st Only) - Vaccination Status or Contraindications
Influenza Vaccine Contraindications — None
2. Influenza Vaccine - Indication
Influenza Vaccine — Indicated
3. Influenza Vaccine - Vaccination Decision
Influenza Decision — Patient/Health Care Proxy Refuses
Query Text:**For patients 3 through 8 years of age, follow up with pharmacy for dosing frequency instructions.**
Provide patient with appropriate Vaccine Information Statement (VIS).
If patient consents:
- Complete Administration Record (Form # 12007) and send order to Pharmacy.
- Document vaccine adminstration on paper record AND on eMAR.
If patient refuses:
- Complete Adminstration Record (Form # 12007) and document "Patient Refuses" below.

Admission 04: Pain Assess — Start: 12/25/16 05:12
Freq: — Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Pain History
Pain History
Hx Chronic Pain — No

Admission 05: Neurological Assess — Start: 12/25/16 05:12
Freq: — Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Neurological History
Neurological History
Neurological History — Yes
Other Neuro Impairments/Disorders — Yes: States history of temporal lobe epilepsy, no seizures
Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16

Continued on Page 58

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Admission 06: Sensory Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Sensory
Sensory Impairments And Aides
Sensory Impairment Yes
Use of Contacts/Glasses Yes: Glasses

Admission 07: Cardiovascular Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Cardiovascular History
Cardiovascular History
Cardiovascular History Yes
Hx Hypertension Yes
Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.

Continued on Page 59

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Admission 08: Respiratory Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Respiratory History
Respiratory History
Respiratory History No
Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Tobacco Use
Tobacco Cessation Assessment
Smoking Status (MU) Current Every Day Smoker
Query Text:**Smoker Definition (current or former): has smoked at least 100 cigarettes (5 packs) or cigar or pipe smoke equivalent during his/her lifetime .**
Amount Used/How Often 2ppd
Household Exposure Type Cigarettes
Tobacco Cessation Information Provided Patient Declined

Admission 09: GI/GU Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
GI History
GI History
GI History No
Nutrition History
Nutrition
A nutrition consult must be entered if any of the questions below are "Yes ."
Nutrition History Able to Obtain
Ongoing Unintentional Weight Loss No
Severe Decrease in Oral Intake Longer than 1 Week No
Evidence of Difficulty Swallowing No
Evidence of Difficulty Chewing No
Gastrointestinal Assessment
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or

Continued on Page 60

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

vomiting.

Genitourinary History
GU History
GU History — No

Genitourinary Assessment
GU Assessment
Genitourinary Assessment Within Normal Limits — Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Admission 10: Skin Assess — Start: 12/25/16 05:12
Freq: — Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)

Skin Assessment
Skin Assessment
4 Eye Skin Assessment Completed by Person #1 — Niver,Brandy L
4 Eye Skin Assessment Completed by Person #2 — Brown,Michele
4 Eye Skin Result — Skin Intact

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Assessment Provider Communication
Provider Notification for Skin Breakdown
Is there Existing Pressure-Related Skin Breakdown — No

Admission 12: Mobility/Musculoskeletal — Start: 12/25/16 05:12
Freq: — Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)

Musculoskeletal History
Musculoskeletal History
Musculoskeletal History — No

Mobility Assessment
Mobility Assessment

Continued on Page 61

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Known Mobility Impairments                No
Admission 13: Safety Assess                               Start:  12/25/16 05:12
Freq:                                                     Status: Complete
 Document    12/25/16 05:50  MIC0258  (Rec: 12/25/16 05:56  MIC0258  BSU-C03)
 Safety/Fall Risk Assessment
     Safety/Fall Risk Assessment
       Mental Status                            Oriented to Own Ability
       Patient Is Willing and Able to Assist in  Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last  No
        12 Months)
       Age                                      Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication     No
        Administered
       Bladder/Bowel Incontinence               No
       Attached Equipment (Lines/Tubes/Etc)      No
       Secondary Diagnosis (2 or More Medical    No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    0
       Fall Risk - Calculated                   Low
       Fall Risk - Determined by RN             Low
        Query Text:**  DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Admission 14: Endocrine/Hematology                        Start:  12/25/16 05:12
Freq:                                                     Status: Complete
 Document    12/25/16 05:50  MIC0258  (Rec: 12/25/16 05:56  MIC0258  BSU-C03)
 Endocrine
     Endocrine/Hematology History
       Endocrine/Hematological Disorders        No
Admission 15: Diabetes Assess                             Start:  12/25/16 05:12
Freq:                                                     Status: Complete
 Document    12/25/16 05:50  MIC0258  (Rec: 12/25/16 05:56  MIC0258  BSU-C03)
 Diabetes
     Diabetes Education/Care
       Is Patient Diabetic                      No
Admission 16: Surgical/Cancer Assess                      Start:  12/25/16 05:12
Freq:                                                     Status: Complete
 Document    12/25/16 05:50  MIC0258  (Rec: 12/25/16 05:56  MIC0258  BSU-C03)
 Surgical/Cancer
     Surgical History
       Surgical History                         Yes
       Surgery Procedure, Year, and Place       Left inguinal hernia repair
     Cancer History
       Hx Cancer                                None
Admission 17: Psychiatric/Psychosocial                    Start:  12/25/16 05:12
```

Continued on Page 62

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Psychiatric/Psychosocial History
Psychiatric/Psychosocial History
Psychiatric/Psychosocial History Yes
Hx Post Traumatic Stress Disorder Yes
Other Psychiatric Issues/Disorders Yes: Transsexualism
Psychosocial Assessment
Psychosocial Assessment
Patient's Psychosocial/Emotional Status Appropriate to Situation
Calm
Alcohol Use None
Recreational/Excessive Substance Use Marijuana
Synthetic Drugs
Abuse Screening Assessment None
Alcohol Use Disorders Identification Test
Blood Alcohol Content
BAC Greater Than or Equal to 100 No
Query Text:Answer "No" if not tested.
AUDIT Screening
How Often Do You Have a Drink Containing Alcohol Never
How Many Drinks Containing Alcohol Do You Have on a Typical Day When You Are Drinking Non-Drinker
How Often Do You Have Six or More Drinks on One Occasion Never
How Often During the Last Year Have You Found You Were Not Able to Stop Drinking Once You Had Started Never
How Often During the Last Year Have You Failed to Do What Was Normally Expected From You Because of Drinking Never
How Often During the Last Year Have You Needed a First Drink in the Morning to Get Yourself Going After a Heavy Drinking Session Never
How Often During the Last Year Have You Had a Feeling of Guilt or Remorse After Drinking Never
How Often During the Last Year Have You Been Unable to Remember What Happened the Night Before Because You Had Been Drinking Never
Have You/Someone Else Been Injured as a Result of Your Drinking No
Has a Relative or Friend, or a Doctor or Other Health Worker, Been Concerned About Your Drinking or Suggested You Cut Down No
AUDIT Total 0
MICA
MICA Yes

Continued on Page 63

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Admission 18: Spiritual/Cultural Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Spiritual History
Spiritual History
Religion — Nonreligious Affliation
Cultural Needs Assessment
Cultural Needs Assessment
Cultural Beliefs to Consider that Would Affect Care — No

Admission 19: Education Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Education
Education Assessment
Patient
Barriers to Learning — None
Preferred/Primary Language — English

Admission 20: Discharge Assess Start: 12/25/16 05:12
Freq: Status: Complete
Document 12/25/16 05:50 MIC0258 (Rec: 12/25/16 05:56 MIC0258 BSU-C03)
Discharge
Discharge
Patient Lives with — Self

Assessment 01: Neurological Start: 12/25/16 05:12
Freq: Status: Discharge
Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Strength Assessment
Assess with Strength Assessment Scale — Yes
Strength/Range of Motion — Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 18
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator

Continued on Page 64

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness — Awake
Alert

Speech/Swallowing Assessment

Speech Pattern — Pressured

Strength Assessment

Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 20

Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous

Continued on Page 65

(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness — Awake
Alert
Strength Assessment
Strength/Range of Motion — Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 20
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens

Continued on Page 66

with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits Yes

Query Text:Within normal limits: Patient
is awake, alert and oriented to person,
place, time, and situation. Pupils are
equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate 16

Agitation/Sedation Score (0) Alert/Calm

Query Text:(4) COMBATIVE: Overly
combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has
sustained awakening (eye-opening/eye
contact) to voice - VERBAL STIMULATION (
greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens
with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Continued on Page 67

Assessments and Treatments - Continued

Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Speech/Swallowing Assessment
Speech Pattern — Clear
Any Evidence of Chewing or Swallowing Difficulties — No
Strength Assessment
Strength/Range of Motion — Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Agitation/RASS Intervention — No Intervention Required

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Assessment/Reassessment: +Neurological
Neurological Assessment

Continued on Page 68

Assessments and Treatments - Continued

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness — Awake
Alert

Speech/Swallowing Assessment

Speech Pattern — Clear

Any Evidence of Chewing or Swallowing Difficulties — No

Strength Assessment

Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 16

Agitation/Sedation Score — (0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal — Yes

Continued on Page 69

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Limits
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Patient Behavior	Anxious Inappropriate Other
Patient Behavior Comment	Irritable
Is Patient Dizzy	No

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation

Respiratory Rate	18
Agitation/Sedation Score	(2) Agitated

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention	No Intervention Required

Document 01/01/17 10:33 JOH0022 (Rec: 01/01/17 10:40 JOH0022 BSU-C12)
Assessment/Reassessment: +Neurological
Neurological Assessment

Neurological Assessment within Normal Limits	Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are

Continued on Page 70

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate 16

Agitation/Sedation Score (-3) Moderate Sedation

Query Text:(4) COMBATIVE: Overly
combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has
sustained awakening (eye-opening/eye
contact) to voice - VERBAL STIMULATION (
greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens
with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Agitation/RASS Intervention No Intervention Required

Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits Yes

Query Text:Within normal limits: Patient
is awake, alert and oriented to person,
place, time, and situation. Pupils are
equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.

Strength Assessment

Strength/Range of Motion Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Continued on Page 71

Assessments and Treatments - Continued

Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/03/17 10:37 JOH0022 (Rec: 01/03/17 11:14 JOH0022 BSU-M10)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness Awake
Alert
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (1) Restless
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful

Continued on Page 72

movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/04/17 10:48 BAR0006 (Rec: 01/04/17 10:54 BAR0006 BSU-M03)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes

Speech/Swallowing Assessment

Speech Pattern	Clear Rambling
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube

Continued on Page 73

(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)
Assessment/Reassessment: +Neurological

Neurological Assessment

Item	Value
Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert
Patient Behavior	Inappropriate
Patient Behavior Comment	pt irritable this AM at the medication window, flipped writer off
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes

Speech/Swallowing Assessment

Item	Value
Speech Pattern	Clear Pressured Rambling
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Item	Value
Strength/Range of Motion	Within Functional Limits

Continued on Page 74

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Agitation/RASS Intervention No Intervention Required

Document 01/06/17 10:20 BAR0006 (Rec: 01/06/17 10:25 BAR0006 BSU-M10)

Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness Awake
Alert
Patient Behavior Inappropriate
Patient Behavior Comment pt irritable this AM at the medication window, flipped writer off
Is Patient Dizzy No
Pupils Equal and Appropriate for Lighting Yes

Continued on Page 75

Assessments and Treatments - Continued

Speech/Swallowing Assessment

Speech Pattern	Clear Pressured Rambling
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(2) Agitated

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention	No Intervention Required

Document 01/08/17 13:23 JOH0022 (Rec: 01/08/17 13:36 JOH0022 BSU-C12)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Speech/Swallowing Assessment

Continued on Page 76

Assessments and Treatments - Continued

Any Evidence of Chewing or Swallowing Difficulties — No

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 18

Agitation/Sedation Score — (1) Restless

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/09/17 11:08 JOH0022 (Rec: 01/09/17 11:14 JOH0022 BSU-C12)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness — Awake
Alert

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 16

Agitation/Sedation Score — (1) Restless

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger

Continued on Page 77

to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has
sustained awakening (eye-opening/eye
contact) to voice - VERBAL STIMULATION (
greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens
with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient
is awake, alert and oriented to person,
place, time, and situation. Pupils are
equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly
combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has

Continued on Page 78

sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Speech/Swallowing Assessment

Speech Pattern	Clear Excessive
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(1) Restless

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)

Continued on Page 79

(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice, but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 16

Agitation/Sedation Score — (1) Restless

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice, but movement or eye opening to PHYSICAL STIMULATION

Continued on Page 80

(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Patient Behavior Comment	paranoid and delusional/ inappropriate and angry

Speech/Swallowing Assessment

Speech Pattern	Excessive Perseverating Pressured
Any Evidence of Chewing or Swallowing Difficulties	No
Speech Comment	loud/shouting at times

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to

Continued on Page 81

PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention	No Intervention Required
Agitation/RASS Comment	calm/in control right now, angry and shouting at select staff this morning

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4

Query Text:For pediatric patients A&O x 4 as appropriate for age.

Patient Behavior Comment	paranoid and delusional/ inappropriate and angry
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes

Speech/Swallowing Assessment

Speech Pattern	Excessive Perseverating Pressured
Any Evidence of Chewing or Swallowing Difficulties	No
Speech Comment	loud/shouting at times

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or

Continued on Page 82

vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 16

Agitation/Sedation Score — (-1) Drowsy

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)

Continued on Page 83

(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 14
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Assessment/Reassessment: +Neurological

Continued on Page 84

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Orientation	A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.	
Patient Behavior	Anxious Cooperative Inappropriate
Is Patient Dizzy	No

Speech/Swallowing Assessment

Speech Pattern	Excessive Perseverating Pressured
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (

Continued on Page 85

but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION
Agitation/RASS Intervention No Intervention Required

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient
is awake, alert and oriented to person,
place, time, and situation. Pupils are
equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (1) Restless
Query Text:(4) COMBATIVE: Overly
combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has
sustained awakening (eye-opening/eye
contact) to voice - VERBAL STIMULATION (
greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens
with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Document 01/20/17 15:19 KER0050 (Rec: 01/20/17 15:43 KER0050 BSU-C12)
Assessment/Reassessment: +Neurological
Neurological Assessment

Continued on Page 86

Assessments and Treatments - Continued

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 18

Agitation/Sedation Score — (0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/21/17 13:32 ROB0100 (Rec: 01/21/17 13:35 ROB0100 CMC-RDC2)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness,

Continued on Page 87

tingling, coldness, or dizziness.
Speech/Swallowing Assessment
Speech Pattern Clear
Any Evidence of Chewing or Swallowing Difficulties No
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly

Continued on Page 88

combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has
sustained awakening (eye-opening/eye
contact) to voice - VERBAL STIMULATION (
greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens
with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient
is awake, alert and oriented to person,
place, time, and situation. Pupils are
equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.
Speech/Swallowing Assessment
Speech Pattern — Clear
Any Evidence of Chewing or Swallowing Difficulties — No
Strength Assessment
Strength/Range of Motion — Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly
combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive

Continued on Page 89

Assessments and Treatments - Continued

(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)

Assessment/Reassessment: +Neurological

Neurological Assessment

- Neurological Assessment within Normal Limits — Yes
  Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
- Level of Consciousness — Awake
  Alert
- Patient Orientation — A&O x 4
  Query Text:For pediatric patients A&O x 4 as appropriate for age.
- Patient Behavior — Cooperative

Speech/Swallowing Assessment

- Speech Pattern — Clear
- Any Evidence of Chewing or Swallowing Difficulties — No

Strength Assessment

- Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

- Respiratory Rate — 16
- Agitation/Sedation Score — (0) Alert/Calm
  Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger

Continued on Page 90

to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Behavior	Appropriate Cooperative

Speech/Swallowing Assessment

Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Continued on Page 91

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)

Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness — Awake
Alert

Strength Assessment
Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive

Continued on Page 92

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Neurological
Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes

Speech/Swallowing Assessment

Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff

Continued on Page 93

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits	Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	
Level of Consciousness	Awake Alert Appropriate
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes

Speech/Swallowing Assessment

Speech Pattern	Clear
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Continued on Page 94

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Agitation/RASS Intervention No Intervention Required

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness Awake
Alert
Appropriate
Patient Behavior Appropriate
Cooperative
Is Patient Dizzy No
Pupils Equal and Appropriate for Lighting Yes
Speech/Swallowing Assessment
Speech Pattern Clear
Any Evidence of Chewing or Swallowing No

Continued on Page 95

Difficulties
Strength Assessment
Strength/Range of Motion Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Agitation/RASS Intervention No Intervention Required
Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness Awake
Alert
Appropriate
Patient Behavior Appropriate
Cooperative
Is Patient Dizzy No

Continued on Page 96

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Pupils Equal and Appropriate for Lighting — Yes

Speech/Swallowing Assessment
Speech Pattern — Clear
Any Evidence of Chewing or Swallowing Difficulties — No

Strength Assessment
Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Agitation/RASS Intervention — No Intervention Required

Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)

Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Level of Consciousness — Awake

Continued on Page 97

Alert
Appropriate
Patient Behavior　Appropriate
Cooperative
Is Patient Dizzy　No
Pupils Equal and Appropriate for Lighting　Yes
Speech/Swallowing Assessment
Speech Pattern　Clear
Any Evidence of Chewing or Swallowing Difficulties　No
Strength Assessment
Strength/Range of Motion　Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate　16
Agitation/Sedation Score　(0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Agitation/RASS Intervention　No Intervention Required
Document　02/03/17 13:08　NAT0065　(Rec: 02/03/17 13:15　NAT0065　BSU-M07)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits　Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting.

Continued on Page 98

Assessments and Treatments - Continued

Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness	Awake Alert Appropriate
Patient Orientation Query Text:For pediatric patients A&O x 4 as appropriate for age.	Person Place Time
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes
Speech/Swallowing Assessment	
Speech Pattern	Clear Inappropriate Perseverating Pressured Rambling
Any Evidence of Chewing or Swallowing Difficulties	No
Strength Assessment	
Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION

Continued on Page 99

Assessments and Treatments - Continued

(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)

Assessment/Reassessment: +Neurological

Neurological Assessment

Item	Value
Neurological Assessment within Normal Limits Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.	Yes
Level of Consciousness	Awake Alert Appropriate
Patient Orientation Query Text:For pediatric patients A&O x 4 as appropriate for age.	Person Place Time
Patient Behavior	Appropriate Cooperative
Is Patient Dizzy	No
Pupils Equal and Appropriate for Lighting	Yes

Speech/Swallowing Assessment

Item	Value
Speech Pattern	Clear Inappropriate Perseverating Pressured Rambling
Any Evidence of Chewing or Swallowing Difficulties	No

Strength Assessment

Item	Value
Strength/Range of Motion	Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Item	Value
Respiratory Rate	16
Agitation/Sedation Score	(0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has

Continued on Page 100

sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness — Awake
Alert
Appropriate

Patient Orientation — A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.

Patient Behavior — Appropriate
Cooperative

Is Patient Dizzy — No

Pupils Equal and Appropriate for Lighting — Yes

Speech/Swallowing Assessment

Speech Pattern — Clear
Perseverating
Rambling

Any Evidence of Chewing or Swallowing Difficulties — No

Strength Assessment

Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 16

Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger

Continued on Page 101

to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness — Awake
Alert
Appropriate

Patient Orientation — A&O x 4
Query Text:For pediatric patients A&O x 4 as appropriate for age.

Patient Behavior — Appropriate
Cooperative

Is Patient Dizzy — No

Pupils Equal and Appropriate for Lighting — Yes

Speech/Swallowing Assessment

Speech Pattern — Clear
Perseverating
Rambling

Continued on Page 102

Assessments and Treatments - Continued

Any Evidence of Chewing or Swallowing Difficulties — No

Strength Assessment

Strength/Range of Motion — Within Functional Limits

Richmond Agitation Sedation Scale (RASS)

Sedation / Agitation

Respiratory Rate — 16

Agitation/Sedation Score — (0) Alert/Calm

Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Agitation/RASS Intervention — No Intervention Required

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)

Assessment/Reassessment: +Neurological

Neurological Assessment

Neurological Assessment within Normal Limits — Yes

Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.

Level of Consciousness — Awake
Alert

Patient Orientation — A&O x 4

Query Text:For pediatric patients A&O x 4 as appropriate for age.

Continued on Page 103

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Speech/Swallowing Assessment
Speech Pattern Clear
Strength Assessment
Strength/Range of Motion Within Functional Limits
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger to staff
(3) VERY AGITATED: Pulls or removes tube (s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive, but movements not aggressive or vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION
Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits Yes
Query Text:Within normal limits: Patient is awake, alert and oriented to person, place, time, and situation. Pupils are equal and size appropriate to lighting. Patient's speech is clear and appropriate with no evidence of swallowing difficulties. No numbness, tingling, coldness, or dizziness.
Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate 16
Agitation/Sedation Score (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly combative or violent, immediate danger

Continued on Page 104

to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has
sustained awakening (eye-opening/eye
contact) to voice - VERBAL STIMULATION (
greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens
with eye contact to voice - VERBAL
STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye
opening to voice - VERBAL STIMULATION (
but no eye contact)
(-4) DEEP SEDATION: No response to voice
, but movement or eye opening to
PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice
or PHYSICAL STIMULATION

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)

Assessment/Reassessment: +Neurological
Neurological Assessment
Neurological Assessment within Normal Limits — Yes
Query Text:Within normal limits: Patient
is awake, alert and oriented to person,
place, time, and situation. Pupils are
equal and size appropriate to lighting.
Patient's speech is clear and
appropriate with no evidence of
swallowing difficulties. No numbness,
tingling, coldness, or dizziness.

Richmond Agitation Sedation Scale (RASS)
Sedation / Agitation
Respiratory Rate — 16
Agitation/Sedation Score — (0) Alert/Calm
Query Text:(4) COMBATIVE: Overly
combative or violent, immediate danger
to staff
(3) VERY AGITATED: Pulls or removes tube
(s) or catheter(s); aggressive
(2) AGITATED: Frequent non-purposeful
movement, fights ventilator
(1) RESTLESS: Anxious or apprehensive,
but movements not aggressive or
vigorous
(0) ALERT/CALM
(-1) DROWSY: Not fully alert, but has

Continued on Page 105

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

sustained awakening (eye-opening/eye contact) to voice - VERBAL STIMULATION (greater than or equal to 10 seconds)
(-2) LIGHT SEDATION: Briefly awakens with eye contact to voice - VERBAL STIMULATION (less than 10 seconds)
(-3) MODERATE SEDATION: Movement or eye opening to voice - VERBAL STIMULATION (but no eye contact)
(-4) DEEP SEDATION: No response to voice , but movement or eye opening to PHYSICAL STIMULATION
(-5) UNRESPONSIVE: No response to voice or PHYSICAL STIMULATION

Assessment 02: Cardiovascular Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) Anti-Embolitic Stockings
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
DVT Assessment
DVT Assessment
Early Ambulation Yes

Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment

Continued on Page 106

Assessments and Treatments - Continued

Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.

DVT Assessment
DVT Assessment
Early Ambulation Yes

Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Blood Pressure in Range No: client refused vital signs
Query Text:90/50 - 140/80 or 20% of
Patient's Stated Baseline
For Pediatric Patients, BP is in normal
range as appropriate for age and
activity level

Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment Refused vital signs

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,

Continued on Page 107

warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment Refused vital signs

DVT Assessment
DVT Assessment
Early Ambulation Yes

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Chest/Cardiac Pain No

Document 01/01/17 10:33 JOH0022 (Rec: 01/01/17 10:40 JOH0022 BSU-C12)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment client declines vital sign check "I am not a patient"
Chest/Cardiac Pain No

Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.

Continued on Page 108

Assessments and Treatments - Continued

```
      Cardiovascular Assessment Comment        Patient continues to decline
                                               having vital signs checked
DVT Assessment
    DVT Assessment
      Early Ambulation                         Yes
Document     01/03/17 10:37  JOH0022  (Rec: 01/03/17 11:14  JOH0022  BSU-M10)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
      Cardiovascular Assessment Within Normal  No
       Limits
       Query Text:Patient reports no chest pain
       . Skin color is appropriate for race,
       warm and dry with normal turgor.
       Capillary refill is less than 3 seconds.
       S1 and S2 are present and regular.
       Heart rate is between 60-100. Blood
       pressure is within 90/50-140/80 or is
       within 20% of stated patient baseline.
      Blood Pressure in Range                  No
       Query Text:90/50 - 140/80 or 20% of
       Patient's Stated Baseline
       For Pediatric Patients, BP is in normal
       range as appropriate for age and
       activity level
      Cardiovascular Assessment Comment        client refuses vital signs.
                                               Appears in no acute physical
                                               distress
Document     01/04/17 10:48  BAR0006  (Rec: 01/04/17 10:54  BAR0006  BSU-M03)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
      Cardiovascular Assessment Within Normal  No
       Limits
       Query Text:Patient reports no chest pain
       . Skin color is appropriate for race,
       warm and dry with normal turgor.
       Capillary refill is less than 3 seconds.
       S1 and S2 are present and regular.
       Heart rate is between 60-100. Blood
       pressure is within 90/50-140/80 or is
       within 20% of stated patient baseline.
      Blood Pressure in Range                  No
       Query Text:90/50 - 140/80 or 20% of
       Patient's Stated Baseline
       For Pediatric Patients, BP is in normal
       range as appropriate for age and
       activity level
      Cardiovascular Assessment Comment        Unable to determine if
                                               assessment is within normal
                                               limits.  Client refuses vital
                                               signs. Appears to be in no
                                               acute physical distress.
DVT Assessment
    DVT Assessment
```

Continued on Page 109

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Blood Pressure in Range No
Query Text:90/50 - 140/80 or 20% of Patient's Stated Baseline
For Pediatric Patients, BP is in normal range as appropriate for age and activity level
Cardiovascular Assessment Comment Unable to determine if assessment is within normal limits. Client refuses vital signs. Appears to be in no acute physical distress.

DVT Assessment
DVT Assessment
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 01/06/17 10:20 BAR0006 (Rec: 01/06/17 10:25 BAR0006 BSU-M10)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Blood Pressure in Range No
Query Text:90/50 - 140/80 or 20% of Patient's Stated Baseline
For Pediatric Patients, BP is in normal range as appropriate for age and activity level
Cardiovascular Assessment Comment Unable to determine if assessment is within normal

Continued on Page 110

```
                                               limits.  Client refuses vital
                                               signs. Appears to be in no
                                               acute physical distress.
DVT Assessment
    DVT Assessment
       Reason DVT / VTE Prophylaxis Not Applied Not Needed
        (QM)
       Early Ambulation                        Yes
Document     01/08/17 13:23  JOH0022  (Rec: 01/08/17 13:36  JOH0022  BSU-C12)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
       Cardiovascular Assessment Within Normal  No
        Limits
        Query Text:Patient reports no chest pain
        . Skin color is appropriate for race,
        warm and dry with normal turgor.
        Capillary refill is less than 3 seconds.
        S1 and S2 are present and regular.
        Heart rate is between 60-100. Blood
        pressure is within 90/50-140/80 or is
        within 20% of stated patient baseline.
       Blood Pressure in Range                 No: client refuses vital signs
        Query Text:90/50 - 140/80 or 20% of
        Patient's Stated Baseline
        For Pediatric Patients, BP is in normal
        range as appropriate for age and
        activity level
       Cardiovascular Assessment Comment       unable to determine
       Chest/Cardiac Pain                      No
Document     01/09/17 11:08  JOH0022  (Rec: 01/09/17 11:14  JOH0022  BSU-C12)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
       Cardiovascular Assessment Within Normal  No
        Limits
        Query Text:Patient reports no chest pain
        . Skin color is appropriate for race,
        warm and dry with normal turgor.
        Capillary refill is less than 3 seconds.
        S1 and S2 are present and regular.
        Heart rate is between 60-100. Blood
        pressure is within 90/50-140/80 or is
        within 20% of stated patient baseline.
       Blood Pressure in Range                 No: declines vital signs
        Query Text:90/50 - 140/80 or 20% of
        Patient's Stated Baseline
        For Pediatric Patients, BP is in normal
        range as appropriate for age and
        activity level
Document     01/10/17 11:48  JOH0022  (Rec: 01/10/17 11:51  JOH0022  BSU-C01)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
       Cardiovascular Assessment Within Normal  No
        Limits
```

Continued on Page 111

Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Blood Pressure in Range No: Refuses vital signs
Query Text:90/50 - 140/80 or 20% of
Patient's Stated Baseline
For Pediatric Patients, BP is in normal
range as appropriate for age and
activity level
Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal No
Limits
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Blood Pressure in Range No: Refuses vital signs
Query Text:90/50 - 140/80 or 20% of
Patient's Stated Baseline
For Pediatric Patients, BP is in normal
range as appropriate for age and
activity level
DVT Assessment
DVT Assessment
Reason DVT / VTE Prophylaxis Not Applied Not Needed
(QM)
Early Ambulation Yes
Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal No
Limits
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment Pt refuses vital signs
Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)

Continued on Page 112

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Yes

Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.

Cardiovascular Assessment Comment Pt refuses vital signs

Cardiac Symptoms Comments patient declined vital sign assessment

DVT Assessment

DVT Assessment

DVT / VTE Prophylaxis Application (QM) None

Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed

Early Ambulation Yes

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Yes

Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.

Blood Pressure in Range Refused

Query Text:90/50 - 140/80 or 20% of Patient's Stated Baseline For Pediatric Patients, BP is in normal range as appropriate for age and activity level

Cardiovascular Assessment Comment Pt refuses vital signs

Cardiac Symptoms Comments patient declined vital sign assessment

DVT Assessment

DVT Assessment

DVT / VTE Prophylaxis Application (QM) None

Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed

Anti-Coagulation Medication No

Early Ambulation Yes

Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Continued on Page 113

Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain. Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiovascular Assessment Comment Refused Vital Signs

Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain. Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiovascular Assessment Comment pt refused vital signs

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain. Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiovascular Assessment Comment pt refused vital signs
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Anti-Coagulation Medication No
Early Ambulation Yes

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain. Skin color is appropriate for race,

Continued on Page 114

warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.

Blood Pressure in Range — No: refusing vitals
Query Text:90/50 - 140/80 or 20% of
Patient's Stated Baseline
For Pediatric Patients, BP is in normal
range as appropriate for age and
activity level

Cardiovascular Assessment Comment — client continues to refuse vital signs

Document 01/20/17 15:19 KER0050 (Rec: 01/20/17 15:43 KER0050 BSU-C12)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.

Document 01/21/17 13:32 ROB0100 (Rec: 01/21/17 13:35 ROB0100 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.

Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits — No
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.

Continued on Page 115

Assessments and Treatments - Continued

Cardiovascular Assessment Comment client refuses vital signs

Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits No

Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.

Cardiovascular Assessment Comment client refuses vital signs

DVT Assessment

DVT Assessment

DVT / VTE Prophylaxis Application (QM) None

Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed

Anti-Coagulation Medication No

Early Ambulation Yes

Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Yes

Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.

DVT Assessment

DVT Assessment

DVT / VTE Prophylaxis Application (QM) None

Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed

Anti-Coagulation Medication No

Early Ambulation Yes

Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Yes

Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood

Continued on Page 116

```
        pressure is within 90/50-140/80 or is
        within 20% of stated patient baseline.
DVT Assessment
    DVT Assessment
       DVT / VTE Prophylaxis Application (QM)   None
       Reason DVT / VTE Prophylaxis Not Applied Not Needed
        (QM)
       Anti-Coagulation Medication              No
       Early Ambulation                         Yes
Document     01/28/17 14:22  VIC0074  (Rec: 01/28/17 14:25  VIC0074  BSU-M07)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
       Cardiovascular Assessment Within Normal  Yes
        Limits
        Query Text:Patient reports no chest pain
        . Skin color is appropriate for race,
        warm and dry with normal turgor.
        Capillary refill is less than 3 seconds.
        S1 and S2 are present and regular.
        Heart rate is between 60-100. Blood
        pressure is within 90/50-140/80 or is
        within 20% of stated patient baseline.
       Cardiovascular Assessment Comment        declined AM vitals sign check
DVT Assessment
    DVT Assessment
       Early Ambulation                         Yes
Document     01/29/17 09:46  SHA0063  (Rec: 01/29/17 09:49  SHA0063  CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
       Cardiovascular Assessment Within Normal  Yes
        Limits
        Query Text:Patient reports no chest pain
        . Skin color is appropriate for race,
        warm and dry with normal turgor.
        Capillary refill is less than 3 seconds.
        S1 and S2 are present and regular.
        Heart rate is between 60-100. Blood
        pressure is within 90/50-140/80 or is
        within 20% of stated patient baseline.
       Cardiovascular Assessment Comment        declined AM vitals sign
                                                assessment
DVT Assessment
    DVT Assessment
       DVT / VTE Prophylaxis Application (QM)   None
       Reason DVT / VTE Prophylaxis Not Applied Not Needed
        (QM)
       Early Ambulation                         Yes
Document     01/30/17 11:21  SHA0063  (Rec: 01/30/17 11:25  SHA0063  CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
    Cardiovascular Assessment
       Cardiovascular Assessment Within Normal  Yes
        Limits
        Query Text:Patient reports no chest pain
```

Continued on Page 117

. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment

DVT Assessment
DVT Assessment

Continued on Page 118

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race, warm and dry with normal turgor. Capillary refill is less than 3 seconds. S1 and S2 are present and regular. Heart rate is between 60-100. Blood pressure is within 90/50-140/80 or is within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment
DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain . Skin color is appropriate for race,

Continued on Page 119

warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None
Reason DVT / VTE Prophylaxis Not Applied (QM) Not Needed
Early Ambulation Yes

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Assessment/Reassessment: +Cardiovascular
Cardiovascular Assessment
Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declined AM vitals sign assessment

DVT Assessment
DVT Assessment
DVT / VTE Prophylaxis Application (QM) None

Continued on Page 120

Assessments and Treatments - Continued

Reason DVT / VTE Prophylaxis Not Applied Not Needed
(QM)
Early Ambulation Yes

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits Yes
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Cardiovascular Assessment Comment declines vital signs

DVT Assessment

DVT Assessment

Early Ambulation Yes

Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is
within 20% of stated patient baseline.
Blood Pressure in Range refuses vital signs
Query Text:90/50 - 140/80 or 20% of
Patient's Stated Baseline
For Pediatric Patients, BP is in normal
range as appropriate for age and
activity level
Cardiovascular Assessment Comment refuses vitals. Denies chest pain or SOB

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)

Assessment/Reassessment: +Cardiovascular

Cardiovascular Assessment

Cardiovascular Assessment Within Normal Limits No
Query Text:Patient reports no chest pain
. Skin color is appropriate for race,
warm and dry with normal turgor.
Capillary refill is less than 3 seconds.
S1 and S2 are present and regular.
Heart rate is between 60-100. Blood
pressure is within 90/50-140/80 or is

Continued on Page 121

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

within 20% of stated patient baseline.
Blood Pressure in Range — No
Query Text:90/50 - 140/80 or 20% of Patient's Stated Baseline
For Pediatric Patients, BP is in normal range as appropriate for age and activity level
Cardiovascular Assessment Comment — client refused vital signs. Denies SOB or chest pain

Assessment 03: Respiratory Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds — Clear

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Respiratory Effort — Normal
Respiratory Pattern — Regular
Cough — None

Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental

Continued on Page 122

oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.

Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.

Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular

Continued on Page 123

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Cough None
Document 01/01/17 10:33 JOH0022 (Rec: 01/01/17 10:40 JOH0022 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Oxygen Devices in Use Now None
Respiratory Effort Normal
Respiratory Pattern Regular
Cough None
Document 01/03/17 10:37 JOH0022 (Rec: 01/03/17 11:14 JOH0022 BSU-M10)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Document 01/04/17 10:48 BAR0006 (Rec: 01/04/17 10:54 BAR0006 BSU-M03)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Yes

Continued on Page 124

Limits
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds — Clear

Document 01/06/17 10:20 BAR0006 (Rec: 01/06/17 10:25 BAR0006 BSU-M10)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 01/08/17 13:23 JOH0022 (Rec: 01/08/17 13:36 JOH0022 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits — Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 01/09/17 11:08 JOH0022 (Rec: 01/09/17 11:14 JOH0022 BSU-C12)
Assessment/Reassessment: +Respiratory

Continued on Page 125

Assessments and Treatments - Continued
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Continued on Page 126

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear

Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No

Continued on Page 127

observation or report of shortness of
breath, significant cough and/or sputum.

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.

Document 01/20/17 15:19 KER0050 (Rec: 01/20/17 15:43 KER0050 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.

Document 01/21/17 13:32 ROB0100 (Rec: 01/21/17 13:35 ROB0100 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The

Continued on Page 128

Assessments and Treatments - Continued

patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)

Continued on Page 129

Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits   Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds   Clear

Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits   Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits   Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds   Clear

Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits   Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The

Continued on Page 130

patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and
normal bilaterally. Breathing is
unlabored. Respiratory rate is regular
and 10 to 20 breaths per minute. The
patient does not require supplemental
oxygen or a breathing device. No
observation or report of shortness of
breath, significant cough and/or sputum.
Auscultation Assessment

Continued on Page 131

Bilateral
Breath Sounds Clear
Document 02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear
Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Assessment/Reassessment: +Respiratory
Respiratory Assessment

Continued on Page 132

Assessments and Treatments - Continued

Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.
Auscultation Assessment
Bilateral
Breath Sounds Clear

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)
Assessment/Reassessment: +Respiratory
Respiratory Assessment
Respiratory Assessment Within Normal Limits Yes
Query Text:Lung sounds are clear and normal bilaterally. Breathing is unlabored. Respiratory rate is regular and 10 to 20 breaths per minute. The patient does not require supplemental oxygen or a breathing device. No observation or report of shortness of breath, significant cough and/or sputum.

Assessment 04: GI Start: 12/25/16 05:12

Continued on Page 133

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Assessment/Reassessment: +GI

Continued on Page 134

Assessments and Treatments - Continued

Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 01/01/17 10:33 JOH0022 (Rec: 01/01/17 10:40 JOH0022 BSU-C12)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 01/03/17 10:37 JOH0022 (Rec: 01/03/17 11:14 JOH0022 BSU-M10)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 01/04/17 10:48 BAR0006 (Rec: 01/04/17 10:54 BAR0006 BSU-M03)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes

Continued on Page 135

Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/06/17 10:20 BAR0006 (Rec: 01/06/17 10:25 BAR0006 BSU-M10)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/08/17 13:23 JOH0022 (Rec: 01/08/17 13:36 JOH0022 BSU-C12)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/09/17 11:08 JOH0022 (Rec: 01/09/17 11:14 JOH0022 BSU-C12)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-

Continued on Page 136

distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.

Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No

Continued on Page 137

stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.
Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Yes
Normal Limits
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.
Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Yes
Normal Limits
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.
Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Yes
Normal Limits
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel
movements. Patient reports no nausea or
vomiting.
Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Yes
Normal Limits
Query Text:Abdomen is soft and non-
distended, with no tenderness noted. No
stated or observed changes in bowel

Continued on Page 138

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

movements. Patient reports no nausea or
vomiting.
Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/20/17 15:19 KER0050 (Rec: 01/20/17 15:43 KER0050 BSU-C12)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/21/17 13:32 ROB0100 (Rec: 01/21/17 13:35 ROB0100 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or

Continued on Page 139

vomiting.
Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.
Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement

Continued on Page 140

Assessments and Treatments - Continued

Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints

Continued on Page 141

Assessments and Treatments - Continued

Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement — no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement — no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement — no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits — Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement — no complaints
Assessment/Reassessment: +GI

Continued on Page 142

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Assessments and Treatments - Continued

Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)
Date of Last Bowel Movement
Date of Last Bowel Movement
Date of Last Bowel Movement no complaints
Assessment/Reassessment: +GI
Abdominal Assessment
Gastrointestinal Assessment Within Normal Limits Yes
Query Text:Abdomen is soft and non-distended, with no tenderness noted. No stated or observed changes in bowel movements. Patient reports no nausea or vomiting.

Assessment 05: Genitourinary Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is

Continued on Page 143

clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to
urinate without difficulty, urine is
clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to
urinate without difficulty, urine is
clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Unable to Determine
Query Text:Patient states ability to
urinate without difficulty, urine is
clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to
urinate without difficulty, urine is
clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to
urinate without difficulty, urine is
clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Continued on Page 144

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding Continent

Document 01/01/17 10:33 JOH0022 (Rec: 01/01/17 10:40 JOH0022 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/03/17 10:37 JOH0022 (Rec: 01/03/17 11:14 JOH0022 BSU-M10)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/04/17 10:48 BAR0006 (Rec: 01/04/17 10:54 BAR0006 BSU-M03)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)
Assessment/Reassessment: +GU

Continued on Page 145

GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/06/17 10:20 BAR0006 (Rec: 01/06/17 10:25 BAR0006 BSU-M10)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/08/17 13:23 JOH0022 (Rec: 01/08/17 13:36 JOH0022 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/09/17 11:08 JOH0022 (Rec: 01/09/17 11:14 JOH0022 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes

Continued on Page 146

Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber.

Continued on Page 147

Patient is continent. Patient is not on dialysis.

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/20/17 15:19 KER0050 (Rec: 01/20/17 15:43 KER0050 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/21/17 13:32 ROB0100 (Rec: 01/21/17 13:35 ROB0100 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Voiding Continent
Urinary Symptoms None
Toileting Methods Toilet

Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber.

Continued on Page 148

Patient is continent. Patient is not on
dialysis.
Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.
Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)

Continued on Page 149

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)

Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)

Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)

Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)

Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)

Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Yes

Continued on Page 150

Limits
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is clear and pale yellow to dark amber. Patient is continent. Patient is not on dialysis.

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)
Assessment/Reassessment: +GU
GU Assessment
Genitourinary Assessment Within Normal Limits Yes
Query Text:Patient states ability to urinate without difficulty, urine is

Continued on Page 151

clear and pale yellow to dark amber.
Patient is continent. Patient is not on
dialysis.

Assessment 06: Skin Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)

Braden Scale
    Braden Scale
        Sensory Perception - Skin Risk Assessment Scale: No Impairment
        Moisture -Skin Risk Assessment Scale: Rarely Moist
        Activity - Skin Risk Assessment Scale: Walks Frequently
        Mobility - Skin Risk Assessment Scale: No Limitations
        Nutrition - Skin Risk Assessment Scale: Adequate
        Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
        Total Score - Skin Risk Assessment (points): 22
        Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
    Skin Breakdown Prevention Strategies
        Low Risk Skin Breakdown Prevention Strategies Reviewed w/ Pt: Yes
        Query Text:Low Risk Strategies:
        Encourage patient to change position every 2 hours, ambulate frequently, maintain adequate nutrition/hydration and develop plan with patient/family (update PRN).
Assessment/Reassessment: +Skin
    Skin Color
        Skin Color: Skin Color Appropriate for Race
    Skin Condition
        Skin Condition: Skin Intact
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
        Is There New or Worsening Pressure-Related Skin Breakdown: No

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)

Braden Scale
    Braden Scale
        Sensory Perception - Skin Risk Assessment Scale: No Impairment
        Moisture -Skin Risk Assessment Scale: Rarely Moist
        Activity - Skin Risk Assessment Scale: Walks Frequently
        Mobility - Skin Risk Assessment Scale: No Limitations
        Nutrition - Skin Risk Assessment Scale: Adequate
        Friction & Shear - Skin Risk Assessment: No Apparent Problem

Continued on Page 152

```
        Scale
       Total Score - Skin Risk Assessment (      22
        points)
        Query Text:Patients with a total score
        of 14 or less are considered to be at
        risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
       Is There New or Worsening Pressure-       No
        Related Skin Breakdown
Document     12/27/16 12:42  VIC0074  (Rec: 12/27/16 12:44  VIC0074  BSU-M09)
Braden Scale
    Braden Scale
       Sensory Perception - Skin Risk            No Impairment
        Assessment Scale
       Moisture -Skin Risk Assessment Scale      Rarely Moist
       Activity - Skin Risk Assessment Scale     Walks Frequently
       Mobility - Skin Risk Assessment Scale     No Limitations
       Nutrition - Skin Risk Assessment Scale    Adequate
       Friction & Shear - Skin Risk Assessment   No Apparent Problem
        Scale
       Total Score - Skin Risk Assessment (      22
        points)
        Query Text:Patients with a total score
        of 14 or less are considered to be at
        risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
       Is There New or Worsening Pressure-       No
        Related Skin Breakdown
Document     12/28/16 10:14  JOH0022  (Rec: 12/28/16 10:19  JOH0022  CMC-RDC2)
Braden Scale
    Braden Scale
       Sensory Perception - Skin Risk            No Impairment
        Assessment Scale
       Moisture -Skin Risk Assessment Scale      Rarely Moist
       Activity - Skin Risk Assessment Scale     Walks Frequently
       Mobility - Skin Risk Assessment Scale     No Limitations
       Nutrition - Skin Risk Assessment Scale    Adequate
       Friction & Shear - Skin Risk Assessment   No Apparent Problem
        Scale
       Total Score - Skin Risk Assessment (      22
        points)
        Query Text:Patients with a total score
        of 14 or less are considered to be at
        risk of developing pressure ulcers:
        15 or More = Low Risk
```

Continued on Page 153

13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No
Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No
Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk

Continued on Page 154

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Color
Skin Color   Skin Color Appropriate for Race
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown   No
Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale   No Impairment
Moisture -Skin Risk Assessment Scale   Rarely Moist
Activity - Skin Risk Assessment Scale   Walks Occasionally
Mobility - Skin Risk Assessment Scale   No Limitations
Nutrition - Skin Risk Assessment Scale   Adequate
Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
Total Score - Skin Risk Assessment (points)   21
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Condition
Skin Condition   Skin Intact
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown   No
Document 01/01/17 10:33 JOH0022 (Rec: 01/01/17 10:40 JOH0022 BSU-C12)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale   No Impairment
Moisture -Skin Risk Assessment Scale   Rarely Moist
Activity - Skin Risk Assessment Scale   Walks Frequently
Mobility - Skin Risk Assessment Scale   No Limitations
Nutrition - Skin Risk Assessment Scale   Adequate
Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
Total Score - Skin Risk Assessment (points)   22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk

Continued on Page 155

12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown: No
Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale: No Impairment
Moisture -Skin Risk Assessment Scale: Rarely Moist
Activity - Skin Risk Assessment Scale: Walks Frequently
Mobility - Skin Risk Assessment Scale: No Limitations
Nutrition - Skin Risk Assessment Scale: Adequate
Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
Total Score - Skin Risk Assessment (points): 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown: No
Document 01/03/17 10:37 JOH0022 (Rec: 01/03/17 11:14 JOH0022 BSU-M10)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale: No Impairment
Moisture -Skin Risk Assessment Scale: Rarely Moist
Activity - Skin Risk Assessment Scale: Walks Frequently
Mobility - Skin Risk Assessment Scale: No Limitations
Nutrition - Skin Risk Assessment Scale: Adequate
Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
Total Score - Skin Risk Assessment (points): 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown: No
Document 01/04/17 10:48 BAR0006 (Rec: 01/04/17 10:54 BAR0006 BSU-M03)
Braden Scale

Continued on Page 156

Assessments and Treatments - Continued

Braden Scale

Sensory Perception - Skin Risk Assessment Scale	No Impairment
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Walks Frequently
Mobility - Skin Risk Assessment Scale	No Limitations
Nutrition - Skin Risk Assessment Scale	Excellent
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	23

Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin

Skin Color

Skin Color	Skin Color Appropriate for Race

Skin Condition

Skin Condition	Skin Intact

Skin Reassessment Provider Communication

Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)

Braden Scale

Braden Scale

Sensory Perception - Skin Risk Assessment Scale	No Impairment
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Walks Frequently
Mobility - Skin Risk Assessment Scale	No Limitations
Nutrition - Skin Risk Assessment Scale	Excellent
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	23

Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin

Skin Color

Skin Color	Skin Color Appropriate for Race

Skin Condition

Skin Condition	Skin Intact

Skin Reassessment Provider Communication

Continued on Page 157

```
    Provider Notification for Skin Breakdown
       Is There New or Worsening Pressure-      No
        Related Skin Breakdown
Document     01/06/17 10:20  BAR0006  (Rec: 01/06/17 10:25  BAR0006  BSU-M10)
Braden Scale
    Braden Scale
       Sensory Perception - Skin Risk           No Impairment
        Assessment Scale
       Moisture -Skin Risk Assessment Scale     Rarely Moist
       Activity - Skin Risk Assessment Scale    Walks Frequently
       Mobility - Skin Risk Assessment Scale    No Limitations
       Nutrition - Skin Risk Assessment Scale   Adequate
       Friction & Shear - Skin Risk Assessment  No Apparent Problem
        Scale
       Total Score - Skin Risk Assessment (     22
        points)
        Query Text:Patients with a total score
        of 14 or less are considered to be at
        risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
Assessment/Reassessment: +Skin
    Skin Color
       Skin Color                               Skin Color Appropriate for
                                                Race
    Skin Condition
       Skin Condition                           Skin Intact
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
       Is There New or Worsening Pressure-      No
        Related Skin Breakdown
Document     01/08/17 13:23  JOH0022  (Rec: 01/08/17 13:36  JOH0022  BSU-C12)
Braden Scale
    Braden Scale
       Sensory Perception - Skin Risk           No Impairment
        Assessment Scale
       Moisture -Skin Risk Assessment Scale     Rarely Moist
       Activity - Skin Risk Assessment Scale    Walks Frequently
       Mobility - Skin Risk Assessment Scale    No Limitations
       Nutrition - Skin Risk Assessment Scale   Adequate
       Friction & Shear - Skin Risk Assessment  No Apparent Problem
        Scale
       Total Score - Skin Risk Assessment (     22
        points)
        Query Text:Patients with a total score
        of 14 or less are considered to be at
        risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
```

Continued on Page 158

Assessments and Treatments - Continued

Is There New or Worsening Pressure-Related Skin Breakdown: No

Document 01/09/17 11:08 JOH0022 (Rec: 01/09/17 11:14 JOH0022 BSU-C12)

Braden Scale

Braden Scale

- Sensory Perception - Skin Risk Assessment Scale: No Impairment
- Moisture -Skin Risk Assessment Scale: Rarely Moist
- Activity - Skin Risk Assessment Scale: Walks Frequently
- Mobility - Skin Risk Assessment Scale: No Limitations
- Nutrition - Skin Risk Assessment Scale: Adequate
- Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
- Total Score - Skin Risk Assessment (points): 22

Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Reassessment Provider Communication

Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown: No

Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)

Braden Scale

Braden Scale

- Sensory Perception - Skin Risk Assessment Scale: No Impairment
- Moisture -Skin Risk Assessment Scale: Rarely Moist
- Activity - Skin Risk Assessment Scale: Walks Frequently
- Mobility - Skin Risk Assessment Scale: No Limitations
- Nutrition - Skin Risk Assessment Scale: Adequate
- Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
- Total Score - Skin Risk Assessment (points): 22

Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Reassessment Provider Communication

Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown: No

Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)

Braden Scale

Braden Scale

- Sensory Perception - Skin Risk Assessment Scale: No Impairment

Continued on Page 159

Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist

Continued on Page 160

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Breakdown Prevention Strategies
Low Risk Skin Breakdown Prevention Strategies Reviewed w/ Pt — Yes
Query Text:Low Risk Strategies: Encourage patient to change position every 2 hours, ambulate frequently, maintain adequate nutrition/hydration and develop plan with patient/family (update PRN).

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race

Continued on Page 161

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued
Skin Condition
Skin Condition Skin Intact
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown No
Wound Consult Ordered No
Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale No Impairment
Moisture -Skin Risk Assessment Scale Rarely Moist
Activity - Skin Risk Assessment Scale Walks Frequently
Mobility - Skin Risk Assessment Scale No Limitations
Nutrition - Skin Risk Assessment Scale Adequate
Friction & Shear - Skin Risk Assessment Scale No Apparent Problem
Total Score - Skin Risk Assessment (points) 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown No
Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale No Impairment
Moisture -Skin Risk Assessment Scale Rarely Moist
Activity - Skin Risk Assessment Scale Walks Frequently
Mobility - Skin Risk Assessment Scale No Limitations
Nutrition - Skin Risk Assessment Scale Adequate
Friction & Shear - Skin Risk Assessment Scale No Apparent Problem
Total Score - Skin Risk Assessment (points) 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown No

Continued on Page 162

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Occasionally
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 21
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/20/17 15:19 KER0050 (Rec: 01/20/17 15:43 KER0050 BSU-C12)

Continued on Page 163

Braden Scale
    Braden Scale
        Sensory Perception - Skin Risk Assessment Scale   No Impairment
        Moisture -Skin Risk Assessment Scale   Rarely Moist
        Activity - Skin Risk Assessment Scale   Walks Frequently
        Mobility - Skin Risk Assessment Scale   No Limitations
        Nutrition - Skin Risk Assessment Scale   Adequate
        Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
        Total Score - Skin Risk Assessment (points)   22
        Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
    Skin Breakdown Prevention Strategies
        Low Risk Skin Breakdown Prevention Strategies Reviewed w/ Pt   Yes
        Query Text:Low Risk Strategies:
        Encourage patient to change position every 2 hours, ambulate frequently, maintain adequate nutrition/hydration and develop plan with patient/family (update PRN).
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
        Is There New or Worsening Pressure-Related Skin Breakdown   No
Document   01/21/17 13:32 ROB0100 (Rec: 01/21/17 13:35 ROB0100 CMC-RDC2)
Braden Scale
    Braden Scale
        Sensory Perception - Skin Risk Assessment Scale   No Impairment
        Moisture -Skin Risk Assessment Scale   Rarely Moist
        Activity - Skin Risk Assessment Scale   Walks Frequently
        Mobility - Skin Risk Assessment Scale   No Limitations
        Nutrition - Skin Risk Assessment Scale   Adequate
        Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
        Total Score - Skin Risk Assessment (points)   22
        Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
        15 or More = Low Risk
        13 or 14 = Medium Risk
        12 or Less = High Risk
    Skin Breakdown Prevention Strategies
        Low Risk Skin Breakdown Prevention Strategies Reviewed w/ Pt   Yes

Continued on Page 164

Query Text:Low Risk Strategies:
Encourage patient to change position
every 2 hours, ambulate frequently,
maintain adequate nutrition/hydration
and develop plan with patient/family (
update PRN).

Assessment/Reassessment: +Skin
Skin Condition
Skin Condition   Skin Intact

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown   No

Document   01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale   No Impairment
Moisture -Skin Risk Assessment Scale   Rarely Moist
Activity - Skin Risk Assessment Scale   Walks Frequently
Mobility - Skin Risk Assessment Scale   No Limitations
Nutrition - Skin Risk Assessment Scale   Adequate
Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
Total Score - Skin Risk Assessment (points)   22
Query Text:Patients with a total score
of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown   No

Document   01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale   No Impairment
Moisture -Skin Risk Assessment Scale   Rarely Moist
Activity - Skin Risk Assessment Scale   Walks Frequently
Mobility - Skin Risk Assessment Scale   No Limitations
Nutrition - Skin Risk Assessment Scale   Excellent
Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
Total Score - Skin Risk Assessment (points)   23
Query Text:Patients with a total score
of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk

Continued on Page 165

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score

Continued on Page 166

of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No
Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 22
Query Text:Patients with a total score
of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No
Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score
of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk

Continued on Page 167

Assessments and Treatments - Continued

13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:

Continued on Page 168

15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No

Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)

Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Occasionally Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — Slightly Limited
Nutrition - Skin Risk Assessment Scale — Adequate
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 20
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Continued on Page 169

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Assessment/Reassessment: +Skin
    Skin Color
        Skin Color   Skin Color Appropriate for Race
    Skin Condition
        Skin Condition   Skin Intact
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
        Is There New or Worsening Pressure-Related Skin Breakdown   No
Document   02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)
Braden Scale
    Braden Scale
        Sensory Perception - Skin Risk Assessment Scale   No Impairment
        Moisture -Skin Risk Assessment Scale   Rarely Moist
        Activity - Skin Risk Assessment Scale   Walks Occasionally
        Mobility - Skin Risk Assessment Scale   No Limitations
        Nutrition - Skin Risk Assessment Scale   Adequate
        Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
        Total Score - Skin Risk Assessment (points)   21
         Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
         15 or More = Low Risk
         13 or 14 = Medium Risk
         12 or Less = High Risk
Assessment/Reassessment: +Skin
    Skin Color
        Skin Color   Skin Color Appropriate for Race
    Skin Condition
        Skin Condition   Skin Intact
Skin Reassessment Provider Communication
    Provider Notification for Skin Breakdown
        Is There New or Worsening Pressure-Related Skin Breakdown   No
Document   02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)
Braden Scale
    Braden Scale
        Sensory Perception - Skin Risk Assessment Scale   No Impairment
        Moisture -Skin Risk Assessment Scale   Rarely Moist
        Activity - Skin Risk Assessment Scale   Walks Frequently
        Mobility - Skin Risk Assessment Scale   No Limitations
        Nutrition - Skin Risk Assessment Scale   Adequate
        Friction & Shear - Skin Risk Assessment Scale   No Apparent Problem
        Total Score - Skin Risk Assessment (points)   22
         Query Text:Patients with a total score

Continued on Page 170

of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Breakdown Prevention Strategies
Low Risk Skin Breakdown Prevention Strategies Reviewed w/ Pt — Yes
Query Text:Low Risk Strategies:
Encourage patient to change position
every 2 hours, ambulate frequently,
maintain adequate nutrition/hydration
and develop plan with patient/family (
update PRN).
Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Condition
Skin Condition — Skin Intact
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No
Wound Consult Ordered — No
Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale — No Impairment
Moisture -Skin Risk Assessment Scale — Rarely Moist
Activity - Skin Risk Assessment Scale — Walks Frequently
Mobility - Skin Risk Assessment Scale — No Limitations
Nutrition - Skin Risk Assessment Scale — Excellent
Friction & Shear - Skin Risk Assessment Scale — No Apparent Problem
Total Score - Skin Risk Assessment (points) — 23
Query Text:Patients with a total score
of 14 or less are considered to be at
risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Color
Skin Color — Skin Color Appropriate for Race
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown — No
Wound Consult Ordered — No

Continued on Page 171

Assessments and Treatments - Continued

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale: No Impairment
Moisture -Skin Risk Assessment Scale: Rarely Moist
Activity - Skin Risk Assessment Scale: Walks Frequently
Mobility - Skin Risk Assessment Scale: No Limitations
Nutrition - Skin Risk Assessment Scale: Excellent
Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
Total Score - Skin Risk Assessment (points): 23
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Assessment/Reassessment: +Skin
Skin Color
Skin Color: Skin Color Appropriate for Race
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown: No
Wound Consult Ordered: No

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)
Braden Scale
Braden Scale
Sensory Perception - Skin Risk Assessment Scale: No Impairment
Moisture -Skin Risk Assessment Scale: Rarely Moist
Activity - Skin Risk Assessment Scale: Walks Frequently
Mobility - Skin Risk Assessment Scale: No Limitations
Nutrition - Skin Risk Assessment Scale: Adequate
Friction & Shear - Skin Risk Assessment Scale: No Apparent Problem
Total Score - Skin Risk Assessment (points): 22
Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk
Skin Reassessment Provider Communication
Provider Notification for Skin Breakdown
Is There New or Worsening Pressure-Related Skin Breakdown: No

Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Braden Scale

Continued on Page 172

Assessments and Treatments - Continued

Braden Scale

Sensory Perception - Skin Risk Assessment Scale	No Impairment
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Walks Frequently
Mobility - Skin Risk Assessment Scale	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	22

Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Skin Reassessment Provider Communication

Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)

Braden Scale

Braden Scale

Sensory Perception - Skin Risk Assessment Scale	No Impairment
Moisture -Skin Risk Assessment Scale	Rarely Moist
Activity - Skin Risk Assessment Scale	Walks Frequently
Mobility - Skin Risk Assessment Scale	No Limitations
Nutrition - Skin Risk Assessment Scale	Adequate
Friction & Shear - Skin Risk Assessment Scale	No Apparent Problem
Total Score - Skin Risk Assessment (points)	22

Query Text:Patients with a total score of 14 or less are considered to be at risk of developing pressure ulcers:
15 or More = Low Risk
13 or 14 = Medium Risk
12 or Less = High Risk

Assessment/Reassessment: +Skin

Skin Color

Skin Color	Pink

Skin Reassessment Provider Communication

Provider Notification for Skin Breakdown

Is There New or Worsening Pressure-Related Skin Breakdown	No

Assessment 07: Safety Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)

Isolation and MRSA Assessment

MRSA Assessment Status

MRSA Assessment	No Update Needed

Continued on Page 173

Assessments and Treatments - Continued

Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment

Reason for Isolation	None
Type of Isolation	Standard Precautions

Isolation Summary

Does Patient Require Isolation	No

Hx of Falls During Hospital Visit

Hx of Falls During Hospital Visit

History of Falls During Hospital Visit	No

Safety/Fall Risk Assessment

Safety/Fall Risk Assessment

Mental Status	Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention	Yes

Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?

Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
Fall Risk - Calculated	Low
Fall Risk - Determined by RN	Low

Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)

Isolation and MRSA Assessment

MRSA Assessment Status

MRSA Assessment	No Update Needed

Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if

Continued on Page 174

isolation items have changed during stay
-Unable to Assess/Obtain: Patient's
condition is emergent and assessment can
not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Yes
Fall Prevention
Query Text:Ask patient: Can you, will
you, and are you able to ring for
assistance?
Recent History of Falls (Within the Last No
12 Months)
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication No
Administered
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical No
Diagnoses)
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level
lower than the calculated Fall Risk. **
This question can be updated based on
nursing judgement. If different than
calculated fall risk, include reason in
comments below (required).
Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items
have not changed since last
documentation
-Update Needed: Upon arrival or if
isolation items have changed during stay
-Unable to Assess/Obtain: Patient's
condition is emergent and assessment can
not be done
Isolation Assessment

Continued on Page 175

Assessments and Treatments - Continued

Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)
Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No
Hx of Falls During Hospital Visit

Continued on Page 176

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                            Forgets/Disregards Limitations
                                                ,Impulsive or Altered
                                                Mentatation
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                      Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication    No
        Administered
       Bladder/Bowel Incontinence               No
       Attached Equipment (Lines/Tubes/Etc)     No
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    45
       Fall Risk - Calculated                   Alarm
       Fall Risk - Determined by RN             Alarm
        Query Text:** DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Document     12/29/16 10:10  SHA0157  (Rec: 12/29/16 10:13  SHA0157  BSU-M09)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                          No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                     None
       Type of Isolation                        Standard Precautions
    Isolation Summary
       Does Patient Require Isolation           No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
```

Continued on Page 177

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Safety/Fall Risk Assessment
Mental Status — Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention — Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) — No
Age — Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered — No
Bladder/Bowel Incontinence — No
Attached Equipment (Lines/Tubes/Etc) — No
Secondary Diagnosis (2 or More Medical Diagnoses) — No
Gait/Transferring — Normal
Score — 0
Fall Risk - Calculated — Low
Fall Risk - Determined by RN — Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment — No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation — None
Type of Isolation — Standard Precautions
Isolation Summary
Does Patient Require Isolation — No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit — No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status — Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention — Yes
Query Text:Ask patient: Can you, will

Continued on Page 178

you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift No

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Yes

Continued on Page 179

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                      Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication    No
        Administered
       Bladder/Bowel Incontinence               No
       Attached Equipment (Lines/Tubes/Etc)     No
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    0
       Fall Risk - Calculated                   Low
       Fall Risk - Determined by RN             Low
        Query Text:**  DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Document     01/01/17 10:33  JOH0022  (Rec: 01/01/17 10:40  JOH0022  BSU-C12)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                          No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                     None
       Type of Isolation                        Standard Precautions
    Isolation Summary
       Does Patient Require Isolation           No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                            Forgets/Disregards Limitations
                                                ,Impulsive or Altered
                                                Mentatation
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
```

Continued on Page 180

assistance?
Recent History of Falls (Within the Last 12 Months) — No
Age — Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered — No
Bladder/Bowel Incontinence — No
Attached Equipment (Lines/Tubes/Etc) — No
Secondary Diagnosis (2 or More Medical Diagnoses) — No
Gait/Transferring — Normal
Score — 45
Fall Risk - Calculated — Alarm
Fall Risk - Determined by RN — Alarm
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift — Yes: given thorazine IM per order
Any Adverse Effects Noted — No

Document 01/02/17 14:10 VIC0074 (Rec: 01/02/17 14:13 VIC0074 BSU-C12)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment — No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation — None
Type of Isolation — Standard Precautions
Isolation Summary
Does Patient Require Isolation — No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit — No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status — Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention — Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for

Continued on Page 181

assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 01/03/17 10:37 JOH0022 (Rec: 01/03/17 11:14 JOH0022 BSU-M10)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Forgets/Disregards Limitations ,Impulsive or Altered Mentatation
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No

Continued on Page 182

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	45
Fall Risk - Calculated	Alarm
Fall Risk - Determined by RN	Alarm

Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None

Document 01/04/17 10:48 BAR0006 (Rec: 01/04/17 10:54 BAR0006 BSU-M03)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed

Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment

Reason for Isolation	None
Type of Isolation	Standard Precautions

Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment

Mental Status	Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention	Yes

Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?

Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication	No

Continued on Page 183

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Administered

Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	Yes
Gait/Transferring	Normal
Score	5
Fall Risk - Calculated	Low
Fall Risk - Determined by RN	Low

Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety

Additional Precautions

Additional Precautions	None

New Medications

New Medications this Shift

Was Patient Started on any New Medications this Shift	No
Any Adverse Effects Noted	No

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)

Isolation and MRSA Assessment

MRSA Assessment Status

MRSA Assessment	No Update Needed

Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment

Reason for Isolation	None
Type of Isolation	Standard Precautions

Isolation Summary

Does Patient Require Isolation	No

Hx of Falls During Hospital Visit

Hx of Falls During Hospital Visit

History of Falls During Hospital Visit	No

Safety/Fall Risk Assessment

Safety/Fall Risk Assessment

Mental Status	Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention	Yes

Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?

Recent History of Falls (Within the Last	No

Continued on Page 184

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
        12 Months)
       Age                                     Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication   No
        Administered
       Bladder/Bowel Incontinence              No
       Attached Equipment (Lines/Tubes/Etc)    No
       Secondary Diagnosis (2 or More Medical  Yes
        Diagnoses)
       Gait/Transferring                       Normal
       Score                                   5
       Fall Risk - Calculated                  Low
       Fall Risk - Determined by RN            Low
        Query Text:** DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Assessment/Reassessment: +Safety
    Additional Precautions
       Additional Precautions                  None
New Medications
    New Medications this Shift
       Was Patient Started on any New          No
        Medications this Shift
       Any Adverse Effects Noted               No
Document     01/06/17 10:20  BAR0006  (Rec: 01/06/17 10:25  BAR0006  BSU-M10)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                         No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                    None
       Type of Isolation                       Standard Precautions
    Isolation Summary
       Does Patient Require Isolation          No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit  No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                           Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
```

Continued on Page 185

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
         you, and are you able to ring for
         assistance?
        Recent History of Falls (Within the Last No
         12 Months)
        Age                                     Less Than 65 Years
        Narcotic/Sedative/Hypnotic Medication    No
         Administered
        Bladder/Bowel Incontinence              No
        Attached Equipment (Lines/Tubes/Etc)     No
        Secondary Diagnosis (2 or More Medical   Yes
         Diagnoses)
        Gait/Transferring                       Normal
        Score                                   5
        Fall Risk - Calculated                  Low
        Fall Risk - Determined by RN            Low
         Query Text:**  DO NOT assign a level
         lower than the calculated Fall Risk.  **
         This question can be updated based on
         nursing judgement.  If different than
         calculated fall risk, include reason in
         comments below (required).
Assessment/Reassessment: +Safety
    Additional Precautions
        Additional Precautions                  None
New Medications
    New Medications this Shift
        Was Patient Started on any New          pt taking ordered meds that
         Medications this Shift                 she has been declining
        Any Adverse Effects Noted               No
Document     01/08/17 13:23  JOH0022  (Rec: 01/08/17 13:36  JOH0022  BSU-C12)
Isolation and MRSA Assessment
    MRSA Assessment Status
        MRSA Assessment                         No Update Needed
         Query Text:
         -No Update Needed: When isolation items
         have not changed since last
         documentation
         -Update Needed: Upon arrival or if
         isolation items have changed during stay
         -Unable to Assess/Obtain: Patient's
         condition is emergent and assessment can
         not be done
    Isolation Assessment
        Reason for Isolation                    None
        Type of Isolation                       Standard Precautions
    Isolation Summary
        Does Patient Require Isolation          No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
        History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
        Mental Status                           Oriented to Own Ability
```

Continued on Page 186

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                      Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication    No
        Administered
       Bladder/Bowel Incontinence               No
       Attached Equipment (Lines/Tubes/Etc)     No
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    0
       Fall Risk - Calculated                   Low
       Fall Risk - Determined by RN             Low
        Query Text:** DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Document     01/09/17 11:08  JOH0022  (Rec: 01/09/17 11:14  JOH0022  BSU-C12)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                          No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                     None
       Type of Isolation                        Standard Precautions
    Isolation Summary
       Does Patient Require Isolation           No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                            Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
```

Continued on Page 187

Assessments and Treatments - Continued

Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No

Continued on Page 188

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
        Bladder/Bowel Incontinence              No
        Attached Equipment (Lines/Tubes/Etc)    No
        Secondary Diagnosis (2 or More Medical  No
         Diagnoses)
        Gait/Transferring                       Normal
        Score                                   0
        Fall Risk - Calculated                  Low
        Fall Risk - Determined by RN            Low
         Query Text:** DO NOT assign a level
         lower than the calculated Fall Risk. **
         This question can be updated based on
         nursing judgement. If different than
         calculated fall risk, include reason in
         comments below (required).
Document    01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)
Isolation and MRSA Assessment
    MRSA Assessment Status
        MRSA Assessment                         No Update Needed
         Query Text:
         -No Update Needed: When isolation items
         have not changed since last
         documentation
         -Update Needed: Upon arrival or if
         isolation items have changed during stay
         -Unable to Assess/Obtain: Patient's
         condition is emergent and assessment can
         not be done
    Isolation Assessment
        Reason for Isolation                    None
        Type of Isolation                       Standard Precautions
    Isolation Summary
        Does Patient Require Isolation          No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
        History of Falls During Hospital Visit  No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
        Mental Status                           Oriented to Own Ability
        Patient Is Willing and Able to Assist in Yes
         Fall Prevention
         Query Text:Ask patient: Can you, will
         you, and are you able to ring for
         assistance?
        Recent History of Falls (Within the Last No
         12 Months)
        Age                                     Less Than 65 Years
        Narcotic/Sedative/Hypnotic Medication   No
         Administered
        Bladder/Bowel Incontinence              No
        Attached Equipment (Lines/Tubes/Etc)    No
        Secondary Diagnosis (2 or More Medical  Yes
         Diagnoses)
        Gait/Transferring                       Normal
```

Continued on Page 189

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Score 5
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift pt taking 80 mg geodon PO
Any Adverse Effects Noted Yes: pt states akathisia

Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No

Continued on Page 190

Assessments and Treatments - Continued

```
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    0
       Fall Risk - Calculated                   Low
       Fall Risk - Determined by RN             Low
        Query Text:** DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Document     01/13/17 08:46  SHA0063  (Rec: 01/13/17 09:08  SHA0063  BSU-C02)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                          No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                     None
       Type of Isolation                        Standard Precautions
    Isolation Summary
       Does Patient Require Isolation           No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                            Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                      Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication    No
        Administered
       Bladder/Bowel Incontinence               No
       Attached Equipment (Lines/Tubes/Etc)     No
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    0
       Fall Risk - Calculated                   Low
```

Continued on Page 191

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
      Fall Risk - Determined by RN              Low
       Query Text:**  DO NOT assign a level
       lower than the calculated Fall Risk.  **
       This question can be updated based on
       nursing judgement.  If different than
       calculated fall risk, include reason in
       comments below (required).
Assessment/Reassessment: +Safety
    Additional Precautions
      Additional Precautions                    None
New Medications
    New Medications this Shift
      Was Patient Started on any New            No
       Medications this Shift
Document     01/14/17 13:32  KEL0078  (Rec: 01/14/17 13:39  KEL0078  BSU-C02)
Isolation and MRSA Assessment
    MRSA Assessment Status
      MRSA Assessment                           No Update Needed
       Query Text:
       -No Update Needed: When isolation items
       have not changed since last
       documentation
       -Update Needed: Upon arrival or if
       isolation items have changed during stay
       -Unable to Assess/Obtain: Patient's
       condition is emergent and assessment can
       not be done
    Isolation Assessment
      Reason for Isolation                      None
      Type of Isolation                         Standard Precautions
    Isolation Summary
      Does Patient Require Isolation            No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
      History of Falls During Hospital Visit    No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
      Mental Status                             Oriented to Own Ability
      Patient Is Willing and Able to Assist in Yes
       Fall Prevention
       Query Text:Ask patient: Can you, will
       you, and are you able to ring for
       assistance?
      Recent History of Falls (Within the Last No
       12 Months)
      Age                                       Less Than 65 Years
      Narcotic/Sedative/Hypnotic Medication     No
       Administered
      Bladder/Bowel Incontinence                No
      Attached Equipment (Lines/Tubes/Etc)      No
      Secondary Diagnosis (2 or More Medical    No
       Diagnoses)
      Gait/Transferring                         Normal
```

Continued on Page 192

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
        Score                                     0
        Fall Risk - Calculated                    Low
        Fall Risk - Determined by RN              Low
         Query Text:**  DO NOT assign a level
         lower than the calculated Fall Risk.  **
         This question can be updated based on
         nursing judgement.  If different than
         calculated fall risk, include reason in
         comments below (required).
     Safety Interventions
        Side Rails Up                             None
Assessment/Reassessment: +Safety
     Additional Precautions
        Additional Precautions                    None
New Medications
     New Medications this Shift
        Was Patient Started on any New            No
         Medications this Shift
        Any Adverse Effects Noted                 No
Document     01/16/17 10:12  COU0002  (Rec: 01/16/17 10:20  COU0002  BSU-M03)
Isolation and MRSA Assessment
     MRSA Assessment Status
        MRSA Assessment                           No Update Needed
         Query Text:
         -No Update Needed: When isolation items
         have not changed since last
         documentation
         -Update Needed: Upon arrival or if
         isolation items have changed during stay
         -Unable to Assess/Obtain: Patient's
         condition is emergent and assessment can
         not be done
     Isolation Assessment
        Reason for Isolation                      None
        Type of Isolation                         Standard Precautions
     Isolation Summary
        Does Patient Require Isolation            No
Hx of Falls During Hospital Visit
     Hx of Falls During Hospital Visit
        History of Falls During Hospital Visit    No
Safety/Fall Risk Assessment
     Safety/Fall Risk Assessment
        Mental Status                             Oriented to Own Ability
        Patient Is Willing and Able to Assist in  Yes
         Fall Prevention
         Query Text:Ask patient: Can you, will
         you, and are you able to ring for
         assistance?
        Recent History of Falls (Within the Last  No
         12 Months)
        Age                                       Less Than 65 Years
        Narcotic/Sedative/Hypnotic Medication     No
         Administered
```

Continued on Page 193

Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal

Continued on Page 194

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. **

Continued on Page 195

This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Safety Interventions
Side Rails Up None

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift No
Any Adverse Effects Noted No

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions

Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal

Continued on Page 196

```
       Score                                    0
       Fall Risk - Calculated                   Low
       Fall Risk - Determined by RN             Low
        Query Text:**  DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Document     01/20/17 15:19  KER0050  (Rec: 01/20/17 15:43  KER0050  BSU-C12)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                          No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                     None
       Type of Isolation                        Standard Precautions
    Isolation Summary
       Does Patient Require Isolation           No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                            Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                      Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication    No
        Administered
       Bladder/Bowel Incontinence               No
       Attached Equipment (Lines/Tubes/Etc)     No
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                        Normal
       Score                                    0
       Fall Risk - Calculated                   Low
       Fall Risk - Determined by RN             Low
        Query Text:**  DO NOT assign a level
        lower than the calculated Fall Risk.  **
```

Continued on Page 197

```
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Document     01/21/17 13:32  ROB0100  (Rec: 01/21/17 13:35  ROB0100  CMC-RDC2)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                         No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                    None
       Type of Isolation                       Standard Precautions
    Isolation Summary
       Does Patient Require Isolation          No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                           Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                     Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication    No
        Administered
       Bladder/Bowel Incontinence              No
       Attached Equipment (Lines/Tubes/Etc)     No
       Secondary Diagnosis (2 or More Medical   No
        Diagnoses)
       Gait/Transferring                       Normal
       Score                                   0
       Fall Risk - Calculated                  Low
       Fall Risk - Determined by RN            Low
        Query Text:**  DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Assessment/Reassessment: +Safety
```

Continued on Page 198

Assessments and Treatments - Continued

Additional Precautions
Additional Precautions None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift No

Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions

Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in

Continued on Page 199

comments below (required).
New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift: No
Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)
Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment: No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation: None
Type of Isolation: Standard Precautions
Isolation Summary
Does Patient Require Isolation: No
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit: No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status: Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention: Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months): No
Age: Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered: No
Bladder/Bowel Incontinence: No
Attached Equipment (Lines/Tubes/Etc): No
Secondary Diagnosis (2 or More Medical Diagnoses): Yes
Gait/Transferring: Normal
Score: 5
Fall Risk - Calculated: Low
Fall Risk - Determined by RN: Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Continued on Page 200

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Assessment/Reassessment: +Safety
    Additional Precautions
       Additional Precautions                  None
New Medications
    New Medications this Shift
       Was Patient Started on any New          No
        Medications this Shift
Document     01/24/17 10:36  SHA0063  (Rec: 01/24/17 10:44  SHA0063  BSU-C12)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                         No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                    None
       Type of Isolation                       Standard Precautions
    Isolation Summary
       Does Patient Require Isolation          No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                           Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                     Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication   No
        Administered
       Bladder/Bowel Incontinence              No
       Attached Equipment (Lines/Tubes/Etc)    No
       Secondary Diagnosis (2 or More Medical  No
        Diagnoses)
       Gait/Transferring                       Normal
       Score                                   0
       Fall Risk - Calculated                  Low
       Fall Risk - Determined by RN            Low
        Query Text:**  DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
```

Continued on Page 201

calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions — None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift — No

Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment — No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation — None
Type of Isolation — Standard Precautions
Isolation Summary
Does Patient Require Isolation — No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit — No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status — Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention — Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) — No
Age — Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered — No
Bladder/Bowel Incontinence — No
Attached Equipment (Lines/Tubes/Etc) — No
Secondary Diagnosis (2 or More Medical Diagnoses) — No
Gait/Transferring — Normal
Score — 0
Fall Risk - Calculated — Low
Fall Risk - Determined by RN — Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. **

Continued on Page 202

This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift No

Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low

Continued on Page 203

Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)

Isolation and MRSA Assessment
- MRSA Assessment Status
  - MRSA Assessment: No Update Needed
    - Query Text:
    - -No Update Needed: When isolation items have not changed since last documentation
    - -Update Needed: Upon arrival or if isolation items have changed during stay
    - -Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
- Isolation Assessment
  - Reason for Isolation: None
  - Type of Isolation: Standard Precautions
- Isolation Summary
  - Does Patient Require Isolation: No

Hx of Falls During Hospital Visit
- Hx of Falls During Hospital Visit
  - History of Falls During Hospital Visit: No

Safety/Fall Risk Assessment
- Safety/Fall Risk Assessment
  - Mental Status: Oriented to Own Ability
  - Patient Is Willing and Able to Assist in Fall Prevention: Yes
    - Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
  - Recent History of Falls (Within the Last 12 Months): No
  - Age: Less Than 65 Years
  - Narcotic/Sedative/Hypnotic Medication Administered: No
  - Bladder/Bowel Incontinence: No
  - Attached Equipment (Lines/Tubes/Etc): No
  - Secondary Diagnosis (2 or More Medical Diagnoses): No
  - Gait/Transferring: Normal
  - Score: 0
  - Fall Risk - Calculated: Low
  - Fall Risk - Determined by RN: Low
    - Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in

Continued on Page 204

comments below (required).
Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None
New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift No
Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)
Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. **
This question can be updated based on

Continued on Page 205

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Assessment/Reassessment: +Safety
    Additional Precautions
       Additional Precautions                     None
New Medications
    New Medications this Shift
       Was Patient Started on any New             No
        Medications this Shift
Document     01/31/17 13:48  SHA0063  (Rec: 01/31/17 13:51  SHA0063  CMC-RDC2)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                            No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                       None
       Type of Isolation                          Standard Precautions
    Isolation Summary
       Does Patient Require Isolation             No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
       History of Falls During Hospital Visit     No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
       Mental Status                              Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                        Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication      No
        Administered
       Bladder/Bowel Incontinence                 No
       Attached Equipment (Lines/Tubes/Etc)       No
       Secondary Diagnosis (2 or More Medical     No
        Diagnoses)
       Gait/Transferring                          Normal
       Score                                      0
       Fall Risk - Calculated                     Low
       Fall Risk - Determined by RN               Low
        Query Text:**  DO NOT assign a level
```

Continued on Page 206

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

lower than the calculated Fall Risk. **
This question can be updated based on
nursing judgement. If different than
calculated fall risk, include reason in
comments below (required).

Assessment/Reassessment: +Safety
- Additional Precautions
  - Additional Precautions: None

New Medications
- New Medications this Shift
  - Was Patient Started on any New Medications this Shift: No

Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)

Isolation and MRSA Assessment
- MRSA Assessment Status
  - MRSA Assessment: No Update Needed
    Query Text:
    -No Update Needed: When isolation items have not changed since last documentation
    -Update Needed: Upon arrival or if isolation items have changed during stay
    -Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
- Isolation Assessment
  - Reason for Isolation: None
  - Type of Isolation: Standard Precautions
- Isolation Summary
  - Does Patient Require Isolation: No

Hx of Falls During Hospital Visit
- Hx of Falls During Hospital Visit
  - History of Falls During Hospital Visit: No

Safety/Fall Risk Assessment
- Safety/Fall Risk Assessment
  - Mental Status: Oriented to Own Ability
  - Patient Is Willing and Able to Assist in Fall Prevention: Yes
    Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
  - Recent History of Falls (Within the Last 12 Months): No
  - Age: Less Than 65 Years
  - Narcotic/Sedative/Hypnotic Medication Administered: No
  - Bladder/Bowel Incontinence: No
  - Attached Equipment (Lines/Tubes/Etc): No
  - Secondary Diagnosis (2 or More Medical Diagnoses): No
  - Gait/Transferring: Normal
  - Score: 0
  - Fall Risk - Calculated: Low

Continued on Page 207

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Fall Risk - Determined by RN             Low
       Query Text:**  DO NOT assign a level
       lower than the calculated Fall Risk.  **
       This question can be updated based on
       nursing judgement.  If different than
       calculated fall risk, include reason in
       comments below (required).
Assessment/Reassessment: +Safety
    Additional Precautions
      Additional Precautions                   None
New Medications
    New Medications this Shift
      Was Patient Started on any New           No
       Medications this Shift
Document     02/02/17 11:10  NAT0065  (Rec: 02/02/17 11:12  NAT0065  CMC-RDC2)
Isolation and MRSA Assessment
    MRSA Assessment Status
      MRSA Assessment                          No Update Needed
       Query Text:
       -No Update Needed: When isolation items
       have not changed since last
       documentation
       -Update Needed: Upon arrival or if
       isolation items have changed during stay
       -Unable to Assess/Obtain: Patient's
       condition is emergent and assessment can
       not be done
    Isolation Assessment
      Reason for Isolation                     None
      Type of Isolation                        Standard Precautions
    Isolation Summary
      Does Patient Require Isolation           No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
      History of Falls During Hospital Visit   No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
      Mental Status                            Oriented to Own Ability
      Patient Is Willing and Able to Assist in Yes
       Fall Prevention
       Query Text:Ask patient: Can you, will
       you, and are you able to ring for
       assistance?
      Recent History of Falls (Within the Last No
       12 Months)
      Age                                      Less Than 65 Years
      Narcotic/Sedative/Hypnotic Medication    No
       Administered
      Bladder/Bowel Incontinence               No
      Attached Equipment (Lines/Tubes/Etc)     No
      Secondary Diagnosis (2 or More Medical   No
       Diagnoses)
      Gait/Transferring                        Normal
```

Continued on Page 208

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
        Score                                   0
        Fall Risk - Calculated                  Low
        Fall Risk - Determined by RN            Low
         Query Text:**  DO NOT assign a level
         lower than the calculated Fall Risk.  **
         This question can be updated based on
         nursing judgement.  If different than
         calculated fall risk, include reason in
         comments below (required).
    Safety Interventions
        Side Rails Up                           None
Assessment/Reassessment: +Safety
    Additional Precautions
        Additional Precautions                  None
New Medications
    New Medications this Shift
        Was Patient Started on any New          No
         Medications this Shift
Document     02/03/17 13:08  NAT0065  (Rec: 02/03/17 13:15  NAT0065  BSU-M07)
Isolation and MRSA Assessment
    MRSA Assessment Status
        MRSA Assessment                         No Update Needed
         Query Text:
         -No Update Needed: When isolation items
         have not changed since last
         documentation
         -Update Needed: Upon arrival or if
         isolation items have changed during stay
         -Unable to Assess/Obtain: Patient's
         condition is emergent and assessment can
         not be done
    Isolation Assessment
        Reason for Isolation                    None
        Type of Isolation                       Standard Precautions
    Isolation Summary
        Does Patient Require Isolation          No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
        History of Falls During Hospital Visit  No
Safety/Fall Risk Assessment
    Safety/Fall Risk Assessment
        Mental Status                           Oriented to Own Ability
        Patient Is Willing and Able to Assist in Yes
         Fall Prevention
         Query Text:Ask patient: Can you, will
         you, and are you able to ring for
         assistance?
        Recent History of Falls (Within the Last No
         12 Months)
        Age                                     Less Than 65 Years
        Narcotic/Sedative/Hypnotic Medication   No
         Administered
        Bladder/Bowel Incontinence              No
```

Continued on Page 209

Assessments and Treatments - Continued

```
        Attached Equipment (Lines/Tubes/Etc)      No
        Secondary Diagnosis (2 or More Medical    No
         Diagnoses)
        Gait/Transferring                         Normal
        Score                                     0
        Fall Risk - Calculated                    Low
        Fall Risk - Determined by RN              Low
         Query Text:**  DO NOT assign a level
         lower than the calculated Fall Risk.  **
         This question can be updated based on
         nursing judgement.  If different than
         calculated fall risk, include reason in
         comments below (required).
     Safety Interventions
        Side Rails Up                             None
Assessment/Reassessment: +Safety
     Additional Precautions
        Additional Precautions                    None
New Medications
     New Medications this Shift
        Was Patient Started on any New            No
         Medications this Shift
Document     02/04/17 11:57  KEL0078  (Rec: 02/04/17 11:59  KEL0078  BSU-M10)
Isolation and MRSA Assessment
     MRSA Assessment Status
        MRSA Assessment                           No Update Needed
         Query Text:
         -No Update Needed: When isolation items
         have not changed since last
         documentation
         -Update Needed: Upon arrival or if
         isolation items have changed during stay
         -Unable to Assess/Obtain: Patient's
         condition is emergent and assessment can
         not be done
     Isolation Assessment
        Reason for Isolation                      None
        Type of Isolation                         Standard Precautions
     Isolation Summary
        Does Patient Require Isolation            No
Hx of Falls During Hospital Visit
     Hx of Falls During Hospital Visit
        History of Falls During Hospital Visit    No
Safety/Fall Risk Assessment
     Safety/Fall Risk Assessment
        Mental Status                             Oriented to Own Ability
        Patient Is Willing and Able to Assist in  Yes
         Fall Prevention
         Query Text:Ask patient: Can you, will
         you, and are you able to ring for
         assistance?
        Recent History of Falls (Within the Last  No
         12 Months)
```

Continued on Page 210

Assessments and Treatments - Continued

Age — Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered — No
Bladder/Bowel Incontinence — No
Attached Equipment (Lines/Tubes/Etc) — No
Secondary Diagnosis (2 or More Medical Diagnoses) — No
Gait/Transferring — Normal
Score — 0
Fall Risk - Calculated — Low
Fall Risk - Determined by RN — Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Safety Interventions
Side Rails Up — None

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions — None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift — No
Any Adverse Effects Noted — No

Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment — No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment
Reason for Isolation — None
Type of Isolation — Standard Precautions

Isolation Summary
Does Patient Require Isolation — No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit — No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status — Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention — Yes

Continued on Page 211

Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?

Recent History of Falls (Within the Last 12 Months)	No
Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
Fall Risk - Calculated	Low
Fall Risk - Determined by RN	Low

Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment/Reassessment: +Safety
Additional Precautions
Additional Precautions None

New Medications
New Medications this Shift
Was Patient Started on any New Medications this Shift No
Any Adverse Effects Noted No

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)

Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions

Isolation Summary
Does Patient Require Isolation No

Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No

Safety/Fall Risk Assessment
Safety/Fall Risk Assessment

Continued on Page 212

Assessments and Treatments - Continued

```
       Mental Status                             Oriented to Own Ability
       Patient Is Willing and Able to Assist in Yes
        Fall Prevention
        Query Text:Ask patient: Can you, will
        you, and are you able to ring for
        assistance?
       Recent History of Falls (Within the Last No
        12 Months)
       Age                                       Less Than 65 Years
       Narcotic/Sedative/Hypnotic Medication     No
        Administered
       Bladder/Bowel Incontinence                No
       Attached Equipment (Lines/Tubes/Etc)      No
       Secondary Diagnosis (2 or More Medical    No
        Diagnoses)
       Gait/Transferring                         Normal
       Score                                     0
       Fall Risk - Calculated                    Low
       Fall Risk - Determined by RN              Low
        Query Text:** DO NOT assign a level
        lower than the calculated Fall Risk.  **
        This question can be updated based on
        nursing judgement.  If different than
        calculated fall risk, include reason in
        comments below (required).
Assessment/Reassessment: +Safety
    Additional Precautions
       Additional Precautions                    None
New Medications
    New Medications this Shift
       Was Patient Started on any New            No
        Medications this Shift
       Any Adverse Effects Noted                 No
Document     02/07/17 12:57  VIC0074  (Rec: 02/07/17 12:59  VIC0074  BSU-C12)
Isolation and MRSA Assessment
    MRSA Assessment Status
       MRSA Assessment                           No Update Needed
        Query Text:
        -No Update Needed: When isolation items
        have not changed since last
        documentation
        -Update Needed: Upon arrival or if
        isolation items have changed during stay
        -Unable to Assess/Obtain: Patient's
        condition is emergent and assessment can
        not be done
    Isolation Assessment
       Reason for Isolation                      None
       Type of Isolation                         Standard Precautions
    Isolation Summary
       Does Patient Require Isolation            No
Hx of Falls During Hospital Visit
    Hx of Falls During Hospital Visit
```

Continued on Page 213

History of Falls During Hospital Visit No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).
Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Yes

Continued on Page 214

Fall Prevention
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last 12 Months) No
Age Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered No
Bladder/Bowel Incontinence No
Attached Equipment (Lines/Tubes/Etc) No
Secondary Diagnosis (2 or More Medical Diagnoses) No
Gait/Transferring Normal
Score 0
Fall Risk - Calculated Low
Fall Risk - Determined by RN Low
Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)
Isolation and MRSA Assessment
MRSA Assessment Status
MRSA Assessment No Update Needed
Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done
Isolation Assessment
Reason for Isolation None
Type of Isolation Standard Precautions
Isolation Summary
Does Patient Require Isolation No
Hx of Falls During Hospital Visit
Hx of Falls During Hospital Visit
History of Falls During Hospital Visit No
Safety/Fall Risk Assessment
Safety/Fall Risk Assessment
Mental Status Oriented to Own Ability
Patient Is Willing and Able to Assist in Fall Prevention Yes
Query Text:Ask patient: Can you, will you, and are you able to ring for assistance?
Recent History of Falls (Within the Last No

Continued on Page 215

12 Months)

Age	Less Than 65 Years
Narcotic/Sedative/Hypnotic Medication Administered	No
Bladder/Bowel Incontinence	No
Attached Equipment (Lines/Tubes/Etc)	No
Secondary Diagnosis (2 or More Medical Diagnoses)	No
Gait/Transferring	Normal
Score	0
Fall Risk - Calculated	Low
Fall Risk - Determined by RN	Low

Query Text:** DO NOT assign a level lower than the calculated Fall Risk. ** This question can be updated based on nursing judgement. If different than calculated fall risk, include reason in comments below (required).

Assessment 08: Psychiatric/Psychosocial Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/25/16 20:07 STE0107 (Rec: 12/25/16 20:09 STE0107 BSU-C02)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Anxious Irritable Uncooperative

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes

Coping Skills Assessment

Patient Compliant with Treatment	Yes
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	Dependent/Unable

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Persecution
Eye Contact	Intense

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Continued on Page 216

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Suicide Risk Degree Low
Suicide Plan Description No Plan
Suicidal Ideation Description None

Document 12/26/16 13:13 VIC0074 (Rec: 12/26/16 13:22 VIC0074 BSU-M04)
Assessment/Reassessment: +Psychosocial/Psychiatric
Psychosocial Assessment
Patient's Psychosocial/Emotional Status Irritable
Assess: Coping Skills
Coping Skills Assessment
Is Patient able to Make Needs Known Yes
Is Patient able to make Self Understood Usually Understood
Does Patient Understand Reason for Hospitalization No
Has Patient Adapted to the Hospital Environment Yes
Reassessment: MHU Questions
Mobility Assessment
Ambulates Independently Yes
Ambulation Assistive Devices None
Patient Can Perform Own ADLs Yes
Patient's Senses Intact Yes
Weight Bearing Status Full Weight Bearing
Coping Skills Assessment
Patient Compliant with Treatment Yes
Communication Ability Fair
Patient Understands Current Problem/ Treatment Plan Yes
Daytime Naps No
Thought Content Assessment
Delusions Persecution
Eye Contact Intense
Self Harm Assessment
Are You Having Thoughts of Harming Yourself No
Lethality Assessment
Suicidal Ideation Description None
Safety Plan Yes: q 15 minute observational checks
Does Patient Need to Be on Increased Safety Precautions No
Initiate 1:1/Constant Observation No

Document 12/27/16 12:42 VIC0074 (Rec: 12/27/16 12:44 VIC0074 BSU-M09)
Assessment/Reassessment: +Psychosocial/Psychiatric
Psychosocial Assessment
Patient's Psychosocial/Emotional Status Irritable
Assess: Coping Skills
Coping Skills Assessment
Is Patient able to Make Needs Known Yes
Is Patient able to make Self Understood Usually Understood
Does Patient Understand Reason for Hospitalization No
Has Patient Adapted to the Hospital Environment Yes

Continued on Page 217

Reassessment: MHU Questions
    Mobility Assessment
        Ambulation Assistive Devices   None
        Patient Can Perform Own ADLs   Yes
        Patient's Senses Intact   Yes
        Weight Bearing Status   Full Weight Bearing
    Coping Skills Assessment
        Patient Compliant with Treatment   Yes
        Communication Ability   Fair
        Patient Understands Current Problem/ Treatment Plan   Yes
        Daytime Naps   No
    Thought Content Assessment
        Delusions   Persecution
        Eye Contact   Intense
    Self Harm Assessment
        Are You Having Thoughts of Harming Yourself   No
    Lethality Assessment
        Suicide Plan Description   No Plan
        Suicidal Ideation Description   None
        Safety Plan   Yes: q 15 minute observational checks
        Are You Having Thoughts of Hurting Others   No
        Does Patient Need to Be on Increased Safety Precautions   No
        Initiate 1:1/Constant Observation   No
Document 12/28/16 10:14 JOH0022 (Rec: 12/28/16 10:19 JOH0022 CMC-RDC2)
Assess: Coping Skills
    Coping Skills Assessment
        Is Patient able to Make Needs Known   Yes
        Is Patient able to make Self Understood   Usually Understood
Reassessment: MHU Questions
    Mobility Assessment
        Ambulates Independently   Yes
        Ambulation Assistive Devices   None
    Thought Content Assessment
        Ideation   Denies All
        Hallucinations   Auditory
        Delusions   Denies
        Thought Content Comments   talking to himself, disorganized, denies being a patient
Document 12/29/16 10:10 SHA0157 (Rec: 12/29/16 10:13 SHA0157 BSU-M09)
Assessment/Reassessment: +Psychosocial/Psychiatric
    Psychosocial Assessment
        Patient's Psychosocial/Emotional Status   Irritable
Assess: Coping Skills
    Coping Skills Assessment
        Is Patient able to Make Needs Known   Yes
        Is Patient able to make Self Understood   Usually Understood
Reassessment: MHU Questions

Continued on Page 218

Assessments and Treatments - Continued

Mobility Assessment
- Ambulates Independently: Yes
- Ambulation Assistive Devices: None

Coping Skills Assessment
- Patient Compliant with Treatment: No
- Communication Ability: Fair
- Patient Understands Current Problem/ Treatment Plan: No

Thought Content Assessment
- Ideation: Denies All
- Hallucinations: Auditory
- Delusions: Grandeur
- Eye Contact: Normal

Self Harm Assessment
- Are You Having Thoughts of Harming Yourself: No

Lethality Assessment
- Suicide Risk Degree: Low
- Suicide Plan Description: No Plan
- Suicidal Ideation Description: None
- Safety Plan: Yes: Q15 minute observation
- Are You Having Thoughts of Hurting Others: No
- Does Patient Need to Be on Increased Safety Precautions: No
- Initiate 1:1/Constant Observation: No
- Psychiatrist Notified: No

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment
- Patient's Psychosocial/Emotional Status: Calm
  Irritable

Assess: Coping Skills

Coping Skills Assessment
- Is Patient able to Make Needs Known: Yes
- Is Patient able to make Self Understood: Usually Understood
- Patient Compliant: No
- Does Patient Understand Reason for Hospitalization: No
- Has Patient Adapted to the Hospital Environment: Yes

Reassessment: MHU Questions

Mobility Assessment
- Ambulates Independently: Yes
- Ambulation Assistive Devices: None
- Patient Can Perform Own ADLs: Yes
- ADLs Completed: Yes
- Patient's Senses Intact: Yes
- Weight Bearing Status: Full Weight Bearing
- Call Bell within Reach: No
- Patient Instructed to Call for Help if Feeling Weak or Dizzy: Yes

Coping Skills Assessment

Continued on Page 219

Assessments and Treatments - Continued

Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Internalization
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	Auditory
Thought Content Comments	appears paranoid
Eye Contact	Fair
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q15 minute observation
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	No

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Patient Can Perform Own ADLs	Yes
ADLs Completed	No
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Poor
Daytime Naps	Yes
Patient Slept Well at Night	Yes
Thought Content Assessment	

Continued on Page 220

Assessments and Treatments - Continued

```
       Ideation                                 Violent
       Ideation Response Plan                   becomes loud and agitated at
                                                times
    Lethality Assessment
       Are You at Risk of Hurting Yourself If   No
        Discharged
Document     01/01/17 10:33  JOH0022  (Rec: 01/01/17 10:40  JOH0022  BSU-C12)
Assess: Coping Skills
    Coping Skills Assessment
       Is Patient able to Make Needs Known      Yes
       Is Patient able to make Self Understood  Usually Understood
Reassessment: MHU Questions
    Mobility Assessment
       Ambulates Independently                  Yes
       Ambulation Assistive Devices             None
    Coping Skills Assessment
       Patient Compliant with Treatment         No: refuses groups and
                                                medication
       Communication Ability                    Fair
    Thought Content Assessment
       Ideation                                 Denies All
       Hallucinations                           Auditory
       Thought Content Comments                 refuses to answer questions
                                                about thoughts or feelings
       Eye Contact                              Normal
    Lethality Assessment
       Suicide Risk Degree                      Low
Document     01/02/17 14:10  VIC0074  (Rec: 01/02/17 14:13  VIC0074  BSU-C12)
Assessment/Reassessment: +Psychosocial/Psychiatric
    Psychosocial Assessment
       Patient's Psychosocial/Emotional Status  Irritable
Assess: Coping Skills
    Coping Skills Assessment
       Is Patient able to Make Needs Known      Yes
       Is Patient able to make Self Understood  Usually Understood
       Does Patient Understand Reason for       No
        Hospitalization
       Has Patient Adapted to the Hospital      Yes
        Environment
Reassessment: MHU Questions
    Mobility Assessment
       Ambulates Independently                  Yes
       Ambulation Assistive Devices             None
       Patient Can Perform Own ADLs             Yes
    Coping Skills Assessment
       Patient Compliant with Treatment         No: declines groups and
                                                medications
       Communication Ability                    Fair
       Patient Understands Current Problem/     No
        Treatment Plan
       Daytime Naps                             No
    Thought Content Assessment
       Thought Content Comments                 Declines 1:1
```

Continued on Page 221

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
    Lethality Assessment
       Safety Plan                              Yes: Q15 minute observation
       Does Patient Need to Be on Increased     No
        Safety Precautions
       Initiate 1:1/Constant Observation        No
Document     01/03/17 10:37  JOH0022  (Rec: 01/03/17 11:14  JOH0022  BSU-M10)
Assessment/Reassessment: +Psychosocial/Psychiatric
    Psychosocial Assessment
       Patient's Psychosocial/Emotional Status  Irritable
                                                Uncooperative
Assess: Coping Skills
    Coping Skills Assessment
       Is Patient able to Make Needs Known      Yes
       Is Patient able to make Self Understood  Usually Understood
Reassessment: MHU Questions
    Mobility Assessment
       Ambulates Independently                  Yes
       Ambulation Assistive Devices             None
    Coping Skills Assessment
       Patient Compliant with Treatment         No
       Communication Ability                    Fair
       Patient Understands Current Problem/     No
        Treatment Plan
       Daytime Naps                             No
    Thought Content Assessment
       Ideation                                 Denies All
       Hallucinations                           Auditory
       Delusions                                Persecution
       Eye Contact                              Normal
    Self Harm Assessment
       Are You Having Thoughts of Harming       No
        Yourself
    Lethality Assessment
       Suicide Risk Degree                      Low
Document     01/04/17 10:48  BAR0006  (Rec: 01/04/17 10:54  BAR0006  BSU-M03)
Assessment/Reassessment: +Psychosocial/Psychiatric
    Psychosocial Assessment
       Patient's Psychosocial/Emotional Status  Calm
                                                Other
       Psychosocial/Emotional Status Comment    States coping about being here
                                                .
Assess: Coping Skills
    Coping Skills Assessment
       Is Patient able to Make Needs Known      Yes
       Is Patient able to make Self Understood  Usually Understood
       Patient Compliant                        No
       Has Patient Adapted to the Hospital      Yes
        Environment
Reassessment: MHU Questions
    Mobility Assessment
       Ambulates Independently                  Yes
       Ambulation Assistive Devices             None
       Patient Can Perform Own ADLs             Yes
```

Continued on Page 222

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	na
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Thought Content Comments	Lots of talk about cyberwar, computers being hacked, not having court when he applied to go to court
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes
Are You Having Thoughts of Hurting Others	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/05/17 10:17 BAR0006 (Rec: 01/05/17 10:21 BAR0006 BSU-M04)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Calm Irritable
Psychosocial/Emotional Status Comment	Irritable to staff this AM

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	na

Continued on Page 223

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Poor
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	Autonomous
Coping Strategies	Distancing Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Thought Content Comments	Paranoid, spreading rumors about patinets, denies being a patient
Eye Contact	Intense
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes
Are You Having Thoughts of Hurting Others	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/06/17 10:20 BAR0006 (Rec: 01/06/17 10:25 BAR0006 BSU-M10)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Irritable
Psychosocial/Emotional Status Comment	Irritable to staff this AM

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	not attending groups, taking oral medications
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
Patient's Senses Intact	Yes

Continued on Page 224

Assessments and Treatments - Continued

Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	na
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Poor
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	Autonomous
Coping Strategies	Distancing Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Delusions	Denies
Thought Content Comments	Questions why being a patient, doesn't believe we are who we are
Eye Contact	Intense
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes
Are You Having Thoughts of Hurting Others	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/08/17 13:23 JOH0022 (Rec: 01/08/17 13:36 JOH0022 BSU-C12)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Uncooperative

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No: refusing group, resists meds strenuously
Does Patient Understand Reason for Hospitalization	No

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
Patient's Senses Intact	Yes

Continued on Page 225

Assessments and Treatments - Continued

Weight Bearing Status — Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy — Yes

Coping Skills Assessment
Patient Compliant with Treatment — No
Communication Ability — Fair

Thought Content Assessment
Ideation — Denies All
Hallucinations — Auditory
Delusions — Denies

Self Harm Assessment
Are You Having Thoughts of Harming Yourself — No

Lethality Assessment
Suicide Risk Degree — Low

Document 01/09/17 11:08 JOH0022 (Rec: 01/09/17 11:14 JOH0022 BSU-C12)

Reassessment: MHU Questions

Thought Content Assessment
Ideation — Denies All
Delusions — Persecution
Thought Content Comments — still believes she is being kidnapped and is being held here without legal cause
Eye Contact — Normal

Self Harm Assessment
Are You Having Thoughts of Harming Yourself — No

Lethality Assessment
Suicide Risk Degree — Low

Document 01/10/17 11:48 JOH0022 (Rec: 01/10/17 11:51 JOH0022 BSU-C01)

Reassessment: MHU Questions

Mobility Assessment
Ambulates Independently — Yes
Ambulation Assistive Devices — None

Thought Content Assessment
Ideation — Denies All
Hallucinations — None
Delusions — Denies
Eye Contact — Normal

Self Harm Assessment
Are You Having Thoughts of Harming Yourself — No
Do You Have Access to Any Objects You Could Use to Harm Yourself — No

Lethality Assessment
Suicide Risk Degree — Low
Suicide Plan Description — No Plan

Document 01/11/17 10:41 BAR0006 (Rec: 01/11/17 10:44 BAR0006 BSU-C09)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment
Patient's Psychosocial/Emotional Status — Irritable, Uncooperative

Assess: Coping Skills

Continued on Page 226

Assessments and Treatments - Continued

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No: refusing group, resists meds strenuously
Does Patient Understand Reason for Hospitalization	No

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes

Coping Skills Assessment

Patient Compliant with Treatment	No
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	Autonomous
Coping Strategies	Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Patient Slept Well at Night	No

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Denies
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No
Do You Have Access to Any Objects You Could Use to Harm Yourself	No

Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes
Are You Having Thoughts of Hurting Others	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/12/17 11:26 JOH0022 (Rec: 01/12/17 11:30 JOH0022 CMC-RDC2)

Reassessment: MHU Questions

Coping Skills Assessment

Patient Compliant with Treatment	No
Communication Ability	Good

Thought Content Assessment

Ideation	Denies All

Continued on Page 227

Assessments and Treatments - Continued

Hallucinations	None
Delusions	Denies
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Do You Have Access to Any Objects You Could Use to Harm Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan

Document 01/13/17 08:46 SHA0063 (Rec: 01/13/17 09:08 SHA0063 BSU-C02)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Irritable Uncooperative
Psychosocial/Emotional Status Comment	angry regarding receiving Geodon per court order

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No: needed security presence to take Geodon
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
Patient's Senses Intact	Yes: wears glasses
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	No
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Defining Problem Emotional Support Request Learning Self-Care Setting Limited Goals Internalization Information Seeking Blaming
Thought Content Assessment	
Ideation	Denies All
Delusions	Persecution

Continued on Page 228

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Eye Contact	Intense
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Do You Have Access to Any Objects You Could Use to Harm Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: every fifteen minutes
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Irritable Uncooperative
Psychosocial/Emotional Status Comment	angry regarding receiving Geodon per court order

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Usually Understood
Patient Compliant	No: needed security presence to take Geodon
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
Patient's Senses Intact	Yes: wears glasses
Weight Bearing Status	Full Weight Bearing
Call Bell within Reach	No
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	Yes
Coping/Decision Making Ability	With Guidance
Coping Strategies	Defining Problem

Continued on Page 229

	Emotional Support Request
	Learning Self-Care
	Setting Limited Goals
	Internalization
	Information Seeking
	Blaming
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Persecution
Eye Contact	Intense
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Do You Have Access to Any Objects You Could Use to Harm Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: every fifteen minutes
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/16/17 10:12 COU0002 (Rec: 01/16/17 10:20 COU0002 BSU-M03)

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Thought Content Assessment	
Ideation	Denies All
Hallucinations	Auditory
Delusions	Persecution
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Do You Have Access to Any Objects You Could Use to Harm Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan

Document 01/17/17 10:41 COU0002 (Rec: 01/17/17 10:43 COU0002 CMC-RDC2)

Continued on Page 230

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Reassessment: MHU Questions
- Mobility Assessment
  - Ambulates Independently: Yes
  - Ambulation Assistive Devices: None
- Thought Content Assessment
  - Ideation: Denies All
  - Hallucinations: Auditory
  - Delusions: Bizzare
  - Thought Content Comments: believes that she has been kidnapped and is here against her will
  - Eye Contact: Fair
- Self Harm Assessment
  - Are You Having Thoughts of Harming Yourself: No
  - Do You Have Access to Any Objects You Could Use to Harm Yourself: No
- Lethality Assessment
  - Suicide Risk Degree: Low
  - Suicide Plan Description: No Plan

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)

Assessment/Reassessment: +Psychosocial/Psychiatric
- Psychosocial Assessment
  - Patient's Psychosocial/Emotional Status: Cooperative, Anxious, Irritable, Uncooperative
  - Psychosocial/Emotional Status Comment: angry regarding receiving Geodon per court order

Assess: Coping Skills
- Coping Skills Assessment
  - Is Patient able to Make Needs Known: Yes
  - Is Patient able to make Self Understood: Usually Understood
  - Patient Compliant: Yes
  - Does Patient Understand Reason for Hospitalization: No
  - Has Patient Adapted to the Hospital Environment: Yes

Reassessment: MHU Questions
- Mobility Assessment
  - Ambulates Independently: Yes
  - Ambulation Assistive Devices: None
  - Patient Can Perform Own ADLs: Yes
  - ADLs Completed: No
  - Patient's Senses Intact: Yes
  - Weight Bearing Status: Full Weight Bearing
  - Patient Instructed to Call for Help if Feeling Weak or Dizzy: Yes
- Coping Skills Assessment
  - Patient Compliant with Treatment: No
  - Communication Ability: Good
  - Patient Understands Current Problem/ Treatment Plan: Yes

Continued on Page 231

Coping/Decision Making Ability	With Guidance
Coping Strategies	Avoidance Selective Attention Defining Problem Emotional Support Request Learning Self-Care Setting Limited Goals Internalization Information Seeking Blaming
Coping Response Effectiveness	Constructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	Auditory
Delusions	Bizzare
Thought Content Comments	believes that she has been kidnapped and is here against her will
Eye Contact	Fair
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Do You Have Access to Any Objects You Could Use to Harm Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: Q 30 min checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/19/17 09:21 JOH0022 (Rec: 01/19/17 09:26 JOH0022 CMC-RDC2)

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Coping Skills Assessment	
Patient Compliant with Treatment	No: refusing to attend group except for community group

Continued on Page 232

Assessments and Treatments - Continued

Communication Ability — Good
Patient Understands Current Problem/ Treatment Plan — No

Thought Content Assessment
Ideation — Denies All
Delusions — Persecution

Self Harm Assessment
Are You Having Thoughts of Harming Yourself — No

Lethality Assessment
Suicide Risk Degree — Low

Document 01/22/17 13:15 JOH0022 (Rec: 01/22/17 13:31 JOH0022 CMC-RDC2)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment
Patient's Psychosocial/Emotional Status — Anxious

Assess: Coping Skills

Coping Skills Assessment
Is Patient able to Make Needs Known — Yes
Is Patient able to make Self Understood — Understood

Reassessment: MHU Questions

Mobility Assessment
Ambulates Independently — Yes
Ambulation Assistive Devices — None

Coping Skills Assessment
Patient Compliant with Treatment — No

Lethality Assessment
Suicide Risk Degree — Low

Document 01/23/17 10:16 BAR0006 (Rec: 01/23/17 10:29 BAR0006 BSU-M03)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment
Patient's Psychosocial/Emotional Status — Other
Psychosocial/Emotional Status Comment — aggitated at times, calm other times

Assess: Coping Skills

Coping Skills Assessment
Is Patient able to Make Needs Known — Yes
Is Patient able to make Self Understood — Understood
Patient Compliant — does not attend groups, taking ordered medications
Does Patient Understand Reason for Hospitalization — Unable to Determine
Has Patient Adapted to the Hospital Environment — Yes

Reassessment: MHU Questions

Mobility Assessment
Ambulates Independently — Yes
Ambulation Assistive Devices — None
Patient Can Perform Own ADLs — Yes
ADLs Completed — declines to shower, uses wash clothe to clean self
Patient's Senses Intact — Yes
Weight Bearing Status — Full Weight Bearing
Patient Instructed to Call for Help if — Yes

Continued on Page 233

Assessments and Treatments - Continued

Feeling Weak or Dizzy

Coping Skills Assessment

Patient Compliant with Treatment	No: no groups, takes court ordered medications
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	unsure
Coping/Decision Making Ability	Autonomous
Coping Strategies	Avoidance Selective Attention Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Delusions	Persecution
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	30 minute checks
Are You Having Thoughts of Hurting Others	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Other
Psychosocial/Emotional Status Comment	remains paranoid and delusional

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes

Continued on Page 234

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center Loc:BEHAVIORAL SERVICES UNIT Bed:202-01
60 F 05/01/1956 Med Rec Num:M000597460 Visit:A00082793308

Assessments and Treatments - Continued

Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Persecution
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Other
Psychosocial/Emotional Status Comment	remains paranoid and delusional

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for	No

Continued on Page 235

Assessments and Treatments - Continued

Hospitalization	
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Patient Instructed to Call for Help if Feeling Weak or Dizzy	Yes
Coping Skills Assessment	
Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Persecution
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 01/28/17 14:22 VIC0074 (Rec: 01/28/17 14:25 VIC0074 BSU-M07)

Assessment/Reassessment: +Psychosocial/Psychiatric	
Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Calm Cooperative

Continued on Page 236

	Irritable
Psychosocial/Emotional Status Comment	irritable at times
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No
Thought Content Assessment	
Eye Contact	Normal
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Psychosocial/Psychiatric	
Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable at times
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes

Continued on Page 237

Assessments and Treatments - Continued

Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Denies
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable when discussing

Continued on Page 238

	medication/ need for on-going admission
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Grandeur
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)

Continued on Page 239

Assessments and Treatments - Continued

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable when discussing medication/ need for on-going admission

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Grandeur
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No

Continued on Page 240

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable when discussing need for on-going admission

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Daytime Naps	No
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Grandeur
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming	No

Continued on Page 241

Yourself
Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)
Assessment/Reassessment: +Psychosocial/Psychiatric
Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable when discussing need for on-going admission

Assess: Coping Skills
Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions
Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	No

Continued on Page 242

Assessments and Treatments - Continued

Thought Content Assessment

Ideation	Denies All
Hallucinations	None
Delusions	Grandeur
Eye Contact	Normal

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment

Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable when discussing need for on-going admission

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No

Continued on Page 243

Assessments and Treatments - Continued

Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Blaming
Coping Response Effectiveness	Destructive
Daytime Naps	No
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Grandeur
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative Irritable
Psychosocial/Emotional Status Comment	irritable when discussing need for on-going admission

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes

Continued on Page 244

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Finding Alternatives Acting on Alternatives Blaming
Coping Response Effectiveness	Constructive
Daytime Naps	No
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Grandeur
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)

Assessment/Reassessment: +Psychosocial/Psychiatric

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative

Assess: Coping Skills

Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes

Continued on Page 245

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Fair
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Finding Alternatives Acting on Alternatives Blaming
Coping Response Effectiveness	Constructive
Daytime Naps	Yes
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Persecution
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No
Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Assessment/Reassessment: +Psychosocial/Psychiatric

Continued on Page 246

Assessments and Treatments - Continued

Psychosocial Assessment	
Patient's Psychosocial/Emotional Status	Appropriate to Situation Calm Cooperative
Assess: Coping Skills	
Coping Skills Assessment	
Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes
Reassessment: MHU Questions	
Mobility Assessment	
Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing
Coping Skills Assessment	
Patient Compliant with Treatment	No: does not attend groups
Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Finding Alternatives Acting on Alternatives Blaming
Coping Response Effectiveness	Constructive
Patient Slept Well at Night	Yes
Thought Content Assessment	
Ideation	Denies All
Hallucinations	None
Delusions	Denies
Eye Contact	Normal
Self Harm Assessment	
Are You Having Thoughts of Harming Yourself	No
Lethality Assessment	
Suicide Risk Degree	Low
Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Are You at Risk of Hurting Yourself If Discharged	No

Continued on Page 247

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Are You at Risk of Hurting Others If Discharged	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No
Psychiatrist Notified	No

Document 02/07/17 12:57 VIC0074 (Rec: 02/07/17 12:59 VIC0074 BSU-C12)

Assess: Coping Skills

Coping Skills Assessment

Is Patient able to Make Needs Known	Yes
Is Patient able to make Self Understood	Understood
Patient Compliant	Yes
Does Patient Understand Reason for Hospitalization	No
Has Patient Adapted to the Hospital Environment	Yes

Reassessment: MHU Questions

Mobility Assessment

Ambulates Independently	Yes
Ambulation Assistive Devices	None
Patient Can Perform Own ADLs	Yes
ADLs Completed	Yes
Patient's Senses Intact	Yes
Weight Bearing Status	Full Weight Bearing

Coping Skills Assessment

Communication Ability	Good
Patient Understands Current Problem/ Treatment Plan	No
Coping/Decision Making Ability	With Guidance
Coping Strategies	Selective Attention Emotional Support Request Learning Self-Care Setting Limited Goals Finding Alternatives Acting on Alternatives Blaming
Patient Slept Well at Night	Yes

Thought Content Assessment

Ideation	Denies All
Delusions	Denies
Eye Contact	Inconsistent

Self Harm Assessment

Are You Having Thoughts of Harming Yourself	No

Lethality Assessment

Suicide Plan Description	No Plan
Suicidal Ideation Description	None
Safety Plan	Yes: 30 minute checks
Are You Having Thoughts of Hurting Others	No
Does Patient Need to Be on Increased Safety Precautions	No
Initiate 1:1/Constant Observation	No

Continued on Page 248

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Document 02/08/17 09:41 JOH0022 (Rec: 02/08/17 09:56 JOH0022 BSU-M06)
Assess: Coping Skills
 Coping Skills Assessment
  Is Patient able to Make Needs Known — Yes
  Is Patient able to make Self Understood — Understood
Reassessment: MHU Questions
 Mobility Assessment
  Ambulates Independently — Yes
  Ambulation Assistive Devices — None
 Thought Content Assessment
  Ideation — Denies All
  Hallucinations — None
  Delusions — Denies
 Self Harm Assessment
  Are You Having Thoughts of Harming Yourself — No
 Lethality Assessment
  Suicide Risk Degree — Low

Document 02/09/17 11:06 JOH0022 (Rec: 02/09/17 11:17 JOH0022 BSU-C02)
Reassessment: MHU Questions
 Mobility Assessment
  Ambulates Independently — Yes
  Ambulation Assistive Devices — None
 Coping Skills Assessment
  Patient Compliant with Treatment — No: no groups
  Communication Ability — Good
 Thought Content Assessment
  Ideation — Denies All
  Hallucinations — None
  Delusions — Denies
 Lethality Assessment
  Suicide Risk Degree — Low

Assessment 09: Significant Occurrences Start: 12/25/16 05:12
Freq: Status: Discharge

Document 12/30/16 14:26 SHA0063 (Rec: 12/30/16 14:30 SHA0063 BSU-M07)
Significant Occurences
 Significant Occurences
  Significant Occurrences — none this shift
   Query Text:
   Please begin each entry with date/time.
   Please do not delete previous entries.
   Include occurrences during this hospital
   stay, such as:
   In-hospital transfer
   Fall/Injury
   Surgical procedure
   Invasive procedure
   New diagnosis since admission

Document 12/31/16 11:25 ELI0005 (Rec: 12/31/16 11:29 ELI0005 BSU-M07)
Significant Occurences
 Significant Occurences
  Significant Occurrences — none this shift
   Query Text:

Continued on Page 249

Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/14/17 13:32 KEL0078 (Rec: 01/14/17 13:39 KEL0078 BSU-C02)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/18/17 13:05 NAT0065 (Rec: 01/18/17 13:10 NAT0065 BSU-C12)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/24/17 10:36 SHA0063 (Rec: 01/24/17 10:44 SHA0063 BSU-C12)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/26/17 10:57 SHA0063 (Rec: 01/26/17 11:03 SHA0063 CMC-RDC2)
Significant Occurences

Continued on Page 250

Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/29/17 09:46 SHA0063 (Rec: 01/29/17 09:49 SHA0063 CMC-RDC2)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/30/17 11:21 SHA0063 (Rec: 01/30/17 11:25 SHA0063 CMC-RDC2)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

Document 01/31/17 13:48 SHA0063 (Rec: 01/31/17 13:51 SHA0063 CMC-RDC2)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure

Continued on Page 251

New diagnosis since admission
Document 02/01/17 14:25 SHA0063 (Rec: 02/01/17 14:28 SHA0063 BSU-M07)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 02/02/17 11:10 NAT0065 (Rec: 02/02/17 11:12 NAT0065 CMC-RDC2)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 02/03/17 13:08 NAT0065 (Rec: 02/03/17 13:15 NAT0065 BSU-M07)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 02/04/17 11:57 KEL0078 (Rec: 02/04/17 11:59 KEL0078 BSU-M10)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer

Continued on Page 252

Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission
Document 02/06/17 12:54 SHA0063 (Rec: 02/06/17 12:59 SHA0063 BSU-M07)
Significant Occurences
Significant Occurences
Significant Occurrences none this shift
Query Text:
Please begin each entry with date/time.
Please do not delete previous entries.
Include occurrences during this hospital
stay, such as:
In-hospital transfer
Fall/Injury
Surgical procedure
Invasive procedure
New diagnosis since admission

CARE Act Assessment Start: 12/25/16 05:12
Freq: Q1HX1,T.PRN Status: Discharge
Document 01/15/17 23:58 BRA0067 (Rec: 01/15/17 23:58 BRA0067 BSU-C02)
CARE Act
Caregiver Identification and Purpose
-Purpose for identifying a caregiver is to include the caregiver in the
discharge planning process and to share post-discharge care and
instruction.
-It is not required to identify a caregiver
-If a caregiver is identified, it can be changed at any time
Patient/Legal Guardian Able to Identify/ Need to Reassess
Decline Caregiver
Consent
Consent Signed N/A or Declined
Document 01/16/17 08:05 JON0059 (Rec: 01/16/17 08:05 JON0059 BSU-M07)
CARE Act
Caregiver Identification and Purpose
-Purpose for identifying a caregiver is to include the caregiver in the
discharge planning process and to share post-discharge care and
instruction.
-It is not required to identify a caregiver

Continued on Page 253

-If a caregiver is identified, it can be changed at any time
Patient/Legal Guardian Able to Identify/ Yes per Patient
Decline Caregiver
Consent
Consent Signed N/A or Declined
Document 02/05/17 13:12 SHA0063 (Rec: 02/05/17 13:14 SHA0063 CMC-RDC2)
CARE Act
Caregiver Identification and Purpose
-Purpose for identifying a caregiver is to include the caregiver in the discharge planning process and to share post-discharge care and instruction.
-It is not required to identify a caregiver
-If a caregiver is identified, it can be changed at any time
Patient/Legal Guardian Able to Identify/ Yes per Patient
Decline Caregiver
Consent
Consent Signed N/A or Declined

CARE Act Reassessment Start: 01/15/17 23:58
Freq: QSHIFT Status: Complete
Document 01/16/17 08:05 JON0059 (Rec: 01/16/17 08:05 JON0059 BSU-M07)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status CARE Act Assessment Updated
Document 01/17/17 20:00 AMA0048 (Rec: 01/17/17 22:28 AMA0048 BSU-M07)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess
Document 01/18/17 08:24 JON0059 (Rec: 01/18/17 08:24 JON0059 BSU-M07)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess
Document 01/18/17 20:00 AMA0048 (Rec: 01/18/17 22:47 AMA0048 BSU-C02)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess
Document 01/19/17 20:00 AMA0048 (Rec: 01/19/17 22:40 AMA0048 BSU-C02)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess
Document 01/20/17 20:00 AMA0048 (Rec: 01/20/17 20:07 AMA0048 BSU-C02)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status Continue to Reassess
Document 01/21/17 09:07 JON0059 (Rec: 01/21/17 09:08 JON0059 BSU-C02)
CARE Act Reassessment Status
CARE Act Reassessment
Reassessment Status CARE Act Assessment Updated

Care Transitions Assessment Start: 02/09/17 14:32
Freq: Status: Discharge
Document 02/09/17 14:32 HJP (Rec: 02/09/17 14:34 HJP BSU-L02)
Care Transitions Assessment
Care Transitions Assessment
Care Transitions Accepted

Continued on Page 254

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Comments

Comments	Introduced program to the pt and discussed the four pillars . Pt declined home visits until she can assess her home environment. I will f/u with the pt on Monday 2/13/17 to potentially set up home visit and assess the pts mood, etc.

Complete Home Medications/Reconciliation Start: 12/25/16 05:12
Text: Check that all drugs have been entered/confirmed in the Home Medications routine in the Summary Tab. Status: Discharge
Freq: ONCE
Document 12/26/16 08:15 JON0059 (Rec: 12/26/16 08:15 JON0059 BSU-C12)

Discharge Checklist - Inpatient Start: 12/25/16 05:12
Freq: Status: Discharge
Document 02/10/17 11:18 SHA0063 (Rec: 02/10/17 11:20 SHA0063 BSU-M09)
Discharge Checklist-Inpatient

General Items

Original Copy of MOLST Given to Patient	Not Applicable
Medical Devices Removed Query Text:*vascular access devices, catheter	Not Applicable
Medications Reviewed Query Text:*discuss purpose,dosage,side effects *discuss the time of the last dose for all medications and when medications should be taken	Yes
Has Belonging	Valuables from Safe Glasses
Plan of Care Reviewed	Explain Diagnosis Condition Changed When to Call 911 Discuss Follow Up Appts

Quality/Core Measures
All MU/QM questions are used in reporting information for hospital payment

Patient Education Provided (MU) Query Text:**select "Yes" if any education was given during the patient's visit; this can include paper department-specific education, patient education videos and instructions, verbal education, etc.	Yes
Problems, Meds and Labs Reviewed for Patient Education (MU) Query Text:**were the documented patient problems, medications, and labs reviewed by the caregiver providing education prior to educating the patient .	Yes
Plan of Care at Discharge (MU)	as reviewed with patient per

Continued on Page 255

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Query Text:Include (use the following structure): *Primary Problem: *Goal: *Instructions: (given to the patient to meet goal) **this information will go to the Patient Portal and be seen by the patient and other providers**	discharge instructions and plan: Patient to follow up at TCMHC for intake on February 13th @ 0830 with Deborah Bearman, RN.
Discharge Assessment	
Mental Status (Patient Portal Info)	Oriented to Own Ability
Able to Perform Age Appropriate ADL's (Patient Portal Info)	Yes
Mode of Discharge	Ambulated
Discharge Instructions Review, Understood; Given to Pt/Caregivers	Yes
Discharge Assessment Comment	Patient discharged home via Medicaid taxi, escorted to main entrance by MHT.

ED Comprehensive Triage Assessment Start: 12/24/16 22:48
Freq: Status: Discharge
Document 12/24/16 22:50 REB0122 (Rec: 12/25/16 00:29 REB0122 ED-C35)

Infectious Disease Screen

Infectious Disease Screen	
Traveled Outside the US in Last 30 Days	No
In the Past 21 Days, Have You Traveled to West Africa OR Had Contact With Anyone Who Has Traveled to West Africa and Is Ill Query Text:Includes Guinea, Liberia, Nigeria, Senegal, and Sierra Leone.	No

Onset/Description of Symptoms

Chief Complaint	
Chief Complaint/Associated Symptoms	Pt brought in via EMS, report being that he is wanting a voluntary MHE. Pt also states that he dosen't have " anywhere to go", and does not " want to freeze". Pt with dx of PTSD, per his report.
Date Of Onset Query Text:*Meaningful Use	12/24/16
Time Of Onset Query Text:*Meaningful Use	22:00
Frequency and Duration of Symptoms Query Text:*i.e. constant or intermittent, how long have symptoms been happening (minutes, hours, days, months, years), how often	unknown
What Makes the Pain/Condition Better/ Worse	unknown
Treatment Of This Condition Prior To Arrival In The ED	EMS callled

Continued on Page 256

Query Text:*i.e. medications, ice, heat, elevation, rest, other

Infectious Disease History

Infectious Disease History — Unable to Obtain/Confirm

Self-Referred Testing

Consent

Is Patient Able to Consent for Self Referred Testing — Yes

Query Text:Select "No" if patient is being treated for life threatening emergency and/or lacks the capacity to consent and has no appropriate person available to provide consent.

Self-Referred HIV Testing

Self-Referred HIV Testing

HIV testing must be offered to all patients ages 13-64. This testing must be offered to this age demographic once every visit.

HIV Testing Information Form Given — Yes

HIV Testing Offered — 12/25/16

Does Patient Consent to HIV Testing — No

Query Text:An "HIV 1&2 AB Self Referred" lab order must be entered if the patient consents to testing.
Use Order Source: Clinical Standard/ Protocol
For Outpatients Use Provider: PAT2507
For Inpatients Use Provider: Attending

Self-Referred Hepatitis C Testing

Self-Referred Hepatitis C Testing

Hepatitis C testing must be offered for all patients born within the range of 1945 through 1965. If this testing has been offered during a previous visit, the requirement is complete; the testing does not need to be reoffered.

Hepatitis C Testing Information Form Given — Yes

Date Hepatitis C Testing Offered — 12/25/16

Does Patient Consent to Hepatitis C Testing — No

Query Text:A "Hepatitis C - Ab Self Referred" lab order must be entered if the patient consents to testing.
Use Order Source: Clinical Standard/ Protocol
For Outpatients Use Provider: Daniel Sudilovsky
For Inpatients Use Provider: Attending

Allegies Documented/Verified

Allergies

Have you Documented and Verified Patient Allergies — Yes

Query Text:Patient Allergies are documented and verified in the Summary Tab.

Continued on Page 257

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

ED Triage History

Pertinent Past Medical History

Item	Value
ED:Past Medical History Query Text:Please be sure to review History under Patient Care for potential additional histories.	PTSD/Gender dysphonia/Temporal lobe epilepsy
History of Medications with Levels Query Text:(i.e.: Coumadin, Lithium, Digoxin, Seizure Meds) *Please be sure to document current medications under Home Medications in the Summary Tab.*	No

ED Triage

Vital Signs

Item	Value
Height	5 ft 7 in
Weight	150 lb
Actual/Estimated Weight	Stated
Temperature	98.5 F
Temperature Source	Temporal Artery Scan
Pulse Rate	90
Respiratory Rate	16
Blood Pressure (mmHg)	171/96
Pain Intensity Query Text:0-10	0
Patient on Room Air	Yes
O2 Saturation	94

MEWS Scoring Tool

Item	Value
Systolic BP	111 - 219
Temperature	96.9 - 100.4
Pulse	51 - 90
Respiratory Rate	12 - 20
Oxygen Saturation	94 - 95
Inspired O2	Room Air
Alertness Scale	Alert
Suspicion For Infection	No
Early Warning Score	1
Modified Early Warning Level	Low
Initial Suspicion For Infection	No
Initial Modified Early Warning Score	1
Initial Modified Early Warning Level	Low

SIRS Scoring Tool

Item	Value
Tachycardia Query Text:>90 bpm	No
Tachypnea Query Text:RR>20 or PaCO2 <32	No
Hypo/Hyperthermic Query Text:Hyperthermic > 38.3C or 101.0F Hypothermic <36.0C or 96.8F	No
SIRS Criteria Present Query Text:If 2 or more SIRS criteria are present, the patient may be septic.	0
Initial SIRS Criteria Present	0

Continued on Page 258

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Safety Assessment Screen
- Do You Feel Emotionally and Physically Safe: No
- Can You Tell Me More: Pt states he is here for " PTSD"

Lethality Risk Screen
- Are You Having Thoughts of Hurting Yourself/Others: No
- Are You Having Thoughts of Suicide: No
- Do You Have a Plan: No
- Have You Tried to Harm Yourself or Others in the Past: No
- Hx Psychiatric Problems: Yes
- If So, What Is Your Diagnosis: PTSD/Gender dysphonia

\-
- Does Patient's Stated Complaint Warrant a STAT EKG Order: No
- Priority/Triage Level: 2 - HIGH RISK
- Primary Chief Complaint: EDMentalHealth

ED Discharge Assessment Start: 12/24/16 22:48
Freq: Status: Discharge
Document 12/25/16 05:00 REB0122 (Rec: 12/25/16 05:06 REB0122 ED-C35)

ED Discharge Assessment

Discharge Information
- Method to Door: Ambulated
- Patient To: CMC Admit

Admission to CMC
- Time Report Initiated: 05:00
- Time Report Given: 05:00
- Report To: MHE
- Provider Type: Registered Nurse
- Name of Person Transporting Patient: RN,PACU

IV Discontinuation
- IV Discontinued: n/a

ED RN Assessment Start: 12/25/16 00:29
Freq: Status: Discharge
Document 12/24/16 22:50 REB0122 (Rec: 12/25/16 00:31 REB0122 ED-C35)

Onset/Description of Symptoms

Chief Complaint
- Chief Complaint/Associated Symptoms: Pt brought in via EMS, report being that he is wanting a voluntary MHE. Pt also states that he dosen't have " anywhere to go", and does not " want to freeze". Pt with dx of PTSD, per his report.
- Date Of Onset: 12/24/16
  Query Text:*Meaningful Use
- Time Of Onset: 22:00
  Query Text:*Meaningful Use
- Frequency and Duration of Symptoms: unknown
  Query Text:*i.e. constant or intermittent, how long have symptoms

Continued on Page 259

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

been happening (minutes, hours, days, months, years), how often

What Makes the Pain/Condition Better/ Worse — unknown

Treatment Of This Condition Prior To Arrival In The ED — EMS callled

Query Text:*i.e. medications, ice, heat, elevation, rest, other

Isolation and MRSA Assessment

MRSA Assessment Status

MRSA Assessment — Update Needed

Query Text:
-No Update Needed: When isolation items have not changed since last documentation
-Update Needed: Upon arrival or if isolation items have changed during stay
-Unable to Assess/Obtain: Patient's condition is emergent and assessment can not be done

MRSA Negative Swab

Negative Nasal Swab this Visit — No

Query Text:If No, Pending, or Unknown, this question should be answered as No

Suspected/Current/Active MRSA Infection

Current Suspect/Active MRSA Infection — No

MRSA Nasal Swab Screening

Confirmed MRSA Positive - Last 12 Months — No

Query Text:** Refer to the "Last Positive MRSA Test Date" query above in the Confirmed Infection/Disease Hx section.

Nursing Home, Dialysis, or ICCU Patient — No

MRSA Screening Results

Place Patient on MRSA Contact Precautions — No

MRSA Nasal Swab Indicated — No

Isolation Assessment

Reason for Isolation — None

Type of Isolation — Standard Precautions

Isolation Summary

Does Patient Require Isolation — No

MEWS Reassessment Criteria

MEWS Reassessment Indicated

WBC Ordered — Yes

WBC > 12000 or < 4000 OR Bands > 10% — No, or No Lab Data Resulted At This Time

Lactate Ordered — Yes

Lactate > 2.0 — No, or No Lab Data Resulted At This Time

MEWS Reassessment Indicated — No

ED RN Assessment P. I

Currently Having Pain

Continued on Page 260

Assessments and Treatments - Continued

Currently Having Pain	No
Respiratory Assessment	
Airway Assessment	Clear
Chest Expansion	Symmetrical
Breath Sounds	
Bilateral	
Breath Sounds	Clear
Heart Sounds/Apical Pulse	
Heart Sounds/Apical Pulse	Regular
Neurologic Assessment	
Level Of Consciousness	Awake Alert Oriented
Skin Assessment	
Skin Temperature	Warm
Skin Color	Skin Color Reflects Adequate Perfusion
Skin Moisture	Normal
Skin Result	Skin Intact
Extremities	
Extremities	Normal
Safety Assessment	
Risk Factors	
Recent History of Falls (Within the Past 3 Months) Query Text:This is scored as 5 if the patient has a history of physiological falls, such as from seizures or an mpaired gait fallen during the past 3 months. If the patient has not fallen, this is scored 0.	No
Mental Status Query Text:When using this Scale, mental status is measured by checking the patient's own self-assessment of his or her own ability to ambulate. If the patient's reply judging his or her own ability is consistent with your nursing observation, the patient is rated as " normal" and scored 0. If the patient's response is not consistent with the nursing observation, or if the patient's response is unrealistic, then the patient is considered to overestimate his or her own abilities and may be forgetful of limitations and scored as 6 .	Oriented to Own Ability
Age Query Text:All children under the age of 2 years will receive a score of 6 and will be considered High Risk. Patients who are 65 years or older will receive a score of 5. All other patients will	2 - 64 Years of Age

Continued on Page 261

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

receive a score of 0.

Ambulatory Aide	None
Query Text:This is scored as 0 if the patient walks without any assistance. This is scored as 3 if the patient uses an aid such as a cane, walker, crutches, wheelchair, or the patient requires assistance from another person.	
Gait	Normal
Query Text:A normal gait is characterized by the patient walking with head erect, arms swinging freely at the side, and striding without hesitation. This gait scores 0. With an impaired gait (score 6), the person may have difficulty rising from a chair (taking several attempts to rise), walk with their head down watching the ground , their gait may be shuffling or unsteady and their balance may be poor. Use of assistive devices is often seen.	
Scoring and Risk Level	
Patient Score	0
Risk Level	0-5 Points = LOW RISK

Query Text:Outpatient low risk interventions:
-Standard handrails in all areas
-Appropriate lighting
-Floors are clear of tripping hazards i.e.;unapproved rugs or mats, equipment
-Chairs with and without arms will be available in all areas
-Wet floor signs will be utilized
-All restrooms are equipped with emergency call bells
-Each outpatient area may have additional unit specific interventions
Outpatient high risk interventions:
-Patients will be placed in a treatment area in close proximity to staff if unaccompanied by a reliable person
-Patients will not be seated on any elevated surface unless a staff member is in constant attendance. If a patient independently assumes an unsafe position, they will be asked +/or assisted to a position of safety
-Audible sound devices, or call bells will be provided to each patient. All patients will be educated in the use.
-All staff are responsible to respond immediately to these calls.
-Each outpatient area may have

Continued on Page 262

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

additional unit specific interventions

Tobacco Use
- Tobacco Cessation Assessment
  - Smoking Status (MU): Current Every Day Smoker
    Query Text:**Smoker Definition (current or former): has smoked at least 100 cigarettes (5 packs) or cigar or pipe smoke equivalent during his/her lifetime .**
  - Household Exposure: Yes
  - Household Exposure Type: Cigarettes
  - Tobacco Cessation Information Provided: N/A Due to Patient Condition

Alcohol/Substance Use
- Alcohol Use
  - Alcohol Use: Occasionally
- Substance Use
  - Substance Use Type: Marijuana

ED RN Assessment
- Additional Precautions
  - Additional Precautions: Other
- Neck
  - Neck: Normal
- Chest
  - Chest: Normal
- Abdomen
  - Abdomen: Normal
- Back
  - Back: Normal
- Head/Face
  - Head/Face: Abnormal
  - Head/Face Comment: Pt here for voluntary MHE

Advance Directives
- Advance Directives
  - Code Status: Full Code
  - Code Status Requires Follow Up?: N
  - Advance Directives Location: No Advance Directives
  - Health Care Proxy: No
  - Living Will: No
  - Medical Orders for Life Sustaining Treatment (MOLST): No

ED Nursing Assessment
- Nursing Assessment
  - Spiritual Needs: No
  - Social Work Referral: No
  - Language Barrier: No

MHU: Group Compliance Start: 12/25/16 05:12
Freq: QSHIFT Status: Complete
Document 12/25/16 20:00 ROB0100 (Rec: 12/25/16 21:10 ROB0100 BSU-M03)

MHU Group Complaince
- Group Compliance
  - Group Compliant: No

MHU: Medication Compliance Start: 12/25/16 05:12
Freq: QSHIFT Status: Complete

Continued on Page 263

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
Document     12/25/16 08:00  VIC0074  (Rec: 12/25/16 09:56  VIC0074  BSU-M03)
MHU Medication Compliance
    Medication Compliance
      Medication Compliant                      No
Document     12/25/16 20:00  ROB0100  (Rec: 12/25/16 21:10  ROB0100  BSU-M03)
MHU Medication Compliance
    Medication Compliance
      Comment                                   N/A
MHU:Adult Group 01- Community Meeting                    Start:  12/25/16 05:12
Freq:                                                    Status: Discharge
Document     12/25/16 09:40  PAT0027  (Rec: 12/25/16 09:40  PAT0027  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
      Community Meeting Comments                declined
Document     12/26/16 09:01  MAT0068  (Rec: 12/26/16 09:01  MAT0068  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
Document     12/27/16 08:48  MAT0068  (Rec: 12/27/16 08:48  MAT0068  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
Document     12/28/16 09:11  ALE0007  (Rec: 12/28/16 09:12  ALE0007  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No: DNA
Document     12/29/16 09:16  SHA0040  (Rec: 12/29/16 09:17  SHA0040  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
      Community Meeting Comments                Goal: To be discharged
Edit Result  12/29/16 09:16  SHA0040  (Rec: 12/29/16 09:20  SHA0040  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No: NA
Document     12/30/16 09:30  ALE0007  (Rec: 12/30/16 09:31  ALE0007  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             Yes: Patient held middle
                                                finger in the air and stated "
                                                Fuck You!"
Document     12/31/16 09:16  ZLA0001  (Rec: 12/31/16 09:16  ZLA0001  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
      Community Meeting Comments                Pt. DNA.
Document     01/01/17 08:54  RYA0008  (Rec: 01/01/17 08:54  RYA0008  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
Document     01/02/17 08:58  ZLA0001  (Rec: 01/02/17 08:58  ZLA0001  BSU-M04)
Adult Group: Community Meeting
```

Continued on Page 264

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments Pt. DNA.

Document 01/03/17 09:09 ALE0007 (Rec: 01/03/17 09:09 ALE0007 CMC-RDC2)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No: DNA

Document 01/04/17 09:30 ZLA0001 (Rec: 01/04/17 09:31 ZLA0001 CMC-RDC2)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No: N/A
Community Meeting Comments Pt. DNA.

Document 01/05/17 09:13 MAT0068 (Rec: 01/05/17 09:13 MAT0068 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No

Document 01/06/17 09:23 SHA0166 (Rec: 01/06/17 09:23 SHA0166 BSU-M07)
Adult Group: Community Meeting
Community Meeting
Community Meeting Comments DNA

Document 01/07/17 10:04 MAT0068 (Rec: 01/07/17 10:04 MAT0068 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No

Document 01/07/17 21:25 TAH0001 (Rec: 01/07/17 21:25 TAH0001 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Community Meeting Comments no goal

Document 01/08/17 10:23 RYA0008 (Rec: 01/08/17 10:24 RYA0008 CMC-RDC2)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No

Document 01/09/17 08:48 MAT0068 (Rec: 01/09/17 08:49 MAT0068 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No

Document 01/10/17 09:08 MAT0068 (Rec: 01/10/17 09:08 MAT0068 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No

Document 01/11/17 09:57 SHA0166 (Rec: 01/11/17 09:57 SHA0166 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Community Meeting Comments DNA

Document 01/12/17 09:24 ZLA0001 (Rec: 01/12/17 09:24 ZLA0001 BSU-M10)
Adult Group: Community Meeting
Community Meeting
Treatment Team Goal Completed No
Community Meeting Comments Pt. DNA.

Document 01/13/17 09:19 SHA0166 (Rec: 01/13/17 09:19 SHA0166 BSU-C01)
Adult Group: Community Meeting
Community Meeting
Community Meeting Comments DNA

Continued on Page 265

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Document     01/14/17 09:49  ZLA0001  (Rec: 01/14/17 09:50  ZLA0001  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
      Community Meeting Comments                Pt. was asked to leave group
                                                due to interuptions
Document     01/15/17 08:59  KEL0010  (Rec: 01/15/17 08:59  KEL0010  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
      Community Meeting Comments                DNA
Document     01/16/17 09:13  SHA0166  (Rec: 01/16/17 09:13  SHA0166  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments                DNA
Document     01/17/17 08:56  ALE0007  (Rec: 01/17/17 08:57  ALE0007  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             Yes: Try to avoid suing this
                                                place-negotiate.
Document     01/18/17 09:21  SHA0166  (Rec: 01/18/17 09:21  SHA0166  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments                Goal:"Mistaken identity."
Document     01/19/17 09:31  SAV0050  (Rec: 01/19/17 09:31  SAV0050  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             No
Document     01/20/17 08:56  KEL0010  (Rec: 01/20/17 08:59  KEL0010  BSU-M04)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             Yes
      Community Meeting Comments                Goal: Establish with
                                                management that Dr. Ehmke is a
                                                narcissist
Document     01/21/17 08:53  MAT0068  (Rec: 01/21/17 08:53  MAT0068  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             Yes
      Community Meeting Comments                build a legal case against dr
                                                L
Document     01/22/17 09:07  MAT0068  (Rec: 01/22/17 09:08  MAT0068  BSU-M04)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed             Yes
      Community Meeting Comments                no goal
Document     01/23/17 08:40  SHA0166  (Rec: 01/23/17 08:40  SHA0166  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments                Goal:"Better control of my
                                                swearing."
Document     01/24/17 08:59  ZLA0001  (Rec: 01/24/17 08:59  ZLA0001  BSU-M03)
Adult Group: Community Meeting
```

Continued on Page 266

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
    Community Meeting
      Treatment Team Goal Completed              No
      Community Meeting Comments                 Goal: to remain calm.
Document     01/25/17 09:13  ZLA0001  (Rec: 01/25/17 09:14  ZLA0001  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              No
      Community Meeting Comments                 Goal: To continue to improving
                                                 that I matter in the world of
                                                 computer programing.
Document     01/26/17 09:03  MAT0068  (Rec: 01/26/17 09:03  MAT0068  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              No
Document     01/27/17 08:58  MAT0068  (Rec: 01/27/17 08:58  MAT0068  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              No
Document     01/28/17 09:11  ZLA0001  (Rec: 01/28/17 09:15  ZLA0001  BSU-M03)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              No
      Community Meeting Comments                 Goal: To make sure my pipes
                                                 doesn't freeze.
Document     01/29/17 09:48  KEL0010  (Rec: 01/29/17 09:48  KEL0010  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              No
      Community Meeting Comments                 DNA
Document     01/30/17 09:00  KEL0010  (Rec: 01/30/17 09:01  KEL0010  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              Yes
      Community Meeting Comments                 Goal: To reassert that I have
                                                 a home to take care of,
                                                 urgently
Document     01/31/17 09:18  ZLA0001  (Rec: 01/31/17 09:21  ZLA0001  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              No
      Community Meeting Comments                 Goal: Check to make sure my
                                                 water didn't freeze
Document     02/01/17 08:55  MAT0068  (Rec: 02/01/17 08:55  MAT0068  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              Yes
      Community Meeting Comments                 talk to D/C planner
Document     02/02/17 08:54  MAT0068  (Rec: 02/02/17 08:55  MAT0068  BSU-M06)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed              Yes
      Community Meeting Comments                 talk to the dr and D/C planner
Document     02/03/17 08:55  SHA0040  (Rec: 02/03/17 08:56  SHA0040  BSU-C01)
```

Continued on Page 267

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed          No
      Community Meeting Comments             Goal: Process mail fowarding
                                             with Allison
Document     02/04/17 10:13  PAT0027  (Rec: 02/04/17 10:13  PAT0027  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments             "persist in formulating
                                             reasons to be discharged.
                                             Worried about her home.
Document     02/05/17 09:53  PAT0027  (Rec: 02/05/17 09:54  PAT0027  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments             "finish g-mail. delete some
                                             more."
Document     02/06/17 09:11  ZLA0001  (Rec: 02/06/17 09:15  ZLA0001  BSU-M06)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed          No
      Community Meeting Comments             Goal: To speard love.
Edit Result  02/06/17 09:11  ZLA0001  (Rec: 02/06/17 09:19  ZLA0001  BSU-M06)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments             Goal: To persuade the Dr that
                                             my 2002 admission was due to
                                             PCP poisoning
Document     02/07/17 08:51  SHA0166  (Rec: 02/07/17 08:51  SHA0166  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Community Meeting Comments             DNA
Document     02/08/17 09:11  MAT0068  (Rec: 02/08/17 09:11  MAT0068  BSU-C12)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed          Yes
      Community Meeting Comments             talk to the dr
Document     02/09/17 09:05  ZLA0001  (Rec: 02/09/17 09:06  ZLA0001  CMC-RDC2)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed          No
      Community Meeting Comments             Goal: To prepared for d/c
                                             tomorrow.
Document     02/10/17 09:21  KEL0010  (Rec: 02/10/17 09:21  KEL0010  BSU-C01)
Adult Group: Community Meeting
    Community Meeting
      Treatment Team Goal Completed          Yes
      Community Meeting Comments             Goal: Take care of business
```

```
MHU:Adult Group 02- Exercise                          Start:  12/25/16 05:12
Freq:                                                 Status: Discharge
Document     12/26/16 09:01  MAT0068  (Rec: 12/26/16 09:01  MAT0068  BSU-C01)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation           Declined
```

Continued on Page 268

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Document 12/27/16 08:48 MAT0068 (Rec: 12/27/16 08:48 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 12/28/16 09:11 ALE0007 (Rec: 12/28/16 09:12 ALE0007 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 12/29/16 09:16 SHA0040 (Rec: 12/29/16 09:17 SHA0040 BSU-C12)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 12/30/16 09:30 ALE0007 (Rec: 12/30/16 09:31 ALE0007 BSU-C12)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Adequately

Document 12/31/16 09:16 ZLA0001 (Rec: 12/31/16 09:16 ZLA0001 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/01/17 08:54 RYA0008 (Rec: 01/01/17 08:54 RYA0008 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/02/17 08:58 ZLA0001 (Rec: 01/02/17 08:58 ZLA0001 BSU-M04)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/03/17 09:09 ALE0007 (Rec: 01/03/17 09:09 ALE0007 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/04/17 09:30 ZLA0001 (Rec: 01/04/17 09:31 ZLA0001 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/05/17 09:13 MAT0068 (Rec: 01/05/17 09:13 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/06/17 09:23 SHA0166 (Rec: 01/06/17 09:23 SHA0166 BSU-M07)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Exercise Group Comments DNA

Document 01/07/17 10:04 MAT0068 (Rec: 01/07/17 10:04 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/08/17 10:23 RYA0008 (Rec: 01/08/17 10:24 RYA0008 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Continued on Page 269

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Document 01/09/17 08:48 MAT0068 (Rec: 01/09/17 08:49 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/10/17 09:08 MAT0068 (Rec: 01/10/17 09:08 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/11/17 09:57 SHA0166 (Rec: 01/11/17 09:57 SHA0166 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/12/17 09:24 ZLA0001 (Rec: 01/12/17 09:24 ZLA0001 BSU-M10)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/13/17 09:19 SHA0166 (Rec: 01/13/17 09:19 SHA0166 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Exercise Group Comments DNA

Document 01/14/17 09:49 ZLA0001 (Rec: 01/14/17 09:50 ZLA0001 BSU-C12)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Asked to leave due to interuptions

Document 01/15/17 08:59 KEL0010 (Rec: 01/15/17 08:59 KEL0010 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/16/17 09:13 SHA0166 (Rec: 01/16/17 09:13 SHA0166 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/17/17 08:56 ALE0007 (Rec: 01/17/17 08:57 ALE0007 BSU-C12)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Adequately

Document 01/18/17 09:21 SHA0166 (Rec: 01/18/17 09:21 SHA0166 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Minimally

Document 01/19/17 09:31 SAV0050 (Rec: 01/19/17 09:31 SAV0050 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/20/17 08:56 KEL0010 (Rec: 01/20/17 08:59 KEL0010 BSU-M04)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Document 01/21/17 08:53 MAT0068 (Rec: 01/21/17 08:53 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group

Continued on Page 270

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Exercise Group Participation Participated Adequately
Document 01/22/17 09:07 MAT0068 (Rec: 01/22/17 09:08 MAT0068 BSU-M04)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Adequately
Document 01/23/17 08:40 SHA0166 (Rec: 01/23/17 08:40 SHA0166 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/24/17 08:59 ZLA0001 (Rec: 01/24/17 08:59 ZLA0001 BSU-M03)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/25/17 09:13 ZLA0001 (Rec: 01/25/17 09:14 ZLA0001 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/26/17 09:03 MAT0068 (Rec: 01/26/17 09:03 MAT0068 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/27/17 08:58 MAT0068 (Rec: 01/27/17 08:58 MAT0068 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/28/17 09:11 ZLA0001 (Rec: 01/28/17 09:15 ZLA0001 BSU-M03)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/29/17 09:48 KEL0010 (Rec: 01/29/17 09:48 KEL0010 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 01/30/17 09:00 KEL0010 (Rec: 01/30/17 09:01 KEL0010 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Minimally
Document 01/31/17 09:18 ZLA0001 (Rec: 01/31/17 09:21 ZLA0001 CMC-RDC2)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined
Document 02/01/17 08:55 MAT0068 (Rec: 02/01/17 08:55 MAT0068 BSU-C12)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Adequately
Document 02/02/17 08:54 MAT0068 (Rec: 02/02/17 08:55 MAT0068 BSU-M06)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Participated Adequately
Document 02/03/17 08:56 SHA0040 (Rec: 02/03/17 08:56 SHA0040 BSU-C01)
Adult Group: Exercise
Exercise Group
Exercise Group Participation Declined

Continued on Page 271

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Document     02/04/17 10:13  PAT0027  (Rec: 02/04/17 10:13  PAT0027  BSU-C01)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Declined
Document     02/05/17 09:53  PAT0027  (Rec: 02/05/17 09:54  PAT0027  CMC-RDC2)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Participated Minimally
Document     02/06/17 09:11  ZLA0001  (Rec: 02/06/17 09:15  ZLA0001  BSU-M06)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Participated Adequately
Edit Result  02/06/17 09:11  ZLA0001  (Rec: 02/06/17 09:19  ZLA0001  BSU-M06)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Participated Minimally
Document     02/07/17 08:51  SHA0166  (Rec: 02/07/17 08:51  SHA0166  BSU-C01)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Declined
Document     02/08/17 09:11  MAT0068  (Rec: 02/08/17 09:11  MAT0068  BSU-C12)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Participated Adequately
Document     02/09/17 09:05  ZLA0001  (Rec: 02/09/17 09:06  ZLA0001  CMC-RDC2)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Declined
Document     02/10/17 09:21  KEL0010  (Rec: 02/10/17 09:21  KEL0010  BSU-C01)
Adult Group: Exercise
    Exercise Group
      Exercise Group Participation              Participated Adequately
```

```
MHU:Adult Group 03- Cog Behavior Ther                 Start:  12/25/16 05:12
Freq:                                                 Status: Discharge
Document     01/02/17 11:41  KYL0051  (Rec: 01/02/17 11:41  KYL0051  BSU-M13)
Adult Group: Cognitive Behavior Therapy
    Cognitive Behavior Therapy
      CBT Participation                         Declined
Document     01/24/17 11:12  KYL0051  (Rec: 01/24/17 11:12  KYL0051  BSU-M13)
Adult Group: Cognitive Behavior Therapy
    Cognitive Behavior Therapy
      CBT Participation                         Declined
```

```
MHU:Adult Group 04- Focus                             Start:  12/25/16 05:12
Freq:                                                 Status: Discharge
Document     12/26/16 11:49  KYL0051  (Rec: 12/26/16 11:50  KYL0051  BSU-M13)
Adult Group: Focus
    Focus Group
      Focus Group Topic                         Stress Management
      Focus Group Response                      Declined
Document     12/27/16 11:41  KYL0051  (Rec: 12/27/16 11:41  KYL0051  BSU-M13)
Adult Group: Focus
    Focus Group
      Focus Group Topic                         Self Awareness
```

Continued on Page 272

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Focus Group Response                        Declined
Document     12/28/16 11:55  KYL0051  (Rec: 12/28/16 11:55  KYL0051  BSU-M13)
Adult Group: Focus
    Focus Group
      Focus Group Topic                           Time Management
      Focus Group Response                        Declined
Document     12/29/16 13:37  MAU0059  (Rec: 12/29/16 13:37  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     12/30/16 12:03  MAU0059  (Rec: 12/30/16 12:03  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/02/17 12:39  MAU0059  (Rec: 01/02/17 12:39  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/03/17 13:46  MAU0059  (Rec: 01/03/17 13:46  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/04/17 13:24  KYL0051  (Rec: 01/04/17 13:25  KYL0051  BSU-C06)
Adult Group: Focus
    Focus Group
      Focus Group Topic                           Time Management
      Focus Group Response                        Declined
Document     01/05/17 11:40  MAU0059  (Rec: 01/05/17 11:40  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/06/17 12:52  KYL0051  (Rec: 01/06/17 12:52  KYL0051  BSU-M13)
Adult Group: Focus
    Focus Group
      Focus Group Topic                           Leisure Education
      Focus Group Response                        Declined
Document     01/09/17 14:54  MAU0059  (Rec: 01/09/17 14:54  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/12/17 13:29  MAU0059  (Rec: 01/12/17 13:30  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/13/17 13:21  MAU0059  (Rec: 01/13/17 13:21  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/16/17 13:56  MAU0059  (Rec: 01/16/17 13:56  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                        Declined
Document     01/17/17 13:31  MAU0059  (Rec: 01/17/17 13:31  MAU0059  BSU-C04)
```

Continued on Page 273

Assessments and Treatments - Continued

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/18/17 14:53 MAU0059 (Rec: 01/18/17 14:53 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/19/17 12:03 MAU0059 (Rec: 01/19/17 12:03 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/23/17 13:52 MAU0059 (Rec: 01/23/17 13:52 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/24/17 12:05 MAU0059 (Rec: 01/24/17 12:05 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/25/17 13:59 KYL0051 (Rec: 01/25/17 13:59 KYL0051 BSU-M13)

Adult Group: Focus
Focus Group
Focus Group Topic Time Management
Focus Group Response Declined
Document 01/26/17 15:07 MAU0059 (Rec: 01/26/17 15:07 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/27/17 12:29 MAU0059 (Rec: 01/27/17 12:29 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/30/17 15:46 MAU0059 (Rec: 01/30/17 15:46 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 01/31/17 13:35 MAU0059 (Rec: 01/31/17 13:35 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 02/01/17 12:58 MAU0059 (Rec: 02/01/17 12:58 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Response Declined
Document 02/02/17 13:26 MAU0059 (Rec: 02/02/17 13:27 MAU0059 BSU-C04)

Adult Group: Focus
Focus Group
Focus Group Topic Community Resources
Focus Group Affect Behavior Engaged
Intrusive
Focus Group Affect Behavior Comment pressured, hyperverbal
Focus Group Interventions Encourage Participation
Validate

Continued on Page 274

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
                                             Redirect
      Focus Group Response                   Participated
                                             Unable to Focus
      Focus Group Comments                   pt. was pressured and
                                             hyperverbal then left group
Document     02/03/17 15:23  MAU0059  (Rec: 02/03/17 15:23  MAU0059  PMRU-C05)
Adult Group: Focus
    Focus Group
      Focus Group Response                   Declined
Document     02/06/17 13:51  MAU0059  (Rec: 02/06/17 13:51  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                   Declined
Document     02/07/17 13:32  MAU0059  (Rec: 02/07/17 13:32  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                   Declined
Document     02/08/17 13:01  MAU0059  (Rec: 02/08/17 13:01  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                   Declined
Document     02/09/17 12:49  MAU0059  (Rec: 02/09/17 12:49  MAU0059  BSU-C04)
Adult Group: Focus
    Focus Group
      Focus Group Response                   Declined
```

```
MHU:Adult Group 05- Dialectical Behav                  Start:  12/25/16 05:12
Freq:                                                  Status: Discharge
Document     12/26/16 14:29  ERI0036  (Rec: 12/26/16 14:29  ERI0036  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                        Cognitive Distortions
      DBT Group Responses                    Declined
Document     12/27/16 14:06  SHA0040  (Rec: 12/27/16 14:06  SHA0040  BSU-C12)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                        Interpersonal Effectiveness
      DBT Group Responses                    Declined
Document     12/28/16 13:49  ZLA0001  (Rec: 12/28/16 13:50  ZLA0001  BSU-M04)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                        Clearifying Goals In
                                             Interpersonal Effectiveness
      DBT Group Responses                    Declined
Document     12/29/16 13:48  SHA0040  (Rec: 12/29/16 13:48  SHA0040  BSU-C12)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                        Interpersonal Effectivness
      DBT Group Responses                    Declined
Document     12/31/16 14:55  KEL0010  (Rec: 12/31/16 14:55  KEL0010  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                    Declined
Document     01/02/17 13:45  KEL0010  (Rec: 01/02/17 13:46  KEL0010  BSU-C01)
```

Continued on Page 275

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                          Mindfulness
      DBT Group Responses                      Declined
Document     01/03/17 14:54  KYL0051  (Rec: 01/03/17 14:54  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                      Declined
Document     01/04/17 14:54  SHA0166  (Rec: 01/04/17 14:54  SHA0166  BSU-C01)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                          mindfulness
      DBT Group Responses                      Declined
      DBT Group Comments                       DNA
Document     01/05/17 14:03  KYL0051  (Rec: 01/05/17 14:03  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                          mindfulness
      DBT Group Responses                      Declined
Document     01/06/17 13:34  ZLA0001  (Rec: 01/06/17 13:34  ZLA0001  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                          Mindfulness: Effectively
      DBT Group Responses                      Declined
Document     01/07/17 15:06  RYA0008  (Rec: 01/07/17 15:06  RYA0008  BSU-C01)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Comments                       DNA
Document     01/08/17 10:23  RYA0008  (Rec: 01/08/17 10:24  RYA0008  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                          Movie Cinematherapy "Hook"
      DBT Group Affect Behavior                Calm
                                               Cooperative
                                               Euthymic
                                               Congruent
      DBT Group Responses                      Participated
                                               Followed Directions
Document     01/09/17 13:55  KYL0051  (Rec: 01/09/17 13:55  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                      Declined
Document     01/10/17 15:37  KYL0051  (Rec: 01/10/17 15:37  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                      Declined
Document     01/11/17 14:00  KYL0051  (Rec: 01/11/17 14:00  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                      Declined
Document     01/12/17 14:51  KYL0051  (Rec: 01/12/17 14:51  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
```

Continued on Page 276

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      DBT Group Responses                         Declined
Document     01/13/17 14:00  KEL0010  (Rec: 01/13/17 14:00  KEL0010  BSU-M04)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                             Radical Acceptance
      DBT Group Responses                         Declined
Document     01/14/17 14:23  KEL0010  (Rec: 01/14/17 14:23  KEL0010  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                         Participated
Document     01/16/17 13:58  KYL0051  (Rec: 01/16/17 13:58  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                         Declined
Document     01/17/17 14:23  KYL0051  (Rec: 01/17/17 14:23  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                         Declined
Document     01/18/17 15:47  KYL0051  (Rec: 01/18/17 15:47  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                         Declined
Document     01/19/17 14:11  KYL0051  (Rec: 01/19/17 14:11  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                             opposite action
      DBT Group Responses                         Declined
Document     01/20/17 13:50  KYL0051  (Rec: 01/20/17 13:50  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                         Declined
Document     01/21/17 10:50  PAT0027  (Rec: 01/21/17 10:50  PAT0027  BSU-C01)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                             goal setting habit change
      DBT Group Responses                         Declined
Document     01/23/17 13:50  KEL0010  (Rec: 01/23/17 13:50  KEL0010  BSU-M04)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                             Cognitive Distortions
      DBT Group Responses                         Declined
Document     01/24/17 14:29  SHA0166  (Rec: 01/24/17 14:30  SHA0166  BSU-C09)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                             interpersonal effectiveness
      DBT Group Responses                         Declined
      DBT Group Comments                          DNA
Document     01/25/17 14:02  ALE0007  (Rec: 01/25/17 14:02  ALE0007  BSU-C01)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                             Interpersonal Effectiveness
      DBT Group Responses                         Declined
Document     01/27/17 13:50  KEL0010  (Rec: 01/27/17 13:50  KEL0010  CMC-RDC2)
```

Continued on Page 277

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                        Declined
Document     01/28/17 10:56  KEL0010  (Rec: 01/28/17 10:56  KEL0010  BSU-C02)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                        Declined
Document     01/30/17 13:45  SHA0040  (Rec: 01/30/17 13:46  SHA0040  BSU-C01)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                            Intro to Mindfullness/ Wise
                                                 Mind
      DBT Group Responses                        Declined
Document     01/31/17 14:39  KYL0051  (Rec: 01/31/17 14:39  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                        Declined
Document     02/02/17 13:43  ZLA0001  (Rec: 02/02/17 13:44  ZLA0001  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                            Mindfulness: Participate.
      DBT Group Responses                        Declined
Document     02/06/17 13:57  KYL0051  (Rec: 02/06/17 13:57  KYL0051  BSU-M13)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                        Declined
Document     02/07/17 14:02  ZLA0001  (Rec: 02/07/17 14:02  ZLA0001  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                            Wise Mind, Reseasonable Mind,
                                                 and Emtional Mind.
      DBT Group Responses                        Declined
Document     02/08/17 13:41  MAT0068  (Rec: 02/08/17 13:41  MAT0068  BSU-C12)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Responses                        Declined
Document     02/09/17 14:23  SHA0040  (Rec: 02/09/17 14:23  SHA0040  CMC-RDC2)
Adult Group: Dialectical Therapy
    Dialectical Behavior Therapy
      DBT Group Topic                            Distress tolerance- SODAS
      DBT Group Responses                        Declined
```

```
MHU:Adult Group 06- Recreation Therapy                Start:  12/25/16 05:12
Freq:                                                 Status: Discharge
Document     12/26/16 15:43  KYL0051  (Rec: 12/26/16 15:44  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Group Topic                       music
      Activity Therapy Attendance                Yes
      Activity Attendance Comment                socializing with peers in the
                                                 milieu
Document     12/27/16 15:30  KYL0051  (Rec: 12/27/16 15:30  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
```

Continued on Page 278

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Activity Therapy Attendance                    No
Document     12/28/16 15:00  KYL0051  (Rec: 12/28/16 15:00  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
      Activity Attendance Comment                    sat in the milieu, observed
                                                     talking to herself
Document     12/31/16 15:08  ZLA0001  (Rec: 12/31/16 15:08  ZLA0001  CMC-RDC2)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    Refused
Document     01/02/17 15:21  KYL0051  (Rec: 01/02/17 15:22  KYL0051  BSU-C01)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/03/17 16:25  KYL0051  (Rec: 01/03/17 16:25  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Group Topic                           music, magazine
      Activity Therapy Attendance                    Yes
Document     01/04/17 15:45  MAU0059  (Rec: 01/04/17 15:45  MAU0059  BSU-C04)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/05/17 14:47  MAU0059  (Rec: 01/05/17 14:47  MAU0059  BSU-M03)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/06/17 16:06  KYL0051  (Rec: 01/06/17 16:06  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/09/17 16:35  KYL0051  (Rec: 01/09/17 16:35  KYL0051  BSU-C11)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/10/17 15:50  MAU0059  (Rec: 01/10/17 15:50  MAU0059  BSU-C04)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/11/17 15:30  KYL0051  (Rec: 01/11/17 15:30  KYL0051  BSU-M07)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/12/17 15:11  MAU0059  (Rec: 01/12/17 15:11  MAU0059  BSU-C04)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/13/17 15:14  MAU0059  (Rec: 01/13/17 15:14  MAU0059  BSU-C04)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance                    No
Document     01/16/17 15:14  KYL0051  (Rec: 01/16/17 15:14  KYL0051  BSU-M13)
```

Continued on Page 279

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/17/17 16:26 KYL0051 (Rec: 01/17/17 16:26 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/18/17 15:47 KYL0051 (Rec: 01/18/17 15:47 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/19/17 15:14 MAU0059 (Rec: 01/19/17 15:14 MAU0059 BSU-C04)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/20/17 15:48 KYL0051 (Rec: 01/20/17 15:48 KYL0051 BSU-C11)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/22/17 16:51 ROB0100 (Rec: 01/22/17 16:51 ROB0100 CMC-RDC2)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Group Topic bingo
Activity Therapy Attendance Refused
Document 01/23/17 15:03 KYL0051 (Rec: 01/23/17 15:03 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/24/17 15:12 KYL0051 (Rec: 01/24/17 15:12 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Group Topic board game
Activity Therapy Attendance Yes
Document 01/26/17 15:07 MAU0059 (Rec: 01/26/17 15:07 MAU0059 BSU-C04)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 01/30/17 15:46 MAU0059 (Rec: 01/30/17 15:46 MAU0059 BSU-C04)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 02/01/17 15:53 KYL0051 (Rec: 02/01/17 15:53 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 02/02/17 15:47 KYL0051 (Rec: 02/02/17 15:47 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No
Document 02/03/17 16:24 KYL0051 (Rec: 02/03/17 16:24 KYL0051 BSU-M13)
MHU: Attendance-Activity Ther
Activity Attendance Assessment
Activity Therapy Attendance No

Continued on Page 280

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Document     02/06/17 15:00  KYL0051  (Rec: 02/06/17 15:00  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance               No
      Activity Attendance Comment               resting in room
Document     02/07/17 16:10  KYL0051  (Rec: 02/07/17 16:10  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance               No
Document     02/08/17 15:14  KYL0051  (Rec: 02/08/17 15:14  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance               No
Document     02/09/17 15:20  KYL0051  (Rec: 02/09/17 15:20  KYL0051  BSU-M13)
MHU: Attendance-Activity Ther
    Activity Attendance Assessment
      Activity Therapy Attendance               Excused
      Activity Attendance Comment               meeting with social worker
```

```
MHU:Adult Group 07- Education                         Start:  12/25/16 05:12
Freq:                                                 Status: Discharge
Document     12/26/16 16:53  RYA0008  (Rec: 12/26/16 16:53  RYA0008  CMC-RDC2)
Adult Group: Education
    Education
      Education Group Response Comment          DNA
      Education Group Comments                  DNA
Document     12/27/16 15:30  KYL0051  (Rec: 12/27/16 15:30  KYL0051  BSU-M13)
Adult Group: Education
    Education
      Education Group Topic                     SODAS
      Education Group Response                  Declined
Document     12/29/16 16:36  JAC0076  (Rec: 12/29/16 16:36  JAC0076  BSU-C01)
Adult Group: Education
    Education
      Education Group Topic                     Introduction to Anger
                                                Management
      Education Group Response                  Declined
Document     12/30/16 23:16  RYA0008  (Rec: 12/30/16 23:16  RYA0008  BSU-C01)
Adult Group: Education
    Education
      Education Group Topic                     Interpersonal Effectiveness
      Education Group Response Comment          DNA
      Education Group Comments                  DNA
Document     01/02/17 17:17  RYA0008  (Rec: 01/02/17 17:17  RYA0008  CMC-RDC2)
Adult Group: Education
    Education
      Education Group Topic                     MICA
      Education Group Comments                  DNA
Document     01/04/17 18:31  RYA0008  (Rec: 01/04/17 18:31  RYA0008  BSU-C01)
Adult Group: Education
    Education
      Education Group Topic                     Stress Management
      Education Group Comments                  DNA
Document     01/06/17 16:00  KAT0036  (Rec: 01/06/17 16:00  KAT0036  BSU-M03)
```

Continued on Page 281

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Adult Group: Education
    Education
      Education Group Topic                     Mental Health Association
      Education Group Response                  Declined
Document     01/08/17 21:25  JAC0076  (Rec: 01/08/17 21:26  JAC0076  BSU-C01)
Adult Group: Education
    Education
      Education Group Topic                     Bingo
      Education Group Response                  Declined
Document     01/09/17 19:38  STE0107  (Rec: 01/09/17 19:38  STE0107  BSU-C02)
Adult Group: Education
    Education
      Education Group Topic                     MICA
      Education Group Response                  Declined
Document     01/09/17 22:12  RYA0008  (Rec: 01/09/17 22:13  RYA0008  BSU-C12)
Adult Group: Education
    Education
      Education Group Topic                     Meditation Group
      Education Group Affect Behavior           Appropriate
                                                Calm
                                                Cooperative
                                                Euthymic
                                                Congruent
      Education Group Response                  Participated
                                                Followed Directions
Document     01/16/17 16:04  STE0107  (Rec: 01/16/17 16:04  STE0107  CMC-RDC2)
Adult Group: Education
    Education
      Education Group Topic                     MICA-Anxiety
      Education Group Response                  Declined
Document     01/19/17 16:11  KIM0012  (Rec: 01/19/17 16:11  KIM0012  BSU-C21)
Adult Group: Education
    Education
      Education Group Topic                     Solution Focused Group
      Education Group Affect Behavior Comment   Did not attend
      Education Group Response                  Declined
      Education Group Comments                  Chose not to attend
Document     01/20/17 17:00  ERI0034  (Rec: 01/20/17 17:00  ERI0034  BSU-C01)
Adult Group: Education
    Education
      Education Group Topic                     comunnity agency group
      Education Group Response                  Declined
Document     01/21/17 16:12  ERI0034  (Rec: 01/21/17 16:13  ERI0034  CMC-RDC2)
Adult Group: Education
    Education
      Education Group Topic                     Pet Therapy
      Education Group Response                  Declined
Document     01/24/17 15:59  JAC0076  (Rec: 01/24/17 16:00  JAC0076  CMC-RDC2)
Adult Group: Education
    Education
      Education Group Topic                     Anxiety
      Education Group Affect Behavior           Calm
                                                Cooperative
```

Continued on Page 282

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
                                              Euthymic
      Education Group Intervevtions           Encourage Participation
      Education Group Response                Participated
 Document     01/26/17 17:35  KIM0012  (Rec: 01/26/17 17:36  KIM0012  BSU-C21)
 Adult Group: Education
    Education
      Education Group Topic                   Solution Focused Group
      Education Group Comments                Did not attend group today.
 Document     01/30/17 16:10  RYA0008  (Rec: 01/30/17 16:17  RYA0008  BSU-C01)
 Adult Group: Education
    Education
      Education Group Topic                   MICA - Autobiography in 5
                                              chapters
      Education Group Comments                DNA
 Document     02/02/17 16:10  KIM0012  (Rec: 02/02/17 16:11  KIM0012  BSU-C21)
 Adult Group: Education
    Education
      Education Group Topic                   Solution Focused Group
      Education Group Affect Behavior         Monopolizing
                                              Redirectable
                                              Full
      Education Group Intervevtions           Validate
                                              Redirect
      Education Group Response                Participated
      Education Group Comments                Intrusive at times, negative
                                              feedback at times, but easily
                                              redirected by staff.
 Document     02/06/17 16:05  ERI0034  (Rec: 02/06/17 16:06  ERI0034  BSU-M06)
 Adult Group: Education
    Education
      Education Group Topic                   MICA
      Education Group Response                Declined
 Document     02/09/17 16:09  KIM0012  (Rec: 02/09/17 16:09  KIM0012  BSU-C21)
 Adult Group: Education
    Education
      Education Group Topic                   Solution Focused Group
      Education Group Comments                Chose not to attend due to
                                              planning for tomorrow's
                                              discharge.
MHU:Adult Group 08- Staff Pass                          Start:  12/25/16 05:12
Freq:                                                   Status: Discharge
 Document     01/07/17 20:43  JAC0076  (Rec: 01/07/17 20:43  JAC0076  BSU-M10)
 Adult Group: Staff Pass
    Staff Pass
      Staff Pass                              No
 Document     01/21/17 13:36  ROB0100  (Rec: 01/21/17 13:36  ROB0100  CMC-RDC2)
 Adult Group: Staff Pass
    Staff Pass
      Staff Pass Comments                     staff pass not ordered for pt
MHU:Adult Group 09- Evening                             Start:  12/25/16 05:12
Freq:                                                   Status: Discharge
 Document     12/27/16 19:25  JAC0076  (Rec: 12/27/16 19:26  JAC0076  BSU-C01)
 Adult Group: Evening
```

Continued on Page 283

```
    Evening
      Evening Group Topic                        Wellness Recovery Action Plan
      Evening Group Participation                Declined
Document     12/28/16 20:01  ERI0034  (Rec: 12/28/16 20:01  ERI0034  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Topic                        stress management
      Evening Group Participation                Declined
Document     12/29/16 19:55  ERI0034  (Rec: 12/29/16 19:55  ERI0034  BSU-C01)
Adult Group: Evening
    Evening
      Evening Group Topic                        self discovery
      Evening Group Participation                Declined
Document     12/30/16 23:16  RYA0008  (Rec: 12/30/16 23:16  RYA0008  BSU-C01)
Adult Group: Evening
    Evening
      Evening Group Topic                        Interpersonal Effectiveness
      Evening Group Participation                Declined
Document     12/31/16 21:08  RAC0013  (Rec: 12/31/16 21:08  RAC0013  BSU-C12)
Adult Group: Evening
    Evening
      Evening Group Participation                Participated Adequately
Document     01/01/17 19:34  KAT0036  (Rec: 01/01/17 19:35  KAT0036  BSU-M04)
Adult Group: Evening
    Evening
      Evening Group Topic                        Journaling
      Evening Group Participation                Declined
Document     01/03/17 20:34  RYA0008  (Rec: 01/03/17 20:34  RYA0008  BSU-C12)
Adult Group: Evening
    Evening
      Evening Group Topic                        Space - Relaxation group
      Evening Group Participation                Declined
Document     01/04/17 19:55  SOP0051  (Rec: 01/04/17 19:55  SOP0051  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Topic                        Journaling
      Evening Group Participation                Declined
Document     01/05/17 19:47  KAT0036  (Rec: 01/05/17 19:47  KAT0036  BSU-C12)
Adult Group: Evening
    Evening
      Evening Group Topic                        Past Vs. Future
      Evening Group Participation                Declined
Document     01/06/17 20:39  JAC0076  (Rec: 01/06/17 20:40  JAC0076  BSU-C12)
Adult Group: Evening
    Evening
      Evening Group Topic                        Rumination
      Evening Group Participation                Declined
Document     01/07/17 21:25  TAH0001  (Rec: 01/07/17 21:25  TAH0001  BSU-C01)
Adult Group: Evening
    Evening
      Evening Group Topic                        Relaxation
      Evening Group Participation                Declined
Document     01/09/17 22:12  RYA0008  (Rec: 01/09/17 22:13  RYA0008  BSU-C12)
```

Continued on Page 284

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308
Assessments and Treatments - Continued

```
Adult Group: Evening
    Evening
      Evening Group Topic                        Journaling
      Evening Group Participation                Declined
Document     01/10/17 22:33  JAC0076  (Rec: 01/10/17 22:33  JAC0076  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Topic                        Wellness Recovery Action Plan
      Evening Group Participation                Declined
Document     01/12/17 20:21  KAT0036  (Rec: 01/12/17 20:22  KAT0036  BSU-M03)
Adult Group: Evening
    Evening
      Evening Group Topic                        Journaling
      Evening Group Participation                Participated Adequately
Document     01/13/17 19:25  ERI0034  (Rec: 01/13/17 19:25  ERI0034  BSU-C01)
Adult Group: Evening
    Evening
      Evening Group Topic                        anger management
      Evening Group Participation                Participated Adequately
Document     01/14/17 20:15  ANI0006  (Rec: 01/14/17 20:15  ANI0006  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Topic                        Journaling
      Evening Group Participation                Declined
Document     01/15/17 19:51  JOH0023  (Rec: 01/15/17 19:52  JOH0023  BSU-C01)
Adult Group: Evening
    Evening
      Evening Group Topic                        Strengths and Weaknesses
      Evening Group Participation                Declined
Document     01/16/17 20:10  JAC0076  (Rec: 01/16/17 20:11  JAC0076  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Topic                        Triggering situation
      Evening Group Participation                Participated Adequately
Document     01/16/17 22:28  STE0107  (Rec: 01/16/17 22:28  STE0107  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Topic                        relaxation
      Evening Group Participation                Declined
Document     01/17/17 20:31  KAT0036  (Rec: 01/17/17 20:31  KAT0036  BSU-C12)
Adult Group: Evening
    Evening
      Evening Group Topic                        WRAP
      Evening Group Participation                Declined
Document     01/18/17 21:20  JAC0076  (Rec: 01/18/17 21:22  JAC0076  CMC-RDC2)
Adult Group: Evening
    Evening
      Evening Group Participation                asleep
Document     01/19/17 21:53  RYA0008  (Rec: 01/19/17 21:53  RYA0008  BSU-C01)
Adult Group: Evening
    Evening
      Evening Group Topic                        Boundaries
      Evening Group Participation                Participated Adequately
```

Continued on Page 285

Document 01/20/17 19:57 ERI0034 (Rec: 01/20/17 19:57 ERI0034 BSU-C01)
Adult Group: Evening
Evening
Evening Group Topic Anger management
Evening Group Participation Declined
Document 01/21/17 22:41 TAH0001 (Rec: 01/21/17 22:41 TAH0001 BSU-C12)
Adult Group: Evening
Evening
Evening Group Topic Cinematherapy
Evening Group Participation Participated Adequately
Document 01/22/17 22:08 STE0107 (Rec: 01/22/17 22:08 STE0107 BSU-M07)
Adult Group: Evening
Evening
Evening Group Topic open discussion
Evening Group Participation Participated Adequately
Document 01/25/17 19:35 ANI0006 (Rec: 01/25/17 19:35 ANI0006 BSU-C12)
Adult Group: Evening
Evening
Evening Group Topic Journaling
Evening Group Participation Participated Adequately
Document 01/26/17 22:35 RYA0008 (Rec: 01/26/17 22:35 RYA0008 BSU-C01)
Adult Group: Evening
Evening
Evening Group Topic "About Me"
Evening Group Participation Participated Adequately
Document 01/28/17 20:41 ANI0006 (Rec: 01/28/17 20:41 ANI0006 CMC-RDC2)
Adult Group: Evening
Evening
Evening Group Topic Journaling
Evening Group Participation Participated Adequately
Document 01/30/17 21:23 RYA0008 (Rec: 01/30/17 21:23 RYA0008 BSU-C01)
Adult Group: Evening
Evening
Evening Group Topic About Me
Evening Group Participation Participated Adequately
Document 01/31/17 21:28 ERI0034 (Rec: 01/31/17 21:29 ERI0034 CMC-RDC2)
Adult Group: Evening
Evening
Evening Group Topic WRAP
Evening Group Participation Declined
Document 02/01/17 20:06 KAT0036 (Rec: 02/01/17 20:06 KAT0036 CMC-RDC2)
Adult Group: Evening
Evening
Evening Group Topic Journaling
Evening Group Participation Participated Adequately
Document 02/02/17 20:53 RYA0008 (Rec: 02/02/17 20:53 RYA0008 BSU-C12)
Adult Group: Evening
Evening
Evening Group Topic Relaxation Group
Evening Group Participation Participated Adequately
Document 02/03/17 20:05 JAC0076 (Rec: 02/03/17 20:06 JAC0076 CMC-RDC2)
Adult Group: Evening
Evening

Continued on Page 286

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Evening Group Topic                         Myths About Anger
      Evening Group Participation                 Declined
      Evening Group Comments                      anger
 Document     02/04/17 22:43  MEG0009  (Rec: 02/04/17 22:44  MEG0009  BSU-C02)
 Adult Group: Evening
    Evening
      Evening Group Topic                         My Tree of Life
      Evening Group Participation                 Participated Adequately
 Document     02/06/17 20:57  RYA0008  (Rec: 02/06/17 20:57  RYA0008  CMC-RDC2)
 Adult Group: Evening
    Evening
      Evening Group Topic                         About Me
      Evening Group Participation                 Participated Adequately
 Document     02/07/17 20:25  ANI0006  (Rec: 02/07/17 20:25  ANI0006  BSU-C12)
 Adult Group: Evening
    Evening
      Evening Group Topic                         WRAP
      Evening Group Participation                 Declined
 Document     02/08/17 19:53  ANI0006  (Rec: 02/08/17 19:54  ANI0006  BSU-C01)
 Adult Group: Evening
    Evening
      Evening Group Topic                         Journaling
      Evening Group Participation                 Participated Adequately
 Document     02/09/17 21:57  RYA0008  (Rec: 02/09/17 21:57  RYA0008  BSU-C03)
 Adult Group: Evening
    Evening
      Evening Group Topic                         About Me
      Evening Group Participation                 Participated Adequately
```

```
MHU:Adult Group 10- Alcohol Anon/Open                      Start:  12/25/16 05:12
Freq:                                                      Status: Discharge
 Document     01/01/17 19:34  KAT0036  (Rec: 01/01/17 19:35  KAT0036  BSU-M04)
 Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                 Declined
 Document     01/05/17 19:53  KAT0036  (Rec: 01/05/17 19:53  KAT0036  BSU-C12)
 Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                 Declined
 Document     01/15/17 19:51  JOH0023  (Rec: 01/15/17 19:52  JOH0023  BSU-C01)
 Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                 Declined
 Document     01/26/17 20:54  KAT0036  (Rec: 01/26/17 20:55  KAT0036  BSU-C12)
 Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                 Declined
 Document     01/29/17 20:54  KAT0036  (Rec: 01/29/17 20:54  KAT0036  BSU-M03)
 Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                 Declined
 Document     02/01/17 20:06  KAT0036  (Rec: 02/01/17 20:06  KAT0036  CMC-RDC2)
 Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
```

Continued on Page 287

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      AA/Open Group Participation                  Declined
Document     02/02/17 20:42  KAT0036  (Rec: 02/02/17 20:42  KAT0036  BSU-C01)
Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                  Declined
Document     02/09/17 20:11  KAT0036  (Rec: 02/09/17 20:11  KAT0036  BSU-C09)
Adult Group: AA/Open
    Alcoholics Anonymous/Open Group
      AA/Open Group Participation                  Declined
MHU:Adult Group 12- Wrap Up                                  Start:  12/25/16 05:12
Freq:                                                        Status: Discharge
Document     12/28/16 20:01  ERI0034  (Rec: 12/28/16 20:01  ERI0034  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           no goal
Document     12/29/16 19:55  ERI0034  (Rec: 12/29/16 19:55  ERI0034  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           Did Not Meet Goal
Document     01/01/17 19:34  KAT0036  (Rec: 01/01/17 19:35  KAT0036  BSU-M04)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           No Goal
Document     01/02/17 22:29  RYA0008  (Rec: 01/02/17 22:29  RYA0008  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           Did Not Meet Goal
      Wrap Up Group Comments                       DNA
Document     01/03/17 20:34  RYA0008  (Rec: 01/03/17 20:34  RYA0008  BSU-C12)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           Did Not Meet Goal
Document     01/06/17 20:06  KAT0036  (Rec: 01/06/17 20:06  KAT0036  BSU-M03)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           No Goal
Document     01/08/17 21:12  JAC0076  (Rec: 01/08/17 21:12  JAC0076  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           no goal
Document     01/11/17 21:07  JAC0076  (Rec: 01/11/17 21:12  JAC0076  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           no goal
Document     01/12/17 20:02  JAC0076  (Rec: 01/12/17 20:02  JAC0076  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           no goal
Document     01/16/17 22:28  JAC0076  (Rec: 01/16/17 22:29  JAC0076  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                           no goal
Document     01/17/17 22:23  KAT0036  (Rec: 01/17/17 22:23  KAT0036  BSU-C12)
```

Continued on Page 288

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Met Goal
Document     01/18/17 23:02  RYA0008  (Rec: 01/18/17 23:03  RYA0008  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Did Not Meet Goal
Document     01/19/17 21:53  RYA0008  (Rec: 01/19/17 21:53  RYA0008  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Did Not Meet Goal
Document     01/20/17 19:57  ERI0034  (Rec: 01/20/17 19:57  ERI0034  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Did Not Meet Goal
Edit Result  01/20/17 19:57  ERI0034  (Rec: 01/20/17 19:58  ERI0034  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        no goal
Document     01/23/17 21:57  JAC0076  (Rec: 01/23/17 21:58  JAC0076  BSU-M04)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Met Goal
Document     01/24/17 22:01  ERI0034  (Rec: 01/24/17 22:01  ERI0034  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Met Goal
Document     01/25/17 20:48  JAC0076  (Rec: 01/25/17 20:48  JAC0076  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Met Goal
Document     01/28/17 21:06  KAT0036  (Rec: 01/28/17 21:06  KAT0036  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Met Goal
Document     01/31/17 21:28  ERI0034  (Rec: 01/31/17 21:29  ERI0034  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Did Not Meet Goal
Document     02/02/17 20:42  KAT0036  (Rec: 02/02/17 20:42  KAT0036  BSU-C01)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Did Not Meet Goal
Document     02/03/17 20:05  JAC0076  (Rec: 02/03/17 20:06  JAC0076  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        asleep
Document     02/06/17 20:57  RYA0008  (Rec: 02/06/17 20:57  RYA0008  CMC-RDC2)
Adult Group: Wrap Up
    Wrap Up
      Wrap Up Group Goal                        Did Not Meet Goal
Document     02/07/17 20:25  ANI0006  (Rec: 02/07/17 20:25  ANI0006  BSU-C12)
Adult Group: Wrap Up
```

Continued on Page 289

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Wrap Up
Wrap Up Group Goal No goal set
Document 02/09/17 20:11 KAT0036 (Rec: 02/09/17 20:11 KAT0036 BSU-C09)
Adult Group: Wrap Up
Wrap Up
Wrap Up Group Goal Met Goal

MHU:Adult- Psychosocial Assessment Start: 12/25/16 05:12
Freq: Status: Discharge
Document 12/26/16 11:31 KIM0012 (Rec: 12/26/16 11:50 KIM0012 BSU-C21)
MHU: Adult- Psych Assess
Referral Source
Bang's
Referral Phone Number .
Reason for Admission
History of Current Episode or Illness

Per MHE in ED: "PT BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR MHE. PT CALM/ COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN. PT DENIES SI, HI ,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "BAD GUYS THAT ARE HACKING MY SOFTWARE ARE TRYING TO KILL ME". PT REMAINED HYPERVERBAL AND AGITATED THROUGHOUT EVAL. PT DENIED ANY CURRENT OUTPT MH TRTMT, OTHER THAN SESSIONS W/ DR KEVIN FIELDS - LAST ONE BEING APPROX 2MOS AGO. PT ALSO DENIES ANY CURRENT HOME MEDS. STATES ONLY CURRENT PROVIDER IS PCP - DR BREIMEN. PT VASCILLATES BTWN REQUESTING

Continued on Page 290

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

	ADMIT AND STATING DESIRE TO BE D/C'd. "
Current Outpatient Providers	
Therapist/Counselor	Dr. Kevin Field, PhD
Psychiatrist	Uncertain
Case Manager	Uncertain
Primary Care Physician	Uncertain
General Information	
Marital Status	Single
Patient's County of Residence	Tompkins
Lives With/Family Composition	Anne Rose reports that she currently has a place to live in Ithaca but is vague about where that place is or the setting. She states that she recently had to leave her home because of the poor condition and that there was no heat and went to the Rescue Mission to seek a place to spend the night. She was turned away from there so she called an ambulance and was brought to the ED at CMC "for a psychiatric interview and a warm place to spend the night" . She states she was "ejected" from four hotels in Ithaca prior to going to the Rescue Mission. She is agitated and guarded and difficult to extract any futher personal information from. She refused to sign ROI for her therapist , Kevin Field, but did provide verbal permission.
Type of Residence	Other
Type of Residence Comment	Unclear what her living situation is.
Employment Status/Occupation	Unemployed. Based on conversation she likely has SSDI for financial resource but she was not clear about this with SW.
Religion	Nonreligious Affliation
Cultural Needs	Patient is transitioned male to female. Require single room on the unit and this accomodation has been made.
Education Comment	Unsure and unable to obtain this information.
Legal System Involved	No
Insurance	

Continued on Page 291

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Insurance	Medicaid
Income	
Employment	Unemployed
SSD	Yes: Possibly
Family Hx Mental Health/Substance Abuse	
Hx Family Depression	Yes: MOTHERR "ATTEMPTED SUICIDE
Current/History of Trauma	
Current Abuse Comment	Unsure
History of Abuse Comment	Unsure and did not elaborate due to agitated manner.
Are You Having Thoughts of Hurting Yourself Or Others	No
History of Violent/Aggressive Behavior	She denies.
PHYSICAL HEALTH/MEDICAL HISTORY	
Social Resources/External Support System	
Support Person	None
Patient's Identified Strengths/Assests/Potentials	
ID Strengths/Assests/Potentials Comment	Reports positive relationship with her therapist, Dr. Kevin Field, and although she will not sign ROI she does give verbal permission to speak with him.
Patient's Identified Problems/Liabilities	
Identified Problems/Liabilities Comment	Unclear what other providers working with this individual or what her living situation really is due the nature of her agitation and guardedness with staff.
Treatment Precautions	
Treatment Precautions	15 Minute Safety Checks
Housing Options	
Housing Options	Return to Previous Arrangement
Treatment Options	
Treatment Options	Return to Current Outpatient Provider
Identified Problems	
Noncompliance	
Identified Problems Comment	Possibly with meds and treatment.
Lack of Housing	
Identified Problems Comment	She suggests there might be a problem with housing but vague .
Group Recommendations	
Group Recommendations	Community Exercise Cognitive Behavior Focus Dialectical Behavior Education

Continued on Page 292

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Evening

Discharge Plan/Anticipated Needs/Referrals

Discharge Comments: Discharge planning to include providing group and individual programming as well as milieu and recreational therapies. Patient will be encouraged to mee with social worker and doctor towards meeting treatment goals and discharge planning options. She refuses to sign ROI's but gives verbal permission to speak to her therapist, Dr. Kevin Field. Her personality remains agitative, guarded, accusatory and difficult to work with as she feels persecuted by being at the BSU when "I only came to the hospital for a psychiatrist interview and a warm place to spend the night". She has put in a court request for hearing as of 12/25 so SW will likely pursue this process as patient's unwillness to work with staff hinders our moving forward with a proper discharge plan. Patient will show readiness for discharge when she is observed and verbalizing improved mood, decrease in aggresive nature.

MHU:Adult- Rec Therapy Assessment Start: 12/25/16 05:12
Freq: Status: Discharge
Document 12/26/16 13:35 KYL0051 (Rec: 12/26/16 13:44 KYL0051 BSU-M13)
MHU: Adult Recreation Therapy 01- Client Interview

General Information

Reason for Visit: PSYCHOSIS NOS

Reason for Visit Additional Information: per chart - 60YO M TO F TRANSGENDER PT HX: BIPOLAR D/O , MANIC W/ PSYCHOSIS, R/O SCHIZOPHRENIA, BORDERLINE PERS D/O, PTSD; BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR MHE. PT CALM/ COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT

Continued on Page 293

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

	BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN DUE TO HIS MENTAL ILLNESS. PT DENIES SI, HI,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "I'M ONE OF THE GOOD GUYS IN SOFTWARE AND BAD GUYS ARE TRYING TO KILL ME".
Living Situation	Currently has issues with housing, unclear where she was staying prior to admission.
Transportation	See Comment
Transportation Comment	unknown
Education	Unknown
Vocation	Unemployed See Comment
Vocation Comments	hx working at Cornell for 8 years and as a computer programmer for 30+ years.
Leisure Profile	
Constructive	unable to obtain
Destructive	denies
Engagement	unable to obtain
Perceived Barriers to Leisure	See Comment
Perceived Barriers to Leisure Comment	unknown
Strengths	
Strengths	unable to obtain
Goals/Areas for Improvement	
Goals/Areas for Improvement	patient fixated on being discharged at this time

MHU: Adult Recreation Therapy 02- Staff Assessment

Cognitive Assessment	
Ability to Follow Directions	Fair
Number of Cues Needed	several
Willingness to Follow Directions	Poor
Group Participation	has yet to attend
Thoughts/Distortions Assessment	
Automatic Thoughts and Distortions	Blaming
Emotional Assessment	

Continued on Page 294

Assessments and Treatments - Continued

Mood — Irritable
Affect — Restricted
Social Assessment
Social — Needs Encouragement
Physical Assessment
Gross Motor Skills — Good
Fine Motor Skills — Good
Summary of Assessment and Clinical Impression
Summary of Assessment and Clinical Impression — Patient was initially polite when this writer introduced herself but then had an irritable edge when this writer asked to meet with patient as patient was only focused on meeting with the doctor and stated "I don't need to talk about recreation. " Patient spoke briefly during our conversation about her job history but other information was difficult to assess. Will attempt to meet with patient later on.
Goals
Patient will communicate her needs and feelings to staff appropriately throughout admission.
Goal Status — New
Patient will demonstrate an improvement in her mood symptoms.
Goal Status — New
Patient will identify leisure interests, strengths and goals.
Goal Status — New
Interventions
Provide opportunities for patient to express her needs and feelings.
Intervention Status — New
Meet with patient to build rapport.
Intervention Status — New
Provide opportunities for patient to identify interests, strengths and goals.
Intervention Status — New

Edit Result 12/26/16 13:35 KYL0051 (Rec: 12/26/16 15:43 KYL0051 BSU-M13)

MHU: Adult Recreation Therapy 01- Client Interview
General Information
Transportation — Walk
Transportation Comment
Leisure Profile
Constructive — Patient enjoys playing the guitar, listening to music and going to concerts
Destructive — Nicotine addicted
Goals/Areas for Improvement
Goals/Areas for Improvement — patient fixated on being discharged at this time and only speaking with the doctor

Edit Result 12/26/16 13:35 KYL0051 (Rec: 12/26/16 16:24 KYL0051 BSU-M13)

Continued on Page 295

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

MHU: Adult Recreation Therapy 01- Client Interview
General Information
Living Situation — Patient reports staying at various hotels prior to her admission.

Edit Result 12/26/16 13:35 KYL0051 (Rec: 12/28/16 11:59 KYL0051 BSU-M13)
MHU: Adult Recreation Therapy 01- Client Interview
General Information
Living Situation — Patient reports staying at various hotels prior to her admission. Patient owns a home in Jacksonville.

Edit Result 12/26/16 13:35 KYL0051 (Rec: 01/23/17 16:16 KYL0051 BSU-C11)
MHU: Adult Recreation Therapy 01- Client Interview
Leisure Profile
Perceived Barriers to Leisure Comment — "being here"
Strengths
Strengths — smart
Goals/Areas for Improvement
Goals/Areas for Improvement — patient fixated on being discharged
MHU: Adult Recreation Therapy 02- Staff Assessment
Cognitive Assessment
Group Participation — attempted one group - was inappropriate, raising voice
Social Assessment
Social — Self-Initiative
Responsive

MHU:Adult- Rec Therapy Progress Note Start: 12/25/16 05:12
Freq: Status: Discharge
Document 01/03/17 14:50 KYL0051 (Rec: 01/03/17 14:54 KYL0051 BSU-M13)
MHU: Adult Recreation Therapy Progress Note
Goals
Patient will communicate her needs and feelings to staff appropriately throughout admission.
Goal Status — In Progress
Goals — Patient is able to communicate her basic needs however struggles to communicate her feelings in an organized manner and continues to be fixated on discharge.
Patient will demonstrate an improvement in her mood symptoms.
Goal Status — In Progress
Goals — Patients mood has mildly improved since admission - patient is still observed to be talking and gesturing to herself and is unable/ unwilling to have a meaningful interaction with staff. Has an irritable edge and limited insight into her admission.

Continued on Page 296

Assessments and Treatments - Continued

Patient will identify leisure interests, strengths and goals.

Goal Status	In Progress
Goals	Patient has identified some leisure interests such as: playing guitar, music, going to concerts but is unable to identify strengths and goals at this time.

Interventions

Provide opportunities for patient to express her needs and feelings.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to express herself.

Meet with patient to build rapport.

Intervention Status	In Progress
Intervention Comments	Continue to meet with patient daily to build rapport.

Provide opportunities for patient to identify interests, strengths and goals.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to identify these areas.

Document 01/10/17 15:37 KYL0051 (Rec: 01/10/17 15:37 KYL0051 BSU-M13)

MHU: Adult Recreation Therapy Progress Note

Goals

Patient will communicate her needs and feelings to staff appropriately throughout admission.

Goal Status	In Progress
Goals	Patient is able to communicate her basic needs however struggles to communicate her feelings in an organized manner and continues to be fixated on discharge.

Patient will demonstrate an improvement in her mood symptoms.

Goal Status	In Progress
Goals	Patients mood has mildly improved since admission - patient is still observed to be talking and gesturing to herself and is unable/ unwilling to have a meaningful interaction with staff. Has an irritable edge and limited insight into her admission.

Patient will identify leisure interests, strengths and goals.

Goal Status	In Progress
Goals	Patient has identified some leisure interests such as: playing guitar, music, going to concerts but is unable to identify strengths and goals

Continued on Page 297

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

at this time.

Interventions

Provide opportunities for patient to express her needs and feelings.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to express herself.

Meet with patient to build rapport.

Intervention Status	In Progress
Intervention Comments	Continue to meet with patient daily to build rapport.

Provide opportunities for patient to identify interests, strengths and goals.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to identify these areas.

Document 01/17/17 16:26 KYL0051 (Rec: 01/17/17 16:26 KYL0051 BSU-M13)

MHU: Adult Recreation Therapy Progress Note

Goals

Patient will communicate her needs and feelings to staff appropriately throughout admission.

Goal Status	In Progress
Goals	Patient is able to communicate her basic needs however struggles to communicate her feelings in an organized manner and continues to be fixated on discharge.

Patient will demonstrate an improvement in her mood symptoms.

Goal Status	In Progress
Goals	Patients mood has mildly improved since admission - patient is still observed to be talking and gesturing to herself and is unable/ unwilling to have a meaningful interaction with staff. Has an irritable edge and limited insight into her admission.

Patient will identify leisure interests, strengths and goals.

Goal Status	In Progress
Goals	Patient has identified some leisure interests such as: playing guitar, music, going to concerts but is unable to identify strengths and goals at this time.

Interventions

Provide opportunities for patient to express her needs and feelings.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to express herself.

Continued on Page 298

Meet with patient to build rapport.

Intervention Status	In Progress
Intervention Comments	Continue to meet with patient daily to build rapport.

Provide opportunities for patient to identify interests, strengths and goals.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to identify these areas.

Document 01/27/17 14:41 KYL0051 (Rec: 01/27/17 14:41 KYL0051 BSU-M13)

MHU: Adult Recreation Therapy Progress Note

Goals

Patient will communicate her needs and feelings to staff appropriately throughout admission.

Goal Status	In Progress
Goals	Patient is able to communicate her basic needs however struggles to communicate her feelings in an organized manner and continues to be fixated on discharge.

Patient will demonstrate an improvement in her mood symptoms.

Goal Status	In Progress
Goals	Patients mood has mildly improved since admission - patient is still observed to be talking and gesturing to herself and is unable/ unwilling to have a meaningful interaction with staff. Has an irritable edge and limited insight into her admission.

Patient will identify leisure interests, strengths and goals.

Goal Status	In Progress
Goals	Patient has identified some leisure interests such as: playing guitar, music, going to concerts but is unable to identify strengths and goals at this time.

Interventions

Provide opportunities for patient to express her needs and feelings.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to express herself.

Meet with patient to build rapport.

Intervention Status	In Progress
Intervention Comments	Continue to meet with patient daily to build rapport.

Provide opportunities for patient to identify interests, strengths and goals.

Intervention Status	In Progress
Intervention Comments	Continue to provide

Continued on Page 299

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

	opportunities for patient to identify these areas.

Document 02/03/17 13:32 KYL0051 (Rec: 02/03/17 13:35 KYL0051 BSU-M13)
MHU: Adult Recreation Therapy Progress Note

Goals

Patient will communicate her needs and feelings to staff appropriately throughout admission.

Goal Status	In Progress
Goals	Patient is able to communicate her basic needs, at times continues to demonstrate agitation towards staff regarding treatment (medications).

Patient will demonstrate an improvement in her mood symptoms.

Goal Status	In Progress
Goals	Patients mood has improved since admission - although continues to have an irritable edge and limited insight into her admission. Patient is more pleasant upon approach and openly talks about her interests.

Patient will identify leisure interests, strengths and goals.

Goal Status	In Progress
Goals	Patient has identified some leisure interests such as: playing guitar, music, going to concerts but is unable to identify strengths and goals at this time aside from being discharged.

Interventions

Provide opportunities for patient to express her needs and feelings.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to express herself.

Meet with patient to build rapport.

Intervention Status	In Progress
Intervention Comments	This writer meets with patient daily and has established rapport. Continue to meet with patient daily to maintain rapport.

Provide opportunities for patient to identify interests, strengths and goals.

Intervention Status	In Progress
Intervention Comments	Continue to provide opportunities for patient to identify these areas.

MHU:Attendance- Discharge Planning Group Start: 12/25/16 05:12
Freq: Status: Discharge

Continued on Page 300

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Document 12/28/16 16:10 KIM0012 (Rec: 12/28/16 16:10 KIM0012 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance
Discharge Planning Group Attendance No
Discharge Planning Group Attendance Comment Chose not to attend.

Document 01/11/17 16:27 KIM0012 (Rec: 01/11/17 16:27 KIM0012 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance
Discharge Planning Group Attendance Refused
Discharge Planning Group Attendance Comment Chose not to attend.

Document 01/18/17 15:57 KIM0012 (Rec: 01/18/17 15:57 KIM0012 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance
Discharge Planning Group Attendance No
Discharge Planning Group Attendance Comment Chose not to participate.

Document 02/01/17 15:58 KIM0012 (Rec: 02/01/17 15:58 KIM0012 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance
Discharge Planning Group Attendance Yes
Discharge Planning Group Attendance Comment Positive participation with staff and peers.

Document 02/08/17 15:41 KIM0012 (Rec: 02/08/17 15:41 KIM0012 BSU-C21)
MHU: Attendance-Discharge Planning Group
Discharge Planning Group Attendance
Discharge Planning Group Attendance Yes
Discharge Planning Group Attendance Comment Positive interaction with staff and peers.

MHU:Attendance- Pet Therapy Start: 12/25/16 05:12
Freq: .ONCE Status: Discharge

Document 12/31/16 21:08 RAC0013 (Rec: 12/31/16 21:08 RAC0013 BSU-C12)
MHU: Attendance-Pet Therapy
Pet Therapy Attendance Assessment
Pet Therapy Attendance Yes

Document 01/28/17 21:06 KAT0036 (Rec: 01/28/17 21:06 KAT0036 CMC-RDC2)
MHU: Attendance-Pet Therapy
Pet Therapy Attendance Assessment
Pet Therapy Attendance Yes

MHU:Evaluation Part 1 Start: 12/25/16 00:29
Freq: Status: Discharge

Document 12/25/16 01:35 GRE0068 (Rec: 12/25/16 03:07 GRE0068 BSU-L03)
Violent Episode Against Others
Violent Episode Against Others
Hx of Violent Episodes Against Others Yes
Episode Comment PT STATES HAS STRUCK EXWIFE IN PAST.

MHU: Evaluation Part 1
General
Date of Evaluation 12/25/16
Time of Evaluation 01:30
Time Called 00:30

Continued on Page 301

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Revisit Within 72 Hours	No
Mode of Arrival	Ambulance
Transported 9.41	Yes
Patient's County of Residence	Tompkins
Chief Complaint/Hx of Current Episode	PT BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR MHE. PT CALM/ COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN. PT DENIES SI, HI ,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "BAD GUYS THAT ARE HACKING MY SOFTWARE ARE TRYING TO KILL ME". PT REMAINED HYPERVERBAL AND AGITATED THROUGHOUT EVAL. PT DENIED ANY CURRENT OUTPT MH TRTMT, OTHER THAN SESSIONS W/ DR KEVIN FIELDS - LAST ONE BEING APPROX 2MOS AGO. PT ALSO DENIES ANY CURRENT HOME MEDS. STATES ONLY CURRENT PROVIDER IS PCP - DR BREIMEN. PT VASCILLATES BTWN REQUESTING ADMIT AND STATING DESIRE TO BE D/C'd.
Significant Stressors at this Time	Emotional Housing Symptoms
Do You Have Access to Firearms	NO
Do You Feel Hopeless/Helpless/Worthless/ Guilty	No

MHU: Lethality Assessment
Feeling Hopeless/Helpless

Continued on Page 302

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Do you Feel Hopeless/Helpless	No
Do you Frequently do Things Suddenly Without Thinking	No
Harming Self/Others	
Do You Have Access to What You Would Use to Cause Harm	No
Have you Ever Tried to Hurt Yourself in the Past	No
Are You Having Thoughts of Hurting Others	No
Do you have a Plan	No
Do You Have Access to What You Would Use to Cause Harm	No
Have you Ever Hurt Others in the Past	Yes
What did you do	"I HIT MY EX-WIFE"
Taking Own Life/Other's Life	
Have you Ever Considered Suicide to End Problems	Yes
Ever Felt Suicide Was the Only Way to End Emotional Pain	No
Do You Sometimes Feel Others Would be Better Off Without You	No
Are you having thoughts of suicide	No
Who Would you tell that you Wanted to Kill Yourself	"NO ONE"
Have you Ever Tried to Kill Yourself in the Past	No
Have you Ever Considered Killing Others to End Problems	No
Ever Felt Killing Others the Only Way to End Emotional Pain	No
Are you Having Thoughts of Killing Others	No
Do you Have a Plan	No
Do You Have Access to What You Would Use to Cause Harm	No
Have you ever Tried to Kill Others in the Past	No

MHU:Evaluation Part 2 Start: 12/25/16 00:29
Freq: Status: Discharge
Document 12/25/16 03:29 GRE0068 (Rec: 12/25/16 04:20 GRE0068 BSU-L03)
MHU: Evaluation Part 2
Review
Clinical Formulation and Rationale: 60YO M TO F TRANSGENDER PT HX: BIPOLAR D/O, MANIC W/ PSYCHOSIS, R/O SCHIZOPHRENIA, BORDERLINE PERS D/O, PTSD; BIBA 9.41 FROM SUNOCO STATION DOWNTOWN AFTER PT CALLED 911 REPORTING ALTERCATION W/ ANOTHER PERSON AT GAS STATION WHICH LED PT TO FEEL UNSAFE. PT REQUESTED TRANS TO ER FOR

Continued on Page 303

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

MHE. PT CALM/COOPERATIVE IN ER UNTIL AWOKEN FOR EVAL, AT WHICH TIME PT BECAME VERY AGITATED, YELLING AT STAFF, ACCUSING ER STAFF OF WAKING HIM TO ABUSE HIM. PT WAS DE-ESCALATED AND CALMED JUST ENOUGH TO CONDUCT EVAL INTERVIEW. PT HYPERVERBAL, DISORGANIZED AND TANGENTIAL PERSEVERATING ON BEING "KICKED OUT" OF MOTEL DUE TO BEING LABELED MENTALLY ILL. PT RELATES THAT HE ATTEMPTED TO GET A BED AT THE FRIENDSHIP CENTER, BUT THEY WOULDN'T ALLOW HIM IN DUE TO HIS MENTAL ILLNESS. PT DENIES SI, HI,SIB OR ANY HX OF THESE. PT MAKING DELUSIONAL STATEMENTS ABOUT BEING "AN OFFICER OF THE FEDERAL GOVM'T" AND "I'M ONE OF THE GOOD GUYS IN SOFTWARE AND BAD GUYS ARE TRYING TO KILL ME". PT ALSO STATES: " CROOKS IN THE FEDERAL GOVM'T ARE TRYING TO KILL ME". PT REMAINED HYPERVERBAL AND AGITATED THROUGHOUT EVAL. PT DENIED ANY CURRENT OUTPT MH TRTMT, OTHER THAN SESSIONS W/ DR KEVIN FIELDS - LAST ONE BEING APPROX 2MOS AGO. PT ALSO DENIES ANY CURRENT HOME MEDS. STATES ONLY CURRENT PROVIDER IS PCP - DR BREIMEN. PT VASCILLATES BTWN REQUESTING ADMIT AND STATING DESIRE TO BE D/C'd. PER PSYCHIATRIST, INVOL ADMIT DEEMED APPROP FOR THIS PT.

Time Reviewed with Provider	01:30
Reviewing Doctor	David Shenker
Time Reviewed with Psychiatrist	03:00
Reviewing Psychiatrist	Rahman,Mafuzur
Disposition	Emergency Admit (9.39)
Admitting Psychiatrist	Rahman,Mafuzur
Follow Up if Not Admitted	PT ADMITTED
Diagnosis	
AXIS I	Psychotic Disorder NOS

Patient: Insurance Information

Insurance Information	
Insurance Company	TOTAL CARE

Continued on Page 304

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Insurance Policy Number                   AN33246W
   Pre-certification Documentation
      Spoke with/contact number                 NAKITA/844-265-7594
      Information Obtained                      AUTH FOR 5 DAYS - 12/25-12/29
      Authorization Number                      11497306
   Time Spent
      Time Spent on MHU Evaluation (minutes)    200
       Query Text:Record total minutes spent on
       MHU Evaluation process for this patient
       .
MHU:Evaluation Part 3                                     Start:  12/25/16 00:29
Freq:                                                     Status: Discharge
 Document     12/25/16 01:35  GRE0068  (Rec: 12/25/16 03:07  GRE0068  BSU-L03)
 MHU: Evaluation Part 3
   Current Outpatient Treatment
      Last Date Seen as Outpatient              2 MOS AGO
      Agency                                    INDEP PSYCHOLOGIST
      Therapist                                 DR KEVIN FIELDS
      Frequency                                 Weekly
 MHU: Evaluation Part 3 History
   History of Past Treatment
      Received Mental Health Treatment          Yes
      List Agencies Where Pt. Has Received      CMC - BSU
       Mental Health Treatment                  ROCHESTER REG FORENSIC UNIT
                                                EPC "X3.5 YRS" 2003
                                                TCMHC
      Medical/Surgical History Relevant to      DENIES
       this Visit
      Hx Head Trauma                            No
      Hx MRSA                                   No
      Hx VRE                                    No
 MHU Evaluation Part 3
   Medications
      Home Medications Reviewed                 Yes
      Medication History                        SPIRONOLACTONE 50MG PO DAILY
   Sleep Pattern
      Hours per Day                             4
   Legal
      Legal System Involved                     No
 MHU: Evaluation Part 3 Family History
   Family Mental Illness/Substance Abuse
      Hx Family Depression                      Yes: MOTHERR "ATTEMPTED
                                                SUICIDE
Nutrition: Assessment                                     Start:  12/25/16 05:12
Freq:                                                     Status: Discharge
 Document     01/02/17 09:52  ALE0011  (Rec: 01/02/17 09:52  ALE0011  DIET-M01)
 Nutrition Only Assessment
   Diagnosis/History
      Current Medical Diagnosis                 psychosis NOS
   Diet
      Diet Order                                limited caffeine
   BMI
      Height                                    5 ft 7 in
```

Continued on Page 305

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Last Documented Weight 150 lb
Body Mass Index (BMI) 23.5
Body Mass Index (BMI) Classification Normal Weight
Query Text:Underweight: <18.5
Normal Weight: 18.5-24.9
Overweight: 25.0-29.9
Obesity (Level I): 30-34.9
Obesity (Level II): 35-39.9
Morbid Obesity (Level III): 40.0 or greater

Nutrition: Interventions
Follow Up
Proposed Rescreen Date 01/04/17
Visit Reason Details Initial

Nutrition Support Assessment
Nutrition Support Composition @ Target Rate/24 Hours

Document 01/04/17 18:02 ALE0011 (Rec: 01/04/17 18:08 ALE0011 DIET-C14)

Nutrition Only Assessment
Diagnosis/History
Current Medical Diagnosis psychosis NOS
Pertinent Past Medical/Surgical History male-to-female transgender; no other hx obtained per H7P
Diet
Diet Order limited caffeine
BMI
Height 5 ft 7 in
Last Documented Weight 150 lb
Body Mass Index (BMI) 23.5
Body Mass Index (BMI) Classification Normal Weight
Query Text:Underweight: <18.5
Normal Weight: 18.5-24.9
Overweight: 25.0-29.9
Obesity (Level I): 30-34.9
Obesity (Level II): 35-39.9
Morbid Obesity (Level III): 40.0 or greater
Labs/Medications/Supplements/Herbals
Pertinent Labs/Fingersticks Reviewed Yes
Pertinent Labs/Fingersticks Comment WNL
Pertinent Medications Risperdal - pt declining
Skin
Skin Breakdown No
Recent Braden Score per Nursing Assessment 22-23

Nutrition: Other Pertinent Information
Assessment Comments
Assessment Comment pt has been agitated, paranoid , irritable on unit; declining meds. Is eating meals per staff notes. Labs WNL. No noted nutrition risk factors identified; no intervention indicated. Will follow per

Continued on Page 306

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

protocol.

Identified Nutrition Diagnosis/Interventions
- Does Patient Have a Nutrition Diagnosis at This Time: None Identified
- Does Patient Have Anticipated Nutrition Interventions: None Identified

Nutrition: Diagnosis
- Nutrition Prescription
  - Nutrition Prescription: limited caffeine

Nutrition: Interventions
- Goal
  - Intervention Goals: Adequate intake to maintain stable body wt
- Follow Up
  - Proposed Rescreen Date: 02/04/17
  - Visit Reason Details: Re-Screen

Nutrition Support Assessment
- Nutrition Support Composition @ Target Rate/24 Hours

Nutrition: Monitoring Start: 12/25/16 05:12
Freq: Status: Discharge

Document 02/03/17 12:52 CRI0054 (Rec: 02/03/17 12:57 CRI0054 DIET-C14)

Nutrition Follow-Up
- Monitoring
  - Monitoring: Geodon and Invega ordered 1/25 ; otherwise, no new meds noted . MD notes that pt remains delusional and unable to safely manage self-care at home. Staff notes better compliance and cooperation. Positive for meals; no reported complaints or concerns. Possible wt gain of 4# in past month (from 168#), so will re-evaluate in another month.
- Skin
  - Skin Breakdown: No
  - Recent Braden Score per Nursing Assessment: 20
- Diet
  - Diet Order: limited caffeine
- Goal
  - Intervention Goals: adequate intake to maintain stable body wt without further wt gain
- Follow Up
  - Proposed Rescreen Date: 03/03/17
  - Visit Reason Details: Re-Screen

Nutrition Support Assessment
- Nutrition Support Composition @ Target Rate/24 Hours

Observation: q30 minutes Start: 01/11/17 13:53
Freq: QSHIFT Status: Discharge

Continued on Page 307

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
Document     01/12/17 08:01  SHA0063  (Rec: 01/12/17 08:01  SHA0063  BSU-M07)
Document     01/12/17 20:00  AMA0048  (Rec: 01/12/17 22:11  AMA0048  BSU-C02)
Document     01/13/17 08:02  SHA0063  (Rec: 01/13/17 08:02  SHA0063  BSU-C02)
Document     01/14/17 09:06  VIC0074  (Rec: 01/14/17 09:06  VIC0074  BSU-C02)
Document     01/14/17 20:00  AMA0048  (Rec: 01/14/17 22:26  AMA0048  BSU-M07)
Document     01/14/17 23:29  BRA0067  (Rec: 01/14/17 23:29  BRA0067  BSU-M07)
Document     01/15/17 08:00  VIC0074  (Rec: 01/15/17 08:07  VIC0074  BSU-C02)
Document     01/15/17 20:00  AMA0048  (Rec: 01/15/17 22:52  AMA0048  BSU-C02)
Document     01/15/17 23:58  BRA0067  (Rec: 01/15/17 23:58  BRA0067  BSU-C02)
Document     01/16/17 08:05  JON0059  (Rec: 01/16/17 08:05  JON0059  BSU-M07)
Document     01/17/17 08:14  JON0059  (Rec: 01/17/17 08:14  JON0059  BSU-M07)
Document     01/17/17 20:00  AMA0048  (Rec: 01/17/17 22:28  AMA0048  BSU-M07)
Document     01/18/17 08:06  JON0059  (Rec: 01/18/17 08:06  JON0059  BSU-M07)
Document     01/18/17 20:00  MEG0009  (Rec: 01/18/17 22:40  MEG0009  BSU-M09)
Document     01/19/17 08:54  SHA0063  (Rec: 01/19/17 08:54  SHA0063  CMC-RDC2)
Document     01/19/17 20:00  AMA0048  (Rec: 01/19/17 22:40  AMA0048  BSU-C02)
Document     01/20/17 08:00  VIC0074  (Rec: 01/20/17 08:58  VIC0074  BSU-M07)
Document     01/20/17 20:00  AMA0048  (Rec: 01/20/17 20:07  AMA0048  BSU-C02)
Document     01/21/17 09:07  JON0059  (Rec: 01/21/17 09:08  JON0059  BSU-C02)
Document     01/21/17 20:10  ROB0100  (Rec: 01/21/17 20:11  ROB0100  CMC-RDC2)
Document     01/22/17 08:12  JON0059  (Rec: 01/22/17 08:12  JON0059  BSU-C02)
Document     01/23/17 08:47  SHA0063  (Rec: 01/23/17 08:47  SHA0063  BSU-M10)
Document     01/24/17 08:00  VIC0074  (Rec: 01/24/17 08:06  VIC0074  BSU-M07)
Document     01/25/17 08:23  JON0059  (Rec: 01/25/17 08:23  JON0059  BSU-C12)
Document     01/26/17 08:00  VIC0074  (Rec: 01/26/17 08:15  VIC0074  CMC-RDC2)
Document     01/26/17 17:25  ROB0100  (Rec: 01/26/17 17:25  ROB0100  BSU-M10)
Document     01/27/17 08:18  SHA0063  (Rec: 01/27/17 08:18  SHA0063  BSU-C12)
Document     01/27/17 23:54  BRA0067  (Rec: 01/27/17 23:54  BRA0067  BSU-C03)
Document     01/28/17 08:00  VIC0074  (Rec: 01/28/17 08:44  VIC0074  BSU-M07)
Document     01/28/17 20:00  KRI0114  (Rec: 01/28/17 23:15  KRI0114  BSU-M07)
Document     01/29/17 09:00  SHA0063  (Rec: 01/29/17 09:00  SHA0063  CMC-RDC2)
Document     01/29/17 20:00  STE0107  (Rec: 01/29/17 22:33  STE0107  CMC-RDC2)
Document     01/30/17 02:12  BRA0067  (Rec: 01/30/17 02:12  BRA0067  BSU-C02)
Document     01/30/17 11:00  SHA0063  (Rec: 01/30/17 11:00  SHA0063  CMC-RDC2)
Document     01/30/17 18:44  SHA0157  (Rec: 01/30/17 18:44  SHA0157  BSU-M10)
Document     01/30/17 19:31  ROB0100  (Rec: 01/30/17 19:32  ROB0100  CMC-RDC2)
Document     01/30/17 19:32  ROB0100  (Rec: 01/30/17 19:32  ROB0100  CMC-RDC2)
Document     01/31/17 02:40  BRA0067  (Rec: 01/31/17 02:40  BRA0067  BSU-C02)
Document     01/31/17 09:33  JON0059  (Rec: 01/31/17 09:33  JON0059  BSU-C03)
Document     01/31/17 20:00  STE0107  (Rec: 01/31/17 21:41  STE0107  CMC-RDC2)
Document     02/01/17 08:00  VIC0074  (Rec: 02/01/17 09:05  VIC0074  BSU-M10)
Document     02/01/17 18:58  SHA0157  (Rec: 02/01/17 18:58  SHA0157  BSU-M07)
Document     02/02/17 08:00  VIC0074  (Rec: 02/02/17 08:02  VIC0074  BSU-M10)
Document     02/02/17 20:00  MEG0009  (Rec: 02/02/17 21:23  MEG0009  BSU-M06)
Document     02/03/17 08:00  VIC0074  (Rec: 02/03/17 08:18  VIC0074  BSU-C02)
Document     02/03/17 14:32  SHA0157  (Rec: 02/03/17 14:32  SHA0157  BSU-L02)
Document     02/04/17 08:00  VIC0074  (Rec: 02/04/17 08:06  VIC0074  BSU-C02)
Document     02/04/17 15:26  SHA0157  (Rec: 02/04/17 15:26  SHA0157  BSU-M07)
Document     02/05/17 09:13  JON0059  (Rec: 02/05/17 09:13  JON0059  BSU-C03)
Document     02/06/17 00:43  BRA0067  (Rec: 02/06/17 00:43  BRA0067  BSU-C03)
Document     02/06/17 08:34  SHA0063  (Rec: 02/06/17 08:34  SHA0063  BSU-M07)
Document     02/06/17 20:00  AMA0048  (Rec: 02/06/17 20:52  AMA0048  BSU-C02)
Document     02/07/17 04:41  BRA0067  (Rec: 02/07/17 04:41  BRA0067  BSU-M10)
```

Continued on Page 308

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
Document     02/07/17 08:03  JON0059  (Rec: 02/07/17 08:03  JON0059  BSU-M06)
Document     02/07/17 20:00  AMA0048  (Rec: 02/07/17 21:52  AMA0048  BSU-C02)
Document     02/08/17 08:00  VIC0074  (Rec: 02/08/17 08:10  VIC0074  BSU-M09)
Document     02/08/17 20:00  AMA0048  (Rec: 02/08/17 22:21  AMA0048  BSU-C02)
Document     02/09/17 08:24  SHA0063  (Rec: 02/09/17 08:24  SHA0063  CMC-RDC2)
Document     02/09/17 20:00  AMA0048  (Rec: 02/09/17 20:11  AMA0048  BSU-M09)
Document     02/10/17 08:16  SHA0063  (Rec: 02/10/17 08:16  SHA0063  BSU-M09)
```

```
Pain Assessment/Reassessment                                Start:  12/25/16 05:12
Freq:   QSHIFT                                              Status: Discharge
 Document     12/25/16 05:50  MIC0258  (Rec: 12/25/16 05:56  MIC0258  BSU-C03)
 Pain Assessment/Reassessment
     Pain Assessment
        Patient Currently Having Pain            No
        Pain Assessment Based Upon               Patient Report
     Interventions
      Please document those interventions you are currently providing.
        Follow Up Evaluation Needed              No
        Time Follow Up Due                       -
 Document     12/25/16 08:00  VIC0074  (Rec: 12/25/16 09:56  VIC0074  BSU-M03)
 Pain Assessment/Reassessment
     Pain Assessment
        Patient Currently Having Pain            No
        Pain Assessment Based Upon               Patient Report
     Interventions
      Please document those interventions you are currently providing.
        Follow Up Evaluation Needed              No
        Time Follow Up Due                       -
 Document     12/25/16 20:00  ROB0100  (Rec: 12/25/16 21:10  ROB0100  BSU-M03)
 Pain Assessment/Reassessment
     Pain Assessment
        Patient Currently Having Pain            No
        Pain Assessment Based Upon               Patient Report
     Interventions
      Please document those interventions you are currently providing.
        Follow Up Evaluation Needed              No
        Time Follow Up Due                       -
 Document     12/25/16 22:59  MIC0258  (Rec: 12/25/16 22:59  MIC0258  BSU-C02)
 Pain Assessment/Reassessment
     Pain Assessment
        Patient Currently Having Pain            No
        Pain Assessment Based Upon               Nursing Observation
                                                 Unable to Obtain-Appears to be
                                                 Sleeping
     Interventions
      Please document those interventions you are currently providing.
        Follow Up Evaluation Needed              No
        Time Follow Up Due                       -
 Document     12/26/16 08:00  VIC0074  (Rec: 12/26/16 08:40  VIC0074  BSU-M03)
 Pain Assessment/Reassessment
     Pain Assessment
        Patient Currently Having Pain            No
        Pain Assessment Based Upon               Patient Report
     Interventions
```

Continued on Page 309

Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/26/16 20:00 KRI0114 (Rec: 12/26/16 22:01 KRI0114 BSU-M09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/26/16 23:55 MIC0258 (Rec: 12/26/16 23:55 MIC0258 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/27/16 08:00 VIC0074 (Rec: 12/27/16 08:05 VIC0074 BSU-M09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 2
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Bilateral Foot
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain See Comment
Level None
Interventions Provided Comment pt declined
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/28/16 05:51 HAL0001 (Rec: 12/28/16 05:51 HAL0001 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be
Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/28/16 08:00 JOH0022 (Rec: 12/28/16 08:00 JOH0022 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment

Continued on Page 310

Assessments and Treatments - Continued

```
      Patient Currently Having Pain            No
      Pain Assessment Based Upon               Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     12/28/16 23:52  HAL0001  (Rec: 12/28/16 23:52  HAL0001  BSU-M09)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            Unable to Determine
      Pain Assessment Based Upon               Nursing Observation
                                               Unable to Obtain-Appears to be
                                               Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     12/29/16 08:00  JOH0022  (Rec: 12/29/16 09:01  JOH0022  BSU-C01)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            No
      Pain Assessment Based Upon               Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     12/29/16 20:00  AMA0048  (Rec: 12/29/16 20:03  AMA0048  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            No
      Pain Assessment Based Upon               Nursing Observation
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain  None
       Level
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     12/30/16 04:50  HAL0001  (Rec: 12/30/16 04:50  HAL0001  BSU-M03)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            Unable to Determine
      Pain Assessment Based Upon               Nursing Observation
                                               Unable to Obtain-Appears to be
                                               Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     12/30/16 08:24  JON0059  (Rec: 12/30/16 08:25  JON0059  BSU-M03)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            No
      Pain Assessment Based Upon               Patient Report
```

Continued on Page 311

Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/30/16 19:25 ROB0100 (Rec: 12/30/16 19:25 ROB0100 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/31/16 08:00 JOH0022 (Rec: 12/31/16 10:22 JOH0022 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 12/31/16 19:41 ROB0100 (Rec: 12/31/16 19:41 ROB0100 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/01/17 04:57 BRA0067 (Rec: 01/01/17 04:57 BRA0067 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/01/17 08:00 JOH0022 (Rec: 01/01/17 08:32 JOH0022 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/01/17 19:10 ROB0100 (Rec: 01/01/17 19:11 ROB0100 BSU-C01)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No

Continued on Page 312

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/01/17 23:49 SHA0009 (Rec: 01/01/17 23:50 SHA0009 BSU-C09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/02/17 08:03 JON0059 (Rec: 01/02/17 08:03 JON0059 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/02/17 20:00 AMA0048 (Rec: 01/02/17 20:13 AMA0048 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/02/17 23:08 MIC0258 (Rec: 01/02/17 23:08 MIC0258 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/03/17 08:00 JOH0022 (Rec: 01/03/17 08:38 JOH0022 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No

Continued on Page 313

Time Follow Up Due -
Document 01/03/17 20:27 ANN0115 (Rec: 01/03/17 20:27 ANN0115 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/04/17 00:51 BRA0067 (Rec: 01/04/17 00:51 BRA0067 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/04/17 08:00 BAR0006 (Rec: 01/04/17 09:11 BAR0006 BSU-M03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/05/17 01:28 HAL0001 (Rec: 01/05/17 01:28 HAL0001 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/05/17 08:00 BAR0006 (Rec: 01/05/17 08:11 BAR0006 BSU-M09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Pain Based Upon Comments pt refused all vitals including answering if she has pain
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None

Continued on Page 314

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Follow Up Evaluation Needed                 No
      Time Follow Up Due                          -
Document     01/05/17 22:34  ANN0115  (Rec: 01/05/17 22:34  ANN0115  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain               No
      Pain Assessment Based Upon                  Nursing Observation
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                 No
      Time Follow Up Due                          -
Document     01/06/17 00:20  HAL0001  (Rec: 01/06/17 00:20  HAL0001  BSU-M07)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain               No
      Pain Assessment Based Upon                  Nursing Observation
                                                  Unable to Obtain-Appears to be
                                                  Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                 No
      Time Follow Up Due                          -
Document     01/06/17 11:16  KER0050  (Rec: 01/06/17 11:16  KER0050  BSU-C12)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain               No
      Pain Assessment Based Upon                  Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                 No
      Time Follow Up Due                          -
Document     01/07/17 00:06  BRA0067  (Rec: 01/07/17 00:06  BRA0067  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain               No
      Pain Assessment Based Upon                  Nursing Observation
                                                  Unable to Obtain-Appears to be
                                                  Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                 No
      Time Follow Up Due                          -
Document     01/07/17 08:00  JOH0022  (Rec: 01/07/17 13:15  JOH0022  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain               No
      Pain Assessment Based Upon                  Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                 No
      Time Follow Up Due                          -
Document     01/07/17 20:00  ROB0100  (Rec: 01/07/17 20:49  ROB0100  CMC-RDC2)
Pain Assessment/Reassessment
```

Continued on Page 315

Assessments and Treatments - Continued

```
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/07/17 23:32  MIC0258  (Rec: 01/07/17 23:32  MIC0258  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Nursing Observation
                                                Unable to Obtain-Appears to be
                                                Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/08/17 08:00  JOH0022  (Rec: 01/08/17 08:21  JOH0022  BSU-C12)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/08/17 20:00  ROB0100  (Rec: 01/08/17 20:04  ROB0100  BSU-M07)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/08/17 22:44  MIC0258  (Rec: 01/08/17 22:44  MIC0258  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Nursing Observation
                                                Unable to Obtain-Appears to be
                                                Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/09/17 08:00  VIC0074  (Rec: 01/09/17 09:18  VIC0074  BSU-M03)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Patient Report
    Interventions
```

Continued on Page 316

Please document those interventions you are currently providing.
Follow Up Evaluation Needed   No
Time Follow Up Due   -

Document 01/09/17 20:00 AMA0048 (Rec: 01/09/17 21:17 AMA0048 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level   None
Follow Up Evaluation Needed   No
Time Follow Up Due   -

Document 01/09/17 23:52 BRA0067 (Rec: 01/09/17 23:52 BRA0067 BSU-C09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed   No
Time Follow Up Due   -

Document 01/10/17 08:00 JOH0022 (Rec: 01/10/17 10:03 JOH0022 BSU-C01)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed   No
Time Follow Up Due   -

Document 01/10/17 20:00 AMA0048 (Rec: 01/10/17 21:02 AMA0048 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   Unable to Determine
Pain Assessment Based Upon   Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level   None
Follow Up Evaluation Needed   No
Time Follow Up Due   -

Document 01/11/17 00:30 BRA0067 (Rec: 01/11/17 00:30 BRA0067 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Nursing Observation
Unable to Obtain-Appears to be Sleeping

Continued on Page 317

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     01/11/17 08:00  BAR0006  (Rec: 01/11/17 09:32  BAR0006  BSU-M09)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Nursing Observation
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain    None
       Level
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     01/12/17 04:06  HAL0001  (Rec: 01/12/17 04:06  HAL0001  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     01/12/17 08:00  JOH0022  (Rec: 01/12/17 10:40  JOH0022  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     01/12/17 20:00  AMA0048  (Rec: 01/12/17 22:11  AMA0048  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Nursing Observation
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain    None
       Level
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     01/13/17 02:53  HAL0001  (Rec: 01/13/17 02:53  HAL0001  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Nursing Observation
                                                 Unable to Obtain-Appears to be
                                                 Sleeping
    Interventions
     Please document those interventions you are currently providing.
```

Continued on Page 318

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/13/17 08:02 SHA0063 (Rec: 01/13/17 08:03 SHA0063 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Pain Based Upon Comments patient is eating breakfast at this time
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/13/17 23:32 HAL0001 (Rec: 01/13/17 23:32 HAL0001 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/14/17 08:00 KEL0078 (Rec: 01/14/17 10:48 KEL0078 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Scale Used 0-10 Numeric
Stated Pain Consistent with Observed Level of Pain N/A
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/14/17 20:00 AMA0048 (Rec: 01/14/17 22:26 AMA0048 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/14/17 23:29 BRA0067 (Rec: 01/14/17 23:29 BRA0067 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions

Continued on Page 319

Please document those interventions you are currently providing.
Follow Up Evaluation Needed   No
Time Follow Up Due   -
Edit Result 01/14/17 23:29 BRA0067 (Rec: 01/15/17 01:35 BRA0067 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Pain Assessment Based Upon   Patient Report
Document 01/15/17 08:00 JUL0094 (Rec: 01/15/17 13:05 JUL0094 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Patient Report
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level   None
Follow Up Evaluation Needed   No
Time Follow Up Due   -
Document 01/15/17 20:00 AMA0048 (Rec: 01/15/17 22:52 AMA0048 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level   None
Follow Up Evaluation Needed   No
Time Follow Up Due   -
Document 01/15/17 23:58 BRA0067 (Rec: 01/15/17 23:58 BRA0067 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed   No
Time Follow Up Due   -
Document 01/16/17 10:37 COU0002 (Rec: 01/16/17 10:37 COU0002 BSU-M03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No
Pain Assessment Based Upon   Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed   No
Time Follow Up Due   -
Document 01/16/17 23:51 MIC0258 (Rec: 01/16/17 23:52 MIC0258 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain   No

Continued on Page 320

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/17/17 10:32 COU0002 (Rec: 01/17/17 10:32 COU0002 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/17/17 22:05 MIC0258 (Rec: 01/17/17 22:05 MIC0258 BSU-M09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/17/17 22:58 MIC0258 (Rec: 01/17/17 22:58 MIC0258 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/18/17 08:00 RAC0066 (Rec: 01/18/17 11:18 RAC0066 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Unable to Determine
Pain Assessment Based Upon Nursing Observation
Pain Based Upon Comments visting calmly with other patients with relaxed facial features
Reassessment of Respiratory Rate
Reassessment of respiratory rate is required for the following:
Dilaudid
Fentanyl
Morphine
Respiratory Rate 16
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None
Follow Up Evaluation Needed No
Time Follow Up Due -
Document 01/18/17 11:16 RAC0066 (Rec: 01/18/17 11:18 RAC0066 CMC-RDC2)

Continued on Page 321

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain — Unable to Determine
      Pain Assessment Based Upon — Nursing Observation
      Pain Based Upon Comments — visting calmly with other patients with relaxed facial features
    Reassessment of Respiratory Rate
     Reassessment of respiratory rate is required for the following:
     Dilaudid
     Fentanyl
     Morphine
      Respiratory Rate — 16
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain Level — None
      Follow Up Evaluation Needed — No
      Time Follow Up Due — -

Document 01/18/17 11:45 RAC0066 (Rec: 01/18/17 11:46 RAC0066 BSU-M09)

Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain — No
      Pain Assessment Based Upon — Patient Report
      Pain Based Upon Comments — 2
      Pain Scale Used — 0-10 Numeric
    Reassessment of Respiratory Rate
     Reassessment of respiratory rate is required for the following:
     Dilaudid
     Fentanyl
     Morphine
      Respiratory Rate — 16
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed — Documentation Associated to Med on eMAR
      Time Follow Up Due — -

Document 01/18/17 20:00 MEG0009 (Rec: 01/18/17 22:40 MEG0009 BSU-M09)

Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain — No
      Pain Assessment Based Upon — Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed — No
      Time Follow Up Due — -

Document 01/18/17 23:57 HAL0001 (Rec: 01/18/17 23:57 HAL0001 BSU-C02)

Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain — No
      Pain Assessment Based Upon — Nursing Observation
      Unable to Obtain-Appears to be Sleeping

Continued on Page 322

Assessments and Treatments - Continued

Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/19/17 08:54 SHA0063 (Rec: 01/19/17 08:55 SHA0063 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/19/17 20:00 AMA0048 (Rec: 01/19/17 22:40 AMA0048 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/20/17 02:40 HAL0001 (Rec: 01/20/17 02:41 HAL0001 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/20/17 12:20 COU0002 (Rec: 01/20/17 12:20 COU0002 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Unable to Determine
Pain Assessment Based Upon Patient Report
Pain Based Upon Comments pt refused vital signs
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/20/17 20:00 AMA0048 (Rec: 01/20/17 20:07 AMA0048 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain None

Continued on Page 323

Level
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/21/17 01:10 HAL0001 (Rec: 01/21/17 01:10 HAL0001 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/21/17 08:00 JOH0022 (Rec: 01/21/17 08:13 JOH0022 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Unable to Determine
Pain Assessment Based Upon See Comment
Pain Based Upon Comments refuses to discuss
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/21/17 20:10 ROB0100 (Rec: 01/21/17 20:11 ROB0100 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Scale Used 0-10 Numeric
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/22/17 03:58 CHR0142 (Rec: 01/22/17 03:58 CHR0142 BSU-C03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/22/17 07:39 JOH0022 (Rec: 01/22/17 07:39 JOH0022 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No

Continued on Page 324

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Time Follow Up Due -

Document 01/23/17 08:53 BAR0006 (Rec: 01/23/17 08:58 BAR0006 BSU-M03)

Pain Assessment/Reassessment

Pain Assessment

Patient Currently Having Pain No

Pain Assessment Based Upon Nursing Observation

Interventions

Please document those interventions you are currently providing.

Interventions Provided for Current Pain Level None

Follow Up Evaluation Needed No

Time Follow Up Due -

Document 01/23/17 23:33 MIC0258 (Rec: 01/23/17 23:33 MIC0258 BSU-C02)

Pain Assessment/Reassessment

Pain Assessment

Patient Currently Having Pain No

Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping

Interventions

Please document those interventions you are currently providing.

Follow Up Evaluation Needed No

Time Follow Up Due -

Document 01/24/17 08:00 JOH0022 (Rec: 01/24/17 10:09 JOH0022 CMC-RDC2)

Pain Assessment/Reassessment

Pain Assessment

Patient Currently Having Pain Yes

Pain Assessment Based Upon Patient Report

Pain Intensity 3

Query Text:0-10

Pain Scale Used 0-10 Numeric

Interventions

Please document those interventions you are currently providing.

Follow Up Evaluation Needed No

Time Follow Up Due -

Document 01/24/17 23:05 MIC0258 (Rec: 01/24/17 23:05 MIC0258 BSU-M07)

Pain Assessment/Reassessment

Pain Assessment

Patient Currently Having Pain No

Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping

Interventions

Please document those interventions you are currently providing.

Follow Up Evaluation Needed No

Time Follow Up Due -

Document 01/26/17 00:08 CHR0142 (Rec: 01/26/17 00:08 CHR0142 BSU-C02)

Pain Assessment/Reassessment

Pain Assessment

Patient Currently Having Pain No

Pain Assessment Based Upon Patient Report

Interventions

Please document those interventions you are currently providing.

Continued on Page 325

Assessments and Treatments - Continued

Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/26/17 08:00 JOH0022 (Rec: 01/26/17 11:20 JOH0022 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/26/17 19:09 ROB0100 (Rec: 01/26/17 19:09 ROB0100 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 2
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
head
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Medication
Follow Up Evaluation Needed Documentation Associated to Med on eMAR
Time Follow Up Due -

Document 01/26/17 20:00 MEG0009 (Rec: 01/26/17 22:06 MEG0009 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/27/17 01:54 SHA0009 (Rec: 01/27/17 01:54 SHA0009 BSU-C09)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/27/17 08:00 JOH0022 (Rec: 01/27/17 11:43 JOH0022 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No

Continued on Page 326

Assessments and Treatments - Continued

Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/27/17 08:00 KER0050 (Rec: 01/27/17 11:47 KER0050 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Intensity 0
Query Text:0-10
Pain Scale Used 0-10 Numeric
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/27/17 11:46 KER0050 (Rec: 01/27/17 11:47 KER0050 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Intensity 0
Query Text:0-10
Pain Scale Used 0-10 Numeric
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/27/17 23:54 BRA0067 (Rec: 01/27/17 23:54 BRA0067 BSU-C03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/28/17 08:00 KEL0078 (Rec: 01/28/17 10:02 KEL0078 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Scale Used 0-10 Numeric
Stated Pain Consistent with Observed N/A
Level of Pain
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/28/17 20:00 KRI0114 (Rec: 01/28/17 23:15 KRI0114 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment

Continued on Page 327

Assessments and Treatments - Continued

Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/29/17 11:25 KAT0203 (Rec: 01/29/17 11:25 KAT0203 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 3
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Right Leg
Pain Description Constant
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Medication
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/29/17 20:00 STE0107 (Rec: 01/29/17 22:33 STE0107 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/30/17 02:12 BRA0067 (Rec: 01/30/17 02:12 BRA0067 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/30/17 08:00 JOH0022 (Rec: 01/30/17 10:44 JOH0022 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/30/17 16:33 SHA0157 (Rec: 01/30/17 16:33 SHA0157 BSU-M10)

Continued on Page 328

```
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            Yes
      Pain Assessment Based Upon               Patient Report
      Pain Intensity                           1
       Query Text:0-10
      Pain Scale Used                          0-10 Numeric
      Stated Pain Consistent with Observed     N/A
       Level of Pain
    Pain Location/Description
      Right Leg
       Pain Description                        Tightness
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain  Medication
       Level
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     01/30/17 18:44  SHA0157  (Rec: 01/30/17 18:44  SHA0157  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            No
      Pain Assessment Based Upon               Nursing Observation
      Stated Pain Consistent with Observed     N/A
       Level of Pain
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain  None
       Level
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     01/30/17 20:49  SHA0157  (Rec: 01/30/17 20:49  SHA0157  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            Yes
      Pain Assessment Based Upon               Patient Report
      Pain Intensity                           1
       Query Text:0-10
      Pain Scale Used                          0-10 Numeric
    Pain Location/Description
      Right Leg
       Pain Description                        Ache
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain  Medication
       Level
      Follow Up Evaluation Needed              No
      Time Follow Up Due                       -
Document     01/31/17 00:27  MEG0009  (Rec: 01/31/17 00:27  MEG0009  BSU-M03)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain            No
      Pain Assessment Based Upon               Nursing Observation
```

Continued on Page 329

Unable to Obtain-Appears to be Sleeping

Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/31/17 08:00 JOH0022 (Rec: 01/31/17 11:58 JOH0022 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/31/17 13:03 SHA0063 (Rec: 01/31/17 13:04 SHA0063 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Right Leg
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Medication
Follow Up Evaluation Needed Yes
Time Follow Up Due 1401

Document 01/31/17 13:47 SHA0063 (Rec: 01/31/17 13:48 SHA0063 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Pain Based Upon Comments re-assessment
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 01/31/17 18:49 SHA0157 (Rec: 01/31/17 18:49 SHA0157 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Right Leg
Pain Description Ache

Continued on Page 330

Assessments and Treatments - Continued

```
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Medication
       Level
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/31/17 20:00  STE0107  (Rec: 01/31/17 21:41  STE0107  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/31/17 23:36  KEV0009  (Rec: 01/31/17 23:36  KEV0009  BSU-C09)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Nursing Observation
                                                Unable to Obtain-Appears to be
                                                Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     01/31/17 23:48  HAL0001  (Rec: 01/31/17 23:48  HAL0001  BSU-C12)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Nursing Observation
                                                Unable to Obtain-Appears to be
                                                Sleeping
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     02/01/17 08:00  VIC0074  (Rec: 02/01/17 09:05  VIC0074  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             Yes
      Pain Assessment Based Upon                Patient Report
      Pain Intensity                            1
       Query Text:0-10
      Pain Scale Used                           0-10 Numeric
    Pain Location/Description
      Right Leg
       Pain Description                         Ache
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Medication
       Level
      Follow Up Evaluation Needed               Documentation Associated to
```

Continued on Page 331

```
                                          Med on eMAR
      Time Follow Up Due                  -
Document     02/01/17 13:50  SHA0063  (Rec: 02/01/17 14:18  SHA0063  BSU-M07)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain       Yes
      Pain Assessment Based Upon          Patient Report
      Pain Intensity                      1
       Query Text:0-10
      Pain Scale Used                     0-10 Numeric
    Pain Location/Description
      Right Leg
       Pain Description                   Ache
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Medication
       Level
      Follow Up Evaluation Needed         Yes
      Time Follow Up Due                  1450
Document     02/01/17 14:24  SHA0063  (Rec: 02/01/17 14:24  SHA0063  BSU-M07)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain       No
      Pain Assessment Based Upon          Patient Report
      Pain Based Upon Comments            re-assessment
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed         No
      Time Follow Up Due                  -
Document     02/01/17 21:12  SHA0157  (Rec: 02/01/17 21:12  SHA0157  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain       Yes
      Pain Assessment Based Upon          Patient Report
      Pain Intensity                      1
       Query Text:0-10
      Pain Scale Used                     0-10 Numeric
    Pain Location/Description
      Right Leg
       Pain Description                   Ache
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   None
       Level
      Follow Up Evaluation Needed         No
      Time Follow Up Due                  -
Document     02/01/17 23:43  HAL0001  (Rec: 02/01/17 23:43  HAL0001  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain       No
      Pain Assessment Based Upon          Nursing Observation
                                          Unable to Obtain-Appears to be
                                          Sleeping
```

Continued on Page 332

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/02/17 08:00 VIC0074 (Rec: 02/02/17 08:02 VIC0074 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Right Leg
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Positioning
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/02/17 20:00 MEG0009 (Rec: 02/02/17 21:23 MEG0009 BSU-M06)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/02/17 23:42 KEV0009 (Rec: 02/02/17 23:43 KEV0009 BSU-M03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/03/17 08:00 JOH0022 (Rec: 02/03/17 10:17 JOH0022 CMC-RDC2)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 4
Query Text:0-10
Pain Scale Used 0-10 Numeric
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Continued on Page 333

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Document 02/03/17 17:42 SHA0157 (Rec: 02/03/17 17:42 SHA0157 BSU-M03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Right Leg
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Medication
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/03/17 20:00 ERI0040 (Rec: 02/03/17 20:40 ERI0040 BSU-M03)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/04/17 00:55 HAL0001 (Rec: 02/04/17 00:56 HAL0001 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/04/17 08:00 JOH0022 (Rec: 02/04/17 08:17 JOH0022 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 4
Query Text:0-10
Pain Scale Used 0-10 Numeric
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/04/17 17:45 SHA0157 (Rec: 02/04/17 17:46 SHA0157 BSU-M07)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1

Continued on Page 334

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
      Query Text:0-10
     Pain Scale Used                        0-10 Numeric
   Pain Location/Description
     Right Leg
      Pain Description                      Ache
   Interventions
    Please document those interventions you are currently providing.
     Interventions Provided for Current Pain   Medication
      Level
     Follow Up Evaluation Needed            Yes
     Time Follow Up Due                     1830
Document    02/04/17 18:30  SHA0157  (Rec: 02/04/17 18:56  SHA0157  BSU-M07)
Pain Assessment/Reassessment
   Pain Assessment
     Patient Currently Having Pain          No
     Pain Assessment Based Upon             Nursing Observation
   Interventions
    Please document those interventions you are currently providing.
     Interventions Provided for Current Pain   None
      Level
     Follow Up Evaluation Needed            No
     Time Follow Up Due                     -
Document    02/04/17 20:00  ERI0040  (Rec: 02/04/17 21:37  ERI0040  BSU-M10)
Pain Assessment/Reassessment
   Pain Assessment
     Patient Currently Having Pain          No
     Pain Assessment Based Upon             Patient Report
   Interventions
    Please document those interventions you are currently providing.
     Follow Up Evaluation Needed            No
     Time Follow Up Due                     -
Document    02/05/17 02:08  CHR0142  (Rec: 02/05/17 02:08  CHR0142  BSU-C03)
Pain Assessment/Reassessment
   Pain Assessment
     Patient Currently Having Pain          No
     Pain Assessment Based Upon             Nursing Observation
                                            Unable to Obtain-Appears to be
                                            Sleeping
   Interventions
    Please document those interventions you are currently providing.
     Follow Up Evaluation Needed            No
     Time Follow Up Due                     -
Document    02/05/17 06:30  CHR0142  (Rec: 02/05/17 06:33  CHR0142  BSU-C03)
Pain Assessment/Reassessment
   Pain Assessment
     Patient Currently Having Pain          Yes
     Pain Assessment Based Upon             Patient Report
     Pain Intensity                         1
      Query Text:0-10
     Pain Scale Used                        0-10 Numeric
   Pain Location/Description
     Right Leg
      Pain Description                      Ache
```

Continued on Page 335

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
                                                    Frequent
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Distraction
       Level                                    Environmental Control
                                                Medication
      Follow Up Evaluation Needed               Yes
      Time Follow Up Due                        0730
Document     02/05/17 08:00  JOH0022  (Rec: 02/05/17 10:36  JOH0022  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             Yes
      Pain Assessment Based Upon                Patient Report
      Pain Intensity                            4
       Query Text:0-10
      Pain Scale Used                           0-10 Numeric
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     02/05/17 18:00  SHA0157  (Rec: 02/05/17 18:37  SHA0157  CMC-RDC2)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             Yes
      Pain Assessment Based Upon                Patient Report
      Pain Intensity                            1
       Query Text:0-10
      Pain Scale Used                           0-10 Numeric
    Pain Location/Description
      Right Leg
       Pain Description                         Ache
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain   Medication
       Level
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     02/05/17 20:00  ERI0040  (Rec: 02/05/17 21:48  ERI0040  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed               No
      Time Follow Up Due                        -
Document     02/05/17 23:58  MIC0258  (Rec: 02/05/17 23:58  MIC0258  BSU-M07)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain             No
      Pain Assessment Based Upon                Nursing Observation
                                                Unable to Obtain-Appears to be
                                                Sleeping
```

Continued on Page 336

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

```
    Interventions
     Please document those interventions you are currently providing.
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     02/06/17 08:00  BAR0006  (Rec: 02/06/17 08:30  BAR0006  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Nursing Observation
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain    None
       Level
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     02/06/17 08:39  BAR0006  (Rec: 02/06/17 08:39  BAR0006  BSU-M10)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              Yes
      Pain Assessment Based Upon                 Patient Report
      Pain Intensity                             1
       Query Text:0-10
      Pain Scale Used                            0-10 Numeric
    Pain Location/Description
      Right Leg
       Pain Description                          Ache
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain    Medication
       Level
      Follow Up Evaluation Needed                Documentation Associated to
                                                 Med on eMAR
      Time Follow Up Due                         -
Document     02/06/17 20:00  AMA0048  (Rec: 02/06/17 20:52  AMA0048  BSU-C02)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Patient Report
    Interventions
     Please document those interventions you are currently providing.
      Interventions Provided for Current Pain    None
       Level
      Follow Up Evaluation Needed                No
      Time Follow Up Due                         -
Document     02/06/17 23:48  KEV0009  (Rec: 02/06/17 23:48  KEV0009  BSU-C03)
Pain Assessment/Reassessment
    Pain Assessment
      Patient Currently Having Pain              No
      Pain Assessment Based Upon                 Nursing Observation
                                                 Unable to Obtain-Appears to be
                                                 Sleeping
    Interventions
     Please document those interventions you are currently providing.
```

Continued on Page 337

Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/07/17 04:41 BRA0067 (Rec: 02/07/17 04:41 BRA0067 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 5
Query Text:0-10
Pain Scale Used 0-10 Numeric
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed Documentation Associated to Med on eMAR
Time Follow Up Due -

Document 02/07/17 08:40 VIC0074 (Rec: 02/07/17 09:08 VIC0074 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Location/Description
Right Leg
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level Medication
Follow Up Evaluation Needed Documentation Associated to Med on eMAR
Time Follow Up Due -

Document 02/07/17 17:11 ERI0040 (Rec: 02/07/17 17:11 ERI0040 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain Yes
Pain Assessment Based Upon Patient Report
Pain Intensity 1
Query Text:0-10
Pain Scale Used 0-10 Numeric
Pain Intensity Goal 0
Query Text:0-10
Pain Location/Description
Right Leg
Pain Description Ache
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed Documentation Associated to Med on eMAR
Time Follow Up Due -

Document 02/07/17 20:00 AMA0048 (Rec: 02/07/17 21:52 AMA0048 BSU-C02)
Pain Assessment/Reassessment

Continued on Page 338

Assessments and Treatments - Continued

Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Interventions Provided for Current Pain Level None
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/07/17 23:42 KEV0009 (Rec: 02/07/17 23:42 KEV0009 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/08/17 08:50 JON0059 (Rec: 02/08/17 08:50 JON0059 BSU-C12)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Patient Report
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/08/17 20:00 ERI0040 (Rec: 02/08/17 20:05 ERI0040 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/09/17 01:39 HAL0001 (Rec: 02/09/17 01:39 HAL0001 BSU-C02)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No
Pain Assessment Based Upon Nursing Observation
Unable to Obtain-Appears to be Sleeping
Interventions
Please document those interventions you are currently providing.
Follow Up Evaluation Needed No
Time Follow Up Due -

Document 02/09/17 20:00 ERI0040 (Rec: 02/09/17 20:06 ERI0040 BSU-M10)
Pain Assessment/Reassessment
Pain Assessment
Patient Currently Having Pain No

Continued on Page 339

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01

60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Pain Assessment Based Upon — Nursing Observation

Interventions

Please document those interventions you are currently providing.

Follow Up Evaluation Needed — No

Time Follow Up Due — -

Document 02/10/17 00:39 SHA0009 (Rec: 02/10/17 00:39 SHA0009 BSU-M09)

Pain Assessment/Reassessment

Pain Assessment

Patient Currently Having Pain — No

Pain Assessment Based Upon — Nursing Observation
Unable to Obtain-Appears to be Sleeping

Interventions

Please document those interventions you are currently providing.

Follow Up Evaluation Needed — No

Time Follow Up Due — -

Patient Privileges — Start: 02/02/17 10:52

Freq: QSHIFT — Status: Discharge

Document 02/02/17 20:00 MEG0009 (Rec: 02/02/17 21:23 MEG0009 BSU-M06)
Document 02/03/17 08:00 VIC0074 (Rec: 02/03/17 08:18 VIC0074 BSU-C02)
Document 02/03/17 14:32 SHA0157 (Rec: 02/03/17 14:32 SHA0157 BSU-L02)
Document 02/04/17 08:00 VIC0074 (Rec: 02/04/17 08:06 VIC0074 BSU-C02)
Document 02/04/17 15:27 SHA0157 (Rec: 02/04/17 15:27 SHA0157 BSU-M07)
Document 02/05/17 09:13 JON0059 (Rec: 02/05/17 09:13 JON0059 BSU-C03)
Document 02/06/17 00:43 BRA0067 (Rec: 02/06/17 00:43 BRA0067 BSU-C03)
Document 02/06/17 08:34 SHA0063 (Rec: 02/06/17 08:34 SHA0063 BSU-M07)
Document 02/06/17 20:00 AMA0048 (Rec: 02/06/17 20:52 AMA0048 BSU-C02)
Document 02/07/17 04:41 BRA0067 (Rec: 02/07/17 04:41 BRA0067 BSU-M10)
Document 02/07/17 08:03 JON0059 (Rec: 02/07/17 08:03 JON0059 BSU-M06)
Document 02/07/17 20:00 AMA0048 (Rec: 02/07/17 21:52 AMA0048 BSU-C02)
Document 02/08/17 08:00 VIC0074 (Rec: 02/08/17 08:10 VIC0074 BSU-M09)
Document 02/08/17 20:00 AMA0048 (Rec: 02/08/17 22:21 AMA0048 BSU-C02)
Document 02/09/17 08:24 SHA0063 (Rec: 02/09/17 08:24 SHA0063 CMC-RDC2)
Document 02/09/17 20:00 AMA0048 (Rec: 02/09/17 20:11 AMA0048 BSU-M09)

Resp Therapy: Tobacco Cessation — Start: 01/04/17 16:52

Freq: .ONCE — Status: Complete

Document 01/04/17 16:52 MIC0246 (Rec: 01/04/17 16:55 MIC0246 RESP-M04)

Tobacco Use

Tobacco Cessation Assessment

Smoking Status (MU) — Current Every Day Smoker

Query Text:**Smoker Definition (current or former): has smoked at least 100 cigarettes (5 packs) or cigar or pipe smoke equivalent during his/her lifetime .**

Amount Used/How Often — 2ppd

Household Exposure Type — Cigarettes

Tobacco Cessation Information Provided — Patient Declined

Resp Therapy: Tobacco Cessation Education

Status

Patient Declined Tobacco Cessation Education — Yes

Phase

Continued on Page 340

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Phase of Quitting Process — Quitting
Quitting Process Comment — pt is using nicotine patches.
Education *ADVISE*
Tobacco Cessation Interventions/ Suggested/Discussed — Patient Declined
Plan *ARRANGE*
Tobacco Cessation Plan — Declined Information
Time Spent
Time Spent on Smoking Cessation — 2

Spiritual Care: Assessment/Intervention Start: 12/25/16 05:12
Freq: Status: Discharge
Document 01/26/17 12:16 TZI0001 (Rec: 01/26/17 12:20 TZI0001 SPIR-C01)
Spiritual Care: Assessment/Intervention Form
Assessment/Intervention
Date of Most Recent Visit — 01/26/17
Length of Visit (in Minutes) — 30 Minutes
Is This a Palliative Patient — No
Visit Location — MHU
Follow-Up Plan — Revisit on Request

01/26/17 12:16 Spiritual Care Note by Szajman,Tziona E

Received request from Anne to see Rev Tim Dean. Visited with Anne today and explained Rev Dean was away fro the next week. Anne said she needed specific information on weddings that only Rev Dean could provide. I said I would leave Rev Dean a note he would receive upon his return and that if Anne left the hospital before they could meet, Anne was welcome to call the Spiritual Care office late next week. Anne continued talking for another 10-15 minutes. Will revisit upon request.

Initialized on 01/26/17 12:16 - END OF NOTE

Vital Signs-Auto Capture Start: 12/25/16 05:12
Text: Status: Discharge
Freq: DAILY@0600
Document 12/26/16 10:39 JON0059 (Rec: 12/26/16 10:48 JON0059 BSU-C12)
Vital Signs-Automatic Capture
Respirations
Respiratory Rate — 16
Document 12/30/16 08:30 JON0059 (Rec: 12/30/16 08:37 JON0059 BSU-M04)
Vital Signs-Automatic Capture
Respirations
Respiratory Rate — 17
Document 01/06/17 08:09 JON0059 (Rec: 01/06/17 08:11 JON0059 BSU-M07)
Vital Signs-Automatic Capture
Respirations
Respiratory Rate — 16
Document 01/10/17 07:51 JON0059 (Rec: 01/10/17 08:30 JON0059 BSU-C12)
Vital Signs-Automatic Capture
Respirations
Respiratory Rate — 18
Document 01/13/17 08:00 JON0059 (Rec: 01/13/17 08:51 JON0059 BSU-M07)
Vital Signs-Automatic Capture
Respirations

Continued on Page 341

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

```
      Respiratory Rate                          16
Document    01/22/17 09:35  JON0059  (Rec: 01/22/17 09:44  JON0059  BSU-C02)
Vital Signs-Automatic Capture
    Respirations
      Respiratory Rate                          16
Document    01/24/17 07:49  VIC0074  (Rec: 01/24/17 08:07  VIC0074  BSU-M07)
Vital Signs-Automatic Capture
    Monitor Operator
      Monitor Operator                          Zlanweah Morlu
    Temperature
      Temperature                               99.0 F
      Temperature Source                        Temporal Artery Scan
    Pulse Rate
      Pulse Rate                                87
    Respirations
      Respiratory Rate                          16
    Blood Pressure
      Blood Pressure (mmHg)                     159/97
      Blood Pressure Mean (mmHg)                111
    Oxygen Saturation
      O2 Sat by Pulse Oximetry                  97
Document    01/25/17 09:37  JON0059  (Rec: 01/25/17 09:38  JON0059  BSU-C12)
Vital Signs-Automatic Capture
    Respirations
      Respiratory Rate                          16
Document    02/07/17 09:06  JON0059  (Rec: 02/07/17 10:55  JON0059  BSU-M06)
Vital Signs-Automatic Capture
    Respirations
      Respiratory Rate                          18
Document    02/08/17 08:58  JON0059  (Rec: 02/08/17 10:22  JON0059  BSU-C12)
Vital Signs-Automatic Capture
    Respirations
      Respiratory Rate                          16
```

```
Weigh Patient                                           Start:  12/25/16 05:12
Freq:  We@0600                                          Status: Discharge
Document    12/28/16 08:39  ZLA0001  (Rec: 12/28/16 08:39  ZLA0001  BSU-M04)
Weigh Patient
    Weight
      Last Documented Weight                    150 lb
      Weight Comment                            Pt. refused.
Document    01/04/17 06:00  BAR0006  (Rec: 01/04/17 09:11  BAR0006  BSU-M03)
Weigh Patient
    Weight
      Weight                                    168 lb
      Last Documented Weight                    150 lb
      Weight Change                             18 lb
      Actual/Estimated Weight                   Actual
      Scale Used                                Standing Scale - Mechanical
       Query Text:To ensure accurate weights,
       be sure to always weigh your patient
       with the same scale.
Document    01/11/17 08:53  SHA0063  (Rec: 01/11/17 08:53  SHA0063  CMC-RDC2)
Weigh Patient
```

Continued on Page 342

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Assessments and Treatments - Continued

Weight
- Weight: 171 lb
- Last Documented Weight: 168 lb
- Weight Change: 3 lb
- Actual/Estimated Weight: Actual
- Scale Used: Standing Scale - Mechanical
  Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.

Document 01/18/17 08:34 ZLA0001 (Rec: 01/18/17 08:34 ZLA0001 CMC-RDC2)
Weigh Patient
Weight
- Weight: 175 lb
- Last Documented Weight: 171 lb
- Weight Change: 4 lb
- Actual/Estimated Weight: Actual
- Scale Used: Standing Scale - Mechanical
  Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.

Document 01/25/17 09:13 ZLA0001 (Rec: 01/25/17 09:14 ZLA0001 BSU-C01)
Weigh Patient
Weight
- Weight: 173 lb
- Last Documented Weight: 175 lb
- Weight Change: -2 lb
- Actual/Estimated Weight: Actual
- Scale Used: Standing Scale - Mechanical
  Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.

Document 02/01/17 08:06 MAT0068 (Rec: 02/01/17 08:06 MAT0068 BSU-C12)
Weigh Patient
Weight
- Weight: 172 lb
- Last Documented Weight: 173 lb
- Weight Change: -1 lb
- Actual/Estimated Weight: Actual
- Scale Used: Standing Scale - Mechanical
  Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.

Document 02/08/17 10:22 JON0059 (Rec: 02/08/17 10:22 JON0059 BSU-C12)
Weigh Patient
Weight
- Last Documented Weight: 173 lb
- Weight Comment: refused

Edit Result 02/08/17 10:22 JON0059 (Rec: 02/08/17 10:24 JON0059 BSU-C12)
Weigh Patient
Weight
- Weight: 172 lb
- Last Documented Weight: 172 lb
- Weight Change: 0 lb

Continued on Page 343

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01
60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

Assessments and Treatments - Continued

Actual/Estimated Weight	Actual
Scale Used	Standing Scale - Mechanical
Query Text:To ensure accurate weights, be sure to always weigh your patient with the same scale.	
Weight Comment	

Clinical Data

PREFERRED LANGUAGE (MU) ENGLISH
Height 5 ft 7 in
Weight 172 lb
Code Status Full Code

Condition Improved
Visit Reason PSYCHOSIS NOS
Language ENGLISH

Diagnosis Code	Name
F31.9	BIPOLAR DISORDER, UNSPECIFIED
F25.9	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED
I10	ESSENTIAL (PRIMARY) HYPERTENSION
F12.90	CANNABIS USE, UNSPECIFIED, UNCOMPLICATED
F60.9	PERSONALITY DISORDER, UNSPECIFIED
Z59.9	PROBLEM RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES, UNSP
F17.210	NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED
F43.10	POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED
F64.0	TRANSSEXUALISM
Z82.49	FAMILY HX OF ISCHEM HEART DIS AND OTH DIS OF THE CIRC SYS
G47.00	INSOMNIA, UNSPECIFIED
Z56.0	UNEMPLOYMENT, UNSPECIFIED

Discharge Information

ED Provider: Shenker,David
Status: Rm Ready
Time Seen by Provider: 12/24/16 22:51
Condition: Improved
Triaged At: 12/24/16 22:50

Emergency Discharge Date/Time: 12/25/16 05:00
Emergency Discharge Disposition: ADMITTED TO CAYUGA MEDICAL
Clinical Impression Psychosis
Emergency Discharge Comment: STRETCHER TO ROOM

Admit Intervention Last Done
ED Discharge Assessment 12/25/16 05:00

Query	Result
Method to Door	Ambulated
Patient To	CMC Admit
Time Report Initiated	05:00
Time Report Given	05:00

Continued on Page 344

BLAYK,BONZE ANNE ROSE
Fac: Cayuga Medical Center **Loc:**BEHAVIORAL SERVICES UNIT **Bed:**202-01
60 F 05/01/1956 **Med Rec Num:**M000597460 **Visit:**A00082793308

Discharge Information - Continued

Report to	MHE
Provider Type	Registered Nurse
Name of Person Transporting Patient	RN,PACU
IV Discontinued	n/a

Inpatient Discharge Date/Time: 02/10/17 11:10
Inpatient Discharge Disposition: HOME
Inpatient Discharge Comment:

Instructions:
Stand-Alone Forms:
Prescriptions: Paliperidone SUSTENNA* [Invega Sustenna*]
Ehmke,Clifford

Visit Report
- Forms:
- Referrals: Cayuga Ctr For Healthy Living (Outside)
TOMPKINS CNTY MENTAL HLTH CTR (Outside)
- Additional text: In Case of Emergency…

Cayuga Medical Center Behavioral Services Unit ph: 607-274-4304
Suicide Prevention and Crisis Services ph: 607-272-1616
National Suicide Prevention Lifeline ph: 800-273-8255
Tompkins County Mental Health Clinic ph: 607-274-6200
Alcoholics Anonymous ph: 607-273-1541
Tompkins County Mental Health Association ph: 607-273-9250

Please go to the nearest emergency room or call 911 if safety concerns arise or your condition worsens

You have declined a referral to the New York State Smokers' Quitline at this time.

If you decide to access this free service in the future you can contact the Quitline toll-free at 866-697-8487. You can access their website at www.nysmokefree.com for more information.

Writer provided Pt. w/ a Personal Health Record. Explained its function, ease of use and encouraged Pt. to utilize this tool post d/c.

You are eligible for medicaid transportation services. To set up a Medicaid Taxi call 866-753-4543
You may also set up Medicaid Taxi services on the website: go to www.medanswering.com and select Secure User Login. You will need a user name and password to access the secure MAS portal.

User Key

Monogram	Mnemonic	Name	Credentials	Provider Type
	ALE0007	Powers,Alexander		Mental Health Technician
	ALE0011	Clinton,Alexandra M	RD	Registered Dietitian
	AMA0048	Fritsche,Amanda	RN	Registered Nurse

Continued on Page 345

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

User Key - Continued

	ANI0006	Kondrk,Anissa		Mental Health Technician
	ANN0115	Hewitt,Anne		Registered Nurse
	BAR0006	Lister,Barbara	RN	Registered Nurse
	BRA0067	Niver,Brandy L	RN	Registered Nurse
	CHR0142	Morse,Chris	RN	Registered Nurse
	COU0002	Wright,Courtney		Student Nurse
	CRI0054	Baker,Cristin S	RD	Registered Dietitian
	ELI0005	LaForest,Elizabeth	RN	Registered Nurse
	ERI0034	Sava,Erica		Mental Health Technician
	ERI0036	Myers,Erin		Mental Health Technician
	ERI0040	Slater,Erica	LPN	Licensed Practical Nurse
	GRE0068	Hardy,Gregg	RN	Registered Nurse
	HAL0001	Burns,Haley	RN	Registered Nurse
	JAC0076	Vanpetten,Jacqueline		Mental Health Technician
	JOH0022	Cottrell,John	RN	Registered Nurse
	JOH0023	Carlisle,John		Mental Health Technician
	JON0059	Powers,Joni Lynn	RN	Registered Nurse
	JUL0094	Dickens,Julie	RN	Registered Nurse
	KAT0036	Powers,Kate		Mental Health Technician
	KAT0203	Race,Katherine	RN	Registered Nurse
	KEL0010	Pudney,Kelsey		Mental Health Technician
	KEL0078	Cosgrove,Kelly Anne	RN	Registered Nurse
	KER0050	Purrier,Kerrie Anne	RN	Registered Nurse
	KEV0009	Gent,Kevin	RN	Registered Nurse
	KIM0012	Owen,Kimberley		Social Worker
	KRI0114	Baker,Kristin	RN	Registered Nurse
	KYL0051	Stevenson,Kylee K		Cert Ther Recreational Spec
	MAT0068	Youngs,Matthew R		Mental Health Technician
	MAU0059	Coats,Maureen		Cert Ther Recreational Spec
	MEG0009	Smith,Megan L	RN	Registered Nurse
	MIC0246	Huynh,Michelle	RT	Respiratory Therapist
	MIC0258	Brown,Michele	RN	Registered Nurse
	NAT0065	Barton,Nathaniel	RN	Registered Nurse
	PAT0027	Schaffhouser,Patricia		Mental Health Technician
	RAC0013	Miller,Rachel		Mental Health Technician
	RAC0066	Ayers,Rachel	RN	Registered Nurse
	REB0122	Cunningham,Rebecca	RN	Registered Nurse
	ROB0100	Parseghian,Roberta E	RN	Registered Nurse
	RYA0008	Campbell,Ryan		Mental Health Technician
	SAV0050	Chaffin,Savannah		Mental Health Technician
	SHA0009	Lewis,Shana	LPN	Licensed Practical Nurse
	SHA0040	Thomas,Shanise		Mental Health Technician
	SHA0063	Aether,Shannon Esme	RN	Registered Nurse
	SHA0157	Saddlemire,Shane	RN	Registered Nurse
	SHA0166	Washington,Shay		Mental Health Technician
	SOP0051	Soeung,Sophany	LPN	Registered Nurse
	STE0107	Taylor,Steven	RN	Registered Nurse
	TAH0001	Hanna-Martinez,Tahlia		Mental Health Technician
	TZI0001	Szajman,Tziona E		Chaplain
	VIC0074	Lanzara,Victoria	RN	Registered Nurse
	ZLA0001	Morlu,Zlanweah		Mental Health Technician

Continued on Page 346

BLAYK,BONZE ANNE ROSE

Fac: Cayuga Medical Center **Loc:** BEHAVIORAL SERVICES UNIT **Bed:** 202-01

60 F 05/01/1956 **Med Rec Num:** M000597460 **Visit:** A00082793308

User Key - Continued

HJP	HAN0052	Priestley,Hannah J		Social Worker